

AFRICARE

ADAMAWA STATE

MATERNAL HEALTH AND CHILD SURVIVAL PROJECT

Bureau of Humanitarian Response

Office of Private and Voluntary Jooperation

United States Agency for Intervention Development

2

FINAL EVALUATION

CSP-III

I September - 14 September, 1997

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EXECUTIVE SUMMARY

AFRICARE, a Private Voluntary Organization (PVO) with headquarters in Washington, D.C has implemented a maternal health (MH) and child survival (CS) VIII project in two rural Local Government Areas (LGAs), Guyuk and Fufore in Adamawa State where primary health care (PHC) services have been least developed. The project was originally programmed for three years (October 1993 to September 1996) but a no-cost extension of one year (up to September 1997) was granted to make up for a 3-month delay in starting the project due to administrative problems and another 5 months lost in 1994 when the project stagnated between April and August due to unanticipated political developments in the country.

The overall goal of the AFRICARE project was to reduce maternal and child mortality and morbidity in the two LGAs by utilizing child survival and maternal health interventions in the LGAs as vehicles to strengthen the management, technical, training and outreach capabilities and skills of the LGAs health personnel.

The Detailed Implementation Plan (DIP) covered eight (8) MH/CS interventions: child immunization; ante-natal visits and TT immunization for pregnant women; growth monitoring; infant and child feeding and safe delivery practices; diarrhoea disease management; child spacing; malaria control and water and sanitation. The DIP was subsequently revised and coverage of the project scaled down to two (2) districts in each of the two LGAs. Based on a base-line survey in one of the LGAs (Guyuk) objectives were set for each intervention area with minimum target rates to be achieved.

The project utilized seven main strategies - i) personnel development ii) community mobilization, organization and participation iii) information, education and communication (IEC) iv) resource and administrative linkages v) intersectoral collaboration vi) management information system (MIS) and vii) sustainability.

A mid-term evaluation was carried out from August 16 to September 8, 1995, after the first 19 months of project implementation. This final evaluation was carried out between September 1-14, 1997 using the following as the main sources of data:

- a) Existing documents and publications from the Federal and State Ministry of Health and other Agencies (national and international) on maternal and child health, primary health care and child survival projects in Adamawa State
- b) The baseline survey carried out for the project formation in the two focus LGAs - Guyuk (Dec. 1993) and Fufore (Jan. 1995)
- c) The Project Agreement and the Detailed Implementation Plan

(DIP)

- d) The quarterly reports and records from the Monitoring and Evaluation (M & E) and the Management Information System files
- e) The mid-term evaluation report carried out from Aug. 16 to Sept. 8, 1995
- f) The report on the final knowledge and practices survey (15 July to 28 July, 1997)
- g) Data collected during field trips to project sites by the Evaluation team (Appendix B)

The assessment of the project accomplishment based on the objectives have been befallen by lack of adequate and appropriate variables in the survey instrument to generate the types of data required to generate adequate and appropriate data to measure the attainment of the stated objectives. Going by what the survey data has estimated, Fufore LGA project area consistently recorded lower achievement rates than Guyuk and this could be probably due to the one year difference on the commencement of project activities in Fufore after Guyuk. Achievement in the provision of water and sanitary facilities in terms of coverage of villages in the LGAs was very low as only 15.2% of deserving villages were provided water and sanitary facilities.

The key child survival **indicators** from the survey show that in Guyuk there were considerable increase in ante-natal visits (60.3 - **81.3%**), ORT/SSS utilization for diarrhoea (33.9 - **57.0%**), immunization coverage (14.0 - **44.9%**), and exclusive breast-feeding (86.0 - 92.2%) than in Fufore where the corresponding rates were 56.4 - 59.8; 39.5 - 47.4; 15.2 - 32.3; and 84.1 - 83.3. Guyuk, however, recorded poorer performance than Fufore in contraceptive usage, literacy and management of diarrhoea. Generally, there were little or no changes in most of the indicators between baseline and final evaluation rates in both LGAs.

AFRICARE has succeeded in laying a solid foundation for the delivery of MH/CS services in the context of PHC in two Districts in each of Guyuk and Fufore LGAs in Adamawa State in the form of staff development, community mobilization for support and the creation of a demand for the services. However, the infrastructure and resources required to operationalize and sustain this effort are yet to be put in place, tried and developed so that they can be replicated as intended.

The weakness in the project implementation is the absence of adequate or sufficient post-training follow-up activities which would have entailed the transformation of knowledge, attitude and skills gained during training into desirable actions during practice in the field and which would have been the trial stage for

sustainability.

Already in place are house numbering and home-based records in all the houses in the project area. A good number of Village Health Workers (**VHWs**) and Traditional Birth Attendants (**TBAs**) have been trained and a new cadre of Community Birth Attendants (**CBAs**) also introduced. Village Development Committees (VDCs) and District Development Committees (DDCs) are existing and already mobilized for co-management of MH & CS activities. Demand for immunization, ante natal and water and sanitation services has increased but these achievements have relied mainly on direct input from the project staff and resources.

LIST OF ABBREVIATIONS

ADA		Adamawa Development Association
ASMOH	-	Adamawa State Ministry of Health
B.I.		Bamako Initiative
CBA		Community Birth Attendant
cs		Child Survival
CSP		Child Survival Project
H.S.M.B.	-	Health Services Management Board
IEC		Information, Education and Communication
M&E	-	Monitoring and Evaluation
MH		Maternal Health
MIS		Management Information System
NGO		Non-Governmental Organization
NPH		National Health Policy
PHC		Primary Health Care
PVO		Private Voluntary Organization
SMOH		State Ministry of Health
TBA		Traditional Birth Attendant
VHWs		Village Health Workers

INTRODUCTION .

1.1 Background:

1.1.1 Historical

The health status of women and children in Adamawa State in North-Eastern Nigeria was in 1993 among the worst in the country. Compared with a national infant mortality rate (IMR) of **102/1,000**, the rate was **144/1,000** in the State and was even as high as **202/1,000** in Guyuk, one of the Local Government Areas (LGA). Similarly the maternal mortality rate (MMR) in the State was **15/1,000** against **8/1,000** for the country.

According to National Health Policy (NHP), primary health care (PHC) is the first level through which extensive health problems of women and children are to be addressed. The NHP has delegated to Local Government Areas (**LGAs**) the responsibility for planning, financing and managing the implementation of PHC, while the State Ministries of Health (SMOH) are to provide guidance and technical assistance to the **LGAs**. The LGAs vary in their capacity to undertake their PHC responsibilities and the major impediments have been identified as lack of funds, failure to understand or accept PHC principles, and in-adequate management, technical and operational skills among the staff as well as collaborative input and support from the recipient communities.

AFRICARE, a Private Voluntary Organization. (PVO) with headquarters in Washington, D.C has implemented a maternal health (MH) and child survival (CS) VIII project in two rural LGAs (Guyuk and Fufore) in Adamawa State with an estimated current population of 266,730 where PHC services have been least developed. The LGAs have comparatively very little health services infrastructure, poor access roads and low literacy rates. The major economic activity is subsistence agriculture and fishing. There are many ethnic groups who can be classified according to three distinct languages .- Hausa, Longuda and Fulfude. Africare project was originally programmed for three years (October 1993 to September 1996) but a no-cost extension of one year (upto September 1997) was granted to make up for a 3-month delay in starting the project due to administrative problems and another 5 months lost in 1994 when the project was stagnated between April and August due to unanticipated political developments in the country.

According to the terms of agreement between Africa and Adamawa State Ministry of Health (ASMOH) signed on 15th February, 1994, Africare was to provide in-country support to the Project at a level up to \$344,540 over the life of the project contingent upon availability of funds. Counterpart funding was expected from ADMOH, the project LGAs and the State Ministry of Water Resources and Rural Development while contributions were also expected from national and international donors. Africare expenditure on operations in the two LGAs amounted to \$27,988 while counterpart and donor expenses were \$75,748 and \$165,430 respectively (Appendix D).

1.1.2 Project Objectives:

The overall goal of the AFRICARE project was to reduce maternal and child mortality and morbidity in the two LGAs by utilizing child survival and maternal health interventions in the LGAs as vehicles to strengthen the management, technical, training and outreach capabilities and skills of the LGAs health personnel. The expectation was that the interventions could improve the LGAs capacity to implement and sustain their PHC programs after the termination of the project which was to serve as a model for other LGAs in the State.

When the Detailed Intervention Plan (DIP) covering the 2 LGAs was submitted in March 1994, it was appraised by Washington to be too ambitious. The DIP covering eight (8) MCH/CS interventions: child immunization; ante-natal visits and TT immunization for pregnant women; growth monitoring; infant and child feeding and safe delivery practices; diarrhoea disease management; child spacing; malaria control; and water and sanitation was subsequently revised and scaled down to two (2) districts in each of the two LGAs. The project objectives in the DIP were, however virtually retained but sharpened.

