COMPASS is a five-year Cooperative Agreement between the government of Nigeria and the United States Agency for International Development (USAID). An integrated health and education project, COMPASS is working in communities in Kano, Nasarawa, Bauchi, Lagos and the Federal Capital Territory in Nigeria.

The Consortium is a partnership between Pathfinder International and its partners, Creative Associates International Incorporated, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs, Management Sciences for Health, Constella Futures, Federation of Muslim Womens' Associations of Nigeria, Civil Society Action Coalition on Education for All, Nigerian Medical Association and Adolescent Health Information Project.

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COMPASS NIGERIA

# COMPASS PROJECT NIGERIA

## A COMMUNITY EMPOWERMENT SUCCESS STORY:

### NIGERIAN COMMUNITIES TAKING ACTION TO IMPROVE HEALTH AND EDUCATION

# MIDTERM ASSESSMENT

Marcie Rubardt
April, 2007

USAID FROM THE AMERICAN PEOPLE

COMPASS NIGERIA

TOGETHER
*we can make life better!*

## ACKNOWLEDGMENT

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throughout its implementation.

# LIST OF ACRONYMS

| | |
|---|---|
| CAC | Community Action Cycle |
| CAPA | Catchment Area Planning and Action |
| CC | Community Coalition |
| COMPASS | Community Participation for Action in the Social Sector |
| EQIT | Education Quality Improvement Team |
| FCT | Federal Capital Territory |
| HQIT | Health Quality Improvement Team |
| LGA | Local Government Area |
| M&E | Monitoring and Evaluation |
| NGO | Non-governmental Organization |
| PDQ | Partnership Defined Quality |
| PLACO | Participatory Learning and Action for Community Ownership |
| PTA | Parent Teacher Association |
| QIT | Quality Improvement Team |



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## EXECUTIVE SUMMARY

This report covers a midterm assessment of the community mobilization component of the COMPASS Project which took place from March 15 to April 6, 2007. Community mobilization is a cross-cutting component of the five-year COMPASS project, funded by USAID to address health and education in 51 Local Government Areas (LGAs) in five states in Nigeria.

The primary community mobilization interventions were the formation of community based coalitions (CCs) and quality improvement teams (QITs) to carry out the CAC/PDQ (Community Action Cycle / Partnership Defined Quality) process in order to identify and address problems related to health and education in their communities. Coalitions are formed at the community level, are made up of representatives from community associations, traditional leaders, religious leaders, and service providers for both health and education and tend to serve as umbrella organizations for sensitization, advocacy, fundraising, and coordination of quality improvement activities. The QITs function at the facility level, are made up of representatives from the facility service providers as well as community members and focus on identification and resolution of problems occurring in their facility. The CCs link to both the QITs and a Local Government Facilitation Team (LGA Facilitation Team) at the Local government Authority (LGA) level. In addition, coalitions meet together in an LGA forum to exchange ideas and develop advocacy agendas together. As of March, 2007, a total of 203 Ccs, 701 QITS both for health and education have been formed. Considering a conservative but ROUGH average of 10 associations per coalition and of 25 members per association, these organizations are likely reaching as many as 51,000 association members who then potentially reach out to the population at large.

The hypothesis for this assessment was that the CAC/PDQ process leads to increased ownership, empowerment, and service accountability which in turn lead to changes in community relationships and health / learning status.

Three teams made up of COMPASS Monitoring and Evaluation (M&E) staff, Community Mobilization Staff, Program Staff; and a consultant who had been involved in the early training for the interventions as overall team leader visited 21 different LGAs in all five COMPASS states. The Community Mobilization Officers visited states where they had not been working, offering the added opportunity for experience exchange as participation in the review. The qualitative interviews at all levels in the LGA were complemented by quantitative data monitoring health facility utilization.

### Key Accomplishments:

The project achieved significant results in terms of impact, infrastructure improvements, other quality improvements, and development of local ownership for the CCs and QITs. Highlights include:

* Health service utilization for family planning, ante-natal care, facility deliveries, and routine immunizations is considerably higher in facilities with CCs and QITs than in matched facilities without these structures.
* Improvements in infrastructure and service provider/community relations, and regular monitoring of services by the QITs led to better quality education and health services. Specific issues such as confidentiality, client respect, and student absenteeism have also been addressed.



* Funds for health and education improvements (more than $1million in FY2006) were leveraged through donations and advocacy to contribute to infrastructure, equipment, drugs, and supplies for both education and health.

* Both women and men were sensitized on immunizations, safe motherhood, family planning, and enrollment in school particularly for girls.

* There is significant enthusiasm and ownership for the CCs/QITS as evidenced by their supporting their operating costs, meeting regularly, independently generating new problems and activities, and monitoring the progress of their activities.

### Challenges

The main community mobilization challenges can be summarized in four:

* People have high expectations for resources from COMPASS both out of their habitual expectations of donors and due to promises made early in the project which were not fulfilled. This said, there are people who acknowledge lack of inputs was a blessing because there is now greater ownership.

* COMPASS tends to be “in the driver's seat” There is a tendency to tell community people what to do and how to organize themselves, rather than lightly providing guidance as the community themselves work out their priorities and approaches. This was particularly notable in the formation and management of the LGA Facilitation Teams,

* The coalitions are underutilized as a strategy at the community level for implementing the COMPASS technical interventions (Child Survival, Reproductive Health, and Basic Education). They have the potential to take the lead and bring their own understanding and experience to bear in addressing technical concerns.

* Although it was a key element of the PDQ process, problem analysis and prioritization is still weak. There has been a tendency to add problems and cursory solutions to the original action plan, rather than continuing to do the more in-depth analysis as part of the community action cycle.

### Recommendations

Essentially all of the recommendations relate to the need to consolidate the accomplishments and to develop a plan for phasing out COMPASS's role in the community mobilization activities. Some of the specific suggestions include:

* Take different levels of LGA / CC competence into account in developing a capacity building plan. This would include reinforcement of problem analysis and CAC, marketing themselves to the LGA and the community, reinforcement of the links between the Parent Teachers' Associations (PTAs), Education QITs, and the coalitions, and encouragement of the service providers in providing guidance. Registration of all CCs also needs to move forward.

* Increase the utilization of the CCs and QITs as a strategy for cultivating real community involvement in and ownership of solutions for increasing the impact of the COMPASS technical interventions.

* Strengthen and institutionalize the LGA Facilitation Team by involving the LGA

themselves in defining their function and composition, and in providing financial support.

* Link coalitions with other donors and organizations through the LGA Chairmen and through implementing partners at the state and national levels.

## Conclusions / Lessons Learned

Some of the most significant strategies contributing to the success of the community mobilization are:

* Use of associations and existing traditional and community-based structures as a foundation for the coalitions has led to their achieving broad reach and scope. This in turn leads to high coverage as well as flexibility and resources in addressing whatever priority problems arise.

* The CCs and QITs are highly complementary structures each supporting what the other is trying to accomplish.

* The insistence by COMPASS on not paying operational costs has shifted the focus of the coalitions by sending the clear message that the coalitions do not belong to COMPASS. This was summarized by one assessment team member: “The communities realized they had underestimated what they could accomplish by themselves with little to no inputs from government or donors”.



# BACKGROUND

COMPASS was designed as a community-driven project, recognizing that it is only with community involvement that COMPASS could achieve the coverage they needed for sustainable behavior change at the community level, along with support for long-term improvement of service quality in health and education.

COMPASS was also funded with the mandate to build on previous USAID project efforts to establish community level participation. These projects included the LEAP project which focused on capacity building in education including that of the PTAs, and two previous health projects which established community structures (CAPAs Catchment Area Planning and Action, and PLACOs - Participatory Learning and Action for Community Ownership) for implementing and maintaining health activities.

Finally, the community mobilization component was conceived as a complement to policy development and advocacy offering a mechanism to work towards policy implementation from the community upwards while simultaneously addressing essential policies at the senior government levels.

# METHODOLOGY

## Hypothesis

The CAC/PDQ approach leads to increased community ownership and empowerment as well as increased service accountability. These in turn lead to changes in community relationships and improvement in health and learning status.

This assessment took the opportunity to assess the different elements of this hypothesis and to document the extent of its truth. The specific objectives for the assessment were to:

Document the accomplishments and intermediate results of the CC /QIT intervention and its value added to the COMPASS Project strategy.

Discuss the challenges and critical issues.

Assess the integration and synergy occurring between the CC/QIT strategy, the overall COMPASS Project strategies and activities, and the social/political environment within which they are working.

Extract lessons learned and recommendations to strengthen the contribution of this intervention to the overall COMPASS Project during the remainder of the project.

## Participants

The assessment team was made up of four State M&E Officers, four State Community Mobilization Officers, one Lagos Program Officer, and the two Abuja Central Office M&E Officers. The overall team leader was a consultant who had been involved during the early design and training for the CAC/PDQ process. In order to cover all five states, the group was divided into three teams led by the two central office M&E officers and the consultant. The Central Office community mobilization and communication staff joined some of the field work and all of the synthesis discussions. FCT was underrepresented on the assessment team due to staff vacancies and turnover, although their sites were still visited. A list of the team members is included in the

annex.

