SUPPORT OF MONITORING AND EVALUATION COMPONENT OF BASICS/NIGERIA PROGRAM

December 1997

David F Pyle, Ph D

BASICS Technical Directive 000 NI 01 036
USAID Contract No HRN-C-00-93-000031-00

TABLE OF CONTENTS

ACKNOWLEDGMENTS

I want to thank Dr Ayodele and his staff for their support during my 2-week assignment in Lagos It was a pleasure to deal with a very competent group of committed professionals I appreciate everyone's sincere efforts to respond to all my requests for data, despite being occupied with their regular responsibilities I wish the project well in its exciting and valuable work

C

ACRONYMS

AFP	Acute Flaccid Paralysis
BASICS	Basic Support for Institutionalizing Child Survival
CBE	Capacity Building Exercise
CBO	Community Based Organization
CEDPA	Center for Education Development and Population Activities
CIDs	Community Immunization Day
CPH	Community Partners for Health
D&G	Democracy and Governance
DPT	Diphtheria, Pertussis, and Tetanus Vaccine
FBQA	Facility Based Quality Assurance
GIS	Geographical Information System
IBHS	Integrated Baseline Health Survey
IEC	Information, Education, Communications
JHU/PCS	Johns Hopkins University/Population Communication Services
LGA	Local Government Authority
M&E	Monitoring and Evaluation
NGO	Nongovernmental Organization
NID	National Immunization Day
NURTW	Nigerian Union of Road Transport Workers
ODI	Organizational Development Index
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PMV	Patent Medicine Vendors
SDI	Social Development Index
SSS	Sugar Salt Solution
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
UPSI	Urban Private Sector Inventory

EXECUTIVE SUMMARY

The purpose of this consultancy was to work with the BASICS/Nigeria staff to review the M&E activities and to determine the most appropriate indicators to monitor on an ongoing basis The project has made remarkable progress in developing an effective structure, organizing and mobilizing the communities, and launching child health care activities, especially immunization In the M&E aspect, several tools have been developed and utilized which provide the project with baseline and follow-up information on caretaker knowledge and behavior and health worker practices The primary findings and recommendations during this assignment include—

- ***Structure and Reach***-The number of CPHs, dyads/triads, and CBOs has increased tremendously as the project has evolved The estimates of population reached directly or potentially have to be credible. **Recommendations:** The estimates of reach should be reviewed and revised, a database of CPHs and dyads/triads and CBOs should be developed, and the GIS should be completed demarcating CPH/dyad and triad/CBO areas of responsibility and utilizing information from the database

- ***Immunization Activity***-The project has made great strides in immunization, particularly in the NIDs and CIDs **Recommendation:** The participating health facilities should report monthly on their routine measles immunization, the results should be reviewed at the regular Governing Board meetings, and feedback given to the individual centers on their performance Historical data (for Lagos since 1995 and Kano since 1996) should be collected and maintained

- ***Health Facility Patient Load***-To determine the effectiveness of community mobilization efforts and level of confidence in the community, it is important to monitor on a monthly basis the number of patients utilizing the in- and out-patient services of the project health sites It is also important to know the number of deliveries by BASICS-trained TBAs **Recommendations:** Each health facility should report to their CPH (who in turn should forward the information to BASICS) the number of its in- and out-patients monthly (by age-under and over 5 years of age) In addition, the number of deliveries by the BASICS-trained TBAs should be included Each facility should post its patient load and immunization (routine and NID/CID) figures on wall charts, and the figures should be discussed at Governing Board meetings Historical patient load and TBA delivery data for all facilities in Lagos (since 1995) and Kano (since 1996) should be collected and maintained

- ***Baseline and Follow-up Surveys***-The IBHSs and CBEs enable the project to determine improvements in caretaker child health behaviors Even at this early stage, some progress can be observed, but the mid-1998 CBEs will be most important to determine the impact of the BASICS strategy **Recommendation:** To have more current feedback on caretaker knowledge and behavior, it is suggested that a supervisor checklist be developed

- ***Facility-based Quality Assurance***-The first round of FBQAs have recently been completed The major problem identified is very small sample sizes in the individual childhood illnesses like diarrhea **Recommendations:** To provide statistically valid samples in the target diseases, a specific number for each disease must be identified Increasing the sample size for BASICS sites is more important that having a control In addition, a supervisor checklist for health worker performance should be designed and tested

- ***Process Monitoring***-An Organizational Development Index (ODI) has been developed as part of the valuable process documentation exercise **Recommendations:** The ODI should be carried out in Kano and repeated after a 6-month interval to determine progress A Social Development Index focusing on women's empowerment, D&G, and political participation should also be developed and tested

- ***Democracy and Governance (D&G) Indicators***-A series of indicators were identified for the D&G component (including micro-credit) of the BASICS/Nigeria project. **Recommendation:** These indicators should be tested and integrated into the regular monitoring of the project activities

I. INTRODUCTION

BASICS/Nigeria requested support from BASICS/headquarters to review the monitoring and evaluation component of its community-based program For the last several years, the Nigeria program and BASICS/Washington have worked closely together in the development of a monitoring and evaluation (M&E) plan Everyone associated with the effort is familiar with the anecdotal evidence about the popularity of the approach involving a series of Community Partners for Health (CPH), this is manifested in the increasing number of requests from private health facilities and community-based organizations (CBOs) in both Lagos and Kano to join or establish new CPHs However, as interest in the BASICS/Nigeria program has grown, especially since the interim evaluation team visited Lagos in January and made a favorable report, there has been increasing concern that the efficacy and effectiveness of the innovative strategy being implemented be supported quantitatively In addition, there was a desire to identify key indicators that could be tracked that would provide the individual CPHs with feedback on their progress

Thus, to improve the management of the program, to provide information to USAID on significant program outcomes, and to ensure that BASICS had the data it required to determine the effectiveness of its operation in Nigeria, BASICS offices in Lagos and Washington agreed that technical support from BASICS/Washington would be appropriate The visit was originally planned for October 1997, but due to delays in procuring a visa, was delayed several months The scope of work for the assignment is included as Appendix A

The consultancy involved reviewing a large volume of program documents, discussing program activities with BASICS/Nigeria and several CPH representatives, and observing the implementation of the national immunization day (NID) at participating health facilities in Lagos USAID/Nigeria was briefed and debriefed on the assignment A list of persons met with can be found in Appendix B

II. FINDINGS AND RECOMMENDATIONS

The major issues that were addressed during this consultancy included accurate population reach figures, immunization activity, health facility patient loads, comparison between baseline (integrated health baseline survey IBHS) and follow-up (capacity building exercise CBE) surveys, the recently completed facility-based quality assurance (FBQA) assessments, process monitoring, and indicators for the democracy and governance (D&G) component The last issue to be discussed in this chapter will be the monitoring and evaluation (M&E) plan for BASICS/Nigeria Together with BASICS/Nigeria country adviser and the monitoring and evaluation program officer, we identified future actions which will enable the program and its collaborating agencies to monitor program activities more effectively in the future

A. Population Reach

Structure: The first number one is interested in the Urban Private Health Sector Project carried out by BASICS/Nigeria is the number of CPHs and health facilities This number has fluctuated a great deal in the last several years as the project has added new areas and expanded within existing areas The decision has been made recently to maintain the number of CPHs at 11, 6 in Lagos and 5 in Kano, despite requests within the two urban areas in which the project is currently active, plus other cities in the country. The number of private health facilities is more difficult to monitor because sites are added to accommodate community demands The number of CBOs also changes from time to time, with inactive ones being dropped and new ones added

In the beginning, each CPH in Lagos was made up of a health facility and a number of neighboring CBOs As the program evolved, new health facilities were added to existing CPHs, with each facility having specific CBOs with which it works The health facility/CBO units under a CPH are referred to as *dyads* (or programming clusters) At present the 6 CPHs in Lagos consist of 18 health facilities that are formed into 13 dyads, and a total of more than 300 CBOs In Kano, the 5 CPHs have 8 health facilities, 47 patent medicine vendors (PMVs)/pharmacists, and 50 CBOs Because the Kano CPHs include PMVs, they are referred to as *triads*, indicating that there are three groups of collaborating entities. A listing of the CBOs in Lagos and Kano is provided as Appendix C