1.1.3 Project Strategies:

To achieve the objectives, the project utilized seven main strategies - i) personnel development (ii) community mobilization, organization and participation (iii) information, education and communication (IEC) (iv) resource and administrative linkages (v) collaboration intersectoral (vi) management information system (MIS) and (vii) sustainability

1.1.4 Management and Administration:

For project management and administration, a U.S.-based MH and CS project specialist provided the oversight, liaison with donors, assistance in external procurement and participated in project evaluations. The Adamawa State MOH provided a Nigerian project manager while Africare provided an expatriate project adviser to ensure that management and administration follow the laid-down procedures.

The Africare/Nigeria Country Representative was responsible for overseeing the project including supervision of the Project Manager and Project Adviser, liaising with USAID and the FMOH through its Director of PHC and Disease Control and providing in-country support to the project. On technical and logistic support for project activities the Project Manager communicated directly with the SMOH in consultation with the Project Adviser and the Africare Country Representative. In addition to the Project Manager, the SMOH also assigned one (but later added 5 others) of its staff who were qualified Community Health Officers as Program Officers who worked closely and assisted the Project Manager and Adviser. An additional nine (9) nurse/midwives were also assigned to the project by the SMOH. Each of the Project Officers was overseeing one or two of the eight project activities. This makes a total complement of fifteen (15) professional staff to the Project Manager from the SMOH.

1.1.5 Financial Management:

All funds for the project were transferred from Washington to the Africare/Nigeria main account in Lagos from where funds were released to the Africare Yola account in Adamawa State. Signatures to the Yola account were the Project Adviser and the Africare Country Representative in Lagos. Transfer of funds responded to prepared annual budgets backed with quarterly work-plans and reports. The Project Accountant in Yola, the Project Manager and the Project Adviser were responsible for maintaining proper accounting and keeping administrative records of expenditure and receipts as well as procurement procedures and inventory records of supplies which were always open for inspection and review by Africare at all times.

1.6 Monitoring and Evaluation of Project:

A schedule for a quarterly reporting of progress of project activities and preparation of action plans was followed by the Project Manager. A mid-term evaluation was carried out from August 16 to September 8, 1995, after the first 19 months of project implementation.

1.2 Evaluation Desisn

1.2.1 Concentualization

Evaluation has been defined as "an assessment of progress made towards pre-determined goals which are clearly defined". It starts by looking into the context in which the goals of an intervention are set and defined by determining whether the goals are appropriate and achievable or feasible within the limits of existing structures and available resources (money, human and material) as well as the felt priorities and level of interest and preparedness of target populations and policy-makers. Assessment of progress also implies the selection of appropriate strategies and indicators of progress and how they can be measured against a standard agreed on as acceptable level of performance. Evaluation is also not limited to "effect" but includes "effort" which is a combination of the various inputs - human, material and money - and how efficiently they are managed including the facilitators and constraints. Two levels of measuring effects are the out-put level which are the immediate changes brought about by the intervention activities and the impact (out come) level which is the ultimate change in the general health status of the target community.

It is on the basis of this conceptual analysis that this evaluation was carried out.

1.2.2 Sources of Evaluation Data

The following were the main sources of data and information for the evaluation:

- a) Existing documents and publications from the Federal and State Ministry of Health and other Agencies (national and international) on maternal and child health, primary health care and child survival projects in Adamawa State
- b) The baseline survey carried out for the project formation in the two focus LGAs - Guyuk (Dec. 1993) and Fufore (Jah. 1995)
- c) The Project Agreement and the Detailed Implementation Plan (DIP)
- d) The quarterly reports and records from the Monitoring and Evaluation (M & E) and the Management Information System files
- e) The mid-term evaluation report carried out from Aug. 16 to Sept. 8, 1995
- f) The report on the final knowledge and practices survey (15 July to 28 July, 1997)

- g)** Data collected during field trips to project sites by the Evaluation team as contained in the following schedule and described in Appendix B.

1.2.3 Final Evaluation Schedule

The schedule of activities for the final evaluation prepared in consultation with the project staff is as follows:

- Day 1 (1/9/97) External Evaluator arrives Yola.
- Day 2 (2/9/97) Meeting with CSP management staff and ASMOH on evaluation schedules.
Preparations/documentation.
- Days 3-6 (3/9/97) Depart for Fufore LGA; meet with LGA policy makers, PHC staff and Traditional Rulers.
Visit Gurin District
i. Meet with PHC staff, VHWS, TBAs and CBAs
ii. Meet DDCs
iii. Visit health facilities/project site
- Day 4 (4/9/97) Visit Malabu district (focus):
i. Meet with PHC staff, VHWS, TBAs and CBAs
ii. Meet DDCs
iii. Visit health facilities/project site
- Day 5 (5/9/97) Visit Daware district (focus):
i. Meet with PHC staff, VHWS, TBAs and CBAs
ii. Meet DDCs
iii. Visit health facilities/project site
- Day 6 (6/9/97) **a)** Review previous week's activities
b) Plan for the next week activities
- Days 7 (7/9/97) Depart for Guyuk LGA; meet with LGA policy makers, PHC staff and Traditional Council.
- Day 8 (8/9/97) **a)** Visit Guyuk District (focus):
i. Meet PHC staff, VHWS, TBAs and CBAs
ii. Meet DDCs
iii. Visit Health Facilities/project site.
b) Visit Bobini District (focus): (Bobini)
i. Meet PHC staff, VHWS, TBAs and CBAs
ii. Meet DDCs
iii. Visit Health Facilities/project site.
- Day 9 (9/9/97) **a)** Visit Banjiram District:
i. Meet PHC staff, VHWS, TBAs and CBAs
ii. Meet DDCs
iii. Visit Health Facilities/project site

- b) Return to Yola:
- Day 10-12
 - a) Meet ASMOH/PHC staff
 - b) Meet Adamawa Development Association
 - c) Meet Africare CSP field staff
 - d) Start compiling draft report
 - e) Brief ASMOH/LGA senior PHC staff and Africare staff
- Day 13 (13/9/97) Review draft report with evaluation team.
- Day 14 (14/9/97) The External Evaluator departs Yola

I. PROJECT ACCOMPLISHMENTS AND LESSONS LEARNED

A. Project Accomplishments

A.1 A Comparison of project accomplishments with D.I.P. objectives

A.1.1 Project Objectives

This section is in three parts — ~~Objectives, Inputs and outputs~~ according to "strategies and outputs based on objectives." According to the signed agreement the project overall goal is to reduce maternal and child morbidity and mortality in the two intervention Local Government Areas (Guyuk LGA and Fufore LGA) by utilizing child survival interventions as a vehicle to strengthen management, technical and outreach capabilities of the two intervention LGA PHC programs, serving as a model to other LGAs in the **State**.

But the goal or outcome is stated as the reduction in maternal and childhood morbidity and mortality, this reduction was not be stated in measurable terms probably because there were no baseline data on morbidity and mortality rates attributable to maternal and health childhood problems and diseases for the project area. The end of project survey does not also contain these estimates.

In the project Agreement:

The project objectives were as follows:

- i) Each LGA will have in place sustainable mechanisms capable to maintain full immunization coverage rates of up to **80%**, with at least half (50%) of an estimated 11,000 children (0-11 months age) per LGA per year continuing to full immunization. Also, at least 80% of 37,560 WRA will receive two doses of tetanus toxoid immunization.
- ii) At least 60% of an estimated 37,350 **WRA** of the intervention communities will be knowledgeable about and using proper preparation and administration of home mixed SSS to treat their children's diarrhea.
- iii) At least 40% of the estimated 8,800 home deliveries (none of which are currently assisted by trained attendants) in each local government area each year will be assisted by a trained traditional birth attendant (TBA).
- iv) At least 10,560 WRA will be made aware of modern methods of child spacing and the percentage of contraceptive acceptors will significantly increase within the cultural and religious norms.
- v) Five persons from each village in the two LGAs (approximately 480 person overall) will be trained to correctly administer malaria treatment for all age groups.
- vi) At least 10,560 **WRA** will be made aware of the importance of exclusive breast feeding and appropriate weaning foods, and 80% of these women will breastfeed exclusively for 4-6 months and introduce appropriate weaning foods at the correct age.
- vii) Up to 24 self-help projects (6/LGa in Yr 2 and 6/LGA in Yr 3) will be supported by Africare private match funds in 24 villages, providing improved food, water and/or sanitation.

The experiences and lessons learned from implementation in the project's intervention LGAs would serve as a model which the Adamawa State Ministry of Health and other LGAs could utilize to strengthen PHC programs in more communities.

In the DIP

By the time the DIP was produced the baseline study from Guyuk LGA containing current information on the status of MH & CS services (Appendix A) was available. Project objectives were therefore re-set as follows:

(i) Project Immunization Objectives by Year C End of Project:

The project's immunization objective was to put in place sustainable mechanisms to maintain full immunization coverage rates of up to **80%**, with at least half (50%) of an average of 3,050 children 0-11 months of age per LGA per year continuing to full immunization.