## Design

The assessment teams covered 21 LGAs, in all five of the COMPASS states. Roughly one third of the total LGAs in each state were randomly selected, but making sure that both urban and rural environments were represented. However, upon review, the Lagos team was concerned that the LGAs selected in Lagos were all relatively weak, so the sample was purposively adjusted to cover both stronger and weaker coalitions. The assessment teams then consulted with the state teams to identify representative urban and rural, and stronger and weaker coalitions within the selected LGAs. One coalition, health QIT and education QIT were selected in each LGA. A list of the selected LGAs and coalitions is included in the annex.

For each LGA visit, the teams held group interviews with a variety of informants, allowing for triangulation from different perspectives. At the community level they talked with the coalition and the selected health and education QITs. They also met with groups of community men and women and the traditional leaders. Finally, they met with the health service providers in the targeted health facility and the teachers in the targeted school. At the LGA level, they met with the LGA Facilitation Team and sometimes the Primary Health Care Officer and/or the Secretary for Education.

In addition to the field visits, the teams met separately with all the LGA Field Officers, and with the COMPASS State Technical Officers to assess their understanding of the benefits and challenges of the approach and how it might be more useful. In states where NGOs had been involved with forming or working with coalitions, they were also interviewed.

An attempt was made to assess coalition members' own perceptions of their organizations by using a team effectiveness questionnaire. Members were asked to rank (never sometimes almost always) how they felt about the level of participation, decision making, use of resources, and progress. While there was some indication that the obviously weaker coalitions scored lower on some of the questions, there was the tendency to mark everything positively and so the tool was not as sensitive as hoped.

The major complement to the qualitative data was the analysis of the routine health center data to compare utilization for routine immunizations, family planning, ante-natal care, and facility deliveries between those facilities with and without QITs and coalitions. Unfortunately, there were no comparable data to offer a quantitative perspective on education.

# COMMUNITY MOBILIZATION IN COMPASS

The community mobilization interventions in COMPASS formed coalitions and quality improvement teams to use a community action cycle (CAC) combined with a “Partnership Defined Quality” (PDQ) quality improvement process to identify and address problems with education and health services in their communities.

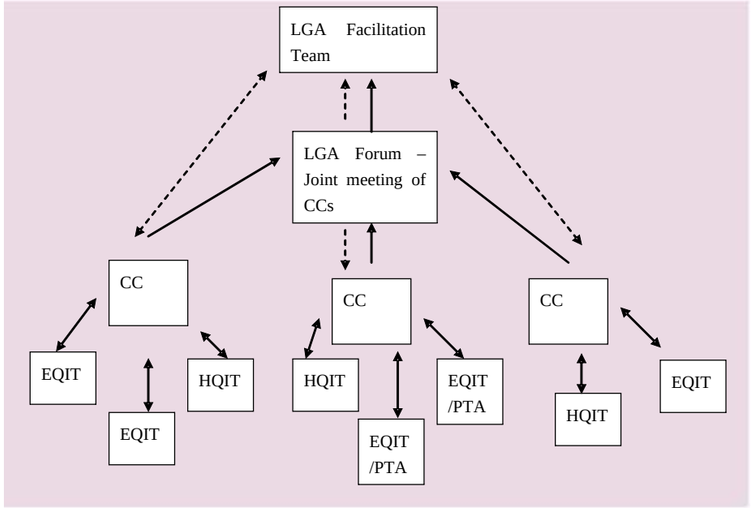
## Structures

Ward / Community Level - Coalitions Traditional leaders, local community-based association representatives, religious leaders and providers join to make a coalition and an executive body. They tend to do awareness raising, fund raise, coordinate activities, link with the LGA, advocacy activities, and to advise the QITs. Some coalitions are very large, considering all association members to also be coalition members, while others consider representatives of the associations to be the coalition members. The roles of specific groups within the coalition as a whole vary widely from one LGA to the next.

Facility-Level Quality Improvement Teams QITs service providers, and community members join together to make a QIT that focuses on problems and solutions specific to their facility. The action plan and activities of these groups are the direct result of the PDQ process, which is described in the next section. There is often more than one education QIT per coalition due to there being several schools in the area. There is also sometimes more than one health QIT per coalition if there is more than one health facility.

LGA Level- LGA Forums and LGA Facilitation Team - The LGA forum offers an opportunity for several coalitions in the same LGA to come together to share ideas, to learn from each other, and to identify common concerns which can be combined to strengthen their advocacy agenda at the LGA level. While most of these are still quite new, in some cases the coalitions, recognizing their benefit, are already taking the lead in organizing and supporting them without COMPASS input. This said, COMPASS still has a role in continuing to advise these forums, particularly to reinforce their problem analysis and CAC skills.

The LGA Facilitation Teams were originally organized by COMPASS to assist with the formation and support of the coalitions, as well as to help coordinate COMPASS activities at the LGA level. Members vary from one state to the next, but include representatives from the LGA, and from other local NGOs. These teams could potentially have a role in long term liaison and support between the coalitions and the LGA. However, in order to institutionalize them in the LGA, the LGA themselves will need to review their function and composition, and consider how their activities might be supported.




The above diagram represents a prototype LGA with coalitions and QITs. However, there is significant variation in the model between the different states. First, only three out of the five states actually have education interventions, and hence Education QITs. Among those, in some cases PTAs were turned into QITs, while in others Education QITs were formed either separately or as sub-committees to the PTAs. In all cases, the forming of the health QIT was linked with the formation of the coalitions, although sometimes the CC was formed first and identified members for the health QIT, while in other cases the health QIT grew out of the PDQ process while the coalition formation was happening concurrently. In Kano and Lagos, the coalitions have sub-

committees for monitoring, for sensitization, and for advocacy. In Bauchi, where there is no education and only one health facility per coalition, the QIT functions more like a sub-committee of the coalition since the health facility is also the main focus of the coalition.

### The CAC/PDQ Process

In order to develop the structures and participation outlined in the previous section, two parallel (and often concurrent) processes occurred. In order to identify coalitions and prepare them for the CAC process, support from the traditional leaders was cultivated and all of the potential community associations were identified. People were gathered in a general meeting to form their coalitions and to identify members of the Executive Board.

The second process was the PDQ process. Clients and service providers were separately led through "Exploring Quality" to define factors they saw as important for good quality services and then brought together in a "Bridging the Gap" meeting to discuss the problems that each group identified and to explore ways to work together to improve their services. Out of the Bridging the Gap meetings, groups of clients and providers for each facility were identified as QITs to work together in an ongoing way to address quality issues, both those that had already been identified, and others as they arise. In the case of education, some states elected to develop the existing Parent Teacher Associations (PTAs) as QITs.
All of the health QITs went through the PDQ process and developed at least their first action plan based on the problems identified. Whether separate education QITs were formed or PTAs converted to QITs, the education QITs did not necessarily follow the same CAC/PDQ process, and their links with the coalitions are less clear.

If coalitions had already been formed, they participated actively in the PDQ process and were usually involved with the selection of the QIT members. If, however, the coalitions were delayed in being formed, the PDQ process and formation of QITs sometimes proceeded without them. Either way, the coalitions include representatives from the QITs and support their activities.

There is significant variation in the level of effort required for the CAC/PDQ process depending on the level of leadership and commitment found in different communities. A range of 5 8 meetings was necessary to form coalitions, Explore Quality and carry out the Bridging the Gap meeting with the resulting formation of the QITs for health and education (in states with the education intervention). This does not take into account "wasted" trips that were made when no one was available to meet or the ongoing support needed in the early months for the coalitions and QITs to gain momentum.

### NGO Role in Coalition Formation

Early in the project there was some confusion as to who would actually be responsible for the necessary "leg work" to meet with people at the community level and go through the CAC/PDQ process. While early plans were that NGOs and independent consultants would be sub-contracted to help with this process the majority of communities were actually mobilized by LGA Field Officers that were directly hired as regular consultants by the project. However, the majority of communities were actually mobilized by LGA Field Officers that were directly hired as regular consultants by the project. These Field Officers have also provided the long term follow- up and support for the coalitions and QITs, and have participated in developing the LGA Facilitation Team. In several states, a couple of NGOs were contracted to form some of the coalitions. However, in almost all cases this was done in a perfunctory manner with little to no follow up provided. The burden ended up back on the LGA Field Officers, in spite of COMPASS having provided resources to the NGOs to pick up the responsibility. The NGOs also did not seem to appreciate how these structures could enhance their other activities.



## Advocacy

Advocacy, particularly raising community issues with the LGA, is a key function of the coalitions. They bring together specific issues raised by their different QITs and organize meetings with the LGA Chairman to mobilize local government support for their concerns. The project developed an advocacy training which was carried out with all of the coalitions. This training included identification of priority issues and development of an advocacy plan including identification of targeted people, desired results, and messages. The most important outcome was to convey the sense that people in the coalitions have a voice with their local government and that advocacy is an effective tool for addressing their needs. This strategy encourages government accountability to its constituents in a country where this has traditionally been absent.

## KEY ACCOMPLISHMENTS

Given that most of the coalitions and QITs have been functioning for fifteen months or less, significant changes can be noted both qualitatively and quantitatively. This is due to their broad reach in the community, the sense of ownership that has been developed, and their ability to successfully improve their situations.

The formation of coalitions and the implementation of advocacy activities contribute directly to project intermediate results including coalitions and QITs with action plans, implementation of advocacy events, and leveraging of additional resources. However, it is important to note that they also potentially provide significant contributions towards the sum of the knowledge and behavior indicators outlined in the technical sections of the plan. Examples of these include coverage for immunizations and Vitamin A, use of family planning, deliveries by skilled attendants, appropriate case management for sick children under five, completion of primary school, increased girl enrollment in primary school, and the use of insecticide treated bednets or exclusive breast feeding.

