

Child Survival X

(FAO-0500-A-00-4038-00)

Uganda

Mid-Term Evaluation



Submitted to:

*United States Agency for International Development
Washington, D.C.*

By:

*Adventist Development and Relief Agency International
Silver Spring, MD*

October 1996

CHILD SURVIVAL X

(Project # FAO-0500-A-00-4038-00)

UGANDA

MID-TERM EVALUATION

MAY 17 -JUNE 7, 1996

EVALUATION TEAM:

Peter O. Mokaya MB, ChB., MPH - Independent Consultant

Annie E. N. Kaboggoza-Musoke - USAID

Betty A. McGraw, CPA - ADRA International

Doris Jorgensen - Director ADRA Uganda

Israel Musoke - Project Director

Ruth Acham - DMOH Representative (Observer)

TABLE OF CONTENTS

LIST OF ACRONYMS	ii
EXECUTIVE SUMMARY	III
I. INTRODUCTION AND BACKGROUND
A. Location Description
B. Justification for Intervention	1
C. The Purpose of Evaluation	1
D. Goals and objectives of the grant	1
E. Specific Project Goals and Objectives	2
F. Implementation Methods	4
G. Evaluation Methodology	4
II. ACCOMPLISHMENTS	6
III. PROJECT EFFECTIVENESS	8
IV. PROJECT RELEVANCE TO DEVELOPMENT	9
V. DESIGN AND IMPLEMENTATION	9
A. Design
B. Management and Use of Data	9
C. Community Education and Social Promotion	10
D. Human Resources for Child Survival	10
E. Supplies and Materials for Local Staff	14
F. Quality	14
G. Supervision and Monitoring	15
H. Regional and Headquarters Support	15
I. PVO's Use of Technical Staff	15
J. Assessment of Counterpart Relationships	16
K. Referral Relationships	17
L. PVO/NGO Networking	17
M. Budget Management	18
VI. SUSTAINABILITY ISSUES	18
VII. RECOMMENDATIONS	21
VIII. SUMMARY	25
APPENDICES	26

LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency
AIC	AIDS Information Center
AMREF	African Medical Research Foundation
CBDA	Community Based Distributing Agent
CBV	Community Based Vaccinators
CDD	Control of Diarrhoeal Diseases
CF	ContactFanner
CS	Child Survival
DIP	Detailed Implementation Plan
DISH	Delivery of Improved Services for Health
DMO	District Medical Office
DMOH	District Medical Officer of Health
HIS	Health Information System
IED	Information, Education and Communication
HP	HealthPromoter
RC	ResistanceCouncil
SCHMC	Sub-County Health Management Committee
SORMAC	Social Marketing of Change
STD	Sexually Transmitted Disease
ST1	Sexually Transmitted Infection
SYFA	Safeguard Youth Against AIDS
VHC	VillageHealthCommittee

EXECUTIVE SUMMARY

The project intervention area is in Luwero District of Uganda, covering the sub-counties of Kalagala and Zirowe of Bamunanika County. The majority of the population is involved in peasant **farming**, with a total population of approximately 55,000 beneficiaries.

The intention of this mid-term evaluation was to assist ADRA Uganda in the assessment of lessons learned and identification of new strategies to facilitate the ultimate success of Child Survival activities in a sustainable manner that incorporates the community (beneficiaries) and utilizes existing structures and systems.

The goal of ADRA Uganda's Child Survival project is to decrease morbidity and mortality and improve the quality of life for low income mothers and children in Kalagala and Zirowe sub-counties of Luwero District.

The evaluation team was composed of one independent consultant, one local USAID representative, one **ADRA/I** representative, the country director, project director and a representative from the **MOH/Uganda**, a total of six members. A total of 17 days were spent in the conduct of the evaluation with a total of 10 field visits (see Appendix/Itinerary), and at a total cost of **US\$7,836**.

The evaluation exercise employed both qualitative and quantitative methodologies which included observation checklists, in-depth interviews and focus group type discussions, together with gathering of information **from** existing reports and materials. No surveys were conducted.

The main project accomplishments were those related to the establishment of a fully functional programmatic and financial technical team, with an equally supportive voluntary team of community health workers, well versed in the key health messages of the project intervention objectives. It was not possible to quantify measurable outcomes without conducting a survey, however, qualitative information gathered indicates significant progress in the right direction. The project design exhibits high quality and applicability of Child Survival programming. Networking with other **PVOs/NGOs** has resulted in sharing of lessons learned **from** other Child Survival and community development programs.

The key recommendations from the mid-term evaluation include the following:

- ▶ a need to consider some form of income generation activities as an incentive to the community volunteers;
- ▶ need for project staff to conduct cluster surveys after 3 to 4 months from period of mid-term evaluation to quantify the exact extent (percentage of achievement) of the end of project objectives. Technical assistance may be sought to undertake this exercise;

- ↗ need to open a line of intensive communication coupled, with sharing of information and resources between ADRA and the counterparts within MOH at all levels;
- ↗ need for more sensitization and mobilization of the beneficiary communities in issues related to project management and sustainability;
- need for some minor modifications to the HIS forms with a view of making them more user friendly;
- ↗ need for ADRA to take a lead role, together with other USAID funded Child Survival projects, to hold a “Child Survival Summit” and share experiences and lessons learned;
- ↗ and finally need for USAID to consider a new paradigm which blends a bottom-up and top-down approach, with integration of existing structures and participation of beneficiary communities to enhance Child Survival in the context of overall sustainable development;

Actual feedback of the evaluation results included, feedback to the local USAID Child Survival Project Officer, the **ADRA/I** representative, the Regional Director (Vice President), the Country Director and **ADRA** Uganda Treasurer, the Project director and Project technical staff, two PVOs with Child Survival projects namely; AMREF and World Vision and the MOH representatives. Planned feedbacks include, feedback to volunteers and community beneficiaries and other collaborating and networking organizations, both locally and at the international level.

The authorship of this mid-term report is the combined effort of the Independent Consultant, the **ADRA/I** representative and the Senior Advisor for Evaluation, ADRA International.

I. INTRODUCTION AND BACKGROUND

A. Location Description

The project intervention area is in Kalagala and Ziobwe sub-counties, of Bamunanika County, in the District of Luwero, Uganda. The majority of the population is involved in peasant farming and totals about 55,0000 beneficiaries. The intervention area is located approximately 30km north of Kampala, the capital city of Uganda.

B. Justification for Intervention

Morbidity and mortality indices coupled with disadvantaged sociopolitical factors were prime considerations in choosing this area for intervention.

A 1992 baseline survey showed that only 55.4% of children 12-23 months of age were fully immunized (compared with a national average of 80% as stated in the proposal). Infant mortality was estimated to be **122/1000**. Although more recent surveys (1994) show some improvement, high drop out rates persist as a major problem (14.3% compared with 7.9% in 1992).

During the many years of civil strife and war in Uganda, this area was devastated socially and economically resulting in inestimable loss of life and destruction of all form of infrastructure including health services in&structure.

The above factors easily justify the wisdom and need for intervening in this area, commonly referred to as the “Luwero Triangle” and hence the award of the grant for CS X.

C. The Purpose of Evaluation

It is the intention of this mid-term evaluation to assist ADRA Uganda in the assessment of lessons learned and identification of new strategies to facilitate the ultimate success of Child Survival Activities in a sustainable manner that incorporates the community (beneficiaries) and utilizes existing structures and systems.

In a nutshell, this mid-term evaluation hopes to help adjust the direction, improve performance, help identify what is working well, suggest areas which need further attention and recommend means of improvement for the remaining life of the project.

D. Goals and Objectives of the Grant

The goal of Uganda’s Child Survival X Project in Kalagala and Ziobwe sub-counties in Luwero District is to improve the health status of women and children in the project target area.

E. Specific Project Goals and Objectives Include

Immunization

1. Children under two: to increase immunization coverage of children under two years from 67% to 80%
2. Women of child bearing age: To increase TT coverage of WCBA **from** 45% to 60%.
3. To increase sustainability of immunization activities (see table on sustainability objectives)

Diarrhea1 Disease Control

1. Reduce the percent of children under two years of age experiencing diarrhea in the past two weeks from 23.3% to 15%.
2. Increase the percent of mothers recognizing signs of dehydration and treating with ORT **from** 55.3% and 61.4% respectively to 70%.

Nutrition

1. Increase the practice of exclusive breastfeeding under four months to 80%.
2. Increase the percent of households having kitchen gardens from 71.7% to 80%.
3. Increase the homes with food availability throughout the year by use of storage facilities from 18.7% to 35%.
4. Increase the percent of mothers who report eating more than usual during pregnancy from 17% to 50%.

Sustainability

1. 32 contact farmers (growing vegetable gardens) will be accessing agricultural extension support for advice.
2. Two seed cooperatives will be operating on a self-sustaining basis.

Growth Monitoring

1. Increase the number of children under two years of age that will have been weighed in the last three months from 67.5% to 75%.

Maternal Care and Family Planning

1. Increase the percentage of mothers who at delivery are assisted by trained health professionals from 78.3% to 85%.
2. Increase the percentage of eligible couples using modern contraceptive methods from 12% to 25%.

Malarial Control

1. Increase the percent of pregnant mothers receiving chemical prophylaxis from 41.7% to 60%.

HIV/AIDS

Decrease the transmission of HIV/AIDS in the present population by targeting 5-15 years old and parents.