(ii) Project CDD Objectives:

The project's objective was that at least 60% of an estimated 19,360 WRAs in the intervention communities would correctly explain how to prepare and administer SSS for ORT, and would have used ORT to treat children who had diarrhea in the previous two weeks.

(iii) Objectives for Increased Nutritional Status of Infants and Weaning-Age of Children:

The objective for **increasing** the nutritional status of the target population was to reduce childhood and maternal morbidity and mortality by promoting exclusive breastfeeding, good weaning practices and maternal nutrition. The project's objective for increasing knowledge of mothers about nutrition was to promote adequate utilization and consumption of locally available foods necessary for the well-being and proper growth of children under three years of age. Mothers would know about proper feeding of the child with inexpensive nourishing foods in the correct quantity and quality. An additional objective was for mothers to understand the association focus on increasing awareness and education, but would assure that enhanced knowledge would lead to behaviour change which should improve nutritional status.

(iv) Growth Monitoring Objectives:

The project planned to establish a mechanism that would assure that at least 50% or more of the estimated 6,200 children aged 0-3 years were weighed at least six times in both LGAs by year 2 and six times in year three, by the final evaluation giving a total of 36,000 children under 3 years of age eligible for growth monitoring.

(v) Project Malaria Objectives

The project's objective was that at least 60% of all fever cases, presumed to be malarial, occurring in children and pregnant women would be appropriately treated with chloroquine. The feasibility of promoting screening of houses, the use of bed nets (both insecticide-impregnated or **not**), the elimination of vector breeding sites, and perhaps other modalities, would be tested.

(vi) Objectives for Water and Sanitation:

The objectives of the water and sanitation component include the reduction of water-borne intestinal infections and promotion of sanitary proper waste disposal facilities. The project would provide professional, technical and management assistance and support to both LGAs PHC staff and the communities in the provision of potable water and sanitary facilities at affordable costs.

Revised Coverage and DIP Objectives:

In addition to reducing the coverage area of the project to 2 districts out of 7 in each of the two LGAs, the DIP objectives were revised in Washington Office of Africare as follows:

Immunization: 3

to increase from 3.3% to 50% full immunization of children 0-11 months

Management of diarrhea:

to increase from 31% to 60% the mothers with children 0-2 months who use ORT (SSS or ORS) as treatment for diarrhea

to increase to 60% the number of mothers who know how to prepare appropriate fluid and solid diets in dietary management of diarrhea

Growth monitoring:

at least 50% of children 0-3 years are weighed at least **six times a year**

to identify seriously malnourished children and provide their mothers with nutrition counselling

to **ensure** that seriously malnourished children receive an improved diet and show evidence of growth

Breast-feeding:

to increase from <1% to 50% number of women who exclusively breastfeed their children for 6 months

to increase the number using improved weaning practices

Pre-natal consultations:

to increase to at least 60% the number of pregnant women have at least one prenatal consultation in their first trimester

to increase to at least 60% the number of pregnant women who have at least 4 prenatal consultations

to increase to at least 60% the number of pregnant women who receive two injections of tetanus toxoid

Safe deliveries:

to increase to at least 33% the number of home deliveries which are assisted by a trained traditional birth attendant (TBA)

Family planning/child spacing

To increase from '2% to 4% the number of women of reproductive age and their husbands who accept the use of modern method of child spacing

A.1.2 Project Input and Outputs (accordins to strategies)

Strategy One: Personnel Development

S/N	INPUTS ACTIVITIES ACCOMPLISHED	OUTPUTS			
		GUYUK LGA		FUFURE LGA	
		DATE	#TRAINED	DATE	#TRAINED
1.	Training PHC staff and the conduct of Baseline Survey.	December 14-18, 1993	45	January 16-20, 1995	59
2.	Training of LGA PHC staff and the conduct of House Numbering Placement of Home-Based records and Community Registration.	September 13-18, 1994	46	Feb./March, 1995	56
3.	T.O.T. Workshop for PHC staff supervisors and clinic in-charge of health facilities.	October 17-19, 1994	72	June 12-17, 1995	48
4.	Training of Traditional Birth Attendants in safe delivery methods, promotion of child spacing and preparation of ORS.	April 24-May 4, 1994	53 TBAs	May 22-June 3, 1995	34 TBAs
5.	Training of Village Health Workers Re: promotion of immunization, ORT, malaria treatment, child spacing and nutrition/hygiene messages.	April 24-May 4, 1994	54	May 22-June 3, 1995	34
6.	Community Birth Attendants trained at the School of Midwifery Re: promotion of basic Midwifery services and supervision of TBAs at the PHC districts.	April 1995-March 1996	7	April '95-March '96	7
7.	MIS Training	May 22-25, 1995	8	May 22-25, 1995	7
8.	Conducted Family Planning and HIV/AIDS Prevention Education Program Planning, Proposal Writing and NGO management Training of Trainers Workshop for NGOs from Adamawa, Born0 and Taraba States	60 persons from 32 NGOs from the 3 States benefitted July 3-8, 1995			
9.	Conducted Nutrition Education and Diarrhoea Management Workshops for PHC CHEWs and some VHWs/TBAs.	November 1995	78	November, 1995	55

S/N	INPUTS	OUTPUTS			
	ACTIVITIES ACCOMPLISHED	GUYUK LGA		FUFORE LGA	
		DATE	#TRAINED	DATE	#TRAINED
10	MIS Training	March 18-19, 1996	15		
11.	Conducted Cold Chain System Maintenance Workshop for PHC staff to boost immunization coverage	August 14-15, 1996	112	September, 12-15, 1996	98
.2	Conducted Health Education and Community Mobilization for CHEWs, VHWS, TBAs and CBAs	September, 26-28, 1996	176	December 22-24, 1996	130
13;	Project staff trained on Project Planning and Proposal Writing a replicate of some aspects of workshops the Project Manager benefitted from the British Council Kaduna	Workshop conducted at project office Yola for 18 project staff, October 1996			
14.	Refresher course for Community Birth Attendants prior to graduation	November, 1996	7		
15.	15 Refresher courses were conducted at district levels for TBAs, VHWS and CBAs, CHEWs at both LGAs. 75 Additional VHWS/TBAs selected from other villages received initial training at district levels in Fufore LGA. The LGA need to complete their training	Jan-March, 1997	148	March/May-, 1997 March, 1997	165 75
16.	Conducted Refresher Course for CBAs trained at the School of Midwifery	July, 1997	7	August, 1997	6

S/N	INPUTS	OUTPUTS			
	ACTIVITIES ACCOMPLISHED	GUYUK LGA		FUFORE LGA	
		DATE	#TRAINED	DATE	#TRAINED
17.	Ten Family Planning Providers trained at Yola to conduct Family Planning Services at the LGA district levels	May 19-June 27, 1997	5	May 19-June 27, 1997	5
18.	Four project staff benefitted from T.O.T. workshop for VHWS/TBAs trainers conducted by Christian Health Association of Nigeria at Garkida. These 4 staff from HSMB could train LGA/NGO, VHWS and TBAs in the future.				

Stratesv Two: Community Mobilization, Orsanization and Participation:

1. **Consultative** meetings were held with LGA **policy** makers, all traditional rulers, religious and community leaders prior to commencement of baseline surveys covering the seven districts in each LGA. Consent was given for their wives to be interviewed and **community representatives who acted as guides** during the baseline surveys were selected. **Community was educated and mobilized for their roles in the CSP activities during project implementation.**
2. An advocacy workshop was conducted for new LGC members and community leaders.
3. PHC Management Committees at LGA headquarters and districts and village levels were established in Guyuk and Fufore LGAs. **These committees are currently being reoriented and strengthened.**
4. **Community mobilization is done prior** to all project activities which require biond-based participation: trainings, demonstrations, self-help projects.
5. The community produced and sold 72 **sanplats after sanplat latrine** construction demonstration workshops were conducted in both LGAs .
6. 2 slow sand filter pot demonstrations were held in Fufore LGA at Karlahi and Yadim and 106 slow sand filter pots were subsequently **produced by women in the communities.**
7. To sanitation units (boreholes, latrines) are under construction at **community participation.**

Strategy Three: Linkages

a) Administrative Linkages:

1. A management Workshop and mobilization workshop of LGA Council members and PHC staff, SMOH and NGOs in the LGA was conducted.
2. VDC/District Development and LGA PHC Management meetings have been on a periodic basis by majority of the district/village, with minutes of their meetings recorded.
3. Institutionalization and integration of the project into the **LGA** PHC system. The nine (9) senior cadre nurse/midwives posted to the districts worked closely with the PHC staff. The Project's Manager, Adviser, Program Officers and the LGAs senior PHC staff together planned, and implement PHC activities including training together at all levels.

b) Resources Linkages:

1. The project provided a 4WD project vehicle in April, 1994. The vehicle was used for transportation of vaccines, drugs and personnel to the communities.
2. The Essential Drugs Program was reactivated in the two LGAs giving health facilities access to essential drugs supplied by the LGA office.
3. The two LGAs provided 127 kits for their village health workers, while Africare provided kits for TBAs.
4. The project bought over 270 scales locally manufactured by CHAN in Jos. These scales were given to TBAs and VHWs in July, 1995 to be used for weighing children under 3 years.
5. VSO provided equipments for clinics and CBAs.
6. The CSP collaborated with the Oncho project and obtained nine Suzuki Motorcycle from UNICEF Zone D' Bauchi for Oncho Control/CSP activities.
7. The project established 40 (forty) Oral Rehydration Therapy centers in the two **LGAs**.
8. Ten VIP pit latrine and ten boreholes are under construction in the two focal LGAs using funds received from the SOS, Holland State and the two LGAs/communities. Ministry of Water Resources and Rural Development, UNICEF supported borehold maintenance training.