Gaya Coalition in Kano State keeps a list of their accomplishments on the wall.

A coalition by coalition list of specific accomplishments is included in the Annex. This does not cover some of the more intangible changes and accomplishments which are listed below.

### *Reach of the CCs / QITs*

The coalitions and QITs are successfully reaching a large number of people. This is partly due to the large scale of the project with coalitions and QITs established in all 51 of the COMPASS LGAs. Coalitions use their membership to reach a wide population base for sensitization and mobilization by making each member responsible for sensitizing and mobilizing the members of their particular association.

The following CCs and QITs had been formed by March, 2007.

| STATE | CCs | QITs |
|---|---|---|
| FCT (6 LGAs) | 28 | 28* |
| Bauchi (8 LGAs) | 43 | 42* |
| Kano (16 LGAs) | 52 | 484** (133 HQIT) |
| Lagos (14 LGAs) | 33 | 59 |
| Nassarawa (7 LGAs) | 47 | 88 |
| TOTAL (51 LGAs) | 203 | 701 |

** These represent health QITs only since education is not among the interventions in these states*
*** This number is proportionately larger because all of the PTAs were developed as QITs. However, some of these have not yet necessarily completed the full PDQ process. (In Lagos and Nassarawa, the number of health and education QITs is about equal)*

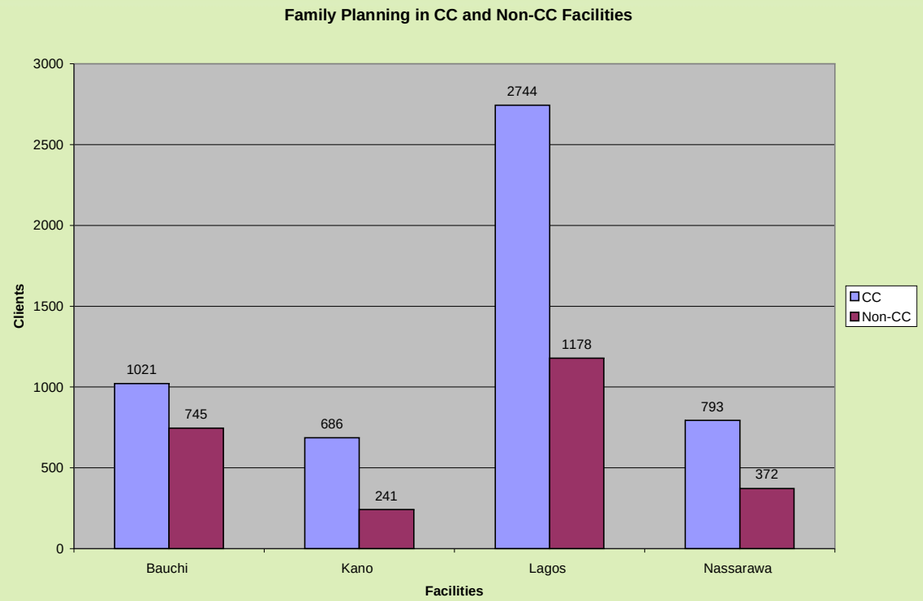
Because coalitions and QITs define their own parameters for membership, there is a wide variation between communities in the number of members involved. In some communities, associations send representatives to the coalitions while in others, all association members are also considered coalition members. Some QITs consider all of their members to be part of the coalitions, while in other communities the QITs may function relatively independently. Given this variation, it is difficult to quantify the number of people reached through this strategy. However, considering a conservative but ROUGH average of 10 associations per coalition and of 25 members per association, it is possible to estimate that these organizations are likely reaching as many as 51,000 association members who then potentially reach out to the population at large, although the link between those members who actively participate in the coalitions and their other association members isn't always as strong as it might be.

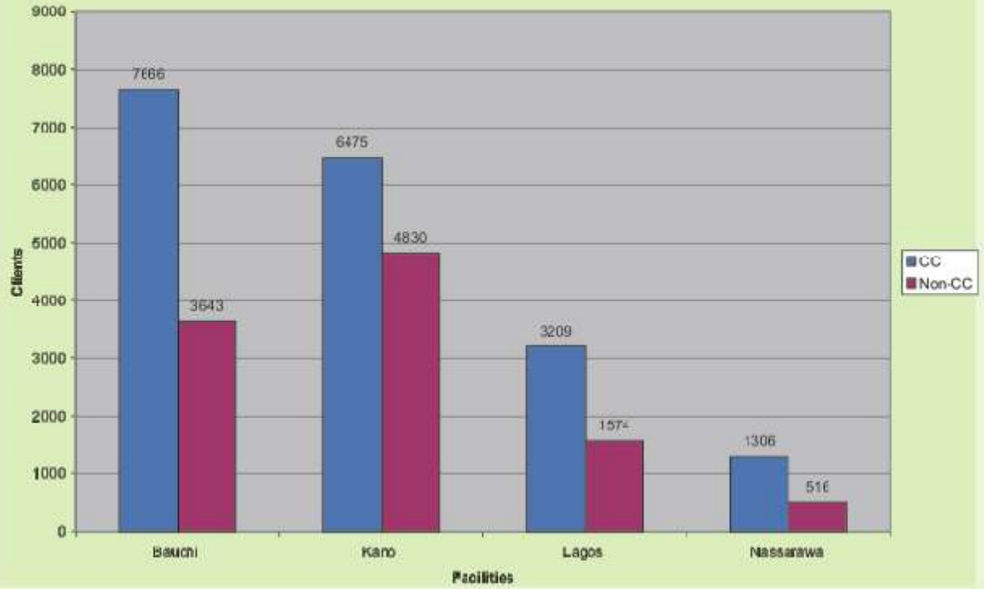
### *Impact on Health and Education*

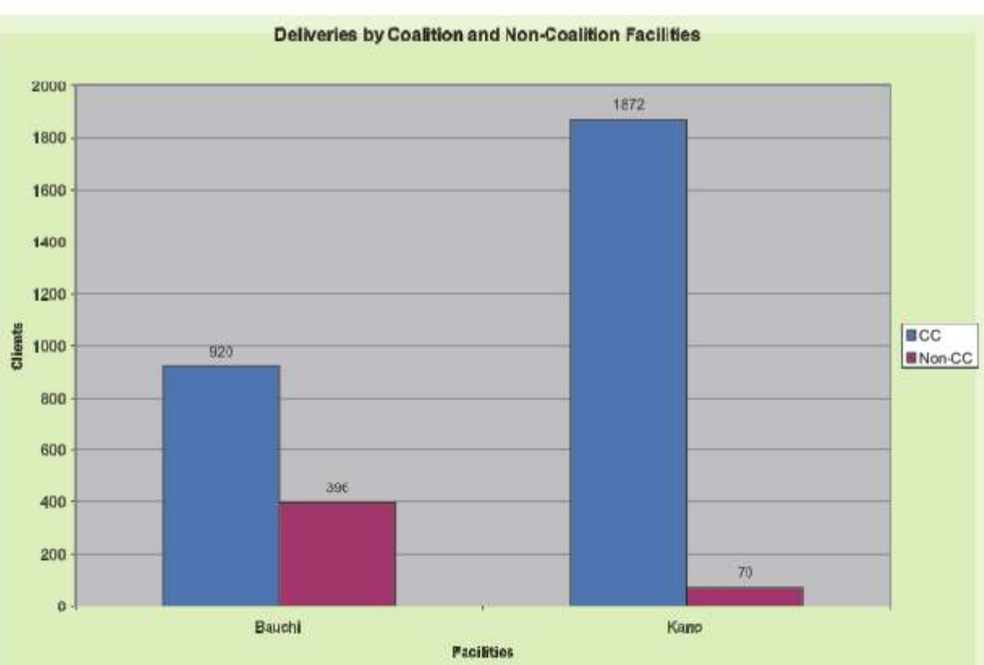
Results of a population based survey which will measure changes in attitudes and practices are pending. Meanwhile, this assessment drew on routine service utilization monitoring data from health facilities, limited polio monitoring data, and qualitatively reported changes in attitudes to conclude that the impact of the community mobilization component of this project has indeed been significant. Unfortunately, similar routine monitoring data were not available for education.

The graphs below compare utilization data for family planning, antenatal care (ANC) or pre-natal care, facility deliveries, and routine immunizations between facilities with coalitions and QITs and those without. Due to staff turnover and difficulties in consistently capturing monitoring data, FCT is not included in these graphs. Because catchment population numbers are not available, these graphs depend on actual numbers. As a result, the coalition and non-coalition facilities groups had to be individually matched for delivery of similar services and for similar patient flow in order to be able to compare these numbers. Where possible, they were also matched from the same LGA in order to control for management variations between the LGAs. Lack of an adequate match meant that in most states it was not possible to include all the coalition health facilities. It is therefore meaningless to compare utilization between the different states. Inherent subjectivity in the matching process is also a limitation of these data.

It is also important to note that in some cases, facilities with coalitions had also received COMPASS renovations and other quality improvement interventions at the facility level making it difficult to attribute all of the difference to the coalitions. However, qualitatively, communities highlighted their feeling that it was the involvement of the coalitions that had really made the difference.