At this point, the health facilities/dyads are adding CBOs at a rapid rate, the number of participating CBOs has increased four-fold in the last year This number will undoubtedly fluctuate as some lose interest and drop out and new recruits join the project As a general rule, dyads assign CBOs to particular areas to preclude overlap Once the Geographical Information System (GIS) is functioning, it will enable the CPHs and dyads to designate and demarcate specific areas of responsibility to CBOs

Reach: In contrast to most programs involving nongovernmental organizations (NGOs) that operate at the community level, the Urban Private Health Project in Nigeria is not able to enumerate a specific population served The umbrella CPHs consist of private facilities and CBOs that join forces to improve child health services and practice in high-risk, underserved areas in two of Nigeria's largest metropolises The participating private health facilities serve clients most of whom live in the surrounding neighborhoods, although a small portion travel considerable distance to obtain health care there Therefore, the facilities have no more than their patient records to indicate the population served Almost all the involved facilities provide in-patient (small, ranging from four to six beds) as well as a full range of out-patient services In addition, the CBOs do not cover clearly demarcated areas Rather, their memberships come from the nearby community and, in most cases, represent only a small portion of the overall population

To date, the Urban Private Health Sector Project has estimated the population reached in two ways direct and potential The first is derived by taking the number of patients served by the

facility, the latter by multiplying the patient number by six, the size of the average urban household in Nigeria The reasoning is simple—that if one member of the family is treated at the facility, all members of that family are likely to utilize it The only problem is that the number of patients visits probably includes some double counting—e g , those who have multiple illnesses in a year or multiple members of one family

To the direct and potential reach figure is added the membership of the CBOs attached to the health facility It must be remembered that the Urban Private Health Project is primarily an information, education, and communications (IEC) effort aimed at changing community child health knowledge and practices Again, the CBOs' membership is taken as directly influenced, based on the expectation that all members of the CBOs will be reached by the project's messages The potential reach of the CBOs is supposed to represent the number in the community that would be influenced by the mobilization efforts of the CBOs Both these figures are very rough estimates at best It is highly likely that some double counting occurs in that those using the health facilities are also members of the CBOs and neighborhoods The multipliers utilized to calculate the potential population reachable through the CBOs appear somewhat exaggerated For example, the number of members of the Nigerian Union of Road Transport Workers (NURTW mostly taxi drivers) is multiplied times 3,420 in the case of Makoko CPH and 2,555 in Jas CPH These numbers were arrived at by calculating the average number of fares each driver has each day The assumption is made that the driver will promote some health message with each person he comes in contact with Different trade groups had different multipliers 1040 for hairdressers, 520 for photographers, carpenters, and market women, 260 for tailors in Lagos Island, and half the number for tailors residing/working in Lawanson In Kano, an extreme case can be found in the CBO referred to as Yakasai Tsintsiya Madaurinki Daya (nature unknown) in the Yakasai CPH that is listed as having 50 members with a potential reach of 648,000 or 12,960 per member This, of course, leads to highly inflated potential reach figures which are not credible

Epidemic Preparedness and Response: The network of CBOs established by BASICS/Nigeria provides a unique ability to mobilize large numbers of people when an epidemic threatens or arises By alerting the CPHs that, in turn, activate their collaborating CBOs, the project is able to get a message across to participating communities within a very short time frame The cholera epidemic in Lagos from August to October demonstrated the capacity of the BASICS network The project convened a workshop on home-based management of cholera (i e , the recognition and management of the disease) Some 36,000 sachets of ORS were procured from UNICEF and distributed through the CPHs/CBOs The number of cholera cases in area hospitals dropped dramatically after the workshop This could be because the workshop was held near the end of the epidemic, but the contribution of the project cannot be dismissed More than anything, it demonstrated what the network was capable of doing There is discussion that the annual meningitis epidemic (usually between December and February) in the northern part of Nigeria could utilize the project's network capabilities in Kano to mobilize the communities for meningitis immunizations BASICS/Nigeria should document its epidemic preparedness and response activities so that everyone fully appreciates what it has achieved and is capable of

achieving It is possible that this community-based network could be utilized to assist in disease surveillance as well—such as identifying and reporting acute flaccid paralysis (AFP) cases

Recommendation: 1) Reach Estimates *It is agreed that the BASICS/Nigeria office will review the direct and potential reach figures for each health facility and CBO in Lagos and Kano to ensure that they represent feasible and realistic estimates These estimates will be shared with BASICS/Washington by mid-January 1998*

2) Database. *It is suggested that the best way to maintain the list of CPHs and CBOs (by dyad/triad) would be to create a database that includes current patient utilization and membership/potential outreach figures This database should be kept up to date as health facilities/CBOs are added or are dropped*

3) GIS. *The implementation of the GIS should be given priority to improve the ability of the field units (CPHs and dyads) to manage their operations, assigning CBOs to designated portions of the community for which they will be responsible for mobilization and communications efforts In addition, the database for each CPH/dyad could be used in the GIS presentations*

B. Immunization Activity

When we refers to CPH immunization activities, it is important to take into account that in most cases these facilities either did not provide such services previously or provided only a very limited number of immunizations prior to involvement in the Urban Private Health Project Now they are providing immunizations as an integral part of their services—routine as well as part of the NIDs

The preferred means of determining whether the immunization mobilization efforts are effective and that a high percentage of the population is being vaccinated would be to conduct coverage surveys A baseline survey (typically utilizing the 30-cluster methodology) prior to the initiation of the immunization intervention would be compared to a sample of the population at periodic intervals after the intervention has been introduced and implemented In the case of the BASICS/Nigeria project, this strategy is considered too costly and time-consuming and the same information is collected by alternative means

Routine: While the number of immunizations now being given at BASICS-connected health facilities is very small, there are indications of a beginning We looked at the records for four health facilities whose immunization activities are summarized in Table I

Table I
DPT3 and Measles Immunizations at Selected Health Facilities, 1995-97

Health Facility	1995		1996		1997 (through 9/12)	
	DPT3	Measles	DPT3	Measles	DPT3	Measles
Jas	0	0	0	0	8	55
Rikky	18	5	37	19	78	36
Roland	0	5	0	0	13	161
Royal	1	0	15	7	15	56

The low number of immunizations provided by the BASICS health facilities is not surprising for several reasons First, prior to BASICS involvement, the private facilities never maintained records They were primarily concerned about financial matters and status Only in July of 1997 did BASICS provide the facilities with registers that allowed them to track such things as the number of immunizations given Even now the number is thought to be low because the health centers rarely have someone who is familiar with record keeping Staff turnover is high and new people are constantly being trained Second, typically, people will chose the free immunization available at the public facility rather than paying for the same thing at a private facility The normal fee is N50 (approximately US$0 60) The amount charged has been reduced since the health facilities now procure their vaccines free of charge from the government rather than purchase them at pharmacies

It can be expected that the number of routine immunizations provided by BASICS-assisted CPHs will remain relatively low Nonetheless, after undergoing BASICS training, the centers now have confidence in their ability to provide potent vaccinations in a high quality manner In addition, they also have established relationships with their Local Government Authority (LGAs) and are able to procure vaccines whenever they require them All the CPHs now procure their vaccines from the government, compared to 17 percent in the initial survey of the CPH in the urban private sector inventory (UPSI)

In addition to basic childhood immunizations, the health facilities began to provide pregnant women and women of child-bearing age with tetanus toxoid (TT)

National Immunization Days: The capacity of the health facilities and their affiliated CBOs to mobilize and to immunize the under-5 years old populations in their neighborhoods is best demonstrated in the NIDs The centers see it to their long-term advantage and a means to establish good relations with the population residing in the vicinity to provide immunizations free of charge during the national immunization efforts All the OPV used is procured from the LGA centers located close to the respective BASICS-connected health facilities Although NIDs for polio eradication started in Nigeria in 1996, BASICS health facilities began to participate

only this year—Lagos in January and Kano in November The progress that they have made in less than one year is quite extraordinary (see **Table II**)