1. By the end of the project, the percentage of 10-15 year old youth who know about the modes of HIV transmission will increase as follows:
 - dirty needles/instruments 26.7% to 60%
 - unprotected sex with infected person 39.1% to 75%
 - blood transfusion 14.3% to 50%
 - mothers to children 1.9% to 35%
2. By the end of the project, the percentage of 10 to 15 year old youth who know how to prevent HIV/AIDS through the following means will increase:
 - abstinence 53.9% to 80%
 - having only one partner 24.8% to 65%
 - using condoms 11.5 to 60%
 - avoid dirty needles/razors 9.3% to 55%
3. Increase from 86.1% to **95%**, those who say they have changed their sexual behavior due to fear of acquiring AIDS.
4. Reduce the percentage of 10-15 year old youth who have ever had sex **from** 8.6% to 5.0%.
5. Increase percent of pregnant women being screened and treated for STDs from 48% and 53% to 70 and 75% respectively.

F. Implementation Methods

The project is an extension of CS VII and is intended to continue the interventions of CS VII which include growth monitoring and nutrition, immunization and diarrheal control; increased emphasis is however placed on maternal care and family planning and HIV/AIDS. Malarial chemoprophylaxis and deworming activities were part of the planned initiatives (see Appendix N).

The primary method of impacting families is through approximately 700 health promoters (**CHWs**), about 32 **CBVs**, 64 **CBDAs** and several **TBA**s. All community members will be targeted by the different interventions.

A major strategy for sustainability is the institutionalizing of support systems for all cadres of community workers through the establishment of a Village Health Committee (VHC). The VHCs together with the already existing Sub-county Health Management Committees (SCHMC) are being mobilized and trained to provide a support system in the following key areas of management;

- supervision
- review of reports
- status and recognition of volunteers in community
- provision of **refresher** training
- replacement of dropouts

In addition to the above, the Health Center staff under the leadership of the Medical Assistant should provide overall management of the cold chain and vaccine supply, in addition to providing other MCH and curative services.

Service delivery strengthening is expected to be accomplished in the area of **MCH/FP** by training appropriate staff (midwives) and provision of a wide choice of contraceptives, including surgical methods like tubal ligation and vasectomy. STD screening and syn-dromic treatment for referred cases is part of the overall reproductive health strategy of integrated service provision.

Formative research, is part of the implementation strategy, particularly in the area of HIV/AIDS using both qualitative and quantitative methodologies.

G. Evaluation Methodology

The evaluation methodology was determined such that it was able to elicit programmatic and financial achievements and their consistency with set goals and objectives. The evaluation

activities focused on the guidelines designed by **USAID** for the Mid-Term Evaluations of all USAID funded Child Survival projects and the supplementary questions. The evaluation team dedicated a significant amount of time on issues related to sustainability. This is in line with USAID policy of encouraging program sustainability of all their projects, especially Child Survival projects.

The evaluation data collection methods included the following:

- general observation (with use of an observation checklist where appropriate)
- interviews (including in-depth interviews and focus group discussion type sessions where appropriate)
- secondary data (including gathering information **from** written material, i.e., reports, HIS forms and literature from collaborating agencies).

Survey methodologies were not employed in this evaluation as they were not deemed appropriate: This was in view of resource constraints, including the time **frame** within which the evaluation was conducted. It is, however, noted that the project has competent staff on the ground, with the requisite technical know-how to conduct surveys including cluster surveys. The evaluation team, therefore, recommended that this exercise be conducted at a later date when time and necessary logistics can be coordinated.

Needless to say, the mid-term evaluation was a “process” evaluation as opposed to a “summative” evaluation, and therefore examined the design and functionality of the project “system” and its’ appropriateness in achieving set goals and objectives.

The evaluation team endeavored to provide the project **staff** with an “external” perspective on the progress and potential for reaching stated objectives on the project by reviewing project outputs and changes in health knowledge and behavior.

Observations and interviews conducted included the following:

- ▶ interviewing recipients/beneficiaries (i.e., RCI - RC3, SCHMC, VHC, **CBV/CBDA** (Trainers of HP), CHW (HP), TBA, CF) (see Appendix/Itinerary for details)
- ▶ interviewing project staff (ADRA staff, **ADRA/I** Representatives, Country Director, Project Director, Technical Advisors (6) and supervisors (2) for each sub-county (see Appendix C on Itinerary for details).

- ▶ interviewing MOH counterpart staff, i.e., District Medical Officer, District Health Visitor, Health Center in charge (MA), **Mid-Wife/CBV**. (see Appendix C on Itinerary for details)
- ▶ interviewing key personnel in other **PVO/NGOs** to establish evidence of effective networking in health and Child Survival or any positive/negative effect on project efficiency and sustainability (see Appendix/Itinerary for details)
- ▶ gathering information from written material. This included the DIP, quarterly reports, annual report, HIS report forms and other relevant literature including financial data.

The evaluation selection process of respondents (we used purposive samples of key respondents in the selection of respondents representative of beneficiary perspectives, staff perspectives, MOH perspectives and collaborating **PVO/NGO** input and perspectives).

II. ACCOMPLISHMENTS

According to the DIP, the project planned to start by October 1, 1994, however, due to unforeseen reasons the project activities did not start until the end of January 1995. Therefore, the project has been operating for sixteen months as of the end of April 1996. This constitutes approximately 40% of the project duration. The project objectives are restated earlier in the introduction of this report while the outputs and planned inputs are outlined below.

The measurable inputs to date include; training sessions held, and supplies provided, while the outputs include persons trained and services provided to the beneficiary communities along the five major interventions of the project namely:

Immunization: All 32 village health committees have been formed and initial mobilization and sensitization to assist CBV and health promoters in immunization activities have been conducted. The 700 health promoters have been selected and inducted in their role as change agents in their respective communities. It is, however, important to note that about 50% of these health promoters are not active.’ 32 CBVs have been identified and given immunization training, however, only about 50% are said to be actively involved in carrying out immunization activities. It was difficult to ascertain the percentage of immunization coverage to date due to inadequate HIS information gathered to date. A cluster survey is recommended three to four months following this mid-term evaluation to determine how close the project is to the 80% immunization coverage target for children under two years and 60% TT coverage for women of child bearing age. Linkages with MOH facilities have been established with the four health facilities in Kalagala and Zirowe and the MOHs office in Luwero through the district health

‘Reasons for this are discussed elsewhere.

visitor. There is evidence that the cold chain is operational, despite concerns about the inadequacy of vaccine carriers for outreach health posts for the **CBVs**.

Diarrhea1 Disease Control: Measurable inputs related to this objective include the 700 squat slabs for toilets provided to the communities at subsidized costs and 4 bore-holes drilled for clean portable water.

Training has been provided by the trainers to health promoters on the relationship between clean water and the control of diarrheal diseases. It was not possible to ascertain how close to the 15% project target reduction in percent of children under two years experiencing diarrhea in the past two weeks and 70% target of mothers recognizing signs of dehydration and treating with ORT from 55.5 to 61.5 respectively. A survey is recommended as for immunization coverage to quantify progress to date.

Nutrition, Food Security and Growth Monitoring: 32 contact farmers have been selected and trained and are reported to be actively involved in carrying out demonstration activities. The evaluation team ascertained evidence of this. Other training activities related to this objective include, orientation of RC committee members on nutrition and food security issues, one demonstration gardening plot on nutrition targeting community mothers conducted at Bugema **ADRA** project site, one focus group study on nutrition conducted targeting community mothers and key messages developed for pregnant mothers.

Safe Motherhood and Family Planning: Measurable inputs and outputs related to this objective include; recruitment and training of 64 community based distribution agents (**CBDAs**), 32 per each sub-county, establishment of 3 FP centers and identification and training of TBAs (TBA training was in progress during the evaluation). It was not possible to extract adequate information from the HIS forms to assess the level of progress towards the target objectives which were: to increase the percentage of mothers who at delivery are assisted by a trained health professional from 78.3% to 85% and to increase the percentage of eligible couples using modern contraceptive methods from 12% to 25%.

HIV/AIDS Control: The baseline for this objective were initially not clear, but following a visit by a consultant from ADRA International in September 1995, formative research was conducted targeting youth aged 10- 15 years, after which specific and measurable objectives were established (see objectives section for details). Although some training on HIV/AIDS have been conducted using all forms of media including drama and song, there is clearly a need to identify what can be achieved in the life of the project and explore linkages of sustaining activities by increasing linkages with other existing structures and organizations in the broader Ugandan context.

Some of the accomplishments to date related to these objectives include: one recreational center for youth identified and functional; identification of four drama groups with one already staging shows; conducting four discussion groups on HIV/AIDS targeting mothers, fathers, boys and

girls; training of six ADRA staff on conducting of focus group discussions (FGD); one **KABP** youth survey on HIV/AIDS; two ADRA technical staff attended national workshops on HIV/AIDS; key HIV/AIDS messages for youth and parents developed and linkages established with NGOs active in HIV/AIDS activities including UNICEF and its Safeguard Youth From AIDs project (SYFA). Obviously more needs to be done with regard to this objective.

Malarial Control and Helminthic treatment: Little or no progress has been made in this related objectives to date. This is largely due to ethical issues related to the use of and dispensing of medications by personnel who are not appropriately trained and qualified, namely **CHWs**. At the moment it is only presumed that pregnant mothers and children infected (or suspected to be infected) are referred to the health facilities for treatment by qualified personnel (see Appendix N). It appears that there is still a debate as to whether the benefits of community treatment outweigh the risks inherent in that strategy. It is an established fact that the uncontrolled use of chloroquine for malaria prophylaxis may lead to resistance and hence render later attacks more difficult and expensive to treat requiring more expensive medications often not within the reach of ordinary community members. The objective of increasing the percent of pregnant mothers receiving chemical prophylaxis from 41.7% to 60% may therefore be **difficult** to achieve in the context of the project design. **The** project staff have no access to drugs and have no control over the management and availability of drugs at the health facilities within the intervention area. This is a major constraint to project objectives.