Strategy Four: Information, Education and Communication (IEC):

1. The CSP/MH project collaborated with ASMOH, and the focal LGAs and actively participated in all the National, State and LGA levels immunization campaigns conducted in 1995, 1996 and 1997. The project **trained** PHC staff/CHEWS who participated in the immunization and its supervision in IEC strategies for awareness and community mobilization.
 - Trained health facility staff and CHWs to deliver health messages.
 - Supervised and delivered health education sessions at village and district level health facilities as part of training and health facility activities.
 - Mobilized community participation and provided hygiene education and maintenance training to support water/sanitation activities.

Strategy Five: Intersectoral Collaboration:

1. The project has actively collaborated with local NGOs and International Development Agencies. Unicef provided N785,720.00 for support of cold chain, refresher and TOT activities.
2. The two VSO midwives obtained cash donations from Hussey Trust Fund (\$470) and the Dutch Reform Church (\$1,000) for the purchase of equipment for community clinics in the two LGAs. Women committees were formed to supervise the use of the equipment.
3. The project wrote **several** proposals for funding of project activities to Dutch Embassy, The British High Commission, and UNICEF.
4. United Methodist Church USA provided funds \$10,00 part of which was used in training CHEWS, VHWS, TBAs and community members in the prevention and control of water and sanitation related diseases. Eight (8) sanplat pit latrines and 1 VIP were constructed for community health facilities and schools in the two LGAs.
5. Ten VIP pit latrine and ten boreholes were constructed in the two focal LGAs using funds received from the SOS, State Ministry of Water Resources, and Rural Development and UNICEF' and the two LGAs/communities. Communities provided labour, sand, water and food.

Strategy Six: Management Information System:

1. **MIS** training for project staff was conducted.
2. A Final Survey exercise was carried out.

3. Training for house numbering, target population registration, placement of clinic and home base records in Guyuk LGA, Daware/Gurin PHC districts in Fufore LGA was conducted.
4. Completion of house numbering in Bobini/Guyuk PHC district in Guyuk LGA, Daware/Gurin PHC districts in Fufore LGA was carried out.
5. The record cards printed were placed in each of focused PHC district, demographic data were obtained and computerized in Bobini/Guyuk PHC district in Guyuk LGA, and Daware/Gurin districts in Fufore LGA. Communities/family heads answered questions and accommodated PHC staff.
6. The CSP mid-term evaluation was conducted between 16th August and 8th September, 1995.
7. A structural framework and schedules for monitoring and supervision of MH/CSP at all levels was established.
8. The Final Evaluation Survey, was carried out in July, 1997.
9. Clinic master cards, personal health cards and children immunization and growth monitoring cards were printed at sharing ratio of 70% by Africare and the two LGAs, pay 30%.
10. The record cards printed were placed in PHC facilities in Bobini/Guyuk PHC district in Guyuk LGA, and Furo village area of Daware districts in Fufore LGA. These cards provide information on population and other socio-economic indices.
11. Fufore LGA printed a counterpart share of the PHC records cards at a cost \$4,300. Guyuk LGA has awarded contract for printing of PHC cards at the cost of \$3,700.
12. A structural framework and schedules for monitoring and supervision of MH/CSP at all levels was set up. The schedules were followed in order to ensure the delivery of vaccines, drugs and staff.

Strategy Seven: Sustainability:

1. In collaboration with the State Ministry of Health and the LGAs, the project designed transport schedules and process of phasing over the project to the communities, the LGAs and State Ministry of Health for continuity and proper supervision.
2. In close collaboration with ASMOH/LGAs, the project has launched the two LGAs into the much advertised Bamako Initiative Approach to PHC implementation. Two B.I. focal persons were trained by the Director PHC/Local Government Affairs. They will ensure the mobilization and election of B.I. committees at district and village levels.

A.1.3 Project Outputs (Accomplishments based on objectives)

The output phase is the assessment of the performance of project intervention activities measured:

1. against the target stated in the objectives of the project and
2. against the key child survival indicators recommended by A.1.D for its BHR/PVC child survival grant-aided projects.

The output data are derived from a final evaluation survey of knowledge, practices and coverage of the project carried out in the two project LGAs - Guyuk and Fufore - from 15th - 28th July, 1997. The survey covered the entire LGA districts instead of the two focus districts in each LGA because the base-line survey to be used for comparison covered the entire LGA districts (Appendix C).

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The findings of the survey on accomplishments based on objectives are shown in Table 1

Table 1 Accomplishments based on Project Objectives:

OBJECTIVES	PERFORMANCE			COMMENTS ON ACCOMPLISHMENTS
	LGA	B/LINE	FINAL	
Immunization: - to increase from 3.3% to 50% full immunization of children 0-11 months	Guyuk:	5.6%	36.7%	Target not accomplished
	Fufore:	11.0%	30.1%	
Management of diarrhea: - to increase from 31% to 60% the mothers with children 0-2 months who use ORT (SSS or ORS) as treatment for diarrhea - to increase to 60% the number of mothers who know how to prepare appropriate fluid and solid diets in dietary management of diarrhea	Guyuk:	33.0%	50.0%	Target not accomplished
	Fufore:	33.1%	46.5%	
	Guyuk:	NA	NA	No appropriate survey questions
	Fufore:	NA	NA	
Growth monitoring: - at least 50% of children 0-3 years are weighed at least six times a year - to identify seriously malnourished children and provide their mothers with nutrition counselling - to ensure that seriously malnourished children receive an improved diet and show evidence of growth	Guyuk:	55.8%	57.9%	Rates are based on "Child has been weighed in the last four months"
	Fufore:	78.3%	60.0%	
	Guyuk:	NA	NA	No appropriate survey questions
	Fufore:	NA	NA	
	Guyuk:	NA	NA	No appropriate survey questions
	Fufore:	NA	NA	

<p><u>Breast-feeding:</u> - to increase from <1% to 50% number of women who exclusively breastfeed their children for 6 months</p> <p>- to increase the number using improved weaning practices</p>	<p>Guyuk: 34.4% 70.9% Fufore: 29.6% 58.0%</p> <p>Guyuk: NA NA Fufore: NA NA</p>	<p>Target increase of 49% not accomplished, even allowing for differences in baseline estimates</p> <p>No appropriate survey question asked</p>
<p><u>Pre-natal consultations:</u> - to increase to at least 60% the number of pregnant women have at least one prenatal consultation in their first trimester</p> <p>- to increase to at least 60% the number of pregnant women who have at least 4 prenatal consultations</p> <p>- to increase to at least 60% the number of pregnant women who receive two injections of tetanus toxoid</p>	<p>Guyuk: 54.3% 78.9% Fufore: 51.9% 57.0%</p> <p>Guyuk: 51.0% 75.3% Fufore: 47.9% 51.8%</p> <p>Guyuk: 62.3% 64.5% Fufore: 49.3 49.6%</p>	<p><u>Rates are based on</u> When you were last pregnant with (name of child) did you receive pre-natal care?" (inconclusive) <u>Rates are based on</u> "How many times did you get ante-natal care? two or more antenatal care" (inconclusive)</p> <p><u>Rates are based on</u> "How many vaccination did you receive?" "two or more vaccination"</p> <p>Target was exceeded prior to intervention in the baseline data in Guyuk but not achieved in Fufore</p>
<p><u>Safe deliveries:</u> - to increase to at least 33% the number of home deliveries which are assisted by a trained traditional birth attendant (TBA)</p>	<p>Guyuk: 15.8% 36.1% Fufore: 15.1% 20.3%</p>	<p>Target exceeded in Guyuk but not accomplished in Fufore</p>

