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**ANNUAL REPORT - SAWSO MATCHING GRANT**

*Grant No. FAO-0158-A-00-4066-00*

**OCTOBER 1994 - SEPTEMBER 1995**

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## I. Background to Grant and Project Context

The Salvation Army has provided health services to developing countries since 1892. It has a broad network of hospitals, clinics, and training programs throughout the world, and it has recently expanded its activities in support of the Child Survival Initiative and HIV/AIDS.

In addition to these recently expanded health activities, there are other pressures that are causing a reexamination of how the Army approaches its health programs. These are:

- 1) the realization that more people, especially the most needy - those traditionally served by the Army, can be reached through community-based health programming;
- 2) the high cost of maintaining a hospital-based system; and
- 3) community-based health programs are more effective in promoting community involvement in health care issues and are more sustainable programs.

At present, the goal of The International Salvation Army is to move toward the provision of genuinely community-based health services by decentralizing its health systems and making them more self sufficient.

This matching grant program builds on both SAWSO and Salvation Army experience in health care and local capacity building. Programs in four countries are targeted: Bangladesh, Indonesia, Ghana, and Zambia. Each of these programs is in a different stage of development and faces unique challenges, from those strictly clinic-based programs to those which have already evolved to a more community-based system. Whatever the case, this grant program will develop and strengthen these programs and develop models to fit different contexts - cultural, medical, and economic. Lessons will be shared between Salvation Army projects and lessons will be learned from the experiences of other PVOs.

The strategies implemented include:

- 1) training health staff and community members in basic health principles and practices;
- 2) developing and applying community-based approaches to existing programs;
- 3) providing local and international technical assistance in management systems, monitoring and evaluation, health information systems, community mobilization, and program and financial sustainability strategies; and
- 4) documenting community-based approaches and sharing those with other programs.

A Knowledge, Practice, and Coverage baseline survey for each of the programs was completed in February-April, 1995. Already the benefits of the matching grant program can be seen. Action plans have been modified to meet newly discovered needs in the communities as a result of the survey, and new strategies proposed where necessary.

## II. Project Methodology

1. The project **goal** is to improve the health status of reproductive-age women and children under-five in targeted communities in Bangladesh, Ghana, Indonesia, and Zambia. The purpose of the project is to increase the capacity of the local Salvation Army NGOs in the four countries so that they can develop, implement, monitor, and evaluate sustainable community-based health programs.

**Objectives** include: providing outreach health services to communities and involving communities in managing their health problems (as opposed to providing clinical services only); developing health information and monitoring and evaluation systems to meet the needs of community-based health projects; and improving the knowledge, skills, and attitudes of project personnel and community members regarding health services and issues.

Participatory **methodologies** are applied and promoted in most areas of the project, from training field staff in participatory training methods for use with field staff and community members, involving community members in baseline survey activities, creating or improving community health committees for participation in the project and public health issues, community health insurance programs, to encouraging community involvement in project planning.

The **strategy** being followed can be examined at two levels: capacity building at SAWSO and capacity building for field health staff. SAWSO's capacity is being increased to enable transfer of knowledge to the local Salvation Army staff managing the projects in specific areas. These areas include baseline health assessments, monitoring and evaluation, and health information systems.

Field capacity is being increased by training and technical assistance received from SAWSO staff, in-country training sessions provided by local consultants, and sharing lessons learned with other NGOs and other Salvation Army programs. Capacity will be built in baseline surveys, monitoring and evaluation, community mobilization, health information systems, and project planning and management.

This strategy includes women at all levels: SAWSO staff has an equal distribution of women and men; women are well represented at the field level -three out of four project directors are women and the majority of community health workers are women; at the community level the project targets women of reproductive age and communities are strongly encouraged to include women on community health committees.

**Key inputs** for achieving this strategy include: conducting a baseline assessment of current health status and approaches to community health in the project catchment areas; technical assistance; training; and information sharing/networking.

General expected **outputs** for the project are:

- 1) personnel trained and capacity built in the above mentioned areas both at SAWSO and in the field;
- 2) health information, monitoring and evaluation, and assessment systems developed;
- 3) improved health service delivery and coverage;
- 4) techniques and methods developed and documented for involving communities in public health issues.

2. The general project accomplishments originally proposed for the first year include the following:

- Finalization of implementation plans (detailed implementation plans).
- Develop and strengthen monitoring and evaluation skills of SAWSO and field staff; work with evaluation consultant.
- Review of quantitative and qualitative grant indicators.
- Design of monitoring and evaluation system for building NGO capacity in health service delivery and for community mobilization.
- Beginning work on developing and refining health information systems for each country project.
- Conduct baseline assessments of health status and approaches to community-based health care.
- Refine computerized training database program.
- Field staff submit status and financial reports to SAWSO.

The following accomplishments have been achieved:

- Detailed Implementation Plans were completed and submitted. Within these plans are results of the baseline survey, action plans, and indicators.
- Monitoring and evaluation skills have been greatly enhanced by training in a knowledge, practice, and coverage baseline survey at both SAWSO and the field level. In addition, SAWSO has been looking at other PVO efforts in this area such as the Primary Health Care Management Advancement Programme. An evaluation consultant is scheduled to work with SAWSO staff this month.
- Quantitative and qualitative indicators have been developed and will be reviewed with the evaluation consultant working with SAWSO this month. Indicators are discussed further in the next section.

- A tentative design of the monitoring and evaluation system is developed and will be reviewed by the evaluation consultant this month.
- Health information systems for each country are either being developed or refined. Three out of the four projects have systems in various stages of completion.
- Baseline assessments were conducted between February and April of this year.
- Refinement of the computerized training database program has not taken place because it was decided that it is not a very useful exercise.
- Field staff have submitted status and financial reports to SAWSO.

### III. Monitoring and Evaluation

1. SAWSO has put into place or is in the process of putting into place all of the monitoring and evaluation activities originally proposed. As capacity has grown at SAWSO in monitoring and evaluation, critical indicators have changed to reflect this new knowledge.

- a. **Baseline Data**

Baseline data was collected through a knowledge, practice, and coverage (KPC) survey developed by Johns Hopkins University. SAWSO staff participated in a two week training course in December, 1994 in KPC survey methodology and techniques.

During the subsequent technical assistance visits to the field, SAWSO staff trained core health team staff in conducting the KPC survey. Surveys were conducted between February-April, 1995. At all project sites, conducting the survey served to educate, motivate, and inspire core team health staff.

Action plans were developed out of survey data and are discussed in the Detailed Implementation Plans submitted in late April, 1995 along with extensive survey reports which outline the baseline data collected.

- b. **Targets**

Targets were set and defined in the action plans developed following the survey for each of the country projects. They are included in the Detailed Implementation Plans which were then reviewed by USAID and recommendations were made for modification as needed.

- c. **Critical Indicators of Effectiveness**

Critical indicators of effectiveness in terms of health service delivery are outlined in the Detailed Implementation Plans for each country project. They have also been reviewed by USAID and modifications made as necessary.

Indicators for other project-wide activities (community involvement, capacity-building, monitoring and evaluation, etc.) have been developed and will be reviewed by the evaluation consultant in mid-September, 1995.

- d. **Monitoring Plan**

SAWSO technical staff will take indicators developed for on-going monitoring to the field on their technical assistance visits this fall. Prior to those trips, the evaluation consultant will review those indicators to assure appropriate coverage and validity. During the visits, SAWSO staff are also reviewing monitoring systems already operating in-country.

Zambia's health information system has been reviewed by an in-country consultant. Indonesia and Bangladesh have existing systems and these systems will be reviewed by in-country consultants. Ghana has been reviewing their own data collection in preparation for discussion with a consultant in mid-October.

**e. Evaluation Plan**

Periodic evaluations take place in country programs already: Bangladesh and Indonesia review project activities annually and Zambia reviews project activities every six months. Activities and processes that take place during these evaluations are being reviewed by SAWSO and consultants to assure that the information collected is relevant (for example, in two of the projects it seems that too much information is collected and not analyzed properly), useful, and shared with communities.

2. The formal mid-term evaluation for the overall grant will take place in August/September 1996. The evaluation consultant visiting SAWSO in mid-September, 1995 will review the evaluation plan developed. The KPC survey will be conducted in late 1997 as part of the final evaluation. Specific arrangements for monitoring and evaluating gender issues, specifically including women as participants and beneficiaries have not been made because the majority of participants and beneficiaries are women.

IV. Review and Analysis of Project Results by Country

***ANNUAL REPORT - SAWSO MATCHING GRANT***

***GHANA***

***OCTOBER 1994 - SEPTEMBER 1995***

***AND***

***RESPONSE TO REVIEW OF DIP***

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**ANNUAL REPORT - SAWSO MATCHING GRANT  
GHANA**

**October 1994 - September 1995**

**Goals**

The primary goals of The Matching Grant project in Ghana are:

- I. To expand and improve outreach and clinic-based health services;
- II. To involve communities in planning, implementing and evaluating health activities.

From January through August 1995, program staff focused their creative energies on community involvement while maintaining the same level of health clinic and outreach services. However, there is evidence of improved service coverage as an immediate result of community participation.

**Matching Grant, Year One Objectives, Strategies and Activities to date:**

**Objectives**

- I. Each of the seven Salvation Army clinics will collaborate with communities in their catchment areas to set up community health committees and work together to prevent and control community health problems.
- II. Health Information Systems will be assessed and redesigned as necessary to facilitate monitoring and evaluation of grant activities.

**Strategies**

Strategies for achieving these objectives were discussed as part of the analysis and planning sessions of the KPC Baseline survey (March 1995).