III. PROJECT EFFECTIVENESS

The fact that the project activities started almost four months after the expected date has delayed the achievement of project objectives. It was not until January 1995 that the DIP was finalized and even then, some objectives and their corresponding indicators were not established until September of 1995. (These drawbacks **affect** both the efficiency and effectiveness of the project.) After the revisions, following two consultant visits from ADU International, the project design began to adequately address targeted high risk groups, with the exception of youth, especially the youth out of school.

Existing activities are such that in-school youth are addressed in areas of HIV/AIDSs, whereas out of school youth may not be easily reached at the “recreational centers.” These centers are actually existing school facilities recommended due to sustainability factors and availability of staff to serve as resource persons.

Concerted effort will be required if the stated objectives are to be met by the end of the project. The full operationalization of the HIS system is imperative if yearly targets are to be met. Monthly feedback meetings between all the key team members, including the technical advisors for each intervention area are highly recommended. There is need for all the technical staff, particularly at field level to internalize the value of data and its importance in determining effectiveness (impact) of project activities.

IV. PROJECT RELEVANCE TO DEVELOPMENT

Commendable efforts have been made by the project to relate to other development efforts in the target area. Linkage with the existing health facilities, schools and agricultural extension workers are a few examples of co-operation and collaboration. The sub-county (RC3) and the village health committee (RC1), have development committees which the project has tapped into and hence making the project activities more likely to be sustainable at the end of the project.

Linkages with other development PVOs, community groups, NGOs and government were explored and found to be existing (see Appendix C)

V. DESIGN AND IMPLEMENTATION

A. Design

The project area and size of impact population remain largely unchanged. Project design is well articulated and reflects a thorough knowledge and understanding of the subject matter.

B. Management and Use of Data

The project generates monthly data relevant to the achievement of project objectives from which quarterly and yearly reports are generated. This data is analyzed to generate information which addresses both qualitative and quantitative aspects of the project.

Examples of these include; Trainers and field supervisors training report forms, CBV activity report forms, CBDA Family Planning Activity: Monthly Reports, Village Health Committee Report Forms, and Health Promoters (Omusawo) General Monthly Report forms (see Appendix J, K, L and M). The evaluation team spent a great deal of time emphasizing the central role of HIS in the overall management of the project at all levels; the need for using gathered information to provide feedback to “grassroot” operatives and community beneficiaries was particularly stressed. This is a problem area currently and a lot of improvement is necessary for “results oriented management” to ensue.

The presence of a competent HIS advisor on the project team is a great asset. The current design of the HIS system adequately addresses the project needs. However, as mentioned earlier the system has not been fully operationalized due to constraints that were not anticipated earlier, the partial co-operation of the different cadres of community volunteers, resulting in incomplete and sometimes inaccurate data being recorded and reported. There is need for these anomalies to be corrected and the information availed in a timely and accurate manner. Furthermore, there is need for the information to be shared with all project staff, counterparts, especially the MOH, and the community members. The main lesson learned from this HIS system is that having a competent HIS coordinator

is only part of a functioning health information system, there is need for all the “stake holders” to understand their roles and to perform them for the system to function properly. This area needs a lot of emphasis, particularly with regard to sharing the information both within ADRA and other outside partners.

C. Community Education and Social Promotion

There is a good balance between health promotion and social mobilization, however there is less emphasis on service provision in this project’s design. Part of the reason why service provision is less, is due to the fact that **ADRA** does not have control over the management of the health facilities and therefore does not have the authority and responsibility to provide oversight over service provision activities like vaccination, and basic curative services resulting from the health promotion. The main information, education and communication activities carried out by the project include transmission of messages related to the five major intervention activities. (see Appendix Health Promoter forms for “key messages”). ADRA has not developed original messages, but rather, has adapted messages that have already been developed, tested and refined by other development agencies working with similar target communities. These agencies include, but are not limited, to UNICEF and AMREF.

There is need, however, for ADRA to ensure that messages communicated to community members are consistent by conducting audience analysis of the target audience and incorporating the findings into the design of the adapted messages. Currently, ADRA is utilizing the MOIWUNICEF posters on HIV/AIDS. To date, ADRA has not developed its own printed I.E.C. materials.

The use of voluntary community members called health promoters who number approximately 700 is a sound approach to community education. This is because of the high chance of internalization of the health messages by beneficiary community members and hence a high likelihood of desired behavioral change and sustainability. The use of traditional drama and song in this project is a further advantage. There is, however, a need for cross-sectional cluster surveys that are representative of the target audience to be conducted to determine and assess the level of learning that has occurred using this methods. An attempt to define indicators of desired behavioral change may need to be specified.

D. Human Resources for Child Survival

The human resources in place to implement the project are divided into two main categories; namely paid and voluntary. The paid category is further divided into the headquarters staff and the field staff. The headquarters staff provide technical assistance in both programmatic and financial aspects of the project’s management. The field staff perform the actual implementation and monitoring of project activities. Apart **from** the

Country Director, who provides overall oversight on project management, the project has full time staff who include; a project director, and six technical advisors namely; one coordinator for HIS, one technical advisor/Agriculture and Nutrition, HIV/AIDS coordinator, AIDS Drama and Literacy Trainer, technical advisor Family Planning, and technical advisor MCH and Safe Motherhood. Each sub-county has one supervisor who oversees all technical and managerial activities in their respective sub-counties and serves as a permanent entry point into the beneficiary community.

These personnel were selected and hired with the respective communities consent and involvement. They therefore “belong” to the respective sub-counties. The project also, has one full time secretary, one driver and a custodian/maintenance person as part of the paid staff The voluntary category include the following:

- 64 community-based distribution agents (CBDA):already organized
- 32 contact farmers (CF):already organized
- 32 community-based vaccinators (CBV):already organized
- 32 community health worker trainers (also **CBDAs/CBVs**)
- 700 community health workers (CHWs)-being organized
- 65 traditional birth attendants (TBAs)-being organized

The evaluation team felt that the above numbers and types of personnel are adequate to meet the technical, managerial and operational needs of the project. It, however, recommended that more integration, as opposed to vertical approaches, be encouraged in responsibility allocation, particularly at the level of field technical advisors; this will be more cost effective and favors sustainability. The evaluation team also endorsed the decision of the project staff of doing away with the trainer supervisors, who were originally proposed but found not to work well. This is a classical example of “lessons learned”.

It was noted that only about 50% of all cadres of community volunteers in the project were active. On further investigation it was established that certain socio-economic factors were contributory to this low level of participation. Poverty related factors were advanced and collated with findings from other PVOs experiences in volunteerism related to Child Survival activities. A high drop-out rate was evident and is an area of concern which the evaluation team attempted to address. The workload of the volunteers seems reasonable. The critical issues were those related to motivation and performance.

Training methodology and duration of each type of worker appears reasonable. Previous experience has shown that revisions and improvements on training methodologies and duration should be based on course evaluation feedbacks. Although **the** project did not initially have standardized forms for recording results of pre- and post-training assessments, this is now in place and being utilized (see Appendix F and G for examples of trainer supervisors training report form for CBDA and CBV). The table below provides a Child **Survival** Training Program Summary for ADRA Uganda’s CS X.

CHILD SURVIVAL TRAINING PROGRAM SUMMARY

Type/	Dates	Training Topics	Topic Hours	Training Methods for Topic
ADRA Staff (All) 1/9-13/95		DIP Workshop Organized by ADRA International	N/A	Group Discussion and Report Writing
Project Director (1) 1/-9-13/95		Seminar on HIV/AIDS organized by DISH	N/A	
MIS Coordinator (3) 11/3-17/95		Workshop on Child Survival/MCH and how to improve and standardize performance.	N/A	Lessons learned through case presentation Lecture Slides on Strategic Planning Discussions on Qualitative Research.
Technical Advisor HIV/AIDS (1) 4/3-7/95		HIV/AIDS TOT course (Course for training Community Workers:TASO	N/A	
Technical Advisor Nutritionist/Agriculturalist (1) 5/23-25/95		Seminar at the District Office on Food Security by the ministry of Agriculture.	Not specified	
Technical Advisor Safe Motherhood(I) 5/8-12/95		Workshop for training Vaccinators:by MOH/DMO	Not specified	
Supervisor (1) 5/8-12/95		Workshop for training Vaccinators by MOH/DMO	Not available	
Technical Advisor Family Planning (1) 5/29-7/7		Course for Family Planning Providers and Safe Motherhood:By DISH	N/A	
IX International Conference on AIDS/STDs in Africa/Kampala Project Director (1)		<ul style="list-style-type: none"> • Challenges of Care for HIV/AIDS patients. • Social and Economic Effects of AIDS. • AIDS Orphans • Laboratory Diagnosis of HIV in Community Setting. 	N/A	<ul style="list-style-type: none"> • Lecture • Poster Presentations • Slide Presentations • Plenary Question and Answer session
ADRA's Staff (All) 9/10-12		Health Information Systems, conducted by a consultant from ADRA International	Not specified	Participants learning in Cluster survey methodology and Qualitative formation research techniques.
Technical Staff (9) 9/4-6/95		Focus Group Discussion Techniques by a Consultant from ADRA International	12 hours	Techniques in administrating FGD's
Sub County Leadership (10+) April 95/2 Meetings		Awareness Creation about Project Interventions in Kalagala/Zirobwe	4hrs @	Discussions and Question Answer Sessions.
Sub County Leadership (3) May 95/2 Meetings		Sensitization about Project Activities in Kalagala/Zirobwe	4hrs @	Discussions and Question Answer Sessions.