<p><u>Family Plannins/Child Swacing</u> - To increase from 2% to 4% the number of women of reproductive age and their husbands who accept the use of modern method of child spacing</p> <p>- to increase use of modern family planning methods from 2% to 5% among women of reproductive age</p>	<p>Guyuk: 4.5% 8.3% Fufore: 8.2% 5.7%</p> <p>Guyuk: 3.0% 5.5% Fufore: 3.8% 2.5%</p>	<p>Target was exceeded prior to intervention in the baseline data more than expected 2% increase in Guyuk but a decline was experienced in Fufore</p> <p>Increase of 3% not accomplished. Fufore suffered a decline</p>
<p>Malaria: - to increase to at least 60% the number of cases of fevers in women and children presumed to be malaria that are properly treated</p>	<p>Guyuk: N.A. 63.6% Fufore: 41.2% 51.6%</p>	<p><u>Rates are based on "Do you know the correct treatment schedule for malaria?" (inconclusive)</u></p>
<p><u>Water and Sanitation:</u> - to promote the provision of potable water basic sanitation and increased food production in 50% of intervention villages.</p>	<p>Guyuk: 12 out of 45 villages or % coverage Fufore: 17 out of 80 villages or % coverage</p>	<p>Target of 50% not accomplished from evidence from other sources (Table 2).</p>

Survey Findings

Targets of 50% for immunization coverage, 60% for use of SSS/ORS for diarrhoea management, 50% for exclusive breast-feeding and increase of 3% in family planning acceptance were not accomplished. However most of the survey from a review of the strengths and weaknesses in the project design, planning and implementation, especially the short life-span of the project, it was expected that the target rates set in the objectives which were calculated to be satisfactory and acceptable levels of performance might not be achievable. Sometimes survey questions did not correspond with objectives as with growth monitoring and pre-natal consultations and sometimes there were no survey questions at all to generate appropriate data for assessing the objectives as with second objective under diarrhoea. Thus the assessment of the project accomplishments based on the objectives has been befallen by lack of adequate linkage variables between the objectives and the survey instrument.

Going by what the survey data has estimated, Fufore LGA project area consistently recorded lower rates than Guyuk and this could be probably due to the one year difference on the commencement of project activities in Fufore after Guyuk. Achievement in the provision of water and sanitary facilities in terms of coverage of villages in the LGAs was very low as shown in the following table 2.

Table 2: **Water and Sanitation Facilities Provided**

LGA	NO OF VILLAGES	NO OF BOREHOLES	NO OF VIP/PIT LATRINE	NO OF BENEFITTED VILLAGES	NO OF FACILITIES PROVIDED
GUYUK	45	5	7	5	12
FUFORE	80	5	12	8	17
TOTAL	125	10	19	13	29

Key Child Survival Indicators

The findings of the survey on the 16 key child survival indicators are shown in Table 3:

Table 3: Project Accomplishments based on key Child Survival Indicator

1.	Mother's Literacy:	
	Guyuk	
	Baseline (N=300)	49.0%
	Final (N=299)	50.2%
	Fufore	
	Baseline (N=299)	15.4%
	Final (N=300)	26.0%
2.	Appropriate Infant Feeding Practices:	
	Exclusive breastfeeding for children 0, 1, 2, and 3 months of age:	
	Guyuk	
	Baseline (N=58)	86.0%
	Final (N=73)	92.2%
	Fufore	
	Baseline (N=50)	84.1%
	Final (N=59)	88.3%
3.	Appropriate Infant Feeding Practices:	
	Introduction of foods for children 5, 6, 7, and 8 months of age:	
	Guyuk	
	Baseline (N=51)	54.6%
	Final (N=77)	58.0%
	Fufore	
	Baseline (N=48)	38.7%
	Final (N=51)	54.9%
4.	Appropriate Infant Feeding Practices:	
	Persistence of breastfeeding for children 20, 21, 22, and 23 months of age:	
	Guyuk	
	Baseline (N=32)	65.6%
	Final (N=19)	68.4%
	Fufore	
	Baseline (N=39)	51.3%
	Final (N=27)	37.0%
5.	Management of Diarrhea Diseases: Continued Breastfeeding	
	Guyuk	
	Baseline	85.6%
	Final	75.8%
	Fufore	
	Baseline	64.8%
	Final	66.4%
6.	Management of Diarrheal Disease: Continued Fluids	
	Guyuk	
	Baseline	90.6%
	Final	86.4%
	Fufore	
	Baseline	66.6%
	Final	72.4%

7.	Management of Diarrheal Disease: Continued Foods	
	Guyuk	
	Baseline	84.4%
	Final	73.2%
	Fufore	
	Baseline	46.3%
	Final	57.9%
8.	Management of Diarrheal Disease: ORT Usage	
	Guyuk	
	Baseline	33.9%
	Final	57.0%
	Fufore	
	Baseline	39.5%
	Final	47.4%
9.	Immunization Coverage (card): EPI Access	
	Guyuk	
	Baseline (N=136)	12.5%
	Final (N=98)	12.2%
	Fufore	
	Baseline (N=136)	8.3%
	Final (N=133)	6.0%
10.	Immunization Coverage (card): EPI Coverage	
	Guyuk	
	Baseline (N=136)	14.0%
	Final (N=133)	44.9%
	Fufore	
	Baseline (N=136)	15.2%
	Final (N=133)	32.3%
11.	Immunization Coverage (card): Measles Coverage	
	Guyuk	
	Baseline (N=136)	13.2%
	Final (N=133)	51.0%
	Fufore	
	Baseline (N=136)	22.1%
	Final (133)	38.3%
12.	Maternal Care: Maternal card (instrument for assessment of both coverage and assess).	
	Guyuk	
	Baseline (N=300)	45.1%
	Final (N=299)	57.5%
	Fufore	
	Baseline (N=98)	33.0%
	Final (N=113)	37.7%
13.	Maternal Care: Timeliness of Measles vaccination	
	Guyuk	
	Baseline (N=299)	44.1%
	Final (N=299)	62.5%
	Fufore	
	Baseline (N=285)	27.0%
	Final (N=300)	33.0%
14.	Maternal Care: Tetanus Toxoid Coverage.	
	Guyuk	
	Baseline (N=215)	62.3%
	Final (N=248)	64.5%

	Fufore		
		Baseline (N=211)	49.3%
		Final (N=115)	49.6%
15.	Maternal care: one or more Ante-natal Visits (Card and Self Report).		
	Guyuk		
		Baseline (N=300)	60.3%
		Final (N=299)	81.3%
	Fufore		
		Baseline (N=280)	56.4%
		Final (N=299)	58.9%
16.	Maternal Care: Modern Contraceptive Usage.		
	Guyuk		
		Baseline	7.0%
		Final	5.7%
	Fufore		
		Baseline	5.0%
		Final	6.4%

Summary

The key child survival indicators show that in Guyuk there were considerable increase in ante-natal visits (60.3 - **81.3%**), ORT/SSS utilization for diarrhoea (33.9 - **57.0%**), immunization coverage (14.0 - **44.9%**), and exclusive breast-feeding (86.0 - 92.2%) than in Fufore but Guyuk recorded poorer performance than Fufore in contraceptive usage, literacy and management of diarrhoea. Generally, there were little or no changes in most of the indicators between baseline and final evaluation rates in both LGAs.

CONSTRAINTS

1. There was a three months delay in the commencement of the project from October 1993 to December, 1993.
2. During the five months USA sanction on Nigeria (April - August, 1994) project activities were suspended.
3. Political, social and economic crisis in the country resulted in high cost and scarcity of materials including petrol and this delayed or prolonged the implementation of project activities.
4. During the four year period, there were frequent changes in political and administrative leadership.
5. Frequent transfer of LGA PHC staff by the Local Government Service Commission especially those already trained by Africare for the project.

6. There was inadequate support and supervision of the activities of **VHWS, TBAs**, and CBAs by the VDCs, DDCs, health facilities and district level CHEWs despite several meetings and promises.
7. The poor road network in the two LGAs especially during raining season often impeded implementation of project activities. During the mid-term evaluation, the evaluation teammembers spent several hours at different villages digging out vehicles slugged in the mud.
8. Delay in the transfer of funds to the project office in Yola was experienced during some periods of the project.
9. Inadequate funding of project activities often resulted in **costly** changes to project activities by the project management.

A.2 Unintended positive and negative effects of project activities

A.2.1 Project Objectives

The objectives of the project have been based on baseline studies and were modified a number of times for a variety of reasons ranging from **"too ambitious"** to **"unanticipated"** project environmental developments. Valuable project time and resources may have been wasted by the need to re-design the project from time to time in response to the changes in objectives, leading to **"sporadic"** pattern of implementation, as a result of which some activities were either abandoned or cancelled in the middle of implementation.

An example is the directive for the scaling from down the coverage of the entire 2 LGAs to 2 selected districts in each LGA to ensure additional focus and depth following the feedback from the review of the Detailed Implementation Plan (DIP) by the Africare Headquarters in the Washington. The project implementation was already 6 months old when this change was made.

Since the project is expected to be a model intervention, it will in addition to showing a demonstration effect be expected to contain elements of sustainability and rewlicability. There are no objectives directly related to this aspect such as cost-management, income generation, financial management and ownership.

The project objectives were based on an estimated population of 245,826 for Guyuk. But as discovered later by the project this 1963 census figure estimate was a gross overestimate of the population contrived to qualify for Federal assistance. Subsequent estimate by the project put the population at 83,111.