Table II
NID (OPV) Performance of Lagos/Kano BASICS-Supported Health Facilities, 1997

Health Facility	January	November	December
I. Lagos			
Rikky	449	1,070	1,484
All Soul's	-	1,013	390
Beebat	-	264	1,000
Ola-abi	-	120	392
Shammah		422	1,200
Nasah	-	960	5,485
Jas	209	1,365	1,109
Royal	243	915	1,320
Rock of Ages		1,010	300
Pine		400	400
Antnie		330	215
Logos	-	24	609
Roland	116	613	637
Salvation Army		453	
Makoko		43	34
Boulutife	-	-	-
Elizir			1,410
Celestial Church			
Subtotal	1,017	9,002	15,985

II. Kano			
Savannah	-	260	318
Merit Care	-	51	198
Sanbell	-	416	404
Semirat (+ outreach)	-	1,192	574
Mai Nasara	-	795	260
Mihiban	-	593	917
Lawal Jafaru Isa (+ 2 outreach sites)	-	778	1,093
Lafiya	-	339	518
Subtotal	-	4,424	4,282
Total		13,426	20,267

The results of the most recent NID in Kano, where the number of polio immunizations given dropped slightly from the November results, are discouraging The explanation is government interference, such as telling CBO volunteers that they should be paid as WHO does (at the rate of N3,000 each) BASICS has a policy against such incentives, appreciating that these payments are totally unsustainable Moreover, the city government is reportedly upset that the BASICS financial support of the CPHs does not pass through their hands

In addition to the OPV immunizations, measles (238 in Lagos and 1,500 in Kano where there was a greater backlog), DPT (183 in Kano), and TT (5,010 in Lagos and 347 in Kano) immunizations were carried out during the November NID

Again, as in the case of the routine services, there is no target population (or denominator) to be reached, and thus, it is not possible for BASICS/Nigeria to quantify its success in terms of percentage of population covered However, it is possible to determine the percentage of population covered by means of coverage surveys, such as the IBHS and follow-up CBEs, but these are time-consuming and resource-intensive efforts which can only be carried out every two years or so, they cannot be counted on for interim data or for management purposes For this reason, we must rely upon the number of immunizations provided, especially in the NIDs, to indicate how successful the health facilities and their associated CBOs have been in mobilizing and immunizing their communities

Recommendation: Reporting. *After considering whether it was desirable to request the health facilities to report routine vaccinations each month, we decided it would be worthwhile since it is*

expected that they will continue to increase the number of immunizations because the government structure is providing so little services in this area In addition, health center performance in NIDs should continue to be reported and analyzed, and feedback presented at meetings of the Governing Board Monthly numbers of DPT3 and measles immunizations for all health facilities in Lagos (since 1995) and Kano (since 1996) should be collected and maintained so that progress can be ascertained

C. Health Facility Patient Load

One of the underlying premises of the Urban Private Health Project is that as the community's knowledge and awareness about the importance of child health increases and they are mobilized plus have increased confidence in their local health facility through greater exposure in such things as the NIDs, utilization of the health facilities will increase Increased usage is also essential if the health centers are to be sustained after BASICS support comes to an end Thus, patient loads (both in- and out-patient) at the health facilities is a good indicator of the effectiveness of BASICS operations in Nigeria

When enquiring about patient loads at the health facilities in Lagos, we discovered that it was not easy to come up with the figures It seems that many of the hospitals and clinics did not maintain accurate records prior to their association with BASICS For example, if no treatment was given, the visit might not be recorded Even now, one facility director mentioned that when he provides free consultation to someone in the community, he usually does not note it in the records Nonetheless, we did collect data for the last several years from a number of the facilities in Lagos which is presented in Table III

Table III
Patient Load at Selected Health Facilities, 1995-97
(with % under-5-years of age where available)

Health Facility	Type of Service	1995 (% <5)	1996 (%<5)	1997 (% <5)
Elizir	In-Patient	828 (48 2%)	573 (51 1%)	378 (40 5%)
	Out-Patient	342 (45 9%)	343 (44%)	542 (51 3%)
Jas	In-Patient	83 (9 6%)	125 (5 6%)	106 (12 4%)
	Out-Patient	1,118 (12 5%)	1,157 (11 7%)	1,032 (13 6%)
Pine	In-Patient	29 (???)	51 (???)	268 (42 2%)
	Out-Patient	126 (???)	104 (???)	1,737 (47 8%)
Rikky	In-Patient	436 (5%)	578 (11 8%)	1,367 (10 5%)
	Out-Patient	1 035 (5%)	1,156 (7 1%)	3,124 (7 2%)
Rock of Ages	In-Patient	206 (26 7%)	336 (31 8%)	326 (31 6%)
	Out-Patient	1,272 (12 7%)	1,256 (19%)	1,586 (23 5%)
Salvation Army	Out-Patient	269 (8 6%)	279 (10.8%)	403 (20.6%)

An analysis of the above data reveals several things In a few of the facilities one can discern an increasing emphasis on the under-5 population (e g , Rikky in-patient, Rock of Ages out-patient, and Salvation Army) There is also evidence of some increase in attendance, especially in the case of Rikky (both in- and out-patient) The 1995 and 1996 figures for Pine look suspiciously low Upon checking, I was informed that it was not impossible to jump from such a low number of patients to the 1997 levels, considering the transformation that took place once the facility joined the BASICS/Nigeria program Previously Pine was considered an elitist facility that only served the higher echelon members of the community Upon joining the Lawanson CPH, it was able to convince the population in its vicinity that it was there to serve their needs The huge increase in in- and out-patient attendance indicates it has succeeded

To date, patient load figures are not reported by the facilities to the BASICS office on a regular basis There is a need for the health facilities to monitor their patient loads, both in- and out-patient to establish trends and to determine if utilization of their center is increasing BASICS needs this information to identify which facility is doing well and which one requires special technical assistance or marketing support to improve its patient load

It is also important that BASICS know the percentage of patients that are under 5 years of age The percentage of patients under-5 should increase as the child health messages and mobilization efforts on behalf of child health have an impact

The BASICS/Nigeria project has trained two TBAs from each CPH It is expected that this improvement in skills will translate into an increased number of deliveries by the trained TBAs They should, in other words, be perceived as providing a higher quality of service and care and therefore, the preferred choice

Recommendation: 1) Reporting. *Each month each health facility should be asked to report the number of patients that have utilized its services, in-patient as well as out-patient The number should be divided into two age groups, those under-5 and those above 5 years of age The number of deliveries by BASICS-trained TBAs should also be reported on a monthly basis A sample report form can be found as Appendix D*

2) Historical Data. *Monthly patient load (both in- and out-patient) records by age (under- and over-5) should be collected from Lagos health facilities (since 1995) and Kano (since 1996) and recorded so that any change occurring since the initiation of BASICS activities can be determined Moreover, the number of deliveries by TBAs in the year prior to their BASICS training should be collected and maintained*

3) Presentation. *Each health facility should post on the clinic walls its utilization figures in the form of bar charts Each month the total number of patients should be shown, with a portion of the bar representing the percentage of under-5s served, both in-patient and out-patient*

4) Discussion. *As in the case of immunization figures, patient load figures should be presented at the Governing Board meetings, and facilities experiencing difficulties (i e , operating below the norm) should be identified for special assistance*

D. Baseline and Follow-up Surveys

The best way to determine if a project like the one BASICS is supporting in Nigeria (i e , much of the effort focused on changing caretakers' behavior relating to child health care) is effective is to conduct surveys of caretaker child health care knowledge and practices The project has developed several instruments which address the needs of the community-based interventions that have been designed The baseline to determine the status of the caretakers' knowledge and practices in child health was collected by means of the USAID-funded integrated baseline health survey (IBHS) that was conducted throughout Nigeria in 1995 For BASICS' purposes, the data was disaggregated according to specific CPHs, meaning that the results of the IBHS can serve as a benchmark against which the project's progress can be monitored