It was decided that:

- Although clinics provide a range of services that are similar from clinic to clinic, attempting to improve services and build community involvement might be difficult to accomplish all at once and in every activity, therefore: Each clinic could choose a particular health intervention to improve and use as an entry point for involving communities in their own health.
- Anum and Begoro clinics chose to focus on immunization, Wiamose and Ba clinics will focus on malnutrition, Duakwa clinic on family planning, and Wenchi clinic on Child to Child health education through the vision screening program.
- Sopa clinic chose a different approach. They will focus on community participation in all health interventions rather than just one.

## **Activities**

Matching Grant activities in support of these strategies included: institutional development, training, team building, supervision, networking and technical assistance. Progress made in these areas from October 1994 through August of 1995 are listed below.

### **Institutional Development**

#### **October - December 1994**

- I. The last three months of 1994 saw the completion of a 5 year plan for building staff skills in planning, management, monitoring and evaluation of health programs. A part of this 5 year plan included an attempt to establish treatment and training protocols and to improve clinic skills. Using hands on assistance, weekend seminars, half day seminars at individual clinics and outside agency trainers, much was accomplished which will directly affect Ghana's ability to implement and sustain the objectives of the Matching Grant project.

As a result of these efforts, the Ghana Matching Grant program has been launched with these institutional improvements in place:

- All clinic staff have been upgraded in their particular job ("All staff" includes every employee including grounds keepers, cleaners, watchmen, ambulance drivers, clinic aides and nurses);
  - Three of seven clinics are operating laboratories with skilled technologist;
  - All ambulance drivers have been certified in vehicle maintenance;
  - Sixty staff members have been trained in counselling.
- II. Clinic teams were chosen to implement the matching grant activities, and teams met to review clinic-specific project objectives and to make preliminary arrangements for the KPC survey.

#### **January - March 1995**

- I. In preparation for the KPC survey, seven clinic health teams were formed. In consultation with the SAWSO consultant, the teams planned and implemented survey activities, tabulated and analyzed the results, and formed a strategic plan for each clinic, based on those results.

## **April - August 1995**

- I. Clinics teams reported the survey results to communities, tribal leaders and government officials in each catchment area.
- II. Community involvement in the health program was discussed, and some communities agreed to form health committees and participate actively in health activities (see team building).
- III. Matching Grant institutional development objectives for year one included revision and/or upgrading the Health Information Systems. Clinic teams reviewed their HIS systems in preparation for having them evaluated and assessed by an in-country HIS specialist in early October. The teams looked at what kinds of data were collected, what data collection instruments are in place, and how the information collected is currently used.

## **October 1995**

During the SAWSO technical assistance visit in October, clinic teams will:

- I. Meet together and share their community-interaction experiences to date. Problems will be identified, lessons learned will be reviewed, and plans will be made for year two of the grant. Changes/adjustments in strategies will be based on the experiences shared. Lessons learned by one clinic will be adapted and/or applied to that intervention in all clinics.
- II. Discuss interactions and collaboration between the health program and Salvation Army corps (church units or parishes), SA volunteer groups (such as The Salvation Army Home League and League of Mercy), other community groups and government organizations.
- III. Discuss the integration of PHC work and HIV/AIDS work in their catchment areas. The Salvation Army in Ghana has recently received a grant to work with HIV/AIDS. The same clinic teams that are involved with the Matching Grant are also implementing the HIV/AIDS work.
- IV. Share their findings with regard to the appropriateness of their HIS systems and decide what help they need from an HIS consultant in order to improve the system process. It is understood that improvements will be constrained somewhat by the reporting requirements of District Health Offices.

## **Team Building and Training**

### **Team Building, April - August 1995**

- I. The core teams formed at the time of the KPC survey have continued to meet, plan and implement the strategies outlined for each catchment area.

II. Community health committees have been formed in Anum, Ba and Sopa.

- Committees in Anum have been trained in immunization mobilization and education. Their activities include: contacting families and encouraging them to bring the children for immunization on outreach days; helping with crowd control; counselling mothers about the side effects of each antigen and when the next immunization is due; reporting on immunization coverage at community meetings and discussing with community members any issues related to the immunization outreach program.
- Community leaders in Ba have formed committees which oversight demonstration gardens in 4 of the outreach communities; The Salvation Army is providing seeds for the farms and technical expertise (The SA Agricultural extension officer) for the gardens; communities are providing the land and the labor to plant and maintain them. Community health committee meetings plan activities and document progress accomplished.
- Community health committees in Sopa have been trained in communication skills, training skills and health education. After the completion of the initial training, community committees and clinic health teams facilitated "Malaria Awareness Day Celebrations" (mini-durbars) in three communities. The celebrations included dramatization of malaria health messages in song, dance and drumming. Participating communities followed the celebration day with a community clean up day during which rubbish sites were identified and dug, and mosquito breeding sites were eliminated. Each community also made a plan for keeping their environment malaria free.

The success of this attempt at involving communities has encouraged the community health committees and clinic teams to continue to make every health intervention "community-friendly".

**Training, April - August, 1995**

- I. Training has been a part of all of the activities listed above: Community health committee training, KPC survey training, and agricultural training.
- II. Other kinds of training took place in Duakwa and Wiamose, where community health committees have not yet been formed:
  - Duakwa trained 9 health workers in family planning. Delegates to the training were Salvation Army staff and representatives from other religious groups who are involved in family planning.

- Wiamose, whose focus in the grant is on malnutrition, have trained under-five clinic staff in: implementation of food preference surveys, nutrition demonstrations and participatory nutrition education.

### **Supervision and Networking**

#### **Supervision, April - August, 1995**

- I. Clinic and outreach supervision has proceeded as usual. A new health project coordinator was appointed effective July 1st. She spent the months of July and August visiting health centers, reviewing project objectives, and discussing project implementation, supervision and evaluation with clinic health teams.
- II. Those clinic who have been able to facilitate the formation of community health committees have added supervisory support for the committees to their ongoing monitoring responsibilities.

#### **Networking, April - August, 1995**

- I. Wiamose clinic teams visited nearby nutrition rehabilitation units to share information and gather ideas for their nutrition rehabilitation activities.
- II. Duakwa invited other religious NGO representatives to participate in their family planning training and used a local community health nurse as a trainer.
- III. Project staff at Ghana headquarters have established links to local health education resources for IEC materials and for training assistance.

### **Technical Assistance**

#### **October 1994 - August 1995**

- SAWSO consultant made three technical assistance visits to Ghana in year one: in October, 1994 to discuss and plan the project start-up activities; January and March for preparation, training and implementation of the KPC survey.
- Internal consultants have been used for training in management, counselling and technical skills building.

## Response to Review of the DIP - SAWSO Matching Grant

### GHANA

The reviewer's critique of the DIP was discussed with the Project Director in Ghana and/or responded to by the SAWSO consultant, based on current field information which was not available when the DIP was written. Field and SAWSO staff feel that the review was a fair assessment of the situation in Ghana. Criticisms were constructive and recommendations were well accepted. Listed below are responses to the specific weaknesses noted by the reviewer.

#### General Comments: Dispersed settings of the seven field sites.

**Recommendation:** none given

**Response:** There is daily communication between all clinics as well as monthly planning meetings in Accra and integrated training activities. However, the Ghana staff recognizes one aspect of the grant implementation plan that is somewhat related to the geographic dispersement of clinic settings.

The potential problem is this: Given the challenge of making the health program community-based, six out of the seven clinics chose to focus on one health intervention at time, using the intervention as an entry point to community, testing strategies for community involvement in that setting before using them in another. For example: Anum chose to focus on immunization, working with community health committees to plan, mobilize, address issues of non-compliance and help overcome resistance to immunization in creative, culturally sensitive ways. (see annual report for other examples). Other clinics chose different interventions to use as entry points to community. The problem with this approach is that even if each clinic improves coverage and related services in one intervention, progress in improving services and coverage in other areas will be very slow even if community participation is high.

The project plans to address this problem in the following fashion: Throughout the life of the grant, strategies that work well will be documented and shared on a quarterly basis. Lessons learned in how to make health services community based will be shared, as well as successful strategies for improving coverage in specific interventions. Clinic teams will be able to apply/adapt those strategies to their own setting without having to re-invent them. The first sharing and documentation of this approach will take place during the SAWSO technical assistance visit in October. At that time plans for sharing information and creative ideas on an ongoing basis will be set in place.

### **Baseline Survey: Immunizations**

**Recommendation:** SAWSO should calculate immunization coverage using the standard 12-23 month age group, and submit the calculations to USAID as an appendix to the survey report.

**Response:** Although all project staff in-country agreed (by unanimous vote) that the current Ghana immunization policy has been changed to reflect setting targets for individual antigens and tracking them separately, rather than setting targets for complete immunization at a certain age, it was anticipated that we might be required to recalculate the coverage again.

To that end, the immunization survey data have been collected and put aside until the SAWSO TA visit scheduled for October 1-8. At that time clinic teams will re-tabulate the questionnaires and re-tabulate the results. Targets for immunization will be revised as appropriate at that time and submitted to USAID as an appendix to the survey report. NB. The SAWSO consultant could have re-tabulated the rates herself in the interest of saving time, but chose not to do so in order that the core survey team could participate in the process and learn from it.

### **Community Involvement**

**Recommendation:** Field staff should report on the results of meeting with project communities as soon as possible, and indicate the specific ways that the communities will participate in project implementation, monitoring and evaluation. Field and SAWSO staff should then draw up a plan that focuses on the specific **changes** that will be made in the project's relationship with the community and submit it to USAID by midterm in the grant. It should include the new or changed **structures** that have been put in place, such as community health committees; the **membership** in any community groups or contacts that are in place, the **frequency** and **setting** of project-community contacts and the **roles** of each of these groups or contacts (i.e. participates in ongoing monitoring of effectiveness of Home Leagues health education program; takes part as a full team member in the final project evaluation; serves as community consultant in the design of health education messages, etc). Only if the roles of community groups, members and leaders are very clear will the project be able to evaluate their effectiveness, and make needed changes to improve the strategy.