A.2.2 Strateaias and Activities

i) Personnel Develowment

The primary strategy for personnel development for PHC services has been the training of different cadres of PHC including Community Health Officers (**CHOs**), Community Health Extension Workers (CHEWs) such as supervisors, assistants and aides, pharmacy technicians, record keepers, store keepers, etc in the National Schools of Health Technology and the Teaching Hospitals scattered in the States in the Country. The project trained a total of 214 village health workers (**VHWs**) and traditional birth attendants (**TBAs**) in a 3-week training which followed national PHC guidelines; 75 **VHWs/TBAs** who completed 1 week of the 3-week training; 14 community birth attendants (CBAs) in a year-long course developed by the School of Nursing/Yola, the Adamawa State Ministry of Health, and Africare; and Up to 210 PHC staff including CHEWs, **CHAs**, nurses/midwives, and other health facility personnel.

Through on-the-job inservice training the project objective was to increase the knowledge and skills of PHC health facility workers to effectively and efficiently provide MH and CS services both at the facility and community levels. But the planning of the training and the development of the curricula appeared to be more based on the **theoretical** analysis of their job descriptions than an assessment of their training needs. Adequate arrangements were also not made for post-training activities to evaluate the transferability of their skills in practice situations. 'For example, although the baseline survey had revealed that supervision of PHC activities by TBAs and VHWs were being done in a sporadic and informal way, there was no evidence that this had changed in the field. TBAs and VHWs knew what to do but there was no good evidence that they were doing it. The home-based records in Bobini District were never filled by the **TBAs/VHWs** and the health workers who were to supervise them did not detect this lapse until we visited the homes in their company. There was therefore, a wide gap between training and its field application.

ii) Community Mobilization, Orsanization and Particiwation

One of the pillars of PHC strategies is the participation of communities in decision-making, financing, implementation and monitoring and evaluation of health services in their communities in collaboration with the

health workers. In the national PHC guidelines for community participation and empowerment, the establishment of various committees at the local government, district and village levels through a process of democratic representation was given as a viable method for community involvement and participation.

In this project a total of 255 members of LGA Development Committee, District Development Committees (DDCs) and Village Development Committees (VDCs) were organized and trained in the performance of their expected roles in community mobilization and support for PHC activities such as drug revolving fund system, remuneration of **TBAs/VHWs** and self-help activities. Observations in the field during visits to some of these committee members showed that there was little collaboration between them and the health facility staff, meetings were irregularly held and there was no on-going operational support to **TBAs/VHWs** although plans were underway. The DDCs in the six districts visited however had capitalized on the visit of the evaluation team to arrange meetings which were well attended, and there was evidence that all that was needed was somebody to give a "push".

In Fufore LGA the DDCs comprising district and village heads are existing administrative structures for governance and it was not difficult to assign them responsibilities related to the health of their people as an additional social obligation, but in Guyuk LGA, the establishment of Districts by government are new structures different from the existing one in which all village heads owe direct allegiance to a single paramount traditional ruler. Thus, the creation of the DDCs according to NPHC guidelines was regarded by many citizens as an affront to the traditional authority as it was believed that the committees were merely paying a lip-service to their duties. In circumstances of this nature, there should be ways of adapting standard guidelines to ensure cultural acceptability so as to achieve program goals and objectives.

iii) Information, Education and Communication (IEC)

This is the first level of intervention for behavioural change if properly designed and adequate arrangements are made to enable target audiences to transform the messages into desirable intended actions. The project staff assembled materials from the SMOH and other NGOs like UNICEF, CHAN, US Peace Corps, the FMOH which were used during training and for community mobilization activities. Community interest **groups**, religious organizations, traditional rulers, schools, etc, were used as channels of communication. The project noted that all previous educational activities on MH and CS were focused on women. However, at the household level,

mothers do not autonomously make all decisions about their own health and their children. Such decisions include choice of treatment and facility which involve financial support and the decision may be made by the husband or member of the family who provides the fund. Educational activities were therefore, extended to these significant others.

iv) Linkages:

There are two broad categories of linkages - administrative and resources linkages.

Administrative Linkages:

This is an important strategy in PHC because certain functions are to be shared between different types and levels of consumers including the community **DDCs**, VDCs and providers such as community-based staff (**TBAs** and **VHWs**) on the one hand and health facility staff and programme managers on the other. Other linkages are between Africare and SMOH and LGA and SMOH. Opportunities for such linkages are meetings, formal and informal, supervisory visits, consultative visits, training workshops and seminars, and communal project work.

Many of the project activities provided special and unique opportunities for administrative linkages but when such activities were not carried out regularly or satisfactorily, linkages were absent.

The opportunities that provided administrative linkages are as follows:

- a) DDC Meetings: The DDC is required to meet regularly in order to be active in performing its assigned role. But the meeting also provides an opportunity for the District PHC Supervisor who is the Secretary of the DDC to meet with the DDC to share the report of the District PHC activities and the problems and concerns.
- b) The Referral System: The system of referral and its operation guarantees regular indirect contact between the community-based TBA/VHW and the health facility.
- c) Recruitment and Posting of Staff: This guarantees a periodic regular check on the health facilities and the LGA.

- d) Clinic Days, Immunization Days: These provide a direct contact between the health staff and consumers (mothers) and on such occasions a large number of mothers can be reached with important information which can be followed up during home visits.
- e) Workshops and Communal Project Works: These create the largest forum for contacts between the various categories of health staff and communities and are useful for planning and evaluation of project activities.

The following summarizes how these linkage opportunities were utilized with their effects on the performance of the project interventions.

- a) DDC meetings used the linkage with the PHC district supervisor to discuss performance and their level of satisfaction with MC & CS services being delivered to the community as well as regularity and irregularity in the supply of vaccines and ivermectin for onchocerciasis control.
- b) The connection between health facilities and the community health workers in their district is unclear. The supervision system was unstructured. The role of the referral health facility as a supply (replenishment of kits and drugs) and supervisory source for **VHWS/TBAs** is not operational: **VHWS/TBAs** did not appear to be linked to identifiable and specific health facilities in their localities. Although, **VHWS/TBAs** tend to refer patients to their local health facility; Home-based records are not filled by **VHWS/TBAs** and are not checked by health-facility-based supervisors as was the case in Bobini district.
- c) Some new recruitment was ill-advised as in the case with the recruitment of a new cadre of Community Birth Attendants (CBAs) who are not fully trained as midwives and are too young to be able to gain acceptance of the **TBAs**, the majority of whom are very elderly women. This problem was observed in Malabu, Daware and Gurin districts and pointed out by the SMOH Director of PHC. In addition, PHC staff by LGA posting does not sufficiently respond to poor staffing situations in the districts. In Guyuk LGA all the five nurse-midwives in the employment of the LGA are located in one health facility in Guyuk leaving the remaining three maternities in other districts without nurse-midwives.
- d) Clinic days (immunization, ante-natal and family planning) are used for I.E.C. activities but there is an apparent shortage of I.E.C. materials to compliment the exercises.

- e) There are no formalized forums for direct linkages between the community and the LGA and between the LGA and the SMOH. Thus the linkage between Africare and LGA was sometimes used to bridge this gap. For example the requests of DDCs for matching grants from their LGAs were being communicated through Africare and advocacy by the LGA was being done through political channels of administration.

The planning and formulation of specific follow-up activities after trainees return to their base are not sufficiently provided for in the training workshop programs as an integral component of training so as to ensure application of the acquired training knowledge and skills.

Resources Linkages:

This is another category of linkages through which community access to external resources is facilitated. The project staff sometimes have information about other related sectors, potential donor agencies and other sources of collaboration which intervention communities can contact but are unknown to them. Information can then be provided to communities on how to make such contacts and what types of collaboration to be solicited.

b

The project has recorded considerable success in collaboration with other sectors of government and NGOs for different components of the project (APPENDIX D).

Technical staff support came from the SMOH in the form of 15 PHC staff comprising 6 programme officers and 9 nurse-midwives whose salaries and emoluments for the 23 month period of the project amounted to \$41,510. In addition, counterpart funds from the State Ministry of Water Resources and Rural Development total \$6,000.00. The two LGAs also spent \$27,988.00 in support of project activities (APPENDIX D). Resource linkage is closely related to inter-sectoral collaboration

- v) **Inter-Sectoral Collaboration:**

The primary sector for the project is the Health Sector. Other sectors from which the project could benefit through collaboration are Works and Housing for the transportation and logistic aspects; Education for development and implementation of IEC activities; Agriculture for food production and distribution as they relate to the nutrition activities for WRA; Water Resources and Rural Development for water and **sanitation** activities; other NGOs local and external for technical

and financial assistance. Inter-sectoral collaboration is important for harnessing and sharing of resources and expertise, conservation and efficiency in the utilization of resources by preventing wastage that could result from duplication and over concentrating of resources, and giving the project the advantage of repeating the benefits of the synergistic effect of different intervention approaches.