The post-intervention survey to determine the effectiveness of BASICS activities is referred to as the capacity building exercise (CBE) The purpose of the CBE(s) was not only to gather data on

the child health care knowledge and practices of the population, but also, and very importantly, to involve and educate the CPHs and CBOs on the need for the training and communication efforts that were being provided through the Urban Private Health Project The instrument collects data on immunization coverage, diarrhea/fever/ARI management, maternal health, choice of health care provider, family planning and STD/HIV/AIDS A series of CBEs were conducted in five of the six CPHs of Lagos, health facility specific, between December 1996 and mid-1997 Additional CBEs are being conducted in Kano and in new health facilities/dyads in Lagos

The content of the CBEs is quite comprehensive One oversight is the exclusion of any nutritional information The IBHSs showed that exclusive breastfeeding is virtually non-existent in Nigeria In addition, the tradition is to express colostrum rather than giving it to the infant It is unfortunate that this important aspect has not been included in the program as an element of its IEC

Table IV compares IBHS and CBE data for immunization coverage and use of ORT in four of the CPHs in Lagos

Table IV
Measles Immunization* and ORT Coverage Rates in Selected Communities in Lagos (IBHS-1995 versus CBE-1997)

CPH	Measles Immunization		ORT Utilization (%)					
			IBHS			CBE		
	IBHS	CBE	SSS	ORS	Total	SSS	ORS	Total
Ajegunle	39 4	39 1	29	0	29	47 6	9 5	57 1
Amukoko	31 6	47 1	27	0	27	61 5	15 4	76 9
Lagos-Salvation Army	21 4	48 3	42 9	10 3	53 2	33	0	33
Lagos-Roland		32 1				46 7	2 7	49 4
Makoko Med Centre	42 9	44	37 5	0	37 5	35	20	55
Makoko - Elizir		43 2				53 3	20	73 3

* by the age of one

It should be mentioned that the immunization rates are very conservative, based on verification of immunization cards only If the mother cannot produce the child's card, the child is not given credit for having had the vaccination even if the mother responds positively to recall questions

This problem was not helped by the fact that some of the private health facilities did not provide immunization cards until recently when the BASICS project supplied all the health facilities with stocks of government-issued growth cards that included immunization history (antigen by date)

The results are mixed Whereas the immunization results in Ajegunle and the two Makoko centers showed little of no improvement, Amukoko and the two centers in Lagos demonstrated increased coverage In the case of ORT, all the facilities with the exception of Lagos showed impressive increases The increase in the use of ORS is particularly noteworthy

While these instruments, especially the CBE, are the most appropriate means of determining project progress, they are time- and resource-consuming exercises which cannot and should not be repeated too frequently It is unlikely that they can be conducted any more regularly than once every two years, or annually at most This is not sufficient to determine project management purposes Therefore, what is required is an interim mechanism that will permit the respective CPHs and health facilities to determine if the health situation in their area is improving In other words, there is a need to design and introduce a supervisory checklist which contains key questions from the CBE and that would be utilized by a supervisor who would periodically visit randomly selected households

Priority must be given to the completion of the follow-up CBEs in Lagos and Kano toward the end of BASICS (i e , in June or July) This would be the second follow up for the CPHs in Lagos and will enable the project to say more about the effectiveness of the community-based strategy The CBE2, involving 100 households randomly selected from the CBOs, will strengthen the data collection effort It is hoped that having a cadre of trained and experienced interviewers will facilitate and accelerate the implementation of these surveys In Kano, the first follow-up CBE will determine the results of the early phase of BASICS' intervention

Recommendation: 1) Nutrition. *In any future CBEs conducted either in Lagos or Kano, nutrition questions should be added, especially on breastfeeding, which is one of the priority behaviors requiring modification and targeted for change*

2) Supervisory Checklist. *There is agreement that the project should develop a simplified checklist with which a supervisory person could sample community members or focus groups on child health care knowledge and practice The project must determine who the proper person would be, where s/he would reside, and how s/he would be paid*

E. Facility-based Quality Assurance (FBQA)

In order to ascertain the quality of health workers in the diagnosis, treatment, and counseling of childhood illness, BASICS/Nigeria has recently completed the collection of data on its baseline FBQA At present, the data is being analyzed

The survey consists of eight questionnaires, each with varying sample sizes, both from BASICS and non-BASICS facilities

I Sick Child Visit (69 BASICS under-5s, 14 non-BASICS)
II Antenatal Visit (46 BASICS pregnant women, 13 non-BASICS)
III Postnatal/FP Visit (13 BASICS women, 8 non-BASICS)
IV Facility Operations (13 BASICS centers)
V Immunization (13 BASICS centers)
VI Sick Child Exit Interview
VII Antenatal Exit Interview
VIII Postnatal/FP Exit Interview

I reviewed the questionnaires and found them generally satisfactory It is curious that hepatitis B is listed as one of the immunizations (question #29 on questionnaire 6) It is not now, nor is it likely to be any time in the near future, included in the package of mandated immunizations As such, it could be listed in the "other" space, if and when anyone ever says responds positively In the same questionnaire, question #42 refers to means of payment The option of "given credit" should be added since several of the facility directors with whom I spoke said that this was a common occurrence In questionnaire 8, question #22, sterilization is listed but is described in parentheses as "tubal legation,"even though tubal ligation is extremely rare in Nigeria I suggest that vasectomy be added to remind people that it is an option and increase awareness that such a simple and safe option exists

The real problem that was identified concerning the FBQA involves sample size, especially when dealing with specific childhood illnesses (e g , diarrhea, ARI, fever) For example, when analyzing diarrhea cases, there were only six cases from the BASICS clinics, and zero from the control group Even in the case of the most common complaint, fever, there were only 31 cases in the BASICS clinics and 6 in non-BASICS These small numbers make it impossible to make any statistically valid comments on facility health worker practices relating to the illnesses in question

The effort to have a control group is to be applauded, however, due to the time and resource intensity of the data collection involved in the FBQA, a question is raised regarding the feasibility of being able to collect a statistically valid sample size. Even the size of the project sample is too small and must be enlarged if BASICS wishes to be able to compare health worker behavior to pre-intervention status

As in the case of household child health care knowledge and practices, it is important to monitor health worker performance on a regular basis Thus, it is suggested that a supervisory checklist for health worker performance could also be useful for CPHs and health facility managers to know where their staff is weak and requires additional training This should also guide the supervisors in the reenforcement of health worker practices in proper diagnosis, treatment, and counseling

Recommendation: 1) Sample Size. *In future FBQAs, it is suggested that no control group be monitored, rather, the size of the BASICS group should be increased The size of the sample should be determined by the number of cases needed to make statistically valid decisions In other words, the surveys should continue to monitor the health facilities until they find a predetermined number of diarrhea cases or fever cases or ARI cases The exact number per illness has to be determined by project personnel, but I believe that 35-40 cases for each childhood illness should be sufficient In terms of the areas already sampled in Lagos, it would be worthwhile to collect additional cases so that sufficiently large samples are available and post intervention (i e., health worker training) comparisons can be made*

2) Supervisory Checklist. *The child survival and M&E program officers should collaborate in developing a supervisory checklists for health worker behavior Again, it must be decided who will carry out this supervision and how it can be funded*

F. Process Monitoring

At present, a very interesting exercise is being undertaken to document the process taking place at the community level in the Urban Private Health Project This study will be valuable to the BASICS project worldwide as it initiates an effort to document the community process in four other countries The Nigerian study has utilized some interesting methodologies One methodology is using the Delphi method to compare community perceptions of need with the priorities as stated in the sub-project proposals Another is an instrument which is used by individual CPHs to determine their progress in the area of organizational development Drawing from several other instruments, Dr Brieger has constructed a tool which appears very useful For the lack of any better term, I will refer to it as the Organizational Development Index (ODI) The ODI consists of three parts organizational structure (13 questions), management and logistics (23 questions), and programming (13 questions) Each question is scored from 0 ("not yet") to 4 ("fully achieved") Individual CPH aggregate scores ranged from a low of 17 to a high of 75 5 A copy of the instrument is presented as Appendix E