Trainer Supervisor (8) S/14-28/95	<ul style="list-style-type: none"> • Training of Trainer Supervisors on • Health and Development • Concepts of CBHC/PHC • Quality and Roles of HP Trainer/Trainer Supervisor • Leadership Skills • Home Visitation Skills • Planning and Workplan • EPYCDD • Nutrition/GrowthMonitoring/Food Security • Family Planning and Safe Motherhood • HIV/AIDS • Field Visitation 	8hn per a day	<ul style="list-style-type: none"> • Participatory methodologies i.e • question/answer sessions • group discussions • role plays • Field visitations practicum at AMREF CBHC Child Survival Project
CBV (30) 8/27-9/8 (Phase 1)	Immunization	<ul style="list-style-type: none"> • CDD-1/2hrs • EPI-23.5hrs • GM/Nutrition 5hrs • SM/FP 1/2hrs 	
Contact Farmers (CF) (32) 8/2-7	<ul style="list-style-type: none"> • Home gardening • Food storage techniques • Vegetable planting 		<ul style="list-style-type: none"> • Demonstrations and practicum
CBDA (32) 1 O/22-		2 weeks (1 00hrs)	<ul style="list-style-type: none"> • Psycho-social methods i.e • group discussions • presentations • role plays • story telling • Both English and Luganda
CBDA (32) 11/4-17/95	<ul style="list-style-type: none"> • Preparation of CBDA area • Population Dynamics • Concepts of PHC/CBDA role • Benefits of Family Planning • Anatomy and physiology of male and female reproductive system. • Life Cycle • Contraception methods, Modern and Natural Methods • Referral and management of side effects. • Family life education (youth fertility management) • Communication skills. • Counselling Skills in family planning. • Records and report writing. 	2 weeks (100hrs)	<ul style="list-style-type: none"> • Psycho-social methods i.e • group discussions • presentations • role plays • Both English and Luganda
CBV (30) Phase 2 12/3-17/95	<ul style="list-style-type: none"> • EPI • Growth monitoring and Nutrition 	45hrs 30min Ihr	<ul style="list-style-type: none"> • Mainly practicum i.e using training manuals, steam sterilizers, vaccine vials, carriers, ice parks, needles/syringes etc.
TBAS	Yet to be reported. Still on going.	N/A	

E. Supplies and Materials for Local Staff

The project director, together with the six technical advisors have access to two desk top computers, two printers and accessories and a photocopy machine. The above have enabled them to produce good quality materials for their training activities, and to prepare different types of reports. The HIS technical advisor, together with the project secretary are currently providing on the job training to make all the technical staff computer literate. An extra computer and printer was supplied to the financial personnel to assist with management of the project's finances. Two motorbikes were supplied to supplement the existing two 4-wheel drive vehicles in carrying on project activities.

The two sub-county supervisors have been provided with motorbikes to facilitate their supervisory responsibilities. A total of four new motorbikes have thus been made available for the project activities.

The 64 **CBDAs** and 32 Vaccinators have been provided with bicycles to enable them to cover longer distances in shorter time. All the CHW have been provided with bags for carrying contraceptives and other supplies relevant for their work. 110 weighing scales have also been provided to the **CHWs**, for growth monitoring activities in the community.

1.E.C audio-visual supplies including a video set and video-cassettes have been supplied for HIV/AIDS prevention activities. Drums and other accessories for drama activities have also been supplied and are currently in use.

The Medical Assistants (M.A.), at the referral sites assured the evaluation team that they receive regular supplies of vaccines for immunization. They, however reported inadequate quantities of vaccines carriers for CBVs to perform outreach activities. Periodic shortage of gas to maintain the cold-chain was also reported by the person in-charge of Zirobwe Health center.

Two contact farmers interviewed confirmed that they have received seedlings and other farming accessory supplies. Several CHWs also benefitted from the seedlings supply.

F. Quality

The evaluation team noted that the project has made concerted efforts to identify and document levels of specific knowledge and skills of mothers (direct beneficiaries), health workers (both at referral site-clinic and community based).

The development and use of different HIS forms (see Appendix J, K, L and **M**) for different levels is a critical factor in enhancing the quality of the project.

It was, however, evident that the HIS system was just starting to function (three months from time of evaluation), therefore more effort will be required to generate information that can be given as feedback to the mothers, community workers and clinic staff on their performance and ability to sustain the project activities beyond the life of the project. There is need for the field staff to carry out a sample survey (cluster survey), on the communication and counselling skills of health workers associated with the project. So far this, exercise has not been carried out. More refresher courses and message reinforcement are definitely needed to improve on quality of knowledge and skills for the different players.

G. Supervision and Monitoring

The project (as discussed in section D earlier) has adequate personnel in place to successfully implement and supervise the project. In our view the sites, frequency and duration of supervisory contacts for all categories of project related staff and volunteers are acceptable and so are the ratios of supervisors to those who are being supervised. From the view point of the health worker, much of the supervision is on-the-job education and administration, there is less counselling and support and even much less performance evaluation. The general consensus is that there is a need for more interactive communication between the supervisor and supervisee to define mutually acceptable criteria of performance indicators for performance evaluation. The implementation of the HIS system discussed earlier will greatly strengthen the supervision and monitoring of the remainder of the project. The development of a form for the SCHMC and the **TBA** is recommended in the second part of this project. These forms coupled with the already developed HIS forms should constitute supervision and monitoring tools that are effective for all year round use. Creation of “supervisory teams”, where the supervisor and supervisee mutually participate and agree on acceptable standards for performance evaluation is recommended.

H. Regional and Headquarters Support

The administrative, monitoring and technical support from **ADRA** International and Regional office, is adequate both in number, timing and needs of field staff (see Appendix E).

The role of the regional office appears unclear, particularly as it relates to the Child Survival project. In view of limited financial resources and ever increasing needs, the frequency and role of headquarter support may need to be reviewed in the light of sustainability of project activities after the life of the project.

I. PVO'S Use of Technical Staff

1. The field staff still require technical assistance in the areas of project monitoring and evaluation. The headquarter **staff** need to strengthen their collaboration and sharing of information and lessons learned with other PVOS.

2. The types and sources of external technical assistance received by the project these include technical staff training, provision of I.E.C. materials, and curriculum development. UNICEF, the DISH project, AMREF, TASO, and the Ministries of Agriculture and Health are among the main sources of external technical support.
3. The single most technical support expressed by project staff is skill related training with career advancement potential. In this regard **ADRA** has already initiated a post graduate training that offers development centered training at several levels, including certificate level, diploma level and degree level to cater for the different staff needs and capabilities. This transfer of knowledge and skills will auger well with sustainability.
4. The short remaining duration of the project and financial limitations are the main constraints to obtaining this kind of technical support.

J. Assessment of Counterpart Relationships

The Ministry of Health (**MOH**) is the chief counterpart in this project. To date several collaborative activities have taken place, these include holding joint training sessions where MOH personnel have served as resource persons. A notable example is the CBDA training and the training of the technical advisor for family planning and safe motherhood organized by **MOH/DISH**. Furthermore, exchanges of materials and human resources have taken place between **ADRA** and the MOH, particularly at the health center level. **ADRA** has also facilitated the transportation of senior MOH staff to and from joint meetings.

The MOH is currently undergoing structural changes with more authority and responsibility transferred to the district level. The District Medical Officer of Health is increasingly poised to be a critical counterpart in the continuity and sustainability of the project. Together with his/her district health management committee, they will oversee all activities in the counties and sub-counties within the Luwero District. The health centers with the in-charges (usually Medical Assistants), and other staff including mid-wives and enrolled nurses will perform key roles as counterparts to the project technical advisors.

Although the communication between the project staff and the MOH is cordial, there is need for the project staff at all levels to make deliberate efforts to involve MOH counterpart staff in the planning and execution of project activities in the second half of the project. Information generated **from** the HIS should be shared with the counterparts and used for decision making to improve performance and meet project objectives.

The counterparts (**MOH**), have a healthy and trusting relationship with the communities. This is evidenced by the existence of a community participative structure right from the

grassroots (RC1) to the district (RC5). Representation of the community at all these levels of decision making ensures that the community needs and concerns are articulated and addressed meaningfully.

K. Referral Relationships

The project has four referral sites namely Bugema, Kalagala, Natyole and Ziobwe health centers: Of these the first three are in Kalagala and Ziobwe Sub-counties respectively. There is evidence of good linkage between this referral sites and the community, as evidenced by the supervision of the Community Based Vaccinators who are trained and supervised by the technical staff at the referral sites (Health Centers) alongside the field technical advisors of the project. There is, however, need for the project staff to involve the referral site staff more closely in planning, decision making and sharing of HIS information. The project should spend some of its resources to facilitate the training of referral site personnel, especially the mid-wives. These will inevitably play a crucial role in the sustainability of projects activities with the community after the project closes. It is also recommended that the village health committees (VHC), ensure that they send monthly reports to the health management committee of the sub-county (SCHMC), of which the health center in-charge is the secretary. This will increase access of the community to the referral sites.