**Response:** Subsequent to the KPC and to the DIP, SAWSO headquarters staff drafted sets of indicators which could be tracked on a continual basis and used to evaluate progress in community involvement, institution building and health intervention strategies. First drafts of those indicators were completed in August of 1995. An evaluation consultant with significant community development expertise has been contracted to review those indicators and suggest appropriate changes/additions that might be useful, by mid-September.

The evaluator will discuss his recommendations and explore necessary adjustments/ changes in the indicators that are appropriate to specific grant countries on September 13, 1995. SAWSO program consultants will carry copies of the evaluation indicators chosen and review them with their respective MG country staff. Ghana staff and the SAWSO consultant will review the indicators in October and use them as a component of their strategic plan for year two of the grant. The plan will include indicators for the community involvement components that were suggested above.

### Training

**Recommendation:** SAWSO should assure that the new Health Project Coordinator has been oriented to the variety of training approaches that may be appropriate for this project and that have been used in other Salvation Army settings, such as the "Training for Transformation" approach. In selecting trainers and training topics for the duration of the grant, care should be taken the trainers and topics selected are oriented to a genuinely participatory and collaborative approach to health and community development. Senior management staff should be the first trained in any new approaches that are to be implemented.

**Response:** The new Health Project Coordinator has had considerable training experience in other assignments. How participatory and which training methodologies she is familiar with will be explored by the SAWSO project consultant in October. Other relevant health staff, such as the previous Health Project Coordinator (who has been asked to stay on for a few months to provide continuity to the program) the Projects Officer (who is implementing Home League health education activities using a process similar to the system used successfully in the Kenya CSI project), and clinic teams who have already begun participatory training of community health committees in their project sites will contribute to the discussion about appropriate training methodologies as well as assessing what kind of training needs to be made available and to whom.

"Training for Transformation" is familiar to some of the project staff, but they have not used it to any great extent because they have focused on delivering services rather than involving communities. It will be one of several training tools made available and explored as part of the annual plan for community participation. Training plans for year two of the grant will be solidified in October and will include training for management staff as a first priority.

### Country Nationals

**Recommendation:** Given the commitment of the project to phase over gradually to Ghanaian staffing, the project should indicate any current plans to phase over any of the existing 10 expatriate positions to national staff, particularly positions having more responsibility in the planning and management of the project.

**Response:** Qualified Ghanaians who are not Salvationists are **not excluded** from serving in responsible positions in the clinics. The limiting factor in terms of clinic heads is that the Salvation Army prefers to have Salvation Army officers (i.e. trained pastors rather than Salvationist church members) in charge if they are professionally qualified to do so. Qualified nurses are in short supply in Ghana at large and even less so within the Salvation Army structure. The Ghanaian government health services have first call on professional staff placements because they pay health staff salaries wherever they are assigned. Secondary level responsibility is assigned to Ghanaian staff wherever possible. To address the shortages of qualified senior level Ghanaian staff, provision has been made in this project for upgrading of current staff so that they can assume more responsibility. They will be included in the training plan put together in October.

### **Project Information System**

**Recommendation:** A consultant who is skilled in the development of small-scale health information systems should be employed early in the project life to assist with the revision of the project's information system.

**Response:** \$2000.00 has been set aside for this purpose. It is expected that an in-country consultant will be identified in time to be introduced to project staff during the October planning meetings. A revised HIS system is expected to be in place by the mid-term of the grant.

### **Evaluation**

**Recommendation:** SAWSO staff should discuss with field staff the project's plan for a final evaluation, reviewing possible sources and uses of qualitative and quantitative data, and determine the general approach that will be taken.

**Response:** (See response to Community Involvement recommendation above). An evaluation consultant has been contracted to help us formulate a plan for evaluation that can be adapted to each country's objectives. An evaluation is planned for September of 1996. It is essentially a mid-term evaluation that is being required in preparation for the application for a project extension from 3 years to 5 years. It will be too soon to use a KPC as a tool for evaluation, so we recognize that focusing on an evaluation plan at this time is critical.

### **Lessons Learned Workshop**

**Recommendation:** Field staff and SAWSO should reconsider the timing of a midterm "lessons learned" workshop.

**Response:** The lessons learned workshop has been postponed till the last year of the grant. Project teams have indicated that when it is held, they would prefer that it be an Ghanaian/NGO workshop rather than an international one. The feeling is that a country specific workshop would be more useful and less expensive.

The opportunity to see how health programs in other countries are implementing projects is of interest to project staff, however. Other ways of sharing information between regions and/or between countries is being explored. One of the ways under consideration is for SAWSO staff to document country specific activities on video as they travel from place to place on their technical assistance visits. Later the videos can be reviewed and shared.

### **Budget**

**Recommendation:** That project staff should discuss how the project will meet its need for technical and training assistance at the field level, and consider allocating some of the headquarters costs to technical assistance for the field.

**Response:** A portion of the technical assistance required for this grant will be supplied by the SAWSO program consultants, either by applying their own expertise or by obtaining technical knowledge gleaned from consultant expertise contracted for headquarters staff and sharing that expertise with country staff on TA visits.

**(See Evaluation response).**

A significant amount of money has been added to the project line item for consultants. Training, HIS and community development consultants in particular, will be sought at country level rather than from outside.

***ANNUAL REPORT - SAWSO MATCHING GRANT***

***ZAMBIA***

***OCTOBER 1994 - SEPTEMBER 1995***

***AND***

***RESPONSE TO REVIEW OF DIP***

## **Annual Report for Zambia Matching Grant October 1994 - September 1995**

### **Activities Accomplished**

The Chikankata primary health care program continued its out-reach activities. The team provided:

- Mother Child Health (MCH) coverage at 25 of the Village Health Clinics (VHC), 9 times during the year
- Immunization, health education and environmental inspections at the 28 schools, 3 times during the year
- Supervision, training follow-up and support to 25 communities each month.

An integrated team representing the community development department and different departments within the hospital spent a week, two separate times in the year at three of the four rural health centers. They provided training for rural health center staff and community volunteers and hold meetings with communities where there are community volunteers and the village health advisory committees. The purpose of the meetings were for relationship building through focussed group discussion and listening surveys. The staff at each of the 4 Rural Health Center visited each Community volunteer at least once a month.

### **Baseline Assessment**

In March 1995, a Knowledge, Practice and Coverage survey (KPC) was conducted of mothers with children under 2 in the catchment area. The survey provides baseline information from which to determine the goals and objectives for the matching grant. The survey was conducted in cooperation between The Salvation Army and USAID, with training provided by PVO Child Survival Support Program, Institute for International Programs of the Johns Hopkins University School of Hygiene and Public Health.

One of the most exciting things about the KPC survey was that within one week of completing the survey a meeting was held with the communities involved in the survey, in which was presented the draft report of the findings. The "Results " and "Discussion" sections of each portion of the survey were presented by the supervising team that analyzed that section. There was then time for discussion and feedback. Over 100 mothers, community health workers, and headmen, from 15 of the 30 communities surveyed, attended the 3-hour long meeting. The community members were very impressed with the quick turn around time and the discussion was very lively. The discussion helped to varify the resusts of the srvey.

### **Changes in Original Plan**

Among the many findings of the survey, one has resulted in major changes. A large number of community trained volunteers are not being utilized. For example, the KPC survey revealed that, in the case of diarrhoea, in response to the question of "Who do you go to for advice?", only eight of the more than 300 mothers surveyed stated that they went to the community health worker. This reveals that they are not using the structure as it should be used; they are not using the community health worker as the first point of referral. There were similar responses for respiratory illnesses and malaria. It was important, therefore, to investigate why they are not being used before training additional community volunteers.

It was decided, that rather than following the original plan of training additional volunteers, the first year of the grant would be spent focussing on retraining and supervisory visits to community volunteers and exploring the reasons why volunteers are not being used. Two day discussion meetings were held with community health workers, trained traditional birth attendants, church service groups, church leaders, community sanitation workers, and HIV/AIDS community counsellors. Each volunteer was also visited by the rural health center staff or the hospital outreach staff at least four times in the year. The outreach staff also met with community health advisory committees in areas surrounding the three of the four rural health center. All these discussions pointed out several constraints that make the current outreach program less effective.

The constraints include difficulty in keeping the rural health centers manned (they are remote and staff don't want to stay there), and the difficulty of providing adequate supervision for community volunteers. It is also a concern that the mobile clinics which continue to go out from the hospital to provide essential services (such as immunization) may be fostering dependency and undermining the work of the community volunteers.

### **Restructuring of the Outreach Program**

It was determined that the outreach program needed to be reorganized as soon as possible in light of the KPC findings and the discussions with communities and community volunteers. In May a team including hospital staff, outreach staff, and external consultants including the SAWSO program consultant met to begin this process of reorganization. The outcome of the re-organization is as follows:

<b>OLD STRUCTURE</b>	<b>NEW STRUCTURE</b>
<ol style="list-style-type: none"> <li>1. Chikankata Hospital connected to four rural health centers, which are connected to 40 village clinics.</li> <li>2. Mobile clinic system run out of the hospital which visits 25 locations, 9 times a year.</li> <li>3. HIV/AIDS, Lep/TB, Nutri, Comm. Dev. and other teams go out to the community separately.</li> </ol>	<ol style="list-style-type: none"> <li>1. Chikankata Hospital focuses on staffing, supporting, supervising and serving as a referral point for the four rural health centers through monthly day-long trips, week-long trips and community-based training. Four rural health centers, with the support of the hospital outreach staff, support the 40 village clinics and the trained volunteers.</li> <li>2. Reduce the mobile clinic program by a 1/3 each year.</li> <li>3. Hospital outreach team go out together forming integrated teams.</li> </ol>
<p>Centralized curative health approach</p>	<p>Community-based primary health care approach, focussing on getting the community involved in developing strategies to understand and deal with there health needs (the process of facilitating community participation is outlined in the response to the Zambia DIP review, pages 3-4).</p>

## **Redesign of the Health Information System(HIMS)**

A local consultant from the University of Zambia, who has worked on developing HIMS for the Ministry of Health, was hired in July to work with the Chikankata Outreach team on redesigning the HIMS. His plans include:

- Reviewing all currently used information gathering tools
- Working with the team to determine what information needs to be collected
- Designing new information gathering tools
- Designing a system for using the tools, which ensures that information is gathered on a regular basis
- Exploring with the team the ways in which this information is used
- Working with the team to ensure that the monitoring and evaluations systems proposed for the grant will work and that the redesigned HIMS system is a useful way of getting the information needed to effectively monitor and evaluate the outreach program
- Train staff to be able to be able to maintain the HIMS system

The current plan is that the redesigned HIMS will be completed in January of 1996.