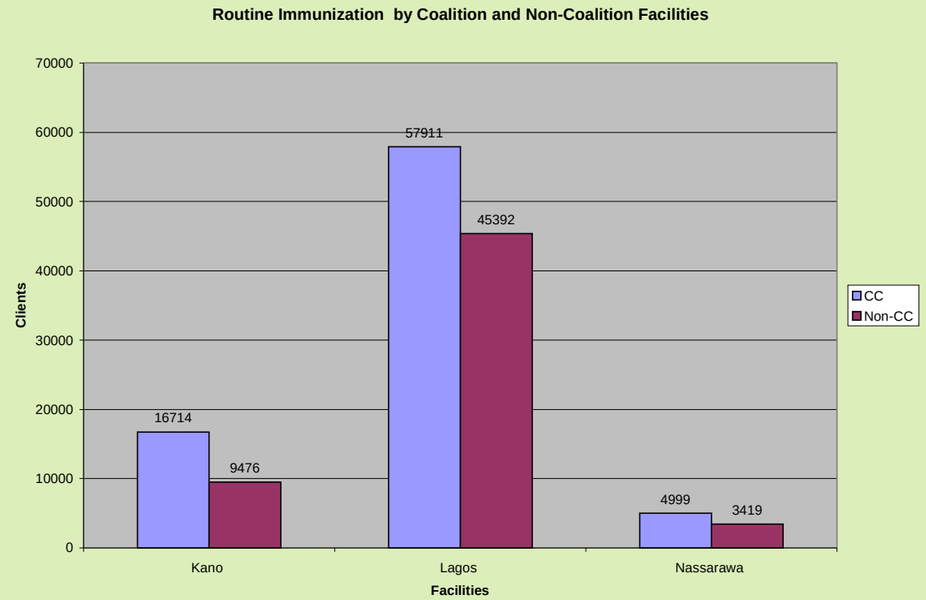







Lagos delivery data were not included because most deliveries occur in general hospitals which are not part of the coalition quality improvement process. Delivery and immunization data were also not readily available in Bauchi.




In addition to the other COMPASS Project interventions, the coalitions and QITs have been utilized in Bauchi and Kano to support the polio eradication campaign. The use of community members from these organizations to sensitize their neighbors on the importance of complete polio immunization and the safety of the vaccine seems to have contributed to lower non-compliance in the COMPASS LGAs than in others. Although there is a wide range of variation, data indicate that COMPASS LGAs have less non-compliance than others. However, they are not disaggregated by where there are coalitions or not, so it is difficult to draw quantitative conclusions about the impact of the coalitions.

Finally, while not quantitative, the teams in the field found the overwhelming perceptions among those who were interviewed that people's attitudes, particularly towards polio immunization and family planning, and people's utilization, particularly for pre-natal care and facility deliveries, had changed. There is thus good agreement between the quantitative and qualitative findings of the assessment.

## *Infrastructure and Monetary Accomplishments*

The contribution of the QITs and coalitions to improving the infrastructure of health facilities and schools has been quite remarkable. Between member contributions, community donations, and funds resulting from advocacy efforts with the LGA, they leveraged over $1 million during the past year. This money was put towards a wide variety of infrastructure activities including construction

of new primary health facilities and schools, renovation of existing facilities, toilet construction, electrification, digging boreholes for water, and provision of equipment and supplies such as furniture, blood pressure cuffs, medicines, school first aid kits, radios and batteries for Interactive Radio Instruction, and exercise books and text books. In other cases, where COMPASS was supporting the renovation of priority facilities but funding was limited, the CCs/QITs provided matching funds to complete the job. These accomplishments are listed in detail in the coalition by coalition list in the annex.

The Education QIT at Kunkura Mabuga Primary School in Ajingi, Kano State with their newly renovated primary school

### *Non-Monetary Accomplishments*

In addition to the fundraising and construction projects, the coalitions and QITs have also been involved in other activities that contribute to the improvement of health and education services in the community. These include:

Advocacy: Members of the coalitions organize themselves to advocate for resources to address problems identified by their QITs. Up to now, these efforts have largely targeted the local government chairmen, although local businesses and corporations have also been targeted.

Sensitization: Coalition and QIT members carry out sensitization activities in their communities. They target both men and women, they do house to house visits as well as group sessions, and they have focused on polio, routine immunization, promotion of pre-natal care and facility deliveries, and promotion of family planning.

Improved provider community relations: Through the process of listening to each other and working together to address the challenges and problems associated with service delivery, providers and clients develop a better understanding of the constraints that each faces and the relationship shifts from one of blame towards one of collaboration.

Supervision and monitoring: The coalitions and QITs have been involved with supervising the renovations carried out in their communities, including those funded by COMPASS. They also monitor health and education services, review routine data such as health service utilization and school absenteeism, and serve as ombudsmen in the case of complaints.

Improvements in quality: In health, QITs have been involved with improving confidentiality, reinforcing provider respect for clients, encouraging TBA referrals for zero-dose polio, and organizing community assistance for sanitation and water supply. In education, QITs have been involved with follow up for absenteeism and non-attendance at school, education on drug prevention, and accompanying classes during field trips and breaks. Both CCs and schools are regularly referring clients for health services.

When asked why he provides funds to assist with refreshments and copying, one service provider responded: "*Now that the community is in the system we understand each other better. The coalitions can help us develop our clinic*."

Extension to non-COMPASS interventions: With QITs independently identifying the priorities they will address, they have moved into broader agendas than those addressed by COMPASS. These have included education subsidies even in the two project states without education interventions, provision of water for health centers and schools, and working with youth to prevent drug use and to discourage violence during the election.

Community labor: Through the coalitions, communities are organized to provide labor to assist with renovations and quality improvement in their facilities. Activities have included assistance with COMPASS or LGA-funded renovations as a "match", regular cleaning of schools or health facilities, carrying water, and assistance with school activities.

As one staff member described these non-monetary accomplishments: "*The most significant change is on the part of the CC/QIT members in their perceptions of development. With the implementation of the PDQ process and the CCs / QITs, they have now recognized how a simple step taken to address provider-client relationships can improve the quality of life of women and children and reduce the trauma families go through as a result of home delivery. Such efforts touch so many lives, sometimes more than what construction of a building can do.*"

### *Sense of Ownership*

The intangible sense of ownership is the ultimate indicator for potential long-term sustainability. The project has been rigorous in denying project support for operational costs to the coalitions and QITs because of the tendency for such support to undermine the sense that these organizations belong to the community. Community members themselves acknowledged that they tend to expect resources from outside to solve their problems, but that these coalitions "*are different because these are really ours*." As one assessment team member summarized it: "*The community underestimated their ability to make changes with little to no government or donor input*".

Dari Community Coalition Members in Nasarawa State during an FGD.

While not all of the coalitions and QITs are successfully exhibiting these characteristics, there are quite a few variables indicating good potential for the sustainability of the coalitions and QITs:

Involvement of existing traditional and community structures: The traditional leaders were involved with the initial quality assessment and the formation of the coalitions and QITs. In addition, building the coalitions and subsequently the QITs on the foundation of the existing associations avoided the introduction of new and parallel structures.

CCs and QITs raising money and supporting operating costs: Some coalitions organize people to bring their own refreshments, others rotate meetings in order to share the load in terms of transport costs, and others get donations to support refreshments from community leaders or businesses. The project has not succumbed to the demands to fill this gap, and people have found they can still manage.

CCs and QITs carrying out regular activities: The CCs and QITs are meeting regularly, keep



minutes of their meetings, and monitor their activities and services in the health facilities and schools. They independently identify problems to address and ways to address them. In general, many of the CCs are still expanding by adding associations, new members, and new activities. Youth have also been added to the membership in some of the coalitions, although they have yet to find much of a voice. Many CCs are raising and managing money. Finally, CCs are beginning to get registered in their LGAs in order to gain recognition and to eventually be able to receive donor funds.

Participants are motivated by improving the situation in their communities: Many CC and QIT members indicated they feel they can make a difference in their communities and that this motivates them to be involved. While less numerous in Lagos than in the other states, this sentiment was still widespread enough to be significant. The newly found skills and results in advocacy seem to have contributed to this sense of empowerment, and add to the motivation.

As one Kano coalition member put it: "*We are poor and have no money, but we can give our time, energy and saliva to sensitize the community and make a difference."*

Another member in Bauchi indicated that: "*Societies progress through participation in self help projects and this motivated me to participate in the QIT especially in this area where mothers are dying during delivery."*

The Kawaji Coalition, Kano, brings their own refreshments for each meeting.

## CHALLENGES

### *Expectations for Resources*

The greatest challenge mentioned by most respondents was the high expectation on the part of the community for resources from COMPASS. People are habituated to having donors and government fix their problems for them, and this is reinforced when they see project staff arriving from outside presumably with resources in hand. These expectations were also exacerbated early in the project by COMPASS's presentation in the community. As part of the "quick win" approach,

they came asking communities to develop project proposals with budgets, raising expectations that COMPASS would be renovating health facilities and schools as well as offering grant money for other activities. As a result of these early misunderstandings, communities are left with the feeling that someone took the money that was promised them. This suspicion often falls back on members of the coalitions, the LGA Field Officer, and the LGA Facilitation Team.