L. PVO/NGO Networking

The project has made commendable efforts to network with other PVOs and NGOs working in health and Child Survival. The list includes the DISH project, World Vision, AMREF, PLAN/I, and the Uganda AIDS Commission to name a few (see Appendix D for list of persons/ organizations networking with the project). The networking has had a positive effect on the project from sharing lessons learned which has assisted the project from having to undergo similar experiences to learn the lessons. The DISH project has, for example, trained project staff and is planning to assist in providing some equipment and supplies to the project referral sites. AMREF has shared its CBDA training curriculum and provided field sites for on-site training of CHWs from the project.

The Uganda AIDS Commission together with UNICEF have provided I.E.C. materials for HIV/AIDS prevention education, while PLAN/I is willing to provide centers for AIDS pre-testing counselling, testing centers and post testing counselling centers with the intervention district.

There is apparent duplication of efforts between the project and PLAN/I as both are undertaking Child Survival activities in the same intervention area, i.e., Kalagala and Ziobwe. Due to inadequate networking and communication, the PLAN/I activities have had a negative effect on the project. This has been mainly due to the approach adopted by PLAN/I which encourages monetary incentives for community participation as opposed

to the project's approach of voluntary community participation. This approach has been counterproductive and has taken its toll on the projects performance. This is elaborated elsewhere in this report.

M. Budget Management

The rate of expenditure to date compares favorably with the project budget (see Appendix A for Country Project Pipeline Analysis). No major shifts have occurred on so far, however, we are making recommendations for a shift of the line item for the Supervisor of Trainers to be utilized for incentive and morale boosting activities that are of an income generation nature. Details will be discussed with the communities involved and agreed upon by all responsible parties. The project can achieve its objectives with the remaining funding, in fact there will be need for a no-cost extension after September 1997. This is due to the fact that the project activities planned to start in October 1994, did not start until January 1995. The extension will ensure that the budget will not be underspent at the end of the project.

For details of Country Pipeline Analysis, (see Appendix A.)

VI. SUSTAINABILITY ISSUES

Sustainability is a major objective of this project. The project has accordingly, undertaken the following steps to promote sustainability of Child Survival activities once the project funds end. The table below provides a summary of planned sustainability objectives and outcomes.

**SUSTAINABILITY GOALS, OBJECTIVES, MID-TERM MEASURES,
AND STEPS TAKEN/NEEDED**

GOAL	END OF PROJECT OBJECTIVES	STEPS TAKEN TO DATE	MID-TERM MEASURE	STEPS NEEDED
<p>A) Village Health Committees will provide a support system for CHWs, CBDAs, CBV, CF</p>	<ul style="list-style-type: none"> • 80% of village health committees providing support system for CHWs, CBDAs • 80% of RCI will take responsibility for monthly weighing sessions. • 100% (32) contact farmers will be accessing extension support for advice. • Two seed cooperatives will be operating on a self sustaining basis. • 100% support for TBAs by providing an active support system. • Achieve sustainable change in social values discussed between parents and children. 	<ul style="list-style-type: none"> • Village health committees undergoing supervisory training on support system for CHW etc. • Approximately 50% of RCI participating in weighing • Training of contact farmers so far. • None • 50% VHC are providing some of the components of support system <ul style="list-style-type: none"> -supervision -report review -recognition status in the community -refresher training -replacement of drop-outs. • Drama, songs and visual including film and video (no cluster survey done yet). 	<ul style="list-style-type: none"> • Approximately 50% VHC have some capacity to provide support to CHWS • Approximately 50% RCI participate in weighing sessions. • Approximately 10% have demonstration gardens and access to AED. • None so far. • Less than 50%. • Determine 50% level. 	<ul style="list-style-type: none"> • Ensure that the remaining 50% have some skills to provide support system to CHWs. • Sensitize members of RCI to participate in weighing sessions. • Train 100% of the contact farmers to have demonstration gardens, access extension support advice. • Both should be operational at the end of the project • Train all VHC on provision of support system. • Do cluster survey as part of end of project evaluation to determine level.

<p>B) Health Center will take responsibility to provide immunization services, fp and provide supervise the CBV/CBDA activities in their communities.</p>	<ul style="list-style-type: none"> • All 3 health centers providing good quality immunization services. • Services as FP referral center in locality. • Quality monitoring of maternal care in all 3 HC. • Improved cold chain monitoring, maintenance and vaccine supply. 	<ul style="list-style-type: none"> • All three providing, but have logistic/supply and cold chain problems. Have some contraceptive supplies. • Not fully functional. • Partially functional. • Some improvements. 	<ul style="list-style-type: none"> • 1.5 should be functional at optimum levels. • Should be at least 50% for all. • Should be at least be 50% functional. • Should be at fully functional in at least 2 clinics. 	<ul style="list-style-type: none"> • Train key HC staff in SM/FP, and EPI service provision and supervisory skills. • Ensure that all systems are functional by end of project. • Work with DMOH to ensure acceptable management in all the 3 HCs • Coordinate with DMOH to ensure functionality of cold chain.
<p>C) The SubCounty Management Committee will take on health provision activities of CS X project</p>	<ul style="list-style-type: none"> • In liaison with the secretary of the committee, ensure that all 5 interventions of CS are continued to meet specific end of project targets. 	<ul style="list-style-type: none"> • Several meetings held with sub-county health committees in Kalegala sub-county chairman is also the sub-county supervisor; also Assistant District Health district Visitors (ADHV) Kalegala/Zirobwe participated in training CBDA/ CBV with ADRA. 	<ul style="list-style-type: none"> • Periodically, preferably at least monthly with ADRA staff. 	<ul style="list-style-type: none"> • Both SHMC should be supportive in the provision of all five essential components of support system <ul style="list-style-type: none"> -supervision -report review -recognition in communities -refresher training -replacement of dropouts.
<p>D) District Health Management Committee will take on health pmotive and preventive activities of CS X project.</p>	<ul style="list-style-type: none"> • Ensure that all 3 health centers are fully functional, well staffed, motivated, necessary equipment and supplies available to carry out intervention by end of project. 	<ul style="list-style-type: none"> • Several contact meetings held with the District Health Visitor, the DMO and the chairman of RCI, who is also the district health education officer-all are supportive of ADRA's efforts. 	<ul style="list-style-type: none"> • Monthly contact with DHV, DHED 	<ul style="list-style-type: none"> • Maintain monthly contact with DHV, DHEO, DMO and ensure their constant participation in all ADRA's community activities

VII. RECOMMENDATIONS

1. **What steps should be taken by ADRA field staff and ADRA headquarters for the project to achieve its output and outcome objectives by the end of the project?**

The implementation of Child Survival X is being undertaken within a much changed socio-economic environment as compared to its predecessor (Child Survival VII). In Chile Survival VII, the spirit of volunteerism was strong and apparently sustainable, a changed environment with new players who have entered the arena (project intervention area) and who are playing by different rules. This has created a scenario resulting in negative attitudes to volunteerism, resulting in low morale and attendant slowing of project activities implementation. This has necessitated the need to review the motivational and incentive factors in place; other than social mobilization and sensitization of the beneficiary communities, there seems to be a need to consider some form of income generation activities as an incentive to the community volunteers with support by the project being limited to providing “seed” **funds** only. It is strongly recommended, however, that given the history of lessons learned, the “projects” will have to be conceived, formulated and managed by the community members themselves through the RC 1, Village Health Committees (VHC). It is hoped that CBVs, **CBDAs**, and Health promoters will be participatory members and that the proceeds **from** these activities will be shared fairly, resulting in increased levels of motivation and therefore willingness to manage the project activities in a sustainable manner. The above recommendation is made in the light of it’s being the lesser of two evils- which the action may avert a looming disintegration of project activities resulting in failure to achieve end term project objectives.

Whereas the HIS system is acceptable and adequately addresses the project output and outcome objectives, the findings of the evaluation team were to the effect that the current HIS system may not be sustainable in the current community setup. This is in view of the need for constant monitoring and supervision of which capacity and capability the VHC level does not currently possess. There is, however, strong optimism that if the ADRA Child Survival HIS forms are modified with simplicity in mind **and** designed along the MOH Health Management Information Systems forms (**HMIS**), while maintaining all the key indicators for project monitoring and evaluation, there is high probability of sustaining the intervention activities at community level with minimum technical support from the Health Center (HC) Committee, Sub-county Health Management Committee (SCHMC), whose secretary is the health center in-charge (usually a Medical Assistant), who is an employee of MOH.

2. **Are there any steps the project and ADRA's headquarters can take to make the project activities more sustainable?**

Needless to state, sustainability of the Child Survival Project activities is one of the cardinal objectives of this project; to achieve this objective, we strongly recommend that a line of intensive communication coupled with sharing of information and resources be opened between ADRA and the counterparts within the MOH at all levels. It would appear **from** the structure of the MOH system, that the most appropriate level of linkage is at the health center level. This is particularly suitable because technically trained staff already exist as Medical Assistants, Enrolled Community Nurses, Midwives and other auxiliary personnel. The above personnel should be trained alongside ADRA technical staff to provide technical assistance and supervision to the community health workers, especially the vaccinators (CBVs) and the community based contraceptive distributor agents (CBDAs). ADRA is therefore strongly encouraged to invest a significant portion of their resources, especially manpower and time, in creating an conducive environment for the existing MOH structure to take over their activities in a sustainable manner. Holding of joint monthly planning and feedback meetings is an example of such linkage activities.