## RESPONSE TO THE ZAMBIA DIP REVIEW

The Zambia DIP review was first reviewed by the SAWSO consultant. The weakness and recommendations were highlighted (including additional comments from the SAWSO consultant) and then sent on to Zambia for the Chikanakata team to discuss the comments and make changes where necessary. The following comments are the results of these discussions.

### Responses to Recommendations

1. **Observation:** A de-emphasis on the less cost-effective elements of the program, such as individual home visits by professional staff and mobile clinics, the time line of activities seems to indicate that these activities will continue unchanged throughout the program.

**Response:** The team agreed with these comments and realized that one reason why they had maintained the level of activities was as insurance. The team acknowledged that it was hard not to be fearful of making a major change without having a safety net to fall back on. The team however decided to reduce the number of mobile clinics trips by 20% and increase the number of visits to the rural health centers by 20% each year of the project. It was acknowledged that it will not be possible to do away with mobile clinics completely because there are some communities within the catchment area that do not have access to a rural health center.

2. **Recommendation:** Project staff should review the objectives and determine if some of the targets for the objectives might be increase. Specifically look at mother's knowledge of vitamin A-rich foods, adding oil to food, etc.; mother's knowledge that measles immunization should be given at nine months; mothers' knowledge of the signs and symptoms of acute respiratory infection; and knowledge that HIV is sexually transmitted. The immunizations objectives should also be increased.

**Response:** This has been an issue extensively discussed in the preparing of the DIP. Because the main goal is to radically change the structure of the Primary Health Care System, there is a fear that some things, like access to immunization, may be affected and therefore we should not set goals which are too high. The team did agree however that it could raise the goals to some degree.

### Revised Indicators

Indicators	% in DIP	Revised %
Increase % of mothers who know to give food rich in Vitamin A	from 48% to 58%	from 48% to 68%
Increase % of mothers who know to give foods rich in iron	from 24% to 34%	from 24% to 44%
Increase % of mothers who know to add oil	from 6% to 16%	from 6% to 36%
Increase % of mothers who know to give more foods after diarrhoea	from 35% to 40%	from 35% to 45%
Increase % of mothers who know chest indrawing is a sign of ARI	from 10% to 15%	from 10% to 40%

Increase % of mothers who know fast, difficult breathing is a sign of ARI	from 42% to 50%	from 42% to 60%
Increase access to immunization (DPT1)	from 72% to 75%	from 72% to 85%
Maintain levels of immunization (OPV3)	at 61%	increase from 61% to 71%
Maintain levels of immunization (Measles)	at 75%	increase from 75% to 80%
Increase % of mothers who know that measles should be given at 9 months	from 13% to 15%	from 13% to 30%
Increase % of mothers who know that HIV is sexually transmitted	from 47% to 52%	from 47% to 75%

3. **Recommendation:** The project should continue to include teaching mothers about dehydration, and emphasize its prevention through the early use of available home fluids and/or ORT, rather than the recognition of dehydration. Community volunteers should be taught to recognize dehydration, but their training should also emphasize preventive methods.

**Response:** Based on past experience, the team feels strongly that mothers will be able to recognize the signs of dehydration. The team also sees the importance of emphasizing preventive methods. It will therefore emphasize in its health education concerning diarrhoea the signs of dehydration, the use of home fluids and/or ORT and other preventive methods.

4. **Recommendation:** Given that the project aims to decrease reliance on clinical health services, health messages (such as going to a health facility to receive treatment when someone is displaying signs of malaria) should be examined to assure that mothers are not being taught to inappropriately increase their reliance on health professionals.

**Response:** Although it is very true that increase reliance on health professionals would be counter-productive, the early recognition and treatment of malaria is very important in an area like Chikankanta where there is a high incidence not only of malaria but cerebral malaria. The message being given to the community is to go to the community health worker as the first point of reference. The community health worker has the drugs to be able to treat malaria and will be able to refer up if needed.

5. **Recommendation:** It is recommended that for subsequent surveys Question 35 be split into at least two separate questions, one relating to methods of transmission and one, perhaps, to knowledge about the latency period. Knowledge of perinatal transmission and accurate understanding of the latency period are two areas of knowledge that are often low, even in high prevalence areas.

**Response:** In subsequent surveys question 35 will be split into at least two separate questions, one relating to methods of transmission and one to knowledge about latency period. Knowledge of perinatal transmission and accurate understanding of the latency period will be stressed in the HIV/AIDS prevention activities.

6. **Recommendation:** The project should more clearly define and develop the roles and responsibilities of community members in implementing the proposed changes in the project.

**Response:** The community involvement portion section of the project design section has been further elaborated as follows:

Promoting community "OWNERSHIP" will take place by shifting the focus away from service delivery to where the community (not just the village health workers or other trained volunteers) as a whole gets involved. The process used is one that has been successful in facilitating community ownership around the problem of HIV/AIDS called community counselling. The process is as follows:

**Community selection** - The project will focus primarily on communities which already have trained volunteers (community health workers, trained traditional birth attendants, church service groups, church leaders, community sanitation workers, and HIV/AIDS community counselling) health advisory committees. The project, however, does want to expand into remote unreached communities. Prior to working intensely with the community, the project will first develop a team of trained volunteers in these communities.

**Relationship building** - The project will start with those communities which have the most active trained volunteers and village health advisory committees. The idea is to work with communities which the project staff already has a good relationship and where there is a spirit of trust, cooperation and health needs are a priority.

**Exploration of problem** - Project staff will sit down with community volunteers, village health advisory committees and the community in general explore to health needs and their root causes. This is a time for both the project staff and the community to come to a better understanding of what the health problems of the specific community are and what are the root causes. The project team can provide useful health information and information concerning other parts of the catchment area, as well as, Zambia. The project staff are participants in this process and in the beginning may play a major role in facilitating discussion. The goal, however, is for the role of the project staff to decrease and the trained volunteers, the village health advisory committees and community to increase.

**Strategy formulation** - After the community has come to a point of understanding concerning the health needs that it is facing it is important to begin formulating strategies for dealing with these needs. It is important that the community determines the strategy and not the project staff. Project staff's input may be needed and links between the community and health institutions may be a part of the strategy.

**Decision-making** - After several strategies are formed the community must then make a decision on which it will implement. The danger here is that in the eyes of the project staff the community might not choose the right strategies to implement. In terms of ownership, however, it is important that the community makes its own decision even if it may be the wrong one.

**Implementation** - The community, supported by the trained volunteers, village health advisory committees and project staff then put into action the strategies which they have decided to implement. It is important that the strategies have built into them ways of monitoring.

**Evaluation** - Once a strategy has been implemented or has been in the process of implementation it is good for the community to see how well it is doing. If the strategies have good monitoring components the information will be there to be able to see how things are going. Seeing strategies succeed will encourage communities to move on to other strategies on their own.

In this project this process will be implemented by having the outreach project staff spend a week at each of the four rural health centers meeting with the health center staff, and the community volunteers, the village health advisory committees and the community in general in communities surrounding the health care centers. The health center staff, community volunteers, and village health advisory committees will be trained in how to facilitate the community counselling process, so that the process will continue in between the visits of the project staff. The plan is that the project staff and the health center staff will move from the role of being the main facilitators of the process to role of providing support and monitoring progress.

#### Summary of Community Development Activities

Community	Meet once a month to consider health issues using community counselling process
Community Trained Volunteers	Both in the initial training and periodic updates volunteers will receive train not only in their specific health area but also in community counselling and how to facilitate the ownership of health issues by the entire community
Village Health Advisory Committee	Their main work is to monitor and build ownership of health issues by the community. The periodic training they receive will focus on process of community counselling and skills for getting and maintaining community involvement.
Project Staff/Rural Health Center Staff	4 day course twice a year with a major focus on community counselling/ community development as well as in general health issues. The focus will be in helping the staff move from a strictly health delivery mind set to working together with the community and building ownership. The goal is to support and monitor the health work happening at the community level and to be a point of referral.

7. **Recommendation:** Following the revision of the HIMS system, by midterm if possible, the project should provide a clear and concise listing of the data to be collected at each level and its uses both for community feedback and within the health system.

**Response:** As stated in the DIP the HIMS system is being evaluated and will be redesigned. A local consultant has already been hired and it is anticipated that the system will be redesigned by mid-January. A priority will be to have a system that has a clear and concise listing of data to be collected and its uses both for community feedback and within the health system.

***ANNUAL REPORT - SAWSO MATCHING GRANT***

***BANGLADESH***

***OCTOBER 1994 - SEPTEMBER 1995***

# ANNUAL REPORT

MG IV GRANT YEAR 1 OCTOBER 1994-SEPTEMBER 1995

## BANGLADESH

### Overview

The first year of the Matching Grant was spent largely on analysis of the current status of the project and in forming plans for future direction. The focal point for this was the Knowledge and Practice Coverage (KPC) survey conducted in February 1995 with technical assistance, training, and oversight from SAWSO. This was a valuable learning experience for the project staff and provided vital information for formulating a Detailed Implementation Plan.