The methodology to date has been to have the CPH go through the exercise and rate themselves In addition, the BASICS/Nigeria community development program officer has rated some of the CPHs Where both the CPH and an outsider have reviewed CPH organizational development status, the results have been averaged Due to the community development program officer being on leave, I was unable to ascertain the variance existing between his ratings and the CPHs' At any rate, each CPH which underwent the exercise was scored on each of the three categories and given a total score (average of the scores from the three elements of the ODI)

One approach that might be tried is to have the CPH and an outsider rate a CPH's organizational development performance separately and then come together to discuss the independent findings and to agree on a score for each question This discussion serves as a valuable opportunity for the CPH to gain an appreciation for what it has achieved and what it still must do in order to strengthen its operations It enables the CPH and BASICS to identify where additional technical

assistance and/or training is required so that during the next organizational review (every six months), it will score higher Thus, the ODI instrument is several things in one a training opportunity, a planning mechanism, and an evaluation/monitoring tool

In discussions with the BASICS/Nigeria staff, especially with the women empowerment/D&G and the M&E program officers, the idea of developing a similar instrument to monitor the effectiveness of the CPHs' community involvement was raised The vision was to design a tool that included such elements as women's empowerment, internal NGO democracy and political participation Such an instrument might be referred to as the Social Development Index (SDI)

Recommendations: 1) Organizational Development Inventory. *BASICS/Nigeria is encouraged to adopt and institutionalize the use of the ODI It should be carried out in the five CPHs in Kano to serve as a baseline In addition, it should be carried out again, in both Lagos and Kano, in mid-1998, prior to the end of BASICS to determine if progress in the important area of organizational capacity has been achieved and which CPHs require additional support*

2) Social Development Index. *The BASICS/Nigeria program officers for women empowerment/D&G, community development, and M&E should lead the effort to design a Social Development Index (SDI) It should be tested and modifications made to make it as useful as possible If found practical and helpful, the SDI should be introduced and a first round of reviews carried out in the CPHs of Lagos and Kano*

G. Democracy and Governance Indicators

Discussions with both USAID/Washington and Nigeria made it clear that both are extremely interested in identifying viable indicators in the area of D&G The need is made all the more important because of the lack of such indicators to date to guide the effort and to enable the field offices and programs to monitor their operations and measure their success

While the CEDPA and JHU/PCS activities in Nigeria are more involved with D&G programming, such activities are also an important part of what BASICS/Nigeria does While in country, I participated in several meetings to discuss D&G indicators Due to the "softness" of the issue, it is not easy to identify indicators that are meaningful, measurable, and operationally feasible As a result of these discussions, keeping in mind BASICS activities, a set of D&G indicators were developed and are included as Appendix F Included are several micro-credit indicators which can be utilized by BASICS/Nigeria when this important component of its program is launched

While much of the focus of the BASICS/Nigeria operation will be on child health issues and measure results in the health area, it is essential that the project monitor the results of its D&G and social mobilization efforts The SDI is one possible instrument in this regard and can provide some at least quasi-quantitative support to monitor progress The project must be able to measure the impact of such activities as the women's empowerment training and mock parliament

Recommendation: Indicators. *The D&G indicators should be tested and those found most useful be integrated into the regular monitoring of the program The possibility should be explored of including a few of the most important and revealing D&G indicators in the community-based CBE surveys*

H. Monitoring and Evaluation Plan

The M&E program officer and I reviewed the M&E activities for PY5 as listed in Attachment I to the annual program report. BASICS/Nigeria has made good progress in their M&E activities and are pretty much on schedule at this point A review of the status of the four activities is as follows

- **Integrated Baseline Health Survey**—The mini-IBHS in Kano has been completed, but the data has yet to be analyzed, however, data analysis should be finished soon The mini-IBHS/UPSI in two new dyads of Lagos is currently being conducted The data collection aspect will be completed by the end of December and the data analyzed by January

- **Facility-based Quality Assurance Assessment**—The FBQA in Lagos has been carried out and the analysis of the data is almost complete The FBQA in Kano is to be conducted in March 1998, and there is no reason at this point why this schedule cannot be met

- **Local Monitoring and Data Use**—This heading is a little confusing, but we assumed that it refers to the CBEs The baseline CBEs (100 households) for six original CPHs in Lagos have been completed The results of three additional dyads in Lagos are in draft form, awaiting typing When completed, the total number of CBEs for Lagos will be nine Four more CBEs will be required for the new dyads in Lagos (All Souls', Beebat, Logos, Ola-Abi) In addition, the CBEs for Kano must be done These and the remaining CBEs in Lagos will be carried out in February 1998 as per the PY5 activity time line

  The second round of CBEs will be conducted in June and July (as scheduled) in Lagos and will include the more extended sampling by selecting an additional 100 households from the CBO populations, plus the normal 100 households around the health facilities These will be carried out in eight of the dyads where a first round CBE has already taken place This should enable the project to determine the effectiveness of its IEC and knowledge and behavior change activities In the other dyads and CPH in Kano where IBHSs have only recently been conducted, there will be only sufficient time to carry out the health facility 100 household CBE (first follow up)

- **Process Documentation**—Most of the field work for the process documentation exercise has been completed Approximately half of the report has been drafted and is well written Dr Brieger expects to require some additional time to process the data and write up the results from Kano and to complete the draft I support the request for additional

time as I believe that this is a valuable exercise, not just for Nigeria but also to share with the other BASICS countries that are about to launch process documentation efforts

III. CONCLUSIONS

The BASICS/Nigeria program has achieved a great deal in its first few years of operation Particularly impressive has been the network of CPHs and CBOs that have been developed These have translated into some positive trends, especially in numbers of immunizations given (particularly in NIDs) and in patient loads, both in- and out-patient, which have apparently benefitted from the increased community involvement In addition, the capacity of the model and strategy to respond to epidemics is encouraging Thus, even though the project has the disadvantage of not having a fixed population with which it deals, there are several indicators for which numbers can be collected and monitored It has been recommended that a monthly reporting form be introduced so that performance in a couple of the most important aspects of the project (immunization, patient loads, TBA-assisted deliveries) can be tracked As the health interventions such as ARI and diarrhea are launched, there will be increased number of indicators to monitor

BASICS/Nigeria thinks that it would be helpful to have a return visit by BASICS/Washington M&E Division as they are gathering and presenting the results of all their data collection efforts prior to the conclusion of BASICS If the Lagos office maintains the current schedule, this follow-up visit would be most useful sometime in August 1998 and should focus on supporting the program as it analyzes and writes up the results of its 4-year effort

APPENDIXES

APPENDIX A

APPENDIX A

Name	David Pyle
B) Account Code	000-NI-01-036
C) Destination	Lagos, Nigeria
D) Dates	November 10 - 24, 1997
E) Fee days	12

F) Scope of Work

In collaboration with the BASICS M&E Program Officer, Pyle will

- Work with USAID/Lagos to prepare a plan for measuring results in 1998
- Assist the BASICS/Nigeria Monitoring and Evaluation Program Officer in developing monitoring forms and a monitoring and evaluation plan for CPHs
- Review the protocol for the local monitoring and data use CBE to be conducted in Kano with the M&E Program Officer
- Review the BASICS M&E plan and process documentation/evaluation
- Review the protocol for the facility-based quality assurance assessment to be conducted in Kano

APPENDIX B

APPENDIX B

List of Contacts

BASICS/Nigeria

Dr J Olu Ayodele	County Adviser
Dr H O Adesina	Monitoring and Evaluation Program Officer
Dr C A Williams	Child Survival Program Officer
Ene Obi	Women Empowerment/D&G Program Officer
Samuel A Orisasona	Community Development Program Officer
A A Iroko	Assistant Program Officer
Maria Elejire	Secretary
Foluso Apantaku	Research Assistant, FBQA Data Analysis (Consultant)
Abiodun Adetoro	Research Assistant, FBQA Data Analysis (Consultant)
J O Akindutire	Research Assistant, Field Data Collection (Consultant)
Ibrahim Beseji	Community Development Officer, Kano
Bill Brieger	Consultant (Process Documentation)

CPHs/Health Facilities

Dr O O Aworo	Director, Roland Hospital & Maternity
Dr A O Sowande	Director, Royal Health Care Hospital
Dr M A Owoeye	Director, Logos Medical Services
Dr A A Oduyoye	Director, Jas Medical Services
Staff	Bolutife Hospital
	Makoko Medical Centre
	Pine Hospital
	Salvation Army Hospital