People also expect COMPASS to provide refreshments if they are calling a meeting. Donors in the past have often provided refreshments and, sometimes, transport money. COMPASS decided not to provide this kind of support because it tends to undermine community ownership for their own meetings. However, people have sometimes found it hard to get people together for meetings as a result. Another complicating factor is that other components of COMPASS, such as the polio campaign, do provide refreshments when they are calling a meeting. This sends out confusing messages to the community. Despite these difficulties, some members recognize that it may have been better in the long run that COMPASS refused such support, because now they are learning to take responsibility themselves for improving the situation in their communities

In order not to whitewash this challenge, the situation in Lagos is worth mentioning. Volunteers, service providers, and staff all expressed skepticism about the possibility of mounting a voluntary effort without individual monetary gain. While the expectation for material resources and personal gain is certainly widespread, it was surprising to staff and participants that a true voluntary effort was indeed possible. This will be further tested, and further adaptations in strategy may be necessary as the project struggles to transfer these organizations towards independence while maintaining volunteer momentum.

Finally, there is a distinct tendency in the communities to value material accomplishments more than the non-material ones, focusing more on expensive infrastructure problems than inexpensive problems where they could easily make a difference. This has been reinforced by COMPASS's focus on measuring leveraged resources and the tendency to “show off” infrastructure improvements.

In Tsanyawa, Kano, the team met with the health QIT. The group started off by apologizing that they had not raised much money nor had they accomplished much. Yet each of their disclaimers was followed by an explanation of the variety of activities they were engaged in. These included working with TBAs in the community to refer to the health center for zero-dose polio, working with the LGA Chairman to get rid of a health provider that was consistently rude to the clients, discussing the importance of respecting confidentiality among all the personnel in the health center, successfully advocating for one of their local staff to be sent to midwifery training in Kano, recruitment of a Kano doctor to come as a volunteer to the village once a week in order to limit the need for referral, and working with the coalition to identify women to be trained in polio administration. It was clear that this QIT was accomplishing a lot in terms of quality improvement  perhaps more than they would have if they were focused on raising money for infrastructure.



## COMPASS in the “Driver's Seat”

There is a tendency on the part of both the community and COMPASS staff to expect COMPASS to “direct” the expectations and activities. From the staff's perspective, the constant pressure for deliverables leaves them feeling they “don't have time” to let the community follow its own process, and that they need to intervene to assure that the activities contribute to COMPASS goals. On the communities' side, as long as “this is COMPASS's project anyway”, it is logical to expect COMPASS staff to take the lead. The challenge comes when goals for ownership and sustainability are also introduced which up to now have been limited. By maintaining leadership and not cultivating other leaders as counterpart implementers, it becomes increasingly difficult for COMPASS to get “out of the driver's seat” and turn management over to those who will be remaining after the project.

In the case of the coalitions, the biggest gap in planning for sustainability comes from the tendency for the LGA Field Officers to be over-involved such that they are not cultivating independent leadership in the LGA Facilitation Team and/or the coalitions themselves. It is not clear at this point who the Field Officers might be “handing over to” at the end of the project, and such responsibility outside of the project is not being cultivated. While the LGA Facilitation Teams were formed by COMPASS and are seen as “coordinating COMPASS activities at the LGA level”, they are still a resource which can potentially meet the mutual need of linking the community (coalitions) with the LGA.

Community coalition meeting in Kuje Area Council of Federal Capital Territory, Abuja Nigeria.

## Maximizing Use of the Coalitions for Technical Programs

While there are many coalitions and QITs that are functioning well in identifying and addressing barriers to utilization in health and education, they tend to be underutilized as a strategy for increasing the coverage and impact of other COMPASS components. There is a range in how the coalitions and other COMPASS components work or don't work together:

The coalitions are ignored as a strategy for increasing impact, while the focus for technical interventions continues to primarily be at the facility level, albeit with some mass mobilization for presentation of behavioral messages.

The coalitions are used to reach the community, but they are told them what to do and how to do it.

Concerns are raised with the coalitions and then they are supported to develop their own strategies and solutions for addressing those concerns.

The first option tends to be that followed by most of the COMPASS technical interventions. While technical staff may be involved in mass community mobilization and / or have other community health workers they use to reach the household level, the primary focus tends to be on service delivery.
The polio campaign has effectively used the second option: using the coalitions to track non-compliant families, do house to house and group sensitization, to conduct community dialogues, and to be trained in vaccine administration. The coalitions are fulfilling these roles quite effectively, and community people are more inclined to listen to them since they are from within the community. COMPASS also tells the coalitions what to do in the community when organizing special events such as Child Health Day or Safe Motherhood Week. For these events, the coalitions are utilized to help get the message out, but they do not take the lead in developing the activities, nor do they particularly have ownership in the process.

Up to now, the third option has only been used in a very limited way, primarily as a strategy to improve male involvement in family planning in Kano and Lagos. Representatives from the coalitions were trained in male involvement concepts, completing the training with development of an action plan to take back to their communities. They then oriented their coalitions to the concepts and their ideas for action, which the coalitions will now hopefully adapt and implement. This is an example of a situation where COMPASS raised an issue (male involvement with family planning) and is leaving it to the community coalitions to determine how they will address it. While still early, it seems this process is yielding positive results, and there are plans to extend the approach to Bauchi and FCT which are states where reproductive health is the only intervention.

Another problem with maximizing the use of the coalitions as a platform for other COMPASS interventions is, in some cases, a significant lack of linking and coordination between the community mobilization structures and activities and strategies used by other components. There are several examples where COMPASS activities tend to undermine a coordinated effort at the community level:

Poor linking between PTAs and other community structures: The use of the PTAs as QITs themselves or as collaborators with education QITs builds on existing structures rather than developing new ones and is a logical continuation from the LEAP Project. Indeed, many of them are quite active, they have successfully managed school renovation grants, and they are carrying out school improvement activities. However, it seems that most of them were not well oriented in the PDQ process, nor were they actively linked with the coalitions or the health QITs. As a result, while the coalitions may be aware of what the PTAs / Education QITs are doing, the members of these organizations are not particularly aware of the coalitions nor do they understand their role in linking with them.

Different community level volunteers: Different project components are using different types of volunteers at the community level. (peer educators for reproductive health, community health promoters for child survival, TBAs trained in some cases). At best, the coalitions were involved with identification and selection of these volunteers and they are simultaneously carrying out their volunteer activities while participating in the coalition structure. However, in other cases, these volunteers are functioning independently and are not linked with the potential reach of the coalitions and QITs. This leads to duplication of effort and decreased impact because the coalitions and associations are not involved with mobilization or awareness raising that would enhance the other activities. Incorporation of health structures from previous projects such as CAPAs and PLACOs was also varied, although the project tried to take these into account during the formation of the coalitions.

Renovations without involving coalitions: In some cases, often where available resources were not otherwise clear, state offices in COMPASS proceeded with finalizing plans for renovations and with contracting for the work without involving the coalitions who were already working in those communities. This sometimes resulted in fixing things that were not a priority for the coalition, and in difficulties with managing work that might otherwise have been organized by the coalitions.

Inconsistent refreshment and transport policy: As mentioned in the section on resources, different project components may be providing refreshments for meetings. While this facilitates calling people together in the short term, it tends to confuse and undermine the expected independence of the coalitions.

## Coalition Skills, Particularly Problem Analysis and CAC

While the community action cycle, root cause analysis for problem solving, and problem prioritization were core components of the CAC/PDQ orientation and the discussions during the Bridging the Gap meetings, coalitions seem to have difficulty applying these skills to the ongoing identification of problems and action planning for their resolution. Even if the first action plan was carefully formulated, it seems that most coalitions are proceeding to add problems to the bottom of their lists without the same critical thinking. This said, there were a few coalitions that were able to articulate their prioritization based on the combined factors of potential impact and feasibility, and the fact that coalitions are adding new problems to the list as they resolve earlier ones is positive.

The other skill set identified by coalitions as needed prior to the end of the project is the ability to identify potential donors, develop proposals, and report on projects once they are funded. While these skills link to the skills in CAC/PDQ, they also build on the effective organizational and financial management skills many coalitions are already exhibiting.

A community leader from Nasarawa State telling COMPASS staff why he donated a piece of land for the construction of a community health centre

## "Appropriate" Participation

Despite best efforts, there is still limited participation by women and youth in most of the coalitions and QITs. Even in those coalitions where women do participate, they have been included primarily to sensitize other women and don't seem to have, nor do they expect, any real decision-making influence. Youth have become involved in a few of the coalitions, and tend to be primarily involved with sensitizing other youth on reproductive health. They are few in number and feel like they can't really participate actively in the presence of their elders. Finally, it has also been challenging to find and involve people who might not be using the education or health services because they tend to be less active in the community in general.

Another issue is the tendency of some members to politicize the coalitions. Many of those involved with the coalitions have political affiliations, or political aspirations themselves. However, it is encouraging that most of the coalitions recognize that politicization is a danger to their effectiveness and they seem to have figured out ways to keep the two separated.

## RECOMMENDATIONS

Up to now, so much effort has been spent on implementation that relatively little thought has gone into how the community mobilization interventions might be maintained after the end of the COMPASS Project. As a result, most of the recommendations coming out of this assessment fall under the rubric of planning for consolidation and phasing over the community component at the end of the project by taking into account what will be needed for it to be sustained. This is particularly timely since the upcoming budget cuts can be used as an opportunity to rigorously begin to implement a gradual phase out plan starting now, rather than waiting to do this until the last year. It is also worth noting that many of these recommendations were already in the Year 3 work plan, and that the proposed decrease in active implementation activities was already expected for Year 4.