The implementation of the water and sanitation component of this project showed successful collaboration between the project and a donor international NGO (VSO), the State Ministry of Water Resources and Rural Development, the State Rural Water Supply and Sanitation Agency and the UNICEF Water **Supply** and Sanitation Unit. Representatives of the collaborating sectors conducted a needs assessment and geological survey in the project **LGAs**, raised additional funds, and organized training and demonstration on molding of concrete latrine slabs (**san plat**), local production of slow sand filtration pots, construction and maintenance of boreholes, a hand pumps., and sanitation units.

NGOs like Lutheran Church and CHAN donated vaccines to boost the State MOH supply and subsidized the cost of purchasing scales for weighing babies. UNICEF provided funds for training of **VHWS/TBAs** in family planning and malaria control and provided some TBA kits as well as motorcycles in thg area of logistics.

vi) Manacrement Information System (MIS):

The baseline survey identified a weakness in record keeping of service delivery and a reporting system for monitoring and evaluation in the project **LGAs**. Although the FMOH had introduced a standardized monitoring and evaluation system of records at all levels of PHC, this was not implemented in the two **LGAs** and a disease surveillance system was therefore not **inplace** for the **LGAs**. There was not also accurate census figures for the **LGAs** to serve as a basis for calculation of vital epidemiological rates. The establishment of MIS was therefore necessary for subsequent monitoring, evaluation and planning of PHC activities in the two **LGAs**.

The project conducted an enumeration survey of the two **LGAs** with age-group breakdowns. Houses were numbered according to national PHC guidelines, home based records were printed and distributed in all houses, and appropriate categories of health care staff were trained on record keeping (filling of the record cards), collation and reporting to the appropriate higher levels of administration. Record keeping and reporting of

fairly high quality have commenced in the health facilities but is yet to start at the community level. Problems remain at both ends; community health worker to health facility and health facility to LGA. The MIS officer of the LGA is however in position.

vii. Sustainability

To serve as a model the project must have built-in sustainability and replicability variables. The focus of interventions were to be management, technical and outreach capabilities for PHC suggesting an improvement on the quality and coverage of the PHC MH and CS services. Some project inputs must have inadvertently worked against sustainability.

The project appeared to have been over-staffed and staffing poorly planned and managed. There were six (6) program officers and nine (9) nurse/midwives posted to the project by the SMOH. The program officers and staff midwives appeared to be essentially doing the same activities. It was difficult to optimally use all these staff because they were too many and their development amounted to a diversion of state staff resources to filling of gaps in the delivery of LGA PHC services (actually taking over from the LGA staff) instead of developing the capacity of the LGAs to cope with the increased demand for services generated by Africare mobilization interventions. The project field activities turned out to be a "do it for them" as opposed to "do it your-self" approach. This operational arrangement also promoted a vertical delivery as opposed to a more desirable horizontal and integrated delivery that PHC has been promoting nationally. For example, in Guyuk District M.C.H. facility, a separate clinic day was assigned to the delivery of each of the MH and CS services and when integration of some of the services was suggested by the evaluation team, the LGA staff admitted that it was possible but it never occurred to them. Africare is seen to be filling the health gap at the District level, and this is probably why the LGAs did not deploy their staff evenly to their districts outside the Headquarters. In Guyuk LGA, all the 5 nurse/midwives in the LGA were concentrated in Guyuk district M.C.H. facility, whereas there were other four (4) of such facilities in the remaining six (6) districts without a nurse/midwife staff.

A.3 FINAL EVALUATION SURVEY

About the Survey:

A.I.D. requires PVOs with BHR/PVC Child Survival grants to conduct a 30-cluster Final Evaluation KPC survey using a standardized questionnaire developed by Johns Hopkins University. The instrument used in both the baseline and final surveys for the survey was modified by PVO field project staff in Adamawa State.

The project phased its activities in the two LGAs as follows:

Guyuk LGA -	December, 1993
Fufore LGA -	January, 1995

The objective of the survey was to provide **Africare/Nigeria**, the participating **LGAs**, and the State Ministry of Health with information on the following:

- Knowledge of mothers of children under two years of age; about: major threats to infant, maternal and child health; ways to prevent immunizable diseases; proper treatment of diarrheal diseases (ORT); the value of growth monitoring; appropriate nutrition/weaning practices; family planning; prevention and treatment of malaria; antenatal care.
- Actual **practices** of mothers with regard to the intervention areas mentioned above
- For children aged 12-23 months: the coverage rates of BCG, **DPT3**, OPV3, and measles vaccine, and the drop out rates between series antigens.

The sampling method used for the survey was a 30-cluster sampling technique. The study population consisted of mothers of children under the age of 24 months living in the project area who benefitted from action messages about key CS interventions provided through project-trained health workers (village health workers (**VHWs**), **TBAs**, Community Health Extension Workers (**CHEWs**), and Community Birth Attendants (**CBAs**)). The survey established estimates of child survival knowledge and assessed the extent of practices (K & P) of the project's primary health care interventions communicated through the community health workers and PHC staff. The resulting population-based data was to help Africare and their counterparts ascertain the impact of project interventions described in the CSVIII DIP. The survey results are contained in Appendix C.

B. PROJECT EXPENDITURES

B.1 Analysis of Project Expenditures

(To be supplied by Africare Offices - Lagos and Washington)

B.2 Project Expenditures by Category.

The project accounts books do not show budgetted amounts but shows the expenditure on MH & CS project as follows:

a. Personnel

1. Field, technical personnel	N420,588		
2. Field, other personnel	N339,149		
3. Fringes	N604,973		
Sub-Total	N1,364,710		
	USD17,059	(9.9%)	

b. Travel/Per Diem

i	Field, in-country	Sub-Total	N6,117,790		
			USD 76,472	(44.6%)	

c. Consultancies

1. Evaluation consultant fees					
2. Other consultant fees: VSO family planning, HIV/AID	N319,509				
3. Consultant travel/per diem	N85,930				
Sub-Total	N405,439				
	USD 5,069	(3.0%)			

d. Procurement

1. Supplies	N1,949,976				
2. Equipment	N144,301				
3. Training	N2,347,517				
Sub-Total	N4,441,794				
	USD 55,522	(32.4%)			

e. Other Direct Costs

1. Communications	N512,120				
2. Facilities	N509,582				
3. Other	N370,384				
Sub-Total	N1,392,086				
	USD 17,401	(10.1%)			
Total	N13,721,819				
	USD 171,523	(100.0%)			

A total of US \$171,523 was spent on the project out of which 44.6% was for travel and per diem while 32.4% was on procurement. Training materials consumed about 16% of project funds. Since the budgetary estimates shown in the DIP are not categorical, a comparison between what is budgetted and actually spent is impossible.

C. LESSONS LEARNED

USAID SUPPORTED PVO CS PROJECTS

This project would have benefitted from the following lessons which are also applicable to other USAID supported PVO CS projects:

1. The listing and timing of activities in DIP should be based on a path analysis that would assist in showing the relationship between the activities, grouping and ordering of the activities and sequencing them in a way that they will jointly and progressively lead to the achievement of the overall goal of the project. A path analysis will also determine whether the implementation plan is feasible or can be contained within the life of the project.
2. A contract agreement spelling out the expected contributions of each collaborating parties at the various stages of implementation should be signed by all the collaborators as part of the planning process. This will forestall unexpected delays and disappointments during implementation and enable the parties to focus their resources on their assigned and acceptable responsibilities and plan ahead.
3. A centralized coordination/steering committee should be institutionalised for projects expected to collaborate with institutional partners (SMOH, LGAs and NGOs). This will enhance joint planning, monitoring and evaluation, exchange of information, decision-making and lay an early foundation for sustainability.
4. The job descriptions and services of all project staff (seconded/posted/hired) should be regulated, supervised and coordinated to ensure high levels of productivity, efficiency and commitment at all times. Staff who are already working or permanently resident in the project areas should have priority in personnel development. There should be some undertaken by employers that staff on whom project resources are to be invested will be available for a minimum length of period to serve in the project area.
5. Projects should be provided with increased technical support input and oversight: i.e. to prepare action/work plan post DIP technical review; visit project mid-way between start and mid-term evaluation to assess progress and do the same mid-way between mid-term and final evaluation; request projects to re-design components where constraints have proven unsurmountable.

6. Project strategies should be seen not to "help" but "develop" communities. When an increased demand is to be created for particular services which should be supplied on a permanent basis, the capacity of the community to permanently meet the increased demand should be the first focus of project to be put in place.
7. Some time should be devoted at beginning of project to orient staff and set tone and structure: acquaint staff with organizational policies, project objectives and job descriptions; offer project staff skills development in community-oriented primary care, participatory approaches for community diagnosis and program implementation, team development, project planning and evaluation.
8. "Incentive" allowances for participating in workshop/training to project staff already receiving salary to do their job should be discouraged. This will screen staff for interest and commitment to service.