USAID/Nigeria

Felix Awantang	Country Administrator
Abdu Garba	Technical/Geographical Manager
Imeh Udom	D&G Manager

USAID/Washington

Neil Woodruff	Responsible for Nigeria, Global

Center for Education and Development for Population Activities (CEDPA)

Joyce Mangwat	Program Officer, D&G
Toyin Akpan	Program Officer
Michelle Karolak-Siegal	Monitoring and Evaluation
Enyantu Ifenne	Research Assistant

Johns Hopkins University/Population Communication Services (JHU/PCS)

Bola Kusemiju	Country Representative
Ibiba George	Research/Evaluation Officer
Rebecca Homes	Staff, PCS/Baltimore

APPENDIX C

APPENDIX C

CPH	Health Facility (Dyad)	CBOs/ PMVs	Patients/ Membership	Potential Impact
I. LAGOS				
1 Ajegunle	Rikky Hosp & Mat	28	5,000	30,000
	All Soul's Clinic	25		
	Beebat Med Center & Mat	30		
	Ola-Abi Memorial Hosp	25		
2 Amukoko	Shammah Hosp	16		
	Nasah Hosp & Mat*			
3 Jas	Jas Medical Services	12	1,200	7,200
4 Lawanson	Royal Health Care Hosp	25	1,300	7,800
	Rock of Ages Hosp	22	2,000	12,000
	Pine Hosp	27	2,000	12,000
	Anthnie	6		
	Logos Medical Services	45		
5 Lagos Island	Roland Hosp	9		
	Salvation Army Hosp*	4		
6 Makoko	Makoko Medical Centre	21		
	Bolutife Hosp*			
	Elizir Clinic*			
	Celestial Church Clinic*			

Lagos Subtotals 6 CPHs, 18 Health Facilities, 13 Dyads 295 CBOs
Reach - Direct = ?????
- Potential = ?????

* Not dyad

II. KANO

1 Badawa	Savannah Clinics Merit Care Hosp 4 Traditionalists			
		13 CBOs	207	53,654
		16 PMVs	12,300	574,668
2 Gama B	Sanbell Hosp Samirat Mat Home Mai Nasara Clinic 8 Traditionalists			
		9 CBOs	1,780	10,680
		10 PMVs	74,960	449,760
3 Gwale	Mihiban Clinic & Mat 9 Traditionalists			
		19 CBOs	2,747	6,680
		15 PMVs	190,930	1,145,960
4 Sheshe/Mandawari	Lafiya Surgery & Medicals 2 Traditionalists			
		6 CBOs		
		1 PMV		
5 Yakasai	Lawal Jafaru Isa Clinic 4 Traditionalists			
		3 CBOs	1,270	818,046
		5 PMVs	114,800	619,925

Subtotals 5 CPHs, 8 Health Facilities & 27 Traditionalists, 50 CBOs, 47 PMVs
Reach - Direct = ?????
- Potential = ?????

LAGOS/KANO HEALTH FACILITIES AND THEIR CBOs

I. LAGOS

ROYAL HEALTH CARE DYAD

1	Omobola Resident Association	-	100
2	Obele-Kolade Resident Association		
3	Photographic Association		
4	Carpenter's Association	-	300
5	S S Mulumba Catholic Church		
6	Baruwa Market Association		
7	Celestial Church of Christ/Ibuje Eran)		
8	Battery Charger's Association	-	40
9	Tailoring Association	-	100
10	Tradition Birth Attendants		
11	Goldsmith Association		
12	Hairdressing Association		
13	Lawanson Rising Stars		
14	Women Empowerment Community		
15	Nigerian Union of Road Transport		
16	Night Market Association	-	200
17	Anjola Oluwa Association		
18	Oluwanipe Koyeni Mosque	-	500
19	Royal Health Staff	-	14
20	Temitope Mosque	-	40
21	Mujayidena Fell Islam	-	200
22	National Council of Muslim Youth Organisation	-	300
23	Nawaru-Deen Society	-	200
24	Holy Trinity Ang Church	-	2000
25	Methodist Church Folawiyo Bankole	-	2000

ANTNIE DYAD

1	Masha Taxi Association
2	NURTW Masha Chapter
3	Soleye Mbonu Ojike
4	Masha Food Vendors Association
5	Onilegogoro Resident Association
6	Shitta Resident Association

PINE DYAD

1 Vulcanizer Association
2 United Tailors Association
3 Iyaloja Women Association
4 NURTW
5 Church Association
6 Irepo Organisation
7 St Lukes Anglican Church
8 Cherubim & Seraphim Church Movement
9 Nylon Association
10 OFUTOP Women Association
11 Ijeshatedo Central Mosque
12 Redeemed Christian Church
13 Fountain of Life Church
14 Ikom Community Association (Ijesha Branch
15 Petty Sellers Association
16 Staff of Pine Hospital
17 Favour Video Club
18 Women Empowerment
19 Youth Links
20 Ireakari Credit & Thrift Co-operative
21 Hairdressers Association
22 National Automobile & Technician Association
23 Duro Oyedoyin Residents Association
24 Nigerian Union of Teachers
25 Fresh Residents Association
26 The Peace Process
27 Ishiabu Welfare Association

LOGOS DYAD

1 Hairdressers Association
2 Tailoring Association
3 Market Women Association - Tejuosho
4 Market Women Association - Iponri
5 Market Women Association - Matthew St
6 Police Wives Association - POWA
7 Nigerian Army Officers Wives Association - Abalti Barracks
8 Nigerian Army Officers Wives Association - Miyong Barracks
9 Women Values Comm Association
10 Caterers Association
11 Traders Association
12 Baptist Church

13 Youths Association
14 Mechanic Association
15 Photographers Association
16 Vulcanizers Association
17 Auto spare parts Association
18 Horologist (Wrist watch Association)
19 Welder Association
20 St Johns Ang Church
21 Assemblies of God Church
22 Boy's Scout Association
23 Road Transport Employers
24 Evangel Power Ministry
25 (NASU) Non Academic Staff Union
26 Mountain of Fire and Miracles
27 Apena, Atunrase, Akobi, Onasanya Resident Association
28 Martins, Rotimi, Jacobs Resident Association
29 Special Marshal of Surulere
30 NURTW
31 Nathan Resident Association
32 K & S Headquarters
33 Jehovah Jireh African Church
34 Hausa Community Tejuosho
35 Jamat Fatah Ade Mem Mosque
36 Alhaja Safiratu Mosque
37 Central Mosque
38 New Estate Baptish Church
39 Qua Iboe Church
40 Luthran Church of Nigeria
41 Apostolic Church
42 St Pauls Anglican Church
43 Hausa Sabaramo Community
44 Trado Medical Association
45 Ijesha Central Mosque

ROLAND DYAD

1 United Tailors Association
2 Hairdressing Association
3 Happy Club of Nigeria
4 Marquis Club
5 Traditional Birth Attendants
6 Quranic Mosque
7 St. Andrews Church
8 Market Women Association
9 Womens Wing Empowerment

SALVATION ARMY DYAD

1 Salvation Army Church
2 Women's Empowerment
3 Youth Association
4 Market Women Association

MAKOKO CPH

1 Aiyetoro Community
2 Acts of the Apostles Church
3 Makoko Red Cross
4 Temidire Market Association
5 Taxi and Danfo Association
6 Odu Community
7 Dr Alli Herbal Home Association
8 Unity Sisters Club
9 Imam Lane Landlord Association
10 Makoko Central Mosque
11 Celestial Church Association
12 Dr Adebisi Herbal Home
13 Ogayemi Resident Association
14 Halleluyah
15 Ewediji Herbal Home
16 Islamic Crusaders
17 St. Daniel Hospital
18 Barry Hospital
19 Champion Hospital
20 Golden Club of Edo
21 Oshofa Members Clinic