Under the overarching theme of working towards phasing over, the following are specific recommendations agreed upon by the assessment team:

1. Reinforce the capacity and skills of the coalitions and QITs in a targeted way, offering more support and skills where they are lacking while encouraging more independent function in those that are already strong.

   a. Carry out a simple organizational capacity / needs assessment: While this does NOT need to be comprehensive and formal, a few simple indicators should be identified to differentiate those coalitions needing extra reinforcement and identify specific skill areas that are weak.

   b. Provide specific skills reinforcement as needed: Reinforce problem prioritization and analysis skills, the capacity to carry out the CAC in an ongoing way, proposal writing, and the ability to monitor and report on progress. While more centralized training may work for information transfer, skills training like this does not effectively get transferred if representatives are trained with the expectations that they will pass on their learning to other members. As a result, this reinforcement needs to be done through mentoring and/or through training at the LGA or even coalition level. LGA Facilitation Team counterparts should also be involved in this reinforcement, getting reinforced themselves in the process. (see below)

   c. Strengthen the links between PTAs, Education QITs, and CCs: The PTAs and education QITs need to be integrated with the coalitions in order to maximize their effectiveness, reinforce integration of health and education, and increase their potential for sustaining their activities. The project should also proactively integrate the PDQ process and the Education QITs with the recently mandated School Development Committees.

   d. Explore strategies to support weaker coalitions : While it will be up to the LGA facilitation teams to work out their strategies on the ground, some suggestions include:

      Consider pairing weaker coalitions with stronger ones through mentoring or idea exchange.

      It may be necessary to review the composition, the representation, and/or the breadth of the existing groups since they may not actually have the "right" representation to function effectively.

      Go through a participatory process of reviewing the roles and responsibilities of the different members and sub-committees.

      Consider whether social consciousness raising exercises or discussions would be helpful as a way to increase participation and motivation.

      Tap lessons learned on working with heterogeneous and urban populations.

e. Increase women and youth participation : Such participation requires a shift in social relationships which takes time and persistence. While significant progress has been made in many instances, the project needs to continue to reinforce the importance of the participation of these two groups in the quality improvement activities in order to maximize their impact. One suggestion, particularly for women, was to identify respected women leaders in the community and to build women's participation through them.

f. Transparently explain lack of COMPASS resource inputs to the communities: Discussion with the community on why COMPASS has not provided the resources that were expected and that further resources are not likely forthcoming would help diminish suspicion of the coalition and facilitation team members.

2. Increase the utilization of CCs and QITs as a strategy to increase the impact of other interventions in health and education.

a. Give CCs and QITs the lead on health and education issues at the community level: Raising awareness on special activities or specific health and education issues, but turning the responsibility for addressing those issues over to the community maximizes both the expertise and the potential impact that community structures can offer.

b. Value no/low-cost interventions in addition to material ones: Provide recognition for the more behaviorally oriented activities to improve quality in addition to the infrastructure improvements. Work with the coalitions to develop realistic time frames for independently funded infrastructure improvements, acknowledging that it takes time to raise money.

c. COMPASS should take more of a coordination and facilitation role at the community and LGA level: As implementation begins to phase over, it is even more important for COMPASS to work towards true integration through coordinated implementation and consistent approaches in a way that can continue after the end of the project.

3. Work towards institutionalization of coalitions.

a. Registration and Recognition of the Coalitions: The coalitions should continue to work towards formal registration at the LGA level in order for them to be recognized and to be able to raise donor support. In addition, they need to make an effort to market themselves and their accomplishments, both within their own communities and in the LGA at large.

b. Strengthen the LGA forum: This, along with reinforcing the advocacy program should be part of institutionalization. However, it is important for the project to function in an advisory role only, allowing the coalitions to truly take the lead in determining the function and operationalization of these activities.

c. Reinforce the role of the service providers: Finally, the service providers



have the potential to become key support people within the coalition structure. They offer advice and orientation on technical issues and can potentially contribute to the leadership. They are also a potential channel for ongoing technical input, through their respective Ministry channels, into activities at the community level.

4. Strengthen LGA Facilitation Team to provide support for the coalitions as well as to link them with the LGA.

a. Review the function and composition of the LGA Facilitation Team: In spite of the fact that both the coalitions and the LGA facilitation were defined and formed by COMPASS, people in the LGA recognize the benefit of the coalitions and the function of the LGA facilitation team in supporting and linking them with the LGA. However, the challenge now is for COMPASS to allow the LGA to take the leadership in defining and reconsidering the composition of this structure so it meets the needs of the LGA not necessarily those of COMPASS. This will potentially lead to institutionalizing them as a structure within the LGA - even with financial support from the LGA for their activities.

b. Build the capacity of the LGA Facilitation Team: Members of the facilitation team need to be versatile in the CAC/PDQ process, including the same problem analysis and proposal writing skills suggested for the coalitions, if they are to facilitate these skills in the coalitions. Working with them as counterparts and co-facilitators is probably the most effective way to build their capacity as facilitators of the process.

5. Link Coalitions with other organizations and donors at the LGA, State, and national levels

a. Orient state and LGA staff towards linking donors with coalitions: When interested donors looking for community connections arrive to the states or LGAs, the people they contact should be able to direct them directly to the LGA Facilitation Teams and the coalitions. COMPASS and the LGA Facilitation Team need to work more closely with the LGA Chairman, donor links at the State level, and other implementing partners to market the coalitions as viable organizations for receiving funding to assure active program implementation at the community level.

b. Look for ways to assist coalitions with funding: While COMPASS took the decision not to fund coalitions directly, it is unfortunate that some of the coalitions have evolved to the point where they could effectively and efficiently use small grants to achieve significant improvements in their services. It may be possible to explore “funneling” money to the coalitions through the NGOs during the next round of grants, thus also reinforcing the expectation that the NGOs will be actively working with these structures at the community level.

6. Rationalize the COMPASS staffing structure to effectively meet the transition needs of the project in the face of budget shortfalls.

a. Review the role, work load and cost effectiveness of the LGA Field Officers:

The Field Officers need to work closely with more senior State COMPASS staff to rationalize their role, expectations, and workload; given the need to consolidate the community mobilization component combined with the cut in their work time. The LGA Field Officers need to more actively shift their role from one of implementation to one of working as a counterpart to strengthen the coalitions and facilitation team implementers.

## BEST PRACTICES / LESSONS LEARNED

This assessment highlights the CAC/PDQ process as a community mobilization strategy which was successfully carried out, on a large scale, yielding significant impact in terms of both health and education behaviors. While there are obviously still stronger and weaker coalitions and QITs, the assessment found situations in all five states where, as outlined in the hypothesis, the process also led to increased community ownership, increased service accountability, and changes in the ways the community viewed their ability to improve the health and education situation in their communities.

### Best Practices

There are several "best practices" in coalition and QIT management that contribute to their success. These include:

1. Coalitions and QITs value non-monetary quality improvement interventions.

   Some coalitions have been successful in identifying and intervening on components of quality services that do not require money. This allows them to make a significant difference in quality while de-emphasizing the need for external funding.

2. Coalitions and QITs keep records and monitor progress.

   The most active coalitions keep records of their members, their meetings, and monitor the progress of their activities. Graphs of health service utilization, school enrollment, as well as running records of activities and accomplishments were particularly effective.

3. Recruitment of retired, active people as leaders.

   In many cases, the leaders of successful QITs and coalitions were retired people who had time to devote to activities, and who were motivated to stay active and make a difference in their communities. Where available, these people are a resource to be tapped.

4. LGA support for LGA Facilitation Team Outreach.

   Where LGAs were beginning to support the activities of the LGA Facilitation Teams, the teams tended to be active and there was interest at the LGA level in maintaining the coalitions because they contribute to improved health and education in the LGA.

5. Coalitions and QITs raise and organize use of operating funds and refreshments.

   Coalitions may seek donations for refreshments, organize contributions of food and money for refreshments on the part of participating members, or agree to meet at times when refreshments are not necessary. However, coalitions' independent resolution of the refreshment issue leads to greater commitment for involvement and participation.



### Lessons Learned

On a larger scale, there were also aspects of the way this process was designed in COMPASS which worked particularly well and might be considered lessons learned to be taken into consideration when developing similar strategies in other projects:

1. Associations and community based organizations, in addition to the traditional structures, were used as a foundation for the CAC/PDQ process.

   By using the existing structures, and by drawing on the wide range of existing community based organizations, both the scope and breadth of the coalition and QIT activities were significantly enhanced. Several people cited the integration of health and education activities, the inclusion of the associations, and the involvement of the traditional structures as elements of the strategy which strengthen the role of the coalitions and QITs.

The Durum Coalition in Bauchi State depended significantly on support from the Chief and influential leaders.

2. The coalitions and QITs significantly complement and enhance each other's function.

   While the CAC/PDQ process and the formation of QITs has been implemented elsewhere, the addition of the coalition component added significant value to the effort. The range of associations involved enhanced the role of the coalitions in coordinating activities, advocacy, fundraising, and sensitization. They provide significant support to the QIT quality improvement activities at the facility level. People also appreciate the "voice" that advocacy gives them.

3. The rigorous denial of resource support for coalition and QIT operating costs led to a significant increase in community responsibility for their own activities.