Community participation is a key component of project sustainability in any community based intervention activity, ADRA's project is no exception; in this regard, it is recommended that more sensitization and mobilization of the beneficiary communities be more aggressively conducted than in the past. The suggested levels of entry include the Subcounty Health Management Committee (SCHMC), which is part of RC3 or Subcounty level of administration in a decentralized system. The strategic linkage at this level includes the role of the health center in-charge (usually Medical Assistant), as the secretary to the SCHMC which includes ten other members elected by the different parishes or local communities. The other level is that of the village health committee, which is a grassroots representation group at a level complimentary with the administrative level of RC 1. ADRA should empower the VHC to manage the activities of the health promoters and provide support and encouragement to the **TBAs**, CBVs and CBDAs who are members of their respective communities.

It is further recommended that ADRA makes concerted efforts to have representation at different levels of district health management committees, especially at the highest district level. This is particularly important as Uganda has undertaken to decentralize its health system and in effect transferring authority and responsibility to the district level. **ADRA's** participation at this levels will have inherent strategic advantages which are conducive to continuity and sustainability of their health activities in Luwero district.

Recommend a link up with the SORMAC project to encourage the CBDAs to "sell " contraceptives and retain some of the proceeds as part of their incentives to provide services free to the community.

3. Are there any steps the project and ADRA's headquarters should take to make the projects activities more applicable, the staff more competent, or the services of higher quality?

After thorough examination of the existing health information system, the evaluation team felt that the system was functional and appropriate as far as meeting the end of project objectives was concerned. However, it was felt that the level of complexity of the HIS forms was not sustainable beyond the life of the project. It was therefore recommended that some minor modifications be made to simplify the forms with a view of making them more user **friendly**, with particular attention to the grassroots users, namely the village health committee members, the traditional birth attendants and the health promoters. It was observed that most of these members are barely literate and therefore can only handle a limited range of information. There is need to put more emphasis in training the above cadres in the “why” of collecting the information other than just the “how” of collecting the data.

The quality of ADRA’s staff both at the headquarters and the field is of acceptable skill and experience and provides a good “fit” for enhancing the achievement of project objectives; it is, however, recommended that close linkages be fostered with other organizations working in similar areas who can provide further training and requisite skills development. An example is the DISH project, whose management has expressed willingness to train **ADRA's** personnel, especially the technical staff (Nurse-Midwives) and midwives working in the health centers located in ADRA’s intervention areas. The SOMARC project personnel have also expressed willingness to train **ADRA's CBDAs** in social marketing skills to enable them sell contraceptives at **affordable** costs to the communities and possibly recover some money which would serve as an incentive. Relevant ADRA personnel are encouraged to follow up on this trainings. At senior level, plans are underway to train the Project Director and the Country Director on advanced project management skills. This is encouraged. It is evident that improved staff quality will convert to higher quality of service provision at all levels of project management. This will increase project efficiency and effectiveness as measured by the set indicators and end of project objectives.

4. Are there any steps the project and ADRA’s headquarters should take to make the lessons learned by this project more widely known by other Child Survival or development projects sponsored by USAID or by ADRA?

It is highly recommended that key **ADRA** personnel should reach out to other **PVOs/NGOs** and share their experiences with other development partners and more importantly to incorporate lessons learned by other similar projects.

This step will avoid “reinventing the wheel” of re-learning the same lessons. It is recommended that ADRA takes a lead role together with other USAID funded Child

Survival projects to hold a summit of some form and share experiences and lessons learned, both at the international and the local levels. The recently held Child Survival Workshop for **ADRA** at the International level is a step in the right direction.

5. Finally, are there any issues or actions that USAID should consider as a result of this evaluation?

Although not at the end of the project, it is evident that the Child Survival Project will succeed in achieving its End of Project objectives, only because of relying on levels of external financial and technical assistance that will be almost impossible to sustain in the context of a **community/Ministry** of Health environment. USAID should consider adopting more sustainable options in the design of future Child Survival projects. USAID has the capacity and capability to achieve that goal if its policy makers view it as a strategic objective.

The conceptual **framework** for this project is based on the achievement of short term objectives which, although in theory are in tandem with long term goals, in reality they do not complement the achievement of the long term goals and are therefore self-defeating to a large measure. A new paradigm, which blends a bottom-up and top-down approach with the integration of existing structures and participation of the beneficiaries' input may in the long run be more cost-effective and sustainable as opposed to the current framework, which has a vertical orientation that propagates "donor dependence" in terms of resources inputs. This paradigm shift is recommended as an alternative.

It is encouraging to note evidence of lessons learned being incorporated into project design. A notable example is the DISH project which, unlike previous designs, incorporates aspects of integration into existing structures of health delivery and attempts to strengthen and build capacity and capability of existing manpower and infrastructure. This design has the potential for sustainability and ownership of by the beneficiary communities.

Current USAID indicators place undue emphasis on "processes" and outputs as opposed to emphasizing results oriented outcomes; the design of Child Survival X is a typical example. Increasingly qualitative indicators of behavioral change in the desired direction should be developed, refined and put into use in future "systems assistance designs" as opposed to current "project designs".

Global merges, interrelationships and interdependence are an attestation to the holistic approach which incorporates the principles of "systems thinking" that embrace the holistic approach to healthcare delivery as an integral part of the total development and improvement of the quality of life. This paradigm, we believe is sustainable and a recommended way ahead for future USAID program designs in CS interventions.

VIII. SUMMARY

The evaluation team was composed of one Independent Consultant, one local USAID representative, one **ADRA/I** representative, the Country Director, Project Director and a representative from the **MOH/Uganda**, a total of six members. A total of 17 days were spent in the conduct of the evaluation with a total of 10 field visits (see Appendix/Itinerary), and at a total cost of **US\$7,835**.

The evaluation exercise employed qualitative methodology which included observation checklists, in-depth interviews and focus group type discussions, together with gathering of information from existing reports and materials. No surveys were conducted.

The main project accomplishments were those related to the establishment of a fully functional programmatic and financial technical staff with an equally supportive voluntary team of community health workers well versed in the key health messages of the project intervention objectives. It was not possible to quantify measurable outcomes without conducting a survey, however qualitative information gathered indicates significant progress in the right direction. The project design exhibits high quality and applicability of Child Survival programming. Networking with other **PVOs/NGOs** has resulted in sharing of lessons learned from other Child Survival and community development programs.

The key recommendations include; a need to consider some form of income generation activities as an incentive to the community volunteers; a line of intensive communication coupled with sharing of information and resources be opened between **ADRA** and the counterparts within the **MOH** at all levels; need for more sensitization of the beneficiary communities be more aggressively conducted; need for some minor modifications to the **HIS** forms with a view to making them more user friendly; need for **ADRA** to take a lead role together with other USAID funded Child Survival projects to hold a “summit” and; share experiences and lessons learned and **finally** a need for USAID to consider a new paradigm which blends a bottom-up and top-down approach with integration of existing structures and participation of beneficiary to enhance overall sustainable development (see Appendix I **Uganda/Unicef** Conceptual Framework for Analysis).

Actual feedback of the evaluation results included, feedback to the local USAID Child Survival Project Officer, the **ADRA/I** representative, the Regional Director (Vice President), the Country Director and **ADRA** Uganda Treasurer, the Project director and technical project staff, two PVOs with Child Survival projects namely **AMREF** and **World Vision** and the **MOH** representatives. Planned feedbacks include, feedback to volunteers and community beneficiaries and other collaborating and network organizations both locally and at the international level.

The authorship of this mid-term report is the combined effort of the Independent Consultant, the **ADRA/I** representative and the Senior Advisor for Evaluation, **ADRA** International.

APPENDIX B

Scope of Work

SCOPE OF WORK FOR CHILD SURVIVAL X - UGANDA MID-TERM EVALUATION

I. INTRODUCTION

This is a scope of work for the Mid-term Evaluation of **ADRA's** USAID funded Child Survival X project which was signed on September **30, 1994** by Mario Ochoa, Executive Vice President of the Adventist Development and Relief Agency. The project was designed to have a three year life beginning on or about October, 1994 and ending September **30, 1997**.

II. THE PURPOSE OF EVALUATION

The primary purpose of the mid-term evaluation is to help **ADRA/Uganda** to assess lessons learned and identify new strategies which would eventually help the ultimate success of the Child Survival Project.

The mid-term evaluation provides an opportunity for the project leaders to be introduced to the opinion of others, learn community views on sustainability of the project activities, and familiarize key local health and development professionals with the project's effectiveness.

In a nutshell the mid-term evaluation of the Child Survival Project is expected to help adjust the direction; improve the performance; help identify what is working well; suggest areas which need further attention; and recommend a means of improvement for the remaining life of the project.

III. GOALS AND OBJECTIVES

In the DIP it is stated that the goal of Uganda's Child Survival X Project is to decrease morbidity/mortality and improve the quality of life for low income mothers and children in Kalagala and Zirombe subcounties, Bamunanka County, Luwero District, Uganda.

At the heart of **ADRA's** strategy is the mother as the primary care giver. **As** such the majority of activities will be educational and promotional in nature. This involves educating and motivating mothers to improve their health practices and encouraging them to increase the utilization of the existing, but enhanced, community services.

The Project's Goals and Objectives Include:

Immunization

- 1 Children under two: To increase immunization coverage of children under two years of age from 67% to 80%.
- 2 Women of child bearing age: To increase **TT** coverage of CBA from 45% to 60%.

- 3 Sustainability objectives: (see page 4 for specific indicators of these objectives)
- 4 Immunization service improvement
 - Improve quality of service at vaccine sites and provide new vaccine sites to increase assess.
 - Improve the cold chain monitoring, maintenance and vaccine supply system.

Diarrheal Disease Control

Diarrheal disease control

- 1 Reduce the percent of children under two years of age experiencing diarrhea in the past two weeks from 23.3% to 15%.
- 2 Increase the percent of mothers recognizing signs of dehydration and **treating with** ORT from 55.3% to 61.4% respectively to 70%.