ALL SOUL'S DYAD

1 National Council of Women Society
2 Aduke Market
3 Dankaka Community
4 Iyaniwura Cooperative Association
5 Layeni Central Mosque
6 Layeni Community Development Council
7 Oyedeji Community Development Association
8 Allau Lateef Central Mosque
9 Hope of Glory Gospel Church
10 Celestial Church of Otto Wolf
11 Ojo Road community
12 Arewu community
13 Jackson Traditional Clinic
14 Ayota Arts Organisation
15 Madona Nursery and Primary School
16 Association of Business Centre
17 NURTW Alaba
18 Peakman's Academy
19 Onorikpo Chambers
20 AF Group of Artists
21 All Souls Hospital
22 Layeni Continuing Education
23 Oyedeji Community Youth Association
24 Alaba Community
25 AF Group of Artists

RIKKY DYAD

1 Rikky Hospital
2 Assemblies of God Church - Cardoso Branch - 1000
3 Eternal Sacred order - Mount of Love
4 Eternal Sacred Order - Mount of New Jerusalem
5 The Church Miracle Chapel
6 Christ Apostolic Church
7 Christ Redemption church
8 Opeloyeru Mosque
9 Oluwa Ni Sola Mosque
10 Folrunso Mosque
11 Ejiro Youth Association
12 Ekuwgbe Youth Association
13 Assemblies of God Church - Itire Road Branch - 700
14 Assemblies of God Church - Alaba Branch

15	Assemblies of God Church - Kirikiri Branch		
16	Assemblies of God Church - Amukoko Branch		
17	St Ebenezer Church		
18	Oyedeji Community		
19	Traditional Medical Association		
20	God's Care Nursery & Primary School		
21	Market Women Association		
22	World Wide Miracle Ministries		
23	Patient Medicine Seller	-	50
24	Traditional Birth Attendants	-	24
25	Mammy Market Women Association (Army Barracks)		
26	Catholic Charismatic renewal fellowship		
27	Assemblies of God Church - Badiya		
28	Temini Jesu C & S Church - Uzor Branch		

JAS MEDICAL SERVICES

1	AHOEMEAGBE	-	30
2	Christ Gospel Apostolic Church	-	650
3	Health Care Association of Igbehin	-	40
4	JAS Medical Association	-	20
5	CRUSADERS	-	80
6	Oladehinde Coker Landlords/Tenants Association	-	500
7	Bosby Nursery/Primary School	-	15
8	Bosby Nursery/Primary School Children	-	400
9	Holy Trinity Anglican Church	-	1000
10	Alfa Nda Welfare Association	-	750
11	NURTW	-	250
12	OSA Association	-	300

ROCK OF AGES DYAD

1	Battery Chargers Association
2.	Fashion Designers Association
3	Mechanic Association
4	Market Women Association
5	Upholstery Association
6	Photographers Association
7	Youth Association
8	Ansar-U-Deen Association
9	Redeem Church Association
10	Patent Medicine Association
11	Panel Beater Association
12	Petty Traders Association

13 Taxi Drivers Association
14 Hair Dressers Association
15 Refrigerator Association
16 Barbers Association
17 Shoe Makers Association
18 Landladies Association
19 Resident Association
20 Community General Secretary Co-ordinator
21 Publicity Officer
22 Residents Doctor [Dr Alli]

SHAMMAH DYAD

Amukoko Market

1	Fish sellers Association	-	108
2	Oporoko Association	-	28
3	Provision sellers Association	-	68
4	Soup Ingredients Sellers Association	-	58
5	Food Stuff Sellers Association	-	41
6	Pepper Sellers Association	-	31
7	Fowl Sellers Association	-	6
8	Pepper Grinders Association	-	14
9	Hausa [Arewa] Community	-	33
10	Amukoko Community Youth Wing	-	45

Muritala Mohammed Market

1	Meat Sellers Association	-	66
2	Vegetable Sellers Association	-	68
3	Pepper Grinders Association	-	3
4	Food Sellers Association	-	3
5	Fish Sellers Association	-	25
6	Cooking Ingredients Association	-	11

****

II. KANO

Badawa Health Partners

Health Facilities/Traditional Practitioners
1 Savannah Clinics
2 Mericare Hospital
3 Kassimu Herbalist
4 Malam Herbalist
5 Haj Aishatu (TBA)
6 Uwani Ado (TBA)

CBOs
1 Vigilant Group of Badawa
2 National Union of Road Transport Workers
3 Woemn's Health Education & Development
4 Sagamja Group
5 Swoden
6 Ilamata
7 Zumunta Badawa
8 National Football Club
9 Samba Boy's Football Club
10 Unguwar Gaya Matasa
11 Zango Matasa
12 Tsauni Matasa
13 Himma Matasa

Pharmacies/Patent Medicine Vendors
1 Olison Medical Store
2 Lizzy Medicine Store
3 Be Healthy Patent Medicine
4 Jeigra Medical Store
5 El-Victore Medical Store
6 Amara Junior Patent Medicine
7 Iwang patent Medicine
8 Victory Patent Medicine
9 Chimmaco Medical Store
10 Health First patent Medicie
11 Asalam Medicine Store
12 Chally General Enterprises
13 Biz Medical Store
14 Kendo Patent Medicine
15 Medical and General Enterprises

GAMA "B" HEALTH PARTNERS

Healthy Facilities/Traditional Practitioners
1 Sanbell Hospital
2 Ha Samrat Maternity Home
3 Mainassara Clinic
4 Hamza Traditional Herbalist Medicine Clinic
5 Haj Gambo Yan Filani (TBA)
6 Hajiya Zuali Mohammed (TBA)
7 Mal Mohammed Hamza (TBA)
8 Haj Hanne Isayku (TBA)

9 Haajiya Umar Yara (TBA)
10 Hajiya Abubakar Abu (TBA)

CBOs
1 Kainuwa Vigilante Group
2 Kano State Youth Patrol
3 Margi Dzakwa Club
4 Hildi Women Association
5 Voice of Gama Association
6 Guda
7 Basange Nipe Youth Development Association
8 Haske-Zumunte Gama
9 Rikon-Amana

Pharmacies/Patent Medicine Vendors
1 Sherrif Jibrin Medicine Store
2 Kings Universal Store
3 Mangoro Mahauta Patent Medicine Store
4 Chagwa Hildi United Patent Medicine Store
5 Kwanar Yan Daru Patent Medicine Store
6 Isamiya-Durami Patent Medicine Store
7 Idris Medical Association
8 Sir Jenny Medical Enterprise
9 Ramadan Medicine Store
10 Nura Alhaji Sharif

GWALE HEALTH PARTNERS

Health Facility/Traditional Practitioners
1 Haj Kubura
2 Haj Kubura (TBA)
3 Hajiya Gogoro Unguwarzoma (TBA)
4 Sarkin Dori Family Bone Setter
5 Rumfar Umar Wanzan
6. Mal Musa Trad Practitioner
7 Wanzanci-Alh. Umaru
8 Wanzanci-Mal Muh Inuwa
9 Muktari Usaini Traditional Barber
10 Alh Sarkin Dori M Kofar Naisa

CBOs
1 Dan Madara Modern Furniture Association
2 Dandago Vigilante Group
3 Gwale Social Group
4 Safinatul Khair Foundation
5 Group of Tailors
6 Fadi Tailoring Organization
7 Gwale Development Association
8 Kofar Naisa Vigilante Group
9 Kungiyar Birkiltoli da Kafintooci
10 Association of Fishers
11 Kofar Naisa Self-Help Group
12 Mubaruil Islam Foundation
13 Non Dadin Kowa Gwale Bashir Inuwa
14 Al-Musban Prog Union K'inaisa
15 Group of Tailors Gwale
16 Motor Mechanics Organization
17 Plumbing Association
18 Bello Dandago Self-Help Group
19 Azumi Dariya Foodseller Association

Pharmacies/Patent Medicine Vendors
1 Al-Muhadda Sahina Chemist
2 Asma'u Medical Store and Patent Medicine Store
3 Gwale Medical Store
4 Sai Godiya Medical Store
5 Diso Medicine Enterprises and Medical Store
6 Girago Venture patent Medicine Store
7 Sauki Chemist
8 Fauziya Patent Medicine Store