The expectation that donors or government will bring resources and resolve problems is deeply engrained and a constant struggle for both the community who expects refreshments and transport reimbursement for attending meetings, and for the staff who are denying the expected resources. In order to successfully begin to shift this expectation and move the community towards responsibility for their own situation, the project needs to be prepared to leave it to the community to get themselves organized without such support, even if it means a delay in getting meetings going and/or being willing to walk away if the community does not respond. Because there is a tendency to believe that the one who pays is the one to whom the process belongs, once the community comes around to taking responsibility for their own activities, the level of ownership and the potential for sustainability are significantly higher than they would have been with project support, and it is quite possible that more will be accomplished.

As a couple of community members from Ajingi and Gaya suggested in Kano (whether correctly or not): *PLACO and LEAP paid for activities and didn't plan for sustainability. But the coalition is ours and it will continue. COMPASS hasn't brought any money anyway we were working before and will continue after because there isn't a difference*.

It is, however, important to understand that the denial of resources for operating costs is not a denial that resources are necessary to resolve a lot of the problems the community faces. Indeed, these communities are very poor and many improvements cost money. The challenge is to find ways to link the community with financial resources whether through the project or elsewhere, without undermining their sense of ownership or contributing to a sense of dependence on the project. This is one of the reasons why it is unfortunate that grant money is not available through the project for those communities that have now independently gained momentum, and why linking with other possible donors is extremely important to retain the momentum that has begun.

4. It is possible to adjust the CAC/PDQ process to achieve participation and ownership even in a poor, urban setting such as Lagos.

The project faced considerably more difficulty in achieving participation and ownership in Lagos, and there are many skeptics when it comes to believing that sustained voluntary effort is possible in that setting. However, the extent to which the CAC/PDQ process achieved participation and ownership even without any payment for operating costs was a surprise to the staff themselves. Several adjustments in the strategy were made in order to facilitate implementation in the urban setting:

- Associations take on greater importance as a tool for mobilizing the community.

- Special care has to be taken to assure representative participation and leadership in a heterogeneous environment. This includes adjusting for special geographic, social, or cultural barriers that may make fair representation difficult. It may also mean that leadership and/or meeting locations need to be rotated in order to equalize participation.



The purpose of the coalitions needs to be clear to everyone from the beginning. This becomes a reference point when the coalition faces challenges or begins to lose momentum. This can also be a basis for raising participants' social consciousness, reminding them of the non-monetary reasons their participation is important. This clarity can also help prevent hijacking of the agenda by special or political interests.

An open-ended time frame for activities and accomplishments allows communities the time they need to figure out their agenda and priorities.

5. Any promises for interventions and resources will be remembered and therefore should only be made when it is clear they will be fulfilled.

This project is still suffering from mistrust and people feeling let down due to promises made two years ago. It is important to realize that people remember what they are told, and any changes need to be transparently shared with them. Otherwise, suspicion falls not only on the project itself, but also on the volunteers and collaborators with the project.

## Conclusion

In summary, this assessment highlighted significant impacts that the coalitions and QITs have had in improving health and education, increasing service accountability, and changing relationships within the communities. However, even more impact could be achieved if they were truly utilized as a platform for all of the COMPASS interventions. Finally, while the process has been well implemented and a large number of active coalitions and QITs have been formed, there is still work to be done in order for these organizations to be able to sustain themselves after COMPASS phases out.

# Annexes

## *Annex 1 List of Assessment Team Members and Sites*

**ASSESSMENT TEAM**

***Temple Jagha,*** *Chief M&E Officer, Central Office, Abuja*
***Daisi Feyistan,*** *Assistant M&E Officer, Central Office, Abuja*
***Rufai Ibrahim,*** *M&E Officer, Bauchi State*
***Zakariya Zakari,*** *M&E Officer, Kano State*
***Omotayo Olugbemi,*** *M&E Officer, Lagos State*
***Bako Shigudu,*** *M&E Officer, Nassarawa State*
***Zainab Magaji,*** *Community Mobilization Officer, Nassarawa State*
***Mohammed Gama,*** *Community Mobilization Officer, Kano State*
***Oluyemisi Ayoola,*** *Community Mobilization Officer, Lagos State*
***Ahmed Ahmed,*** *Community Mobilization Officer, Bauchi State*
***Joseph Ajiboye,*** *Senior Technical Resource Manager, Lagos State*
***Adeola Olunloyo,*** *Program Officer for Communication, Abuja Central Office*
***Mabiala Ma-Umba,*** *Senior Program Advisor for Community Mobilization and Communication, Abuja Central Office*

### SITES VISITED

| STATE | LGA | COMMUNITY |
|---|---|---|
| FCT | AMAC | Jiwa |
| | AMAC | Karu |
| | Kuje | Kwaku |
| | Kuje | Robochi |
| NASSARAWA | Kokona | Kwara |
| | Keana | Kwara |
| | Karu | Karu and Luvu |
| LAGOS | Ajeromi Ifelodun LGA | Amukoko CC |
| | Alimosho LGA | Egbe Idimu CC |
| | Badagry LGA | Marina CC |
| | Ibeju Lekki LGA | Awoyaya CC |
| | Lagos Mainland LGA | Iwaya CC |
| | Ojo LGA | Ojo CC and Iba CC |
| BAUCHI | Bauchi | Tashan Babiye |
| | Kirfi | Bara |
| | Bauchi | Durum |
| KANO | Tsanyawa | Tsanyawa |
| | Ajingi | Ajingi Sakalawa |
| | Gaya | Gaya Arewa |
| | Gwale | Mushe |
| | Nassarawa | Kawaji |

## *Annex 2* Executive Summary for Community Feedback

A midterm assessment of the community mobilization component of the COMPASS Project took place from March 15 to April 6, 2007. Community mobilization is a cross-cutting component of the five-year COMPASS project, funded by USAID to address health and education in 51 Local Government Areas (LGAs) in five states in Nigeria.

The primary community mobilization interventions were the formation of community based coalitions (CCs) and quality improvement teams (QITs) to carry out the CAC/PDQ (Community Action Cycle / Partner Defined Quality) process in order to identify and address problems related to health and education in their communities. Coalitions are formed at the community level, are made up of representatives from community associations, traditional leaders, religious leaders, and service providers for both health and education, and tend to serve as umbrella organizations for sensitization, advocacy, fundraising, and coordination of quality improvement activities. The QITs function at the facility level, are made up of representatives from the facility service providers as well as community members, and focus on identification and resolution of problems occurring in their facility. The CCs link to both the QITs, and a Local Government Facilitation Team (LGA Facilitation Team) at the Local government Authority (LGA) level. In addition, coalitions meet together in an LGA forum to exchange ideas and develop advocacy agendas together. As of March, 2007, a total of 203 CCs, with 701 QITS both for health and education have been formed. Considering a conservative but ROUGH average of 10 associations per coalition and of 25 members per association, these organizations are likely reaching as many as 51,000 association members who then reach out to the population at large.

### Key Accomplishments

The project achieved significant results in terms of impact, infrastructure improvements, other quality improvements, and effectively functioning community structures. Highlights include:

Health service utilization for family planning, ante-natal care, facility deliveries, and routine immunizations is considerably higher in facilities with CCs and QITs than in matched facilities without these structures.

Improvements in infrastructure and service provider/community relations, and regular monitoring of services by the QITs led to better quality education and health services. Specific issues such as confidentiality, client respect, and student absenteeism have been addressed.

Funds for health and education improvements (more than $1million in FY2006) were leveraged through donations and advocacy to contribute to infrastructure, equipment, drugs, and supplies for both education and health.

Both women and men were sensitized on immunizations, safe motherhood, family planning, and enrollment in school particularly for girls.

The CCs/QITs are functioning effectively with growing activities and membership.

### Challenges

The main community mobilization challenges include:

People have high expectations for resources from COMPASS, sometimes limiting their ability to recognize what they can accomplish on their own. This said, there are people who acknowledge that lack of support from COMPASS may have been a blessing because the coalitions now belong to them,

and they are breaking the habit of expecting outside people to solve their problems.

Ongoing implementation of the community action cycle with in-depth analysis and prioritization of additional problems is still challenging.

## Recommendations

Work with the coalitions to identify and provide the additional skills and support they will need in order to assure their sustainability after the end of the project. These might include: reinforcement of problem analysis and CAC, marketing themselves to the LGA and the community, reinforcement of the links between the Parent Teachers' Associations (PTAs), Education QITs, and the coalitions, and encouragement of the service providers in providing guidance. Registration of all CCs also needs to move forward.

Strengthen the LGA Facilitation Team by involving the LGA themselves in defining their functionand composition, and in providing financial support.

Link coalitions with other donors and organizations through the LGA Chairmen and through implementing partners at the State and national levels.

**Conclusions / Lessons Learned**

Some of the most significant strategies contributing to the success of the community mobilization are:

Use of associations and existing traditional and community-based structures as a foundation for the coalitions has led to their achieving broad reach and scope. This in turn leads to high coverage as well as flexibility and resources in addressing whatever priority problems arise.

The CCs and QITs are highly complementary structures each supporting what the other is trying to accomplish.

The insistence by COMPASS on not paying operational costs has shifted the focus of the coalitions by sending the clear message that the coalitions do not belong to COMPASS. This was summarized by one assessment team member: “The communities realized they had underestimated what they could accomplish by themselves with little to no inputs from government or donors”.