A follow-up SAWSO technical assistance visit in June 1995 helped to clarify issues raised in the KPC Survey and in the development of the detailed implementation plan. The project is preparing to introduce some new monitoring components in the second year of the grant. Some new objectives were formed and restructuring of old objectives planned. The following table outlines some changes in project objectives - a completely revised detailed implementation plan to be submitted shortly will discuss changes more comprehensively.

### 1. Restructured Objectives

OLD OBJECTIVES	NEW OBJECTIVES OR ADDITIONS
Weight Monitoring and Nutrition education for reduction in malnutrition	Restructured objective to include: <ul style="list-style-type: none"><li>● Early breastfeeding counselling</li><li>● Weaning practices counselling</li><li>● Monitor kitchen garden use</li></ul>
Diarrheal Disease: monitoring use of ORS	<ul style="list-style-type: none"><li>● Monitor appropriate feeding during and after episodes.</li><li>● Safe water &amp; sanitation motivation.</li></ul>
Maternal Care Monitoring	<ul style="list-style-type: none"><li>● Monitor practice of protein enriched food and leafy green vegetable intake in addition to present monitoring and education.</li></ul>
TB detection & treatment monitored.	Educate on early signs and symptoms of TB

## **2. Staff Training and Education**

This first year of the Grant has been largely devoted to Staff Training and Education, to strengthen the ability of VHW's (the survey indicated that they were not sought for advice when child was ill) and supporting staff to disseminate knowledge and influence practice of healthy lifestyles in an effective and meaningful way. It was felt that this was needed on a priority basis before any influence for community change can develop. Staff from other Salvation Army programs have also been included in training sessions conducted for project staff, the actual cost of training being charged to the different programs. Training modules have been developed, translated and tested on staff and will be further modified for future use in an expanded training program in the future.

### **Special Training Accomplished by the Project:**

- AIDS awareness and knowledge given to all staff members in training sessions.
- Basic counselling training given to AIDS Team members.
- Training of all nurses, VHWs, Health Educators and support clinic staff in universal precautions.
- Communication and Motivation Training for VHWs for three days.
- Training of Trainers for Health Educators and Leprosy Control Assistant for seven days.

### **Training given to Staff from outside the Project:**

- Training of Laboratory Technicians in HIV testing.
- EPI Training from local Government for upgrading skills.
- Office Assistant receiving Computer Training for three months.
- Health Services Director in India for six weeks leprosy training sponsored by The Leprosy Mission.
- Project Manager attended Training at GTZ in Dhaka in Goal Oriented Project Planning of 5 days. This is the first phase of a three-phase training programme for mid level management.

### **3. Community Education**

The main obstacle to effective change in the community is that men have been excluded from health education by Village Health Workers. This is mainly due to cultural prohibitions which prevent dialogue by women with men outside the family circle. No NGO in Bangladesh has been able to overcome fully the social barriers of this conservative society. Through new strategies introduced for HIV/AIDS awareness in the community both men and women are becoming involved in sharing information and education through community gatherings and volunteer educators.

#### **Training and Education for Community Members & Volunteers:**

- Traditional Birth Attendant Refresher Training - 2 days in which issues of early breastfeeding, weaning, immunization, and maternal dietary practice were highlighted.
- Training of new Bari Mothers who are depo-holders for ORS packets-for one day.
- Community based seminars for HIV/AIDS and Leprosy awareness which included truck and bus drivers, youth groups, religious groups, with use of video and slide presentations.
- In addition the Training Center has been used by other organizations for training and time was given for HIV/AIDS and Leprosy awareness by Project trainers to those attending. They included:
  - Village traditional healers and pharmacists from the Jessore District-240 participants.
  - Village nurses and midwives-100 participants.

### **4. Increase in Self Support**

Through rental of the training facilities to other organizations the project has been able to increase its self-earned income. In addition, project staff are being used as resource in training for the other organizations. This has included Government training programs conducted at the Center.

***ANNUAL REPORT - SAWSO MATCHING GRANT***

***INDONESIA***

***OCTOBER 1994 - SEPTEMBER 1995***

***AND***

***RESPONSE TO REVIEW OF DIP***

## ANNUAL REPORT - SAWSO MATCHING GRANT

### INDONESIA

Since the completion of the Detailed Implementation Plan in April, 1995, the Salvation Army primary health project in Central Sulawesi has progressed in each of the areas which have begun with the Matching Grant. The activities detailed below are in addition to the ongoing work of the PHC project in the areas of infant feeding, childhood nutrition, diarrheal disease, acute respiratory infection, immunization, maternal care, malaria. In these areas the ongoing work of education, preventive care and treatment has proceeded, involving village health workers, traditional birth attendants, field supervisors and the project core team.

The areas of new developments in this period are the following:

#### 1. Public Health Committees

The health team is working with three communities to develop public health committees (PHCs). To date there have been discussions with these communities about the importance of public health committees as a tool for taking control of their own health needs. The communities are then assisted in forming PHCs made up of honorary chairman, advisor, chairperson, secretary and representatives for various sectors (training, health, education, activities/funds). Throughout their work with the PHCs the team has focused on facilitating community responsibility, being careful not to assume direction or make the community's work dependent on service delivery by project staff.

Currently the three PHCs are meeting regularly, promoting health care curriculum in local schools, receiving training in how to do under 5 growth monitoring, sponsoring family health competitions and trying to provide an example of healthy living. In general the low educational standards and difficult economic situation are the strongest obstacles to active community involvement. It is hoped that at least the economic issue will be somewhat addressed by the agricultural extension work, but more strategic responses are beyond the scope of the current project.

The low educational levels in the communities affects all of the projects educational efforts. The team has struggled to find innovative ways of conveying health-related messages. They have intensified the use of appropriate visual learning aids - such as homemade posters - to spark interest and facilitate comprehension. A video is being locally made and there is hope for using video in other ways. In general there is an effort to make learning more participatory and to encourage the community to initiate action. This is one of the areas to be focused on during the technical assistance visit by the SAWSO Program Consultant in November.

The lack of direction from prominent villagers has been an obstacle to building effective community organization. In response, 15 village headmen are being trained in public health issues. During the second half of the year the focus will be on integrating more of the influential people in the village. A special effort will be made to reach out to religious leaders, emphasizing the importance of addressing health as part of holistic spiritual development.

## 2. Agricultural Extension

Although virtually all of the families in the area are agriculturalists, their production does not provide nutritious foods for day-to-day consumption because plots tend to be located too far from the homes. During the six months in which an agriculturalist has been working with the core team 5 model village gardens have been established. The model gardens demonstrate effective land use and agricultural techniques. In their educational efforts the agriculturalist and the field workers are emphasizing the importance of balanced nutrition for good health. The agriculturalist demonstrates the suitable nutritious crops, how to raise disease-resistant breeds of poultry and how to keep animals penned so that they do not destroy crops.

## 3. Community Health Insurance

Using knowledge gained from participating in workshops and observing projects of the Indonesian Association of Christian Hospitals in North Sulawesi, the health team has begun their work in this area with the mothers of children under 5 who participate in activities at each clinic. Currently the health team is establishing community-wide health insurance funds in two communities. The message being promoted is that community health insurance is a concrete expression of cooperative responsibility for health and a way of addressing the needs of the indigent. During the SAWSO technical assistance visit there will be a review of the progress made in this area and training in appropriate management methods.

## 4. HIV-AIDS

This last semester has signaled the beginning of open discussion of the pandemic in the project area. After an initial period of staff training and discussion, work has begun in the form of a generalized, initial informational campaign. This involves group discussion during meetings of women's groups, training for Salvation Army officers, young people (7-16 years) and the public health committees. The nature of the infection, the forms of transmission and the effects have been explained. People are concerned about how to prevent transmission and the health team has encouraged people to avoid sexual contact with people outside of their communities. The other focus of prevention education has been to discuss the importance of strong family and couple relationships. The strategies for incorporating HIV-AIDS education in the primary health care agenda of the project will also be reviewed during the SAWSO technical assistance visit.

## 5. Capacity Building

In addition to the work at the community level with the public health committees and the community health insurance funds, capacity building in this period has involved specialized training for project participants at each level:

- \* 25 officers and 25 local representatives of the Salvation Army are being trained in principles of public health, community participation and HIV-AIDS education and prevention.
- \* Young nurses who have recently finished their training at the Salvation Army teaching facility in Palu have also participated in workshops on public health committees prior to their stints as village nurses.
- \* Children ages 7-13 have participated in workshops addressing hygiene, nutrition, etc. These themes have also been discussed with religious leaders.

## Response to Review of DIP - SAWSO Matching Grant

### INDONESIA

The reviewer's responses to the DIP were discussed with the Project Director in Sulawesi and consensus was reached on each of the issues addressed. In general both field and SAWSO staff agree with the review. The following are responses to specific weaknesses which were highlighted:

#### **Nutrition:**

The reviewer was correct in pointing out the discrepancy in recommended weaning ages in the DIP - the standard age for weaning should be stated as 4-6 months instead of 5-8 months. 4-6 months is the age used when educating mothers in the field.

The term "weaning foods" for ages 10-24 months was used (incorrectly) in the DIP as a shorthand for the list of foods stated in the KPC survey. This has been corrected (see attached table).

#### **Diarrheal disease:**

Both SAWSO staff and field staff believe that asking who uses a latrine is feasible and is a more accurate indicator than number of latrines built or in operation. In the area there are many families who have latrines but do not use them. There is a strong cultural predilection for defecating in or around water and it has been difficult to convince people to use the latrines.