Nutrition

- 1 Increase the practice of exclusive breastfeeding under four months to 80%.
- 2 Increase the percent of household having kitchen gardens form 7 1.7% to 80%.
- 3 Increase the homes with food availability throughout the year by use of food storage facilities from 18.7% to 35%.

Sustainability

- 1 32 contact farmers (growing vegetable gardens) will be accessing agriculture extension support for advice.
- 2 Two seed cooperatives will be operating on a self sustaining basis.

Growth Monitoring

- 1 Increase the number of children under two years **of age** that will have been weighed in the last three months from 67.5% to 75%.

Maternal Care and Family Planning

- 1 Increase the percentage of mothers who at delivery are assisted by a trained health professional **from** 78.3% to 85%.
- 2 Increase the percentage of eligible couples using modern contraceptive methods from 12% to 25%.

Malaria Control

- 1 Increase the percent of pregnant mothers receiving chemical prophylaxis from 41.7% to 60%.

HIV/AIDS

Decrease the transmission of HIV/AIDS in the present and **future** population by targeting 5-15 year olds and parents.

1 By the end of the project, the percentage of 10-15 year old youth who know about the modes of **HIV** transmission will increase as follows:

- dirty needles/instruments **26.7%** to 60%
- unprotected sex with infected person 14.3% to 50%
- blood transfusion 1.9% to 35%

2 By the end of the project, the percentage of 10 to 15 year old youth who know how to prevent HIV/AIDS through the following means will increase:

- abstinence **53.9% to 80%**
- having only one partner **24.8% to 65%**
- using condoms 11.5% to 60%

3 Increase from 86.1% to 95%, those who say they have changed their sexual behavior due to the fear of acquiring AIDS.

4 Reduce the percentage of 10-15 year old youths who have ever had sex **from 8.6% to 5.0%**.

5 Increase percent of pregnant women being screened and treated for STDs 50% **from** baseline.

The DIP's measurable objectives and indicators for sustainability

A major strategy for sustainability will be the institutionalizing of support systems for the community level workers (**CHWs, CBVs, CBDAs**) in the local Village Health Committee who will be trained and mobilized to provide the five key elements of the support system.

These key elements are:

- 1 supervision
- 2 review of reports
- 3 recognition of the volunteers in the community
- 4 **refresher** training
- 5 replacement of dropouts

In addition, the subcounty Health Management Committee will assume responsibility for monitoring the cold chain and vaccine supply, and will be included as partners in implementation and monitoring the overall project activities in each of the two subcounties.

Specific Objectives for Sustainability

The following measurable objectives and indicators are used to track progress towards sustainability. Each of the objectives listed will enhance the sustainability of the community based health care system in the area targeted, which is one of the primary goals of the project.

INTERVENTION	SUSTAINABLE ACTIVITIES	INDICATOR
General	80% of village health committees providing support system for CHWs, CBDAs, CBVs	Percentage of VHCs providing for all five essential components of support system: <ul style="list-style-type: none"> · Supervision · Report review · Recognition/status in community · Refresher training · Replacement of drop-outs
EPI	<ul style="list-style-type: none"> · Improve quality of service at vaccine sites and provide new vaccine sites for better access · Improve the cold chain monitoring, maintenance, and vaccine supply system 	<ul style="list-style-type: none"> · Number of community sites missing one vaccination day in past 6 months · Number of days refrigerator temperature has not been between 0 and 8 C during the past 3 months · Number of days out of stock in past 3 months
GM/Nutrition	<ul style="list-style-type: none"> · 80% of RC 1s will have taken consistent responsibility of monthly weighing sessions · 32 contact farmers will be accessing extension support for advise. Two seed cooperatives will be operating on a self-sustaining basis 	<ul style="list-style-type: none"> · Percent of RC 1s having missed one months weighing session in past 6 months · Number of contact farmers · See co-op records
MC/FP	<ul style="list-style-type: none"> · Emergency transport system locally managed · Quality monitoring of MC locally institutionalized · Support system for TBAs active · CBDA support system from VHC active · FP referral center in local HC 	<ul style="list-style-type: none"> · Number of functioning emergency transport systems · TBA reports · HC midwife reports · Percentage of VHCs providing all five essential components of support systems: <ul style="list-style-type: none"> · Supervision · Report Review · Recognition/status i n community · Refresher training · Replacement of drop-outs · HC reports

HIV/AIDS	<ul style="list-style-type: none"> • Responsibility for recreation clubs for 5-14 year olds institutionalized in a local school and/or church group • Sustainable change in traditional social values discussed between parents and children and transmitted to young people by elders 	<ul style="list-style-type: none"> • Number of teachers/church group leaders functioning as the leaders of recreation clubs. • End-of-Project evaluation as measured against findings of formative research component
----------	--	--

At the end of the Child Survival grant, both personnel resources and support systems will be left in place which will continue to sustain the interventions undertaken during the duration of the **grant**.

Iv. EVALUATION METHODS

A. Evaluation Concept

It is helpful to remember that the process of evaluation is never far from its social setting. In view of this, the evaluating team may realize that no matter how objectively the data was gathered and analyzed, in the end, the **final** interpretation can not totally be free of the social and political climate of the time and the personal biases of the evaluator. Therefore, the evaluating team is expected to be unduly astute with its written presentation as this involves the lives of many whose welfare could be affected either positively or negatively. The team may keep in mind that we are social beings and as such, every assessment we do apparently takes place in a **cultural** context. Consequently, there are ideas that do not make sense outside their social milieu

This evaluation takes place in the context of two cultures, that of the funder’s culture and that of the beneficiary’s culture. The evaluating team should keep in mind that it is undertaking a major responsibility in its attempt to make a cross-cultural analysis and interpretations.

B. Evaluation Activities

The evaluation activities will focus on the guidelines designed by USAID for the Mid Term Evaluations of all USAID funded child survival projects and the supplementary questions. The evaluation team is reminded that all USAID funded Child Survival projects are required to respond to the sustainability questions and issues outlined in the Child Survival Guidelines.

It is obvious that a beneficial evaluation is a result of reliable data collection. Collection methods may include: general observations, surveys, interviewing recipients and/or staff, gathering information from written material, and so on.

In the preparation of the final report, the evaluating team is requested to provide the reader with, as much as possible, accurate sources of its information and conclusions. In fact, all evaluation statements must be backed by existing data. When this is not the case, the team is required to

state this fact and provide a rationale for its observations and conclusions.

It goes without saying that every country is unique and Uganda is not **an** exception. In the event that there maybe questions which do not apply. Please, do not manipulate the questions to manufacture its applicability, but explain why the question does not apply.

Following these guidelines and taking the program objectives and the measurable objectives and indicators for sustainability as listed above, the evaluation team is expected to perform the following.

First, the evaluation team should provide project staff with an external perspective on the progress and the potential for reaching stated objectives on the project, by reviewing project outputs and changes in health knowledge or practices.

Secondly, the evaluation team should assess whether the project is being carried out in a competent manner and make sure that priorities for action are clearly identified. In addition to this, the team should identify any need for further training, examine the community participation, assess the effectiveness of income generating activities, if one exists, and evaluate the adequacy of technical backstopping by **ADRA/I**.

Finally, when necessary, the team should recommend a course of action that will promote the highest quality performance for the rest of the life of the project.

V. **FREEDOM OF INFORMATION**

The ultimate responsibility for gathering and disseminating information from all of its regional offices around the world lies within **ADRA/I**. Therefore, **ADRA/I** expects the evaluation team particularly the hired consultants, to turn to **ADRA/I** all the data and other information which were used as the basis of the team's final inferences.

It is ADRA's position that no evaluation is final until it is presented to **ADRA/I's**, discussed with the consultants in an open manner, clear understandings of all conclusions and any **differing** views are reached between the consultant and **ADRA/I** as reflected in the final document.

ADRA/I considers it unethical for any member of the evaluation team to use information gathered during the evaluation assignment for anything other than the evaluation under study. Should viable reason present itself for using the information obtained for other purposes, then, **ADRA/I** must be consulted and prior permission secured. This must be adhered to, especially when the material is of a controversial nature and exclusively involves ADRA's internal affairs.

VI. **COMPOSITION OF THE EVALUATION TEAM**

The evaluation team will consist of Dr. Peter Mokaya (Independent Consultant), Betty McGraw (**ADRA/Hq**), Doris Jorgensen, (ADRA/Uganda Country Director), Israel Musoke Subakigye,

(ADRA/Uganda Health Coordinator), one individual from (USAID/Uganda) and one individual from (MOH).