II. PROJECT SUSTAINABILITY:

The weakness in the project implementation is the absence of adequate or sufficient post-training follow-up activities which would have entailed the transformation of knowledge, attitude and skills gained during training into desirable actions during practice in the field. This would have allowed the identification and appraisal of enabling and reinforcing factors in practice situations as well as the constraints. There lies the true test of sustainability as opposed to speculative promises, advice and suggestions that were being made at the end of the project.

A. Community Participation

TBAs and VHWS were given kits to be used in their practice after their training. These kits were to be replenished from time to time. The responsibility to replenish these kits was given to the District Development Committees but what to replenish and how to do it were not ironed out. The VHWS and TBAs started to purchase their own drugs and other materials to replenish their kits in order to live up to the expectations of their clients. Also the health facility staff know it is their duty to supervise the activities of the TBAs/VHWS and serve as referral points to them but they were not seen to be performing this role. Another result of this was that home based records which have been distributed to all households were not used by the VHWS/TBAs and this was not detected by the health facility staff who were expected to check them.

Another confounding factor in sustainability is the project input of additional technical staff (nurse/midwives) and logistic support (transportation) provided by the project. The project initially succeeded in increasing community demand for MCH and CS services but when the available LGA District staff could not cope with the increased services, the project staff instead of working with the community and the LGA to provide additional staff requested the State Health Services Management Board to post some of its nurse/midwives from the State Specialist Hospital to the LGA. The project and the LGA had to provide additional funds to support these staff and the LGA rested its responsibility to increase its staff or deploy the available ones evenly to the districts. Similarly when the supply of drugs and vaccines from the State to LGA and then to District health facilities and community out-reach centres became irregular, the project also provided transportation to fill the gap. At the time of project termination, neither of the two LGAs has made arrangement to replace the loaned staff from the State Health Services Management Board while only one has made partial arrangement for transporting vaccines. During the last two months when the project vehicles were withdrawn, immunization activities in the communities were paralysed in many parts of the districts. Thus the project input to bridge gaps in the delivery of services so as to show a demonstration effect turned out to have created a dependency situation on the project by the focus LGAs and their communities instead of fostering self-reliance. The result was that inadequacy of staff and logistic problems of vaccine supply are now seen as major threat to sustainability by the district health staff and the district development committees after Africare's pull-out.

B. The NGO : ADAWATER of the ADAMAWA DEVELOPMENT ASSOCIATION

ADAWATER is an arm of a local NGO, the ADAMAWA DEVELOPMENT ASSOCIATION (ADA) which is an association of community leaders drawn from all parts of Adamawa State. ADA was formed in 1994 by a pioneer group of 13 members which has been increasing. Membership is open to all adults of Adamawa State. The objectives of ADA are:

1. Mobilizing the community for collective action so as to achieve meaningful development.
2. Encouraging the community towards identifying problems affecting the development of the State and finding solutions to these problems.
3. Promoting the spirit of self-help and self-reliance among citizens.

4. Encouraging suitable fundamental education for citizens and assisting them in solving their everyday common and individual problems.
5. Exploring ways and means of developing better health services and good sanitation habits in the community.
6. Removing serious political obstacles to progress and helping to create a truly balanced program for development.
7. Awareness of self-government and obtaining experiences in organizing ourselves and working together as teams in the fields of Agriculture, Co-operatives, Education, Health, Commerce, Industries and the provision of infrastructural facilities.
8. Encouraging the spirit of competition among the various communities around us and cooperating with authorities in promoting development.

In keeping with the objectives, ADA has been cooperating with AFRICARE, UNICEF, VSO (Voluntary Services Overseas) and other Agencies in carrying out their community projects by mobilizing the various communities for action and cooperation. ADA is recognized by the SMOH, the VSO, UNICEF and AFRICARE as a formidable NGO that is dedicated to the development of Adamawa State. ^b

ADAWATER of ADA has submitted a proposal to Africare in which it has planned to "to mobilize 189 communities to develop safe and adequate water resources using a variety of technologies, i.e. boreholes, hand-dug wells, infiltration galleries and water harvesting; 60 communities will build functioning sanitation facilities. Adjunct programs will train 360 women potters in 90 communities in the construction of slow sand filter pots for household water security, and 30 adolescents from 20 communities in environmental sanitation". Under this plan ADAWATER will take over the water and sanitation component of the Africare MH and CS project. The MOH Director of PHC indicated his cooperation with ADA in supplying technical assistance and staff which ADA has requested in the spirit of existing policy of the MOH to cooperate and encourage community development activities by **NGOs.**

C. ABILITY AND WILLINGNESS OF COUNTERPART INSTITUTIONS TO SUSTAIN ACTIVITIES: THE SMOH OPTION

During the meeting the SMOH and the Evaluation Team it is suggested that a "Child Survival Extension Services" office be created by the SMOH in the PHC directorate to carry out the last important phase of the project which is mobilization of LGA resources and the building and strengthening of PHC

infrastructures whereby PHC staff can make use of this acquired knowledge and skills to deliver a more efficient MCH and CS services to meet the high demands which the project has generated on a sustainable level.

This will require that:

1. The services of those interested and committed State M.O.H. and H.S.M.B. staff deployed to Africare be retained and sustained for one year (October 1, 1997 - September 30, 1998).
2. The staff should operate under the Division of PHC and Disease Control of the SMOH as a separate Unit of "Child Survival Extension Services".
3. A steering committee for the Child Survival Extension Services Unit be set up comprising the State Director of PHC as Chairman, and the Project Manager of the Unit, the Chairman of the two project LGAs and then PHC Supervisors, as well as the District Heads of the focus, districts as members.
4. The steering committee for the Child Survival Extension Services Unit should solicit for funds and other forms of support to foster self-reliance of the LGAs in the delivery of MH/CS services.

The Evaluation team discussed this sustainability plan for the Africare MH & CS Project with the Director of PHC ASMOH on Thursday, 11th Sept, 1997. The Director agreed with option 3 on ADA's taking over of the water and sanitation component of the project. He, however, did not see a need for the setting up a new unit of Child Survival Extension Services as the S.M.O.H. has developed a PHC structure to which the Africare project can be integrated. Africare has been strengthening existing PHC structures in the two LGAs and that is what the SMOH has started to do in the other LGAs through Bamako Initiative (B.I.) which is supported with Federal funds through the Petroleum Trust Fund (PTF). B.I. has been introduced in the two project **LGAs**, in fact Africare CSP has supported this effort as a mechanism for assuring sustainability and it will be difficult to justify the allocation of special additional funds to replace **Africare's**. According to the Director, the sustainability plan which will **be** permanent is the bringing of the two LGAs back into the overall scheme of PHC implementation in the State and **LGAs**. The SMOH staff which have been deployed to Africare will be assigned to different Units in the PHC administrative structure from where they will carry out their specialized duties not only in the two Africare project LGAs but in other LGAs of the State.

D SUSTAINABILITY PLAN, OBJECTIVES, STEPS TAKEN AND OUTCOMES

AFRICARE has succeeded in laying a solid foundation for the delivery of MH/CS services in the context of PHC in two Districts in each of Guyuk and Fufore KGAs in Adamawa State in the form of staff development, community mobilization for support and the creation of a demand for the services. However, the infrastructure and resources required to operationalize and sustain this effort need to be put in place, tried and developed so that they can be replicated as intended.

Already in place are house numbering and home-based records in all the houses in the project area. A good number of Village Health Workers and Traditional Birth Attendants have been trained and a new cadre of CBAs also introduced. VDCs and DDCs are existing and mobilized for co-management of MH & CS activities. Demand for immunization, ante natal and water and sanitation services has increased but these achievements have relied mainly on direct input from the project staff and resources.

Goal: The next goal is to develop the infrastructure and mobilise resources for transforming the knowledge, skills, and competencies acquired by the LGA staff in the 4 Districts into operational actions that can be sustained on a permanent basis.

End of Project objectives: The project will seek the approval of the State Ministry of Health for an extension of one year as a Child Survival Extension Services Unit to work mainly on sustainability. If a Child Survival Extension Services Unit is approved the Unit will put, among others, the following in place within 12 months of its operation.

- i) A list of names and location of all trained TBAs/VHWS in the focus districts and the names and locations of health facility and the facility staff (supervisor) to which each TBA/VHW is attached.
- ii) A list of referral centers in the focus districts and the services provided in them.
- iii) An operational system for the distribution and replenishment of kits used by trained TBAs and VHWS in the focus districts under the directive of health facility staff, DDCs and VDCs.
- iv) An operational Management Information System including home-based records, facility-based records and reporting to the LGA and SMOH.
- v) An operational integrated system for the delivery of facility-based MH and Cs services.
- vi) An operational logistic system for the regular collection and distribution of drugs and vaccines.

vii) An operational monitoring and supervision system.

Steps Taken to Date

The SMOH has launched Bamako Initiative (BI) in the two project LGAs and PHC Committees are being established at all levels - LGA, District and Community - along the national guidelines for community participation and ownership of PHC services.

III EVALUATION TEAM

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