#### **Acute respiratory infection:**

The reviewer was correct in pointing out the confusion of the abbreviations for URI and ALRI in the DIP. This has been corrected (see attached table). In the project area the term ALRI is not used, however mothers are taught to recognize the signs of ALRI.

#### **Maternal care:**

Field and SAWSO staff maintain that the goal of 90% family planning use, although ambitious is feasible given the baseline of 81%. That high baseline figure does not surprise field staff and seems consistent with the Indonesian government's very strong emphasis on family planning.

In Objective 1e the term "trained personnel" does refer to TBAs as well as clinic personnel. The TBAs are all trained and most have been involved in the program for several years, receiving yearly refresher and new knowledge courses as well as monitoring by field supervisors. They are all equipped with a kit containing soap, apron, scissors, rubber gloves, kidney basin, plastic, cord, ties, gauze, alcohol, etc.

Women with high risk profiles are referred pre-labor to a clinic and are strongly urged to be close to the clinic prior to delivery. However, there are no hostels for expectant mothers associated with the clinics and many women are unable to leave home for any period of time to wait delivery. Those women do run the risk of being delivered by TBAs who are unable to deal

with the most severe complications. However, it is not feasible to attempt a transport system, given the arduous terrain - those in this situation may be several days distance by walking paths from clinics. It may be possible to consider creating hostels for expectant mothers but that is not within the scope of the current Matching Grant.

In addition to the factors described above, there is interesting research (although not from the catchment area) which documents rural Indonesian women's resistance to being delivered by community-based midwives (government certified personnel).<sup>1</sup> Women feel more confident with TBAs who are "valued for their experience in birthing and their ability to calm and relax their clients..." Midwives, on the other hand, are valued for their technical and problem-solving skills in emergencies. This association with problems is significant - for many women discussing possible complications is considered prophetic and they will not act to prevent such possibilities. To the degree that this research is indicative of beliefs in the catchment area, it further highlights the difficulties of inducing preventive action.

#### **Malaria:**

Although knowledge and practice of treatment for malaria was not addressed in the KPC survey, field staff report that mothers are very aware of the necessity of treatment and know that they can receive chloroquine at clinics in the area. Previously, VHWs were supplied with basic medicines, including chloroquine which they were to distribute at a small cost, as needed. However, the VHWs were inundated by demands for free medicine by family members, placing undue financial burdens on them. Medicines are now only available at the clinics, except for a few of the most isolated villages where the VHWs do keep a supply of basic antibiotics and chloroquine.

One issue which is unclear to SAWSO staff is the degree to which finishing the course of treatment is emphasized in health education. We will investigate this.

#### **AIDS:**

It was suggested by the reviewer that raising awareness did not sufficiently encompass understanding of transmission. In the area of HIV-AIDS it is crucial to consider the context. The pandemic is still intangible because there are no known cases of infection and very little migration to urban areas where infection is higher. In addition, it is only within the last year that the government has lifted the ban on public discussion of AIDS. Modes of transmission are discussed in AIDS education and awareness sessions.

The recommendation is made that other NGO projects be observed. The field staff has received training in HIV-AIDS education from the Indonesian Association of Christian Hospitals in Northern Sulawesi, which has a community-based program. HIV-AIDS is being included in the health curriculum at all levels of the project. A review of the specific format of the information

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<sup>1</sup> Mother Care Working Paper #19, as reported in *MotherCare Matters*, Vol. 5, No.1 Feb/Mar. 1995

and discussions at the staff and community levels will be part of the next technical assistance visit in November. Examples of Salvation Army experience in Zambia and elsewhere have been referred to and will continue to inform the work in Sulawesi.

**Institution building:**

The recommendation to include percentages instead of absolute figures (as targets) in the plans for institution building has been implemented (see attached table).

**Information system:**

The question was raised by the reviewer as to the quality of the information supplied by the VHWs and TBAs. The information is reviewed by both the FWs and the Core Team for statistical anomalies and is also checked against the information gathered by both the FWs and the Core Team on their community visits. The importance of careful information gathering is emphasized with the VHWs and TBAs during their annual training sessions and supervisory visits. Again, the geography of the area makes it necessary to rely on these local, trained volunteers for data collection.

The importance of feedback of data collected was pointed out: there is feedback and VHWs and TBAs are informed of where their communities stand relative to others. There are periodic competitions between villages.

**Staffing:**

SAWSO and field staff are aware of the need for additional supervisory staff and the budget includes two new positions. However, it has been difficult to find suitable candidates. The pool of VHWs would be a logical source but most of them are female and it would be unacceptable for them to travel alone for long distances between villages. If it is impossible to find new FWs, it will be suggested that the most capable and willing VHWs be upgraded to some form of local supervisory role. The implications for compensation for this new level would have to be defined.

The organizational chart has been changed to reflect the same job titles as the budget narrative (see attached chart).

**Evaluation Plan:**

The recommendation to conduct a midterm evaluation including both the results of the KPC survey and a study of project impact reflects the intention of the field and SAWSO staff. An independent consultant will participate in this work.

**Sustainability and costs:**

The cost:beneficiary ratio is relatively high. The most significant factor is transportation costs which are extremely high. Transportation includes both the means (usually horses which have become more expensive to rent since the increase in local coffee prices has raised their opportunity cost for farmers) and the time and supplies expended during travel. The project owns a couple of horses and has considered purchasing several more but it is not clear that this

would be less expensive, given the need to have horses at a number of different "launching sites" within the area, the expense of upkeep, etc.

The expenditure on medicines was mentioned as a point of concern. In addition to curative medicines, the figure of \$54,000 also includes some of the cost of contraceptives. Although the government had been subsidizing contraceptives the amounts of subsidized contraceptives for rural areas was reduced during the last year and a half and has only recently been restored. The project chose to buy the missing amounts rather than shut down its distribution in these areas.

The amount budgeted for medicines also includes the cost of medicines supplied to VHWs in lieu of other compensation for their services. This system will be reviewed to ensure that there are not systematic abuses.

In general the expenditures for medicine will be further clarified during the next technical assistance visit.

## I. Infant Feeding

**GOAL:** By the end of the project period, increase the use of appropriate infant feeding practices.

Objectives	Indicator (from KPC survey)	Major Inputs and Activities	Outputs	Monitoring When/Where
<p>1.a Increase the % of infants breastfed within eight hours of birth from 26% to 40%.</p> <p>1.b Increase the % of infants breastfed exclusively during the first 4 months from 71% to 90%.</p> <p>1.c Increase the % of infants introduced to solid or semi-solid foods at an appropriate age from 13% to 50%.</p>	<p>2.a % of infants breastfed within 8 hours of birth.</p> <p>2.b % of infants breastfed exclusively during the first 4 months.</p> <p>2.c % of infants introduced to solid or semi-solid foods at appropriate ages.</p>	<p>3.a Training for VHWS and TBAs.</p> <p>3.b Informal and participatory educational activities promoted by VHWS and FWs (including women's meetings).</p> <p>3.c Village visits by Core Team 2x/year to reinforce health messages and provide support for VHW.</p> <p>3.d Supervision by FWs.</p>	<p>4.a 370 VHWS trained.</p> <p>4.b 75 TBAs trained.</p> <p>4.c 550 meetings of women's groups held.</p>	<p>5.a Monthly community meetings to review infant health status (including incidence and type of medical consultations).</p> <p>NOTE: Where they exist, Community Health Comms. will assume this function.</p> <p>5.b Training reports.</p> <p>5.c Monthly supervision reports by FWs.</p>

#### IV. Acute Respiratory Infection

**GOAL:** By the end of the project period, improve the treatment of upper respiratory infection in young children.

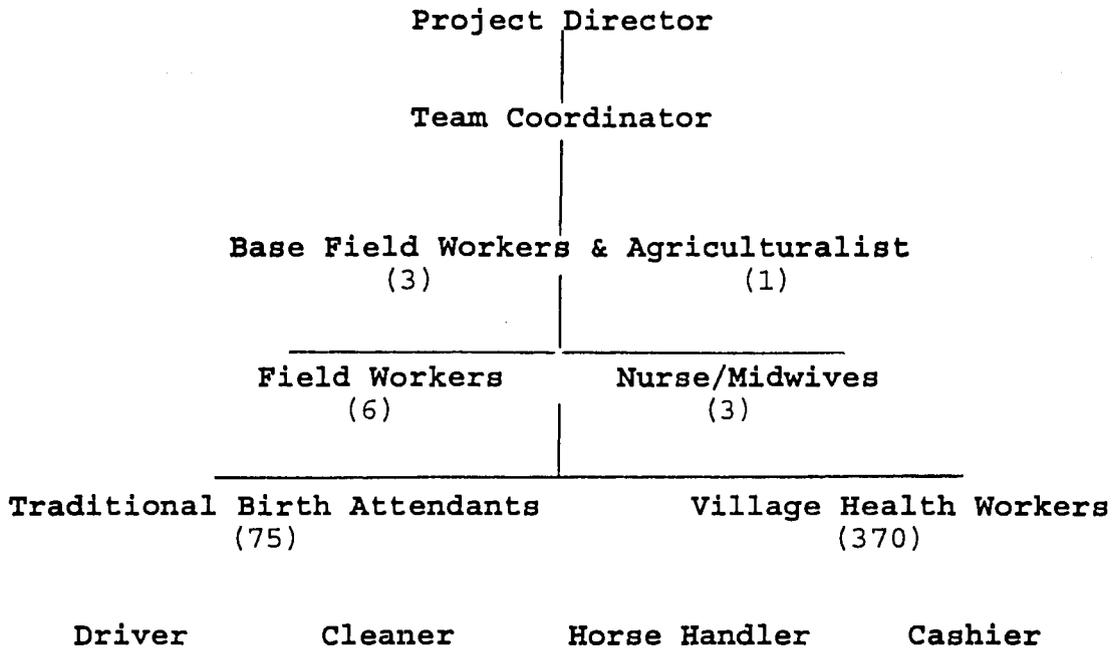
Objectives	Indicator (from KPC survey)	Major Inputs and Activities	Outputs	Monitoring When/Where
<p>1.a Increase the % of mothers able to identify the signs of acute lower respiratory infection (ALRI) from 28% to 40%.</p> <p>1.c Increase the % of mothers seeking skilled help for ALRI from 58% to 70%.</p>	<p>2.a % of mothers who recognize the danger signs of ALRI.</p> <p>2.b % of mothers who sought skilled help for ALRI.</p>	<p>3.a Training for VHWS in treatment and referral of URI.</p> <p>3.b Educational activities promoted by VHWS and FWs in treatment of URI.</p> <p>3.c Village visits by Core Team 2x/year to reinforce health messages and provide medical treatment of URI.</p>	<p>4.a 370 VHWS trained in treatment and referral of URI.</p>	<p>5.a Monthly community meetings to review child health data collected by VHWS (including incidence and type of medical consultations).</p> <p>NOTE: Where they exist, Community Health Comms. will assume this function.</p> <p>5.b Monthly supervision reports by FWs and Core Team.</p>