9 Darul-Aman Patent Medicine Store
10 Maimuna Medical Store
11 Imperial Health Limited
12 Sauki Medicine Store
13 Kana Da Right Group of Comp. Chemist Shop
14 Rising Sun Patent Medicine Store Gwale
15 Dabo patent Medicine Store Gwale
16 Fnums Medicine Store Hausawa

SHESHE/MANDAWARI COMMUNITY PARTNERS FOR HEALTH

Health Facility/Traditional Practitioners
1 Lafiya Surgery & Medicals
2 Traditional Healer
3 Traditional Bone Setter

CBOs
1 Sheshe Builders Association
2 Tailoring Association
3 Sheshe/Kwalwa Vigilante Group
4 Mandawari Vigilante Group
5 Mandawari Self-Help Group
6 Sheshe Self-Help Group

Patent Medicine Vendor
1 Nagarta Medicine Store

YAKASAI HEALTH PARTNERS

Health Facility/Traditional Practitioners
1 Ja'afar ISA Clinic
2 Bello Sanni
3 Abdulhamid Alasan
4 Zulai Ibrahim
5 H A'Ishatu Abubakar

CBOs
1 Daya
2 Yakasai Drama Group
3 Yakasai Zumunta

Pharmacies/Patent Medicine Vendors

1 Sharma Chemist
2 Sa'a Patent Medicine Store
3 Gaskiya Patent Medicine Store
4 Zahiyya
5 Ansar (Amwad)

APPENDIX D

APPENDIX D

MONTHLY REPORTING FORM

HEALTH FACILITY: _____ **MONTH:** _____

I. PATIENT LOAD

TYPE OF PATIENT	UNDER 5 (<59 months)	OVER 5	TOTAL
IN-PATIENT			
OUT-PATIENT			

II. ROUTINE IMMUNIZATIONS (UNDER 0NE, 1-2 Years)

ANTIGEN	NUMBER	
	<1	1-2 Years
BCG		
DPT3		
MEASLES		

III. TBA DELIVERIES

TBA NAME	NUMBER
#1 -	
#2 -	

APPENDIX E

COMMUNITY PARTNERS FOR HEALTH
SELF-STUDY GUIDE

ATTACHMENT V
Organization Development
Index Instrument

Please hold a meeting with all governing board members present to discuss the following items about the development of your CPH Someone should take minutes of the discussion and a second person should mark the form below Please submit a copy of the completed form and the minutes to BASICS Be sure to fill in the "Comments" section with specific examples

A. ORGANIZATIONAL STRUCTURE

CPH NAME: _____

In our CPH we have ...	fully achieved	partially achieved	just started	not yet	*COMMENTS*
1 a written constitution, bye-laws or charter					
2 a memorandum of understanding among member CBOs/HFs that includes all current members to-date					
3 a clear policy statement that tells our purpose/mission					
4 officers who all have clearly defined titles, responsibilities, and duties					
5 committees that are appropriate for getting our work done					
6 regular board meetings					
7. regular general meetings					
8. Set realistic and achievable goals					
9. Involved all members in programme planning					

In our CPH we have ...	fully achieved	partially achieved	just started	not yet	*COMMENTS*
10 A reliable system for communicating and sharing information among our members					
11 a concrete way of ensuring that women play a central role in the CPH					
12 A concrete way to ensure that youth play a central role in the CPH					
13 Made necessary or timely changes in leadership as required					

B. MANAGEMENT AND LOGISTICS

In our CPH we have ...	fully achieved	partially achieved	just started	not yet	*COMMENTS*
1. a secretariat					
2 a well kept system of minutes, records and documentation					
3 adequate furniture for our secretariat					
4 Adequate space for meetings (either at secretariat or with CBOs)					
5 minimal essential equipment for our secretariat (bought or loaned)					
6 appropriate volunteer or paid staff to run the secretariat					

In our CPH we have ...	fully achieved	partially achieved	just started	not yet	*COMMENTS*
7 adequate volunteers any time we run a programme					
8 an organized in-service training programme for our leaders and members					
9 been able to organize successful fundraising					
10 a clearly defined catchment, service or membership area					
11 involved the general community in contributing resources to ensure our long term success					
12 Established links with other organizations, associations and agencies (governmental, non-governmental and voluntary) within and outside the community to help promote our goals					
13 Established standard referral links with other health services as necessary					
14 Established lasting links with various donor agencies					
15 Set up and maintained a bank account					
16. Established an accounting/auditing system with regular reporting to the CPH					
17 Developed an annual budget for overall organizational management					

In our CPH we have ...	fully achieved	partially achieved	just started	not yet	*COMMENTS*
18 Actual expenditures and income that match in our budget					
19 Set up regular sources on income from dues, membership, etc					
20 Developed other income generation activities for the sustaining the organization					
21 Set up a monitoring system to get feedback about progress toward our goals - e g. immunization coverage					
22 Have a plan for expansion of the CBO/HF membership of the CPH					
23 Hve actually recruited new CBO/HF members into the CPH within the past year					

C. PROGRAMMING

In our CPH we have ...	fully achieved	partially achieved	just started	not yet	*COMMENTS*
1. A written overall plan of action that has been revised/updated as needed					
2 A specific plan of activities for the current quarter (3-month period)					
3 A specific budget for each plan of action or activity					
4 Expenditures that match the budget for each programme					

In our CPH we have ...	**fully achieved**	**partially achieved**	**just started**	**not yet**	*COMMENTS*
5 A system for reviewing progress on plans and activities					
6 Written reports on each specific activity on an annual basis and when the activity was completed					
7 A health education component of each of our major activities and programmes					
8 Developed locally appropriate health educational materials and activities (e g posters, drama)					
9 Engaged in advocacy to ensure that local policy makers are aware of the needs of children, youth, women, mothers and poor people					
10 Planned a comprehensive programme of activities that address all aspects of primary health care					
11 Adequately trained personnel and volunteers to undertake each programme and activity					
12 Established a good working relationship with the local media TV, radio, newspapers, magazines					
13 Maintained a regular, standard and reliable childhood immunization programme for the community					

(Please list any additional activities and achievements of the CPH on a separate sheet and attach)

APPENDIX F

APPENDIX F

D&G AND MICRO-CREDIT INDICATORS

In hopes of selecting a few key indicators under each category that will serve USAID as well as the NGOs involved in D&G efforts and be feasible to monitor, BASICS/Nigeria suggests the following

A. KAP

1. **Coverage:** To begin with it is relevant/appropriate to track the # of NGOs USAID is funding in this sector:
   # of NGOs funded by USAID with D&G activities
   # of members in the NGOs funded by USAID and having D&G activities
   % of households in NGO's area of responsibility having an trained in D&G

2 **Human Rights:**
   % of NGOs with at least 2 persons trained in Human Rights, and/or
   % of NGOs training members in Human Rights
   # of NGO members trained in HR

3. **Political Participation:**
   % of NGO members registered to vote

4. **Women's Political Empowerment (WPE):**
   % of participating NGOs with at least 2 persons trained in WPE
   % of participating NGOs training members in WPE
   # of participating NGO members trained in WPE
   % of governing seats in participating NGOs contested by women
   % of officials which are female in participating NGOs

B. INTERNAL DEMOCRACY

1. **Leadership:** % of NGOs with leaders/board members elected through open elections

2. **Transparency:**
   % of NGOs with regular general meetings as specified in constitution and
   % of NGOs having regular meetings that have minutes available to all

C. NGO FUNCTIONING IN THE COMMUNITY

1. **Membership:** see first indicator under KAP

2. Organizational Capacity:

% of D&G NGOs in "mature" category (structure, management/logistics, operations) [using BASICS instrument]

D. NETWORKING

1. Coalition: % of D&G NGOs belonging to coalition of NGOs

SUGGESTED INDICATORS FOR MICRO-CREDIT

1 # of Micro-Credit groups formed

2 # of members of Micro-Credit groups

3 # of Micro-Credit loans made (by CPH)

4 %of women wanting Micro-Credit loans who received them

5 % of women with Micro-Credit loans who have increased their income by
< 10% ___, 10 1-20%____, 20 1-30%____, >30%____