## *Annex 3 Compiled List of Recommendations*

Under the overarching theme of working towards phasing over, following are specific recommendations agreed upon by the assessment team:

1. Reinforce the capacity and skills of the coalitions and QITs in a targeted way, offering more support and skills where they are lacking while encouraging more independent function in those that are already strong.
   a. Carry out a simple organizational capacity / needs assessment:
   b. Provide specific skills reinforcement as needed: Reinforce problem prioritization and analysis skills, the capacity to carry out the CAC in an ongoing way, proposal writing, and the ability to monitor and report on progress.
   c. Strengthen the links between PTAs, Education QITs, and CCs. The project should also proactively integrate the PDQ process and the Education QITs with the recently mandated School Development Committees.
   d. Explore strategies to support weaker coalitions. Suggestions include:
      i. Pairing weaker coalitions with stronger ones
      ii. Review the composition, the representation, and/or the breadth of the existing groups
      iii. Review roles and responsibilities of the different members
      iv. Consider social consciousness raising exercises
      v. Tap lessons learned on working with heterogeneous and urban populations.
   e. Increase women and youth participation .
   f. Transparently explain lack of COMPASS resource inputs to the communities.

2. Increase the utilization of CCs and QITs as a strategy to increase the impact of other interventions In health and education.
   a. Give CCs and QITs the lead on health and education issues at the community level.
   b. Value no/low-cost interventions in addition to material ones
   c. COMPASS should take more of a coordination and facilitation role at the community and LGA level

3. Work towards institutionalization of coalitions.
   a. Registration and Recognition of the Coalitions.
   b. Strengthen the LGA forum.
   c. Reinforce the role of the service providers.

4. Strengthen LGA Facilitation Team to provide support for the coalitions as well as to link them with the LGA.
   a. Review the function and composition of the LGA Facilitation Team.
   b. Build the capacity of the LGA Facilitation Team:

5. Link Coalitions with other organizations and donors at the LGA, State, and national levels
   a. Orient state and LGA staff towards linking donors with coalitions:
   b. Look for ways to assist coalitions with funding:

6. Rationalize the COMPASS staffing structure to effectively meet the transition needs of the project in the face of budget shortfalls.
   a. Review the role, work load and cost effectiveness of the LGA Field Officers:

## *Annex 4 Compiled Accomplishments by Coalition and QIT*
### *Activities Completed by October, 2006*

| LGA | Facility/ Community | CC or QIT | List all Projects *Completed* by end Year 2 |
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| **KANO STATE** | | | |
| Nasarawa | Gwagwarwa | Gwagwarwa CC | · Provision of a standby Generator to maternity section of Gwagwarwa Maternal and Child Health Clinic (MCH) by Gwagawarawa CC and provide daily fuel for the Generator.<br>· Repair of borehole at Gwagwarwa MCH by Gwagwarwa CC.<br>· Gwagwarwa CC sponsored house to house RI and ANC mobilization.<br>· Have CC office.<br>· Have stand by transport for transporting emergency cases to specialist hospital.<br>· Repaired broken doors at the Gwagwarwa MCH.<br>· Referred clients to Gwagwarwa MCH. |
| Nasarawa | Kaura Goje | Kaura Goje Health post .QIT | · Dug a well at the Kaura Goje health post.<br>· Renovated toilet at the Kaura Goje Health post.<br>· Conduct community mobilization RI and ANC every month. |
| Nasarawa | GAMA | Gama Health post QIT | · Built a 3 sitter toilet at Gama Health post.<br>· Conduct house to house community mobilization during IPD.<br>· Advocated for the building of the maternity at Gama Health post.<br>· Selected for water project by USAID water project. |
| Nasarawa | Kawaji | Kawaji CC | · Conducted integrated Mass awareness on RH/FP, CS and BE at the Kawaji Health post.<br>· Kawaji CC advocated for a build of tokarawa Health post.<br>· Kawaji CC registered as legal entity.<br>· Kawaji CC open a organizational account.<br>· Kawaji CC registered with National Directorate of Employment (NDE-Kano) and have been given a loan of shoe making machine, Hair dressing equipment and Furniture spray machine.<br>· Kawaji CC donate drugs to health facility in kawaji.<br>· Kawaji CC conduct every month general Sanitation of Sanusi General Hospital.<br>· Kawaji CC opened bank account , has ID card and letter headed paper with logo.<br>· Kawaji donated drugs for first aid boxes to 38 schools worth N19,000. |
| Gaba-sawa | Zakiria | Zakirai CC | · Constructed a Doctor's Lodge at Zakirai PHC by Zakirai CC.<br>· A borehole dug at the Zakirai PHC by the zakirai CC.<br>· NYSC Doctor posted to Zakirai PHC advocated by Zakirai CC.<br>· Zakirai CC now registered as legal entity.<br>· Zaikirai CC provide 4 schools with IRI radio batteries.<br>· Zakirai CC routinely conduct Community Dialogue during IPDs. |
| Gabasawa | Gabasawa | Gabasawa - CC | · Conducted integrated mass awareness on RH/FP, CS, and BE at the Gabasawa BHC 1000 women in attendance. And 140 children immunized during the mass awareness.<br>· Advocated for the renovation of additional class room at Gabasawa Primary school.<br>· Donated 7 packets of batteries to Gabasawa primary school for IRI Program. |
| Gaya | Gaya Arewa Gaya Kudu Kademi | Gaya CC LGA forum (Gaya kudi, Gaya Arewa and Kademi-CCs) | · Donations of 52 radios for Interactive Radio Instructions (IRI) Program to 30 COMPASS supported Primary Schools by Gaya LGA CC Forum.<br>· Renovation of six blocks of classrooms at Gaya Arewa and Gaya Kudu primary schools by member of house of assembly representing Gaya constituency influenced by Gaya LGA CC Forum.<br>· Advocated for the repair of Gaya Hospital Generator Gaya Arewa CC and Gaya Kudu CC now registered a legal entity .<br>· Gaya Arewa, kudu and Kademi CC donated 4 dozen of radio batteries to 4 schools. |
| Gwale | Gwale | Gwale – CC | · Donations of 20 benches to ANC section of Gwale MCH by Gwale QIT.<br>· Volunteerism by a Doctor, Pharmacist and Midwife to work in the evening at Gwale MCH influenced Gwale QIT.<br>· NYSC Doctor posted to Gwale MCH advocated by Gwale Ccs.<br>· Electrified the Gwale MCH.<br>· Conduct Community Dialogue during IPDs. |
| Gwale | Gwale | Dorayi CC | · Advocated for the building of health facility at Dorayi town.<br>· Conduct community dialogue and community mobilization during IPDs. |
| Dala | Adakawa | Adakawa Helth post QIT | · Donations of a weighing scale, a BP Apparatus, a Stethoscope, a ceiling fan and leather carpet to Adakawa health post Adakawa QIT.<br>· Provision of water supply and repair of mattresses at Dala MCH by Dala CC. |
| Dala | Fuskar Arewa | Fuskar Arewa CC | · Advocated for the expansion of Fuskar Arewa health center worth N9 Million Naira.<br>· Fuskar Arewa now CC registered as legal entity. |
| Dala | Dala CC | Kofar Mazugal Health post QIT | · Have put on a gate for the health post.<br>· Have increased wall height of the health post for security reasons. |
| Tsanyawa | Tsanyawa | Tsanyawa CC | · Donation of N50, 000.00 land for expansion of kunkurawa primary school by Tsanyawa CC.<br>· Two Doctors volunteered to work at weekends in the comprehensive health center Tsanyawa influenced by Tsanyawa CC. |
| AJINGI | K/Mabuga | Ajingi CC | · Renovations of two classrooms at K/Mabuga primary school by Ajingi CC.<br>· Provide drugs to the Ajingi Health center for revolving. |
| Kabo | Kabo town | Kabo CC | · Renovated Kabo Cortage hospital maternity.<br>· Donation of 20 benches to Zango Islamiya primary school.<br>· Conduct community mobilization and community dialogue during the IPDs. |
| Kabo | Durum | Durum –CC | · Electrified the Durum health facility ( Quality site ).<br>· Advocated for a land for the expansion of Durum quality site.<br>· Supply water daily to Durum Health center.<br>· Donated 3 curtains to Gabasawa primary school staff office.<br>· Durum CC replaced the missing iron sheet at the Shada Health post. |
| Kabo | Garo | Garo CC | · Repaired the generator of Garo health center.<br>· Donated overhead water tank to Garo primary school.<br>· Renovated staff quarters of Garo primary school.<br>· Donated 150 copies of English texts books to the teachers and pupils of Galadima Primary school , Garo SMPS, Danja Primary school and Gude central primary school. |
| Bichi | Saya | Saye -CC | · Conducted Mass Awareness on Nutrition, Girl child education , RH. RI, and malaria control to 800 women and 100 men.<br>· Donated ANC/RI drugs to Saye health clinic.<br>· Donate food items to Bichi General Hospital for food demonstration at the ANC unit. |
| Garko | Garko | Garko CC | · Donated 10 packs of batteries to 5 schools for IRI. |
| Warawa | warawa | Warawa -CC | · Renovated the toilet of Warawa health quality site. |
| Garko | Garko | Garko CC | · Put up the iron Gate at the Garko PHC (Quality site). |
| **LAGOS STATE** | | | |
| Ajeromi-Ifelodun | Dankaka; Aiyeke and Araromi Akere PHC) | CC | · Renovation and equipping of Akere PHC by LGA Chairman as a result of advocacy by CC.<br>· Mobilization of community members to utilize RH/FP & CS services at the PHC and during NIDs.<br>· Renovation of 2 primary schools through CC advocacy. |
| Alimosho | Egbe-Idimu | CC | · Mobilizes community members for NIDs and Local Immunization Days.<br