**IX. INSTITUTION BUILDING**

**Goal: By the end of the project period, increase the organizational capacity at the community, project and national Salvation Army levels.**

Level	Objectives	Indicators	Activities	Monitoring
<b>Community</b>	1.a Increase community responsibility for and awareness of components of primary health care.	2.a 20% of communities have operational Health Committees.  2.b 80% of headmen in villages with CHCs participating in CHCs.  2.c 10% of communities have operational community health insurance plans.	3.a Establishment and training of Community Health Committees.  3.b Training of CHCs to operate Community health insurance plans.  3.c Implementation of community health insurance plans.	4.a Core Team meetings with FWs.  4.b FW's monthly supervision reports.  4.c Project Administrator's quarterly reports.  4.d SAWSO bi-annual field reports.
<b>Project</b>	1.b Increase staff capacity to analyze health data and track key indicators.  1.c Strengthen staff capacity to evaluate and plan community-based health care activities.  1.d Promote systematization of project experience by Core Team.	2.d # of synthetic monthly evaluation reports.  2.e # of qualitative evaluations of progress in fostering community participation.  2.f Written presentation of methodolgical conclusions.	3.c Implementation of KPC Survey.  3.d Review and improve PIS System. Identify key indicators and ratios. Develop formats for presenting data at different project levels/frequencies.  3.e CT seminar to define lessons learned.	4.e 2nd KPC survey.  4.f Project Administrator's quarterly report.  4.g SAWSO bi-annual field reports.

ORGANIZATIONAL CHART



## V. Management: Review and Analysis of Headquarters/Support Functions

1. a. **Project planning and management activities.** On-going project planning and management activities occurred during the year. On each of the technical assistance visits to the field planning activities take place. These are outlined in the individual country sections.

Formal planning and management activities at SAWSO covered:

- The KPC survey which was a fairly large undertaking considering the amount of people and logistical plans involved.
  - The development of the Detailed Implementation Plans.
  - Review of project status and outline of "next steps" during July/August, 1995 to assure that SAWSO is meeting activities and plans set forth in the proposal and logframe.
  - Planning for the mid-term evaluation during July/August/September, 1995.
- b. **Staff Resources.** Both technical and management staff resources are adequate to meet program needs. SAWSO is considering a shift in program staff for one of the country programs (Bangladesh) to assure technical needs are met.
- c. **Training.** In addition to training taking place in the field which is discussed in individual country sections, the following has taken place at SAWSO:
- Training for all SAWSO Program Consultants plus two field staff in KPC survey methodology.
  - On-going informal training by SAWSO health technical specialist.
  - One Program Consultant attended 3-day overview of the Primary Health Care Management Advancement Programme.
- d. **Logistical Support.** Extensive logistical support was provided by SAWSO to field programs for the KPC survey. In two of the four country projects, special assistance visits were made to prepare for the survey. In a third, special arrangements were made for a staff member from the international Salvation Army to arrive ahead of time for preparations.
- e. **Technical Assistance.** Two technical assistance visits per year was the planned number of visits for the reporting period. However, in three of the four projects more visits were made to prepare for the KPC survey and to respond to the enthusiastic response and changes in action plans that were a result of the survey.

Technical assistance received at SAWSO included: consultation with Johns Hopkins for the KPC survey and consultation for development of the Detailed Implementation Plans. Technical assistance will also occur in mid-September for evaluation.

2. There are no major variances in any of the above categories. SAWSO originally intended to receive all major areas of technical assistance from the Johns Hopkins School of Public Health. While they provided good training and technical assistance for the KPC survey, SAWSO feels that further technical assistance (in monitoring and evaluation, HIS systems, etc.) can be coordinated more effectively with independent consultants.

SAWSO does not anticipate any problems in meeting final project objectives. The only areas where SAWSO anticipates any changes is in the "information sharing" area. Instead of having an international conference to share project experiences, there will be in-country and possibly regional efforts. There are three reasons for this:

- 1) The grant was reduced from five years to three along with a reduction in funds;
- 2) field staff feel that they would benefit more from sharing with other programs in-country run by other NGOs; and
- 3) at this time SAWSO feels that in-country sharing with other NGOs is a more cost-effective approach.

The revised logframe accompanying this report reflects this change.

## VI. Financial Report

1. Attached is a pipeline analysis with actual expenditures through June 30, 1995 and projected expenditures through September 30, 1995.
2. During the first quarter of this fiscal year the requests for funds by the field was slower than usual due to the fact that more effort and time was spent in planning for both the implementation plans and the KPC surveys. For example, in the case of Zambia, less funds were spent on training to date than anticipated because they were engaged in a reorganization of the program. This will not be the case starting in August, 1995 because the reorganization is completed. We will be very close to budget by September 30, 1995.
3. Letter of credit drawdowns have been slow because SAWSO utilizes its own funds first and is then reimbursed by federal funds. There will be no change in the rate of drawdowns; the rate will be approximately once a month.
4. No fundraising plans and activities.
5. There have been no problems in meeting our agreed cost-share. SAWSO is currently matching USAID funds equally.

**PROJECT FINANCIAL OVERVIEW**

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	(1) Actual Expenditures 10-1-94 to 6-30-95			(2) Projected Expenditures 7-1-95 to 9-30-95			(3) Total Expenditures 10-1-94 to 9-30-95		
	AID	SAWSO	TOTAL	AID	SAWSO	TOTAL	AID	SAWSO	TOTAL
<b>COST ELEMENTS:</b>									
a) Salaries	67,271	67,271	134,542	36,087	36,087	72,174	103,358	103,358	206,716
b) Fringe Benefits	10,365	10,365	20,730	4,887	4,888	9,775	15,252	15,253	30,505
c) Travel & Per Diem	51,528	51,528	103,056	8,438	8,438	16,876	59,966	59,966	119,932
d) Subcontracts	0	0	0	0	0	0	0	0	0
e) Other Direct Costs	5,823	5,823	11,646	25,368	25,368	50,736	31,191	31,191	62,382
f) Procurements	18,257	18,257	36,514	22,540	22,539	45,079	40,797	40,796	81,593
g) Indirect Cost	30,235	30,235	60,470	19,201	19,201	38,402	49,436	49,436	98,872
<b>TOTAL</b>	<b>183,479</b>	<b>183,479</b>	<b>366,958</b>	<b>116,521</b>	<b>116,521</b>	<b>233,042</b>	<b>300,000</b>	<b>300,000</b>	<b>600,000</b>

## **VII. Lessons Learned and Long-Term Project Implications**

It will be more useful to discuss lessons learned after the first year of the project. Lessons have been learned this year, but for the most part they revolve around the baseline survey, local participation, and collaborating with other agencies.

Conducting the baseline surveys have been a very useful exercise for both SAWSO and field project staff. The following lessons were learned:

- Begin planning logistics early because these surveys are a very large undertaking.
- Manually tabulating the data is a very exhausting but a more useful task than using EPI-Info. The health team feels more familiar with the data and becomes more involved in the planning that follows.
- There is great value in a survey which empowers the people involved at all levels of the project - staff, community, and local government - the survey becomes a very potent team builder. Make use of the momentum generated by the survey even if it means delaying some other project activities such as training.

Lessons learned regarding local participation and community mobilization is that it is a long process and there is a need to begin working on these issues immediately. Take advantage of the enthusiasm generated by the baseline survey. Also, field staff benefit from having processes and examples to follow and learn from: steps commonly used when entering communities, tasks performed by community health committees, etc.

The lesson learned regarding networking and collaborating with other agencies is that the projects have benefitted more from collaboration and contact with other local agencies than expected. For example, in the case of Indonesia, to date there have been more lessons learned regarding community participation strategies from other local NGOs than from external sources. Project personnel need to be encouraged to seek out these other agencies because sometimes they get mired down in the day-to-day management of the project, or if other agency personnel are expatriates, local Salvation Army staff are less likely to approach them. However, this is changing with explicit encouragement and information from SAWSO staff.

## **VIII. Recommendations**

At the end of the first year of the grant, our recommendations follow lessons learned quite closely and comprise five major recommendations:

- The more participatory the baseline survey can be - the better, although it may be expensive and time consuming.
- Local governments are more likely to respond to your project needs if you have something concrete to present to them, such as baseline survey data. Therefore, if you are approaching them have something in-hand.
- Make use of the enthusiasm built by the baseline survey - don't delay because there seems to be a more appropriate time at a later date.
- Try to conduct the baseline survey as close to the beginning of the project as possible. It is time-consuming and a lot of energy goes into it while other important tasks receive less attention.
- Closely examine the field's needs (especially for a matching grant project): if they have a strong community orientation, they may need a strong PVO health program officer; alternatively, if the field's health technical background is very strong, then it may be more appropriate to provide a program officer with more of a community development background.