VII. CALENDAR OF EVALUATION ACTIVITIES - 1996

Travel to Uganda	May 17
Design of evaluation reviewed by team	May 18 pm
Uganda evaluation visit	May 19-June 7
Writing of report by evaluation team	June 9-11
Report due at ADRA International	June 14

VIII. REPORT FORMAT

The Mid-Term Evaluation Document will be written using the following outline:

- 1 **Title Page:** The title page will state the name and project number, names and titles of consultants, and date and name of the document.
- 2 **List of Acronyms:** Unusual or obscure acronyms should be identified at the beginning of the report.
- 3 **Executive Summary:** The executive summary synthesis should be no more than two pages in length and will include: background of project, evaluation methodology, accomplishments and impact of the project, concerns and recommendations.
- 4 **Table of Contents:** The table of contents should outline each major topic section, appendices, figures, maps, tables, etc.
- 5 **Body of the evaluation:** The body of the evaluation report will include the following in sequential order:
 - *Introduction and background*
The introduction and background will include at a minimum: justification for awarding grant, goals and objectives of the grant, implementation methods, and the purpose of the evaluation.
 - *Evaluation Methodology*
The evaluation methodology will include at a minimum: description of data collection and evaluation sites selection processes.
 - *Sustainability Issues*
The section on sustainability issues will include sequential responses to the sustainability questions and issues outlined in the Child Survival Mid Term Evaluation Guidelines.
 - *Supplementary Issues and Questions*
This section will address in sequence the supplementary issues and questions outlined in this Scope of Work.
- 6 **Appendices:** The appendices included will be at the discretion of the evaluation team. However, the appendices must include the scope of work, itinerary for the evaluation visit., list of individuals interviewed/surveyed during the evaluation,

surveys and interviewer questionnaires, references cited, and maps. Additional appendices such as case studies, etc. may be included as determined appropriate by the evaluation team.

IX. BUDGET FOR EVALUATION

The budget for the Mid-Term Evaluation of **ADRA/Uganda's** Child Survival X project is attached.

APPENDIX C

Itinerary for Evaluation Visit

Mid-Term Evaluation Itinerary for CS-X Uganda May 19 - June 7

Date	Activity/Persons Interviewed
1 ^{9th} May (Sunday)	Debrief Project Director/Project Overview.
20 th May (Monday)	<p>Morning: Debrief Director ADRA Uganda</p> <p>Afternoon: Meet Project staff/debrief HIS Technical Advisor.</p>
21 st May (Tuesday)	<p>Morning: Interview technical advisors SafeMotherhood and Family Planning</p> <p>Afternoon: Hold discussions with Treasurer and Director ADRA Uganda.</p>
22 rd May (Wednesday)	<p>Morning: Meeting with local USAID CS contact person/Anne E.Kaboggoza Musoke</p> <p>Afternoon: Interview project technical advisors/Joseph Hayuni/John Kiyimba.</p>
23 rd May (Thursday)	<p>Morning: Interview the two sub-county supervisors and Technical Advisor/Agri. and Nutrition</p> <p>Afternoon: Debrief ADRA/I Mid-Term Evaluation Team Member/Betty A. McGraw</p>
24 th May (Friday)	Field visit/Bugema Health Center, Observe/Interview Medical Assistant and Midwife, Wilson Byakuno/Sarah Kiyenga respectively.
25 th May (Saturday)	Day off
26 th May (Sunday)	<p>Morning: Interview World Vision Child Survival Project Director/Johnson Ngorok</p> <p>Afternoon: Review of relevant reports/ start report compilation.</p>
27 th May (Monday)	<p>Morning: Visit DMOH and interview key personnel, i.e DMOH/Dr. Noah Lukoda and District Health Visitor/MS. Ruth Acham (Discuss issues of sustainability /take over</p>

of CS X activities and request one of them to join evaluation team as MoH representative.

27th May (continued)

Afternoon: Visit “DISH” field office and interview key personnel/MS. Aderela Bayada (Reproductive Health Services Trainer- Luwero training center) - Find out extent of networking and their collaboration with ADRA in aspects of reproductive health i.e **STD/FP/HIV/Aids**)

28th May (Tuesday)

Morning: Field visit to PLAN/I Field Office in Luwero/Conduct in-depth interviews with key personnel with a view to eliciting possible areas of collaboration with **ADRA's CS X project activities in Kalagala/Ziobwe**. Interview Field Office Manager/Steven Kadaali. (Probe for possible duplication of effort and possibilities of partnership with ADRA in implementation)

Afternoon: Visit AMREF field office in Luwero. Find out level of collaboration with **ADRA's CS X project** and share lessons learned on the sustainability of Child Survival projects activities. Interview Program Coordinator/Geoffrey Musisi and Child Survival Project Coordinator/l&. Juliana Mubiru (Probe on issue allowances to MoH staff and community volunteers.)

29th May (Wednesday)

Morning: Visit Uganda Aids Commission (UAC) and interview Desk Officer for Special Groups including the Safe Youth from Aids Project (SYFA) /Gabriel Kalungi (Explore issues related to Aids information Centers (AIC) and Safeguard Youth from Aids Project (SYPA) together with the National Aids documentation center (NADC), their linkage with the District Aids Coordination Committee (**DACC-RC5**), Sub-County Aids Coordination Committee (SCACC) and how

ADRA's Child Survival Aids related activities can be linked up to the existing structure for continuity and sustainability of project activities. Visit Unicef Country **Office** and interview person responsible for HIV/Aids /Tim M. **Rwabuhemba/Assistant Project Officer/and** find out about the Basic Education, Child Care and Adolescent Development (BECCAD), a partnership between the government of Uganda and Unicef.

29th May (continued)

Country Programme (1995 - 200) in the context of ADRA's Child Survival activities sustainability. Share Unicef s lessons learned with **ADRA**.

Afternoon: Visit and interview Health Director of SDA Health Services/Uganda in the context of networking and collaboration with ADRA's Child Survival activities for Sustainability and partnership.

30th May (Thursday)

Morning: Document AMREF/World Vision /**PLAN/I/Unicef/DMO** "sustainability issues/PVO networking/linkages etc.

Afternoon: Visit DISWSOMARC Country **Office** and interview Population Projects **Coordinator/Niranjala** Kanesathasan and explore possibilities of Social Marketing for Change (SOMARC) training ADRA's **CBDAs** to sell contraceptives at nominal fee to clients as an additional sustainability strategy. Document their lessons learned in the context of their Ugandan experience with a view to sharing with **ADRA** Child Survival X.

31st May (Friday)

Field visit to Kalagala; Observe/Conduct interviews with the following beneficiaries' representatives;

Chairman RC3: **Kalagala/John** Kaddu

Chief RC3: **Kigozi Ali** Chairman Sub-county Health Management Committee/Andrew Semambo (also Supervisor interviewed earlier)

Trainer: John Kityo (find out concern with workload, trainer technical knowledge, incentives/volunteerism)

CBV/CBDA: Joseph Sindyona (find out relationship with Health Center and VHC, concerns over incentives, content and quality of technical information, community perspectives of their role, any respect (status) and or appreciation), competence to deal with HIS forms and understanding of supervision/reporting and refresher training/replacement role of sub-county health management committee.

Medical Assistant Kalagala Health Center: Mr. Charles Musoke (**find** out if he has understanding of **ADRA** HIS forms, whether he appreciates his role as supervisor/trainer of midwives and CBV if he participates in **ADRAs** training activities, level of motivation and willingness and ability to take over supervision, reporting, report review, refresher training of **CBVs/CBDA** with the assistance of midwives at the HC.

Chairman of Busika village health committee (**VHC**): (Presentation of brief report of Child Survival activities) (interview to include whether they know that ADRA Child Survival will end and whether able and willing to sustain activities of **CBDAs**, TBAs and health promoters by providing supervision, handling and reviewing reports, giving recognition and status to community volunteers, providing refresher training and replacing drop-outs to ensure continuity of Child Survival activities after **ADRA** closes down. Probe on concerns about morale and spirit of volunteerism of the health promoters, find out their level of understanding of the HIS forms and whether they have internalized the fact that forms and information contained therein is for proper supervision and self-management.

Health Promoter: Monicah Nachiimba
(include whether they **fully** understand the key messages in the HIS forms reflecting the main CS X interventions), **find** out level of morale and willingness to continue with community volunteerism in health activities (Carefully probe on the issue of “soap” as an incentive).

1 st June (Saturday)

Day off

2rd June (Sunday)

Report reviews and update of findings

3rd June (Monday)

Morning: Field visit to Contact Farmer in **Kalagala/Mr. Sempa**; Observe food security activities and evidence of home gardening. Inquire role as contact farmer. (Make observations of kitchen gardens, presence and use of granary, types of crops cultivated, all season etc.

Afternoon: Discuss budgetary and HIS aspects of evaluation in the context of sustainability and suggest possible recommendations with **ADRA/I** evaluation representatives (Betty/Mike) and other evaluation **team** members. (Incorporate feedback to evaluation recommendations). Update evaluation report/ recommendations (input from team members)

4th June (Tuesday)

Morning: Field visit to Ziobwe Health facility and conduct activities similar to Kalagala. (Health center and CF later)

Afternoon: Exit debrief visit to **USAID** with Child Survival contact **person/Ms. Anne Musoke** at USAID offices. All members of evaluation team present except MOH representative (Incorporate feedback of meeting into evaluation report recommendations)

5th June (Wednesday)

Morning: Exit debrief with AMREF Country Office

Child Survival project
officer/Mrs.Bemadette Busingye
Babishangire and World Vision Country
office/HIV/Child Survival programs contact
person: Ham Owouri.

Afternoon: Field visit to Ziobwe Health Center and interview Medical Assistant (in-charge/Stephen **Mbazira/discuss** current level of participation in CS X activities and discuss ways of working closer with ADRA staff with view of taking over the project activities, management and supervision after ADRA stops their contribution. Conduct an exit debrief with DMOH representative/Ruth Acham/emphasis on closer collaboration with **ADRA** with view to sustaining activities in the two Sub-counties beyond the life of **ADRAs CS X** project.

6th June (Thursday)

Morning: Debrief ADRA Director, ADRA Treasurer, Regional Director (Vice- President), Associate Health Director **ADRA/I** and incorporate their input into evaluation report recommendations.

Afternoon: Conduct exit debrief for project staff at project office site.

7th June (Friday)

Debrief MOH **Entebbe/Depart** for Nairobi.