## IX. Attachments to Annual Report

Attachments include:

1. Original logical framework
2. Modified logical framework

**LOGICAL FRAMEWORK**  
**SAWSO FY94 MATCHING GRANT**  
Building Local NGO Capacity in Community Health

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
<p><u>GOAL</u></p> <p>To improve the health status of reproductive-age women and children under-five in targeted communities in Bangladesh, Indonesia, Ghana, and Zambia.</p>	<p><b>1. Decreased IMR.</b>            1.1 % of children under 2 receive DPT1, DPT3, measles.            1.2 % of children under-5 with diarrhea who are receiving ORS/SSS &amp; appropriate feeding management.            1.3 % of children under-5 gain weight each month.</p> <p><b>2. Decreased MMR.</b>            2.1 Increased # and % of family planning acceptors.            2.2 % of pregnant women receive tetanus toxoid.</p> <p><b>3. Increased recognition &amp; treatment of HIV/AIDS.</b>            3.1 % of pregnant women diagnosed with STDs.            3.2 % of pregnant women diagnosed HIV (clinical or lab test).            3.3 % of children under-5 diagnosed HIV (clinical or lab test).            3.4 % of clinic attendees diagnosed with TB.</p>	<ul style="list-style-type: none"> <li>● Program health baseline and follow-up surveys</li> <li>● Clinic records</li> <li>● Road to Health cards</li> <li>● At-risk registers</li> <li>● Program Health Information system reports</li> <li>● Evaluation reports</li> </ul>	<p>(purpose to goal)</p> <ul style="list-style-type: none"> <li>● Increased community development and participation will improve the health status of women and children.</li> <li>● Countries remain politically and economically stable.</li> <li>● No major disasters or emergencies that impede progress toward improved health.</li> </ul>

<p><u>PURPOSE</u></p> <p>To increase the capacity of local NGOs in four countries to develop, implement, monitor, and evaluate sustainable community-based health programs.</p>	<p><u>EOGS</u></p> <ol style="list-style-type: none"> <li>1. M&amp;E systems used effectively in each country.</li> <li>2. HIS systems used effectively in each country.</li> <li>3. Community-based approaches to health are developed and documented.</li> <li>4. One or more of the documented community-based approaches are in place and functioning in each country.             <ol style="list-style-type: none"> <li>4.1 # of community groups formed and functioning.</li> <li>4.2 # of community-initiated strategies which have been implemented.</li> <li>4.3 % of programs where fee for service is instituted.</li> <li>4.4 % of programs where community health staff compensated for work by community.</li> <li>4.5 % of programs where sanitation activities are maintained by community.</li> </ol> </li> <li>5. All community-based programs have effective referral systems to accessible clinics.</li> </ol>	<ul style="list-style-type: none"> <li>● Program documents.</li> <li>● Observation.</li> <li>● Status reports.</li> <li>● Baseline and follow-up survey on NGO capacity.</li> </ul>	<p>(outputs to purpose)</p> <ul style="list-style-type: none"> <li>● Improving health status is a priority for communities.</li> <li>● Sufficient vaccines, drugs, and medical supplies are available.</li> <li>● Governments or Salvation Army can maintain sufficient level of medical staff in high incidence HIV areas.</li> </ul>
<p><u>OUTPUTS</u></p> <p>1. Outreach health services are provided</p> <p>2. Systems developed.</p>	<ol style="list-style-type: none"> <li>1.1 # of service delivery activities in # communities per year.</li> <li>1.2 # PHC staff visits to communities per year.</li> <li>2.1 M&amp;E for each local NGO by year 2.</li> <li>2.2 M&amp;E for SAWSO by year 1.</li> <li>2.3 HIS for each local NGO by year 2.</li> <li>2.4 Rapid KPC for local NGOs and SAWSO in year 1.</li> </ol>	<ul style="list-style-type: none"> <li>● Program documents</li> <li>● Field status reports</li> <li>● Documents (forms, plans, data base, etc.)</li> </ul>	<p>(inputs to outputs)</p> <ul style="list-style-type: none"> <li>● Community social organizations continue to function.</li> <li>● Project personnel and community members will have the opportunity to apply KSAs.</li> </ul>

<p>3. Improved knowledge, skills and attitudes (KSAs) of project personnel and community members.</p>	<p>3. # and % of program participants who meet performance standards established for:</p> <ul style="list-style-type: none"> <li>● health service delivery</li> <li>● health education</li> <li>● community development</li> <li>● health management</li> </ul>	<ul style="list-style-type: none"> <li>● Follow-up training evaluation</li> <li>● Supervisor documents</li> <li>● Field reports</li> </ul>	
<p><b>INPUTS/ACTIVITIES</b></p>			
<p>1. Baseline assessment of current approaches to community health and planning</p>	<p>1.1 Five country assessments conducted and plans developed by the end of year 1.</p>	<ul style="list-style-type: none"> <li>● Documents</li> <li>● Surveys</li> </ul>	<ul style="list-style-type: none"> <li>● Logistical barriers (e.g. local politics, natural disasters, U.S./host government relations) do not prevent delivery of inputs.</li> </ul>
<p>2. Technical assistance</p>	<p>2.1 # SAWSO consultations on program management.</p> <p>2.2 # IHQ consultations on health policies, integrated management, strategies.</p> <p>2.3 # local consultations on curriculum development.</p> <p>2.4 # of evaluation consultant interventions.</p> <p>2.5 # consultations on community-based programming.</p>	<ul style="list-style-type: none"> <li>● Field status reports</li> <li>● Consultant reports</li> </ul>	<ul style="list-style-type: none"> <li>● National governments will continue to look favorably at Salvation Army as a vehicle for meeting health needs.</li> <li>● The proposed Matching Grant countries remain on A.I.D. approved list.</li> <li>● Approval of program by USAID Missions, AID/PVC.</li> </ul>
<p>3. Training</p>	<p>3.1 See country descriptions (D21) which identify # and type of events.</p>	<ul style="list-style-type: none"> <li>● Health Trainfo database</li> </ul>	
<p>4. Information sharing/networking</p>	<p>4.1 # in-country conferences and workshops attended by # program staff.</p> <p>4.2 # Inter-project visits by # country project staff.</p> <p>4.3 Two regional SA health conferences with # participants by year 3.</p> <p>4.4 SA international health conferences attended by # program staff in year 5.</p> <p>4.5 Quarterly newsletter distributed.</p>	<ul style="list-style-type: none"> <li>● Trip and conference reports</li> <li>● Newsletter</li> </ul>	
<p>5. Funding</p>	<p>5.1 See budget.</p>	<ul style="list-style-type: none"> <li>● Financial reports</li> </ul>	

January 14, 1994

**LOGICAL FRAMEWORK**  
**SAWSO FY94 MATCHING GRANT**  
**Building Local NGO Capacity in Community Health**

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<p>3. Improved knowledge, skills and attitudes (KSAs) of project personnel and community members.</p>	<p>3. # and % of program participants who meet performance standards established for:</p> <ul style="list-style-type: none"> <li>● health service delivery</li> <li>● health education</li> <li>● community development</li> <li>● health management</li> </ul>	<ul style="list-style-type: none"> <li>● Follow-up training evaluation</li> <li>● Supervisor documents</li> <li>● Field reports</li> </ul>	
<p>4. Methods &amp; techniques for community mobilization in health issues documented.</p>	<p>4.1 # of diff. approaches documented.</p> <p>4.2 # of community health committees formed &amp; functioning.</p>	<ul style="list-style-type: none"> <li>● documents</li> <li>● field reports</li> <li>● observation</li> </ul>	
<p><u>INPUTS/ACTIVITIES</u></p> <p>1. Baseline assessment of current approaches to community health and planning</p> <hr/> <p>2. Technical assistance</p> <hr/> <p>3. Training</p> <hr/> <p>4. Information sharing/networking</p> <hr/> <p>5. Funding</p>	<p>1.1 Five country assessments conducted and plans developed by the end of year 1.</p> <hr/> <p>2.1 # SAWSO consultations on program management.</p> <p>2.2 # IHQ consultations on health policies, integrated management, strategies.</p> <p>2.3 # local consultations on curriculum development.</p> <p>2.4 # of evaluation consultant interventions.</p> <p>2.5 # consultations on community-based programming.</p> <hr/> <p>3.1 See country descriptions (D21) which identify # and type of events.</p> <hr/> <p>4.1 # in-country conferences and workshops attended by # program staff.</p> <p>4.2 # visits by project staff to other in-country NGO projects.</p> <p>4.5 The International Salvation Army medical newsletter discusses MG project innovations.</p> <hr/> <p>5.1 See budget.</p>	<ul style="list-style-type: none"> <li>● Documents</li> <li>● Surveys</li> </ul> <hr/> <ul style="list-style-type: none"> <li>● Field status reports</li> <li>● Consultant reports</li> </ul> <hr/> <ul style="list-style-type: none"> <li>● Health Trainfo database</li> </ul> <hr/> <ul style="list-style-type: none"> <li>● Trip and conference reports</li> <li>● Newsletter</li> </ul> <hr/> <ul style="list-style-type: none"> <li>● Financial reports</li> </ul>	<ul style="list-style-type: none"> <li>● Logistical barriers (e.g. local politics, natural disasters, U.S./host government relations) do not prevent delivery of inputs.</li> <li>● National governments will continue to look favorably at Salvation Army as a vehicle for meeting health needs.</li> <li>● The proposed Matching Grant countries remain on A.I.D. approved list.</li> <li>● Approval of program by USAID Missions, AID/PVC.</li> </ul>

September 1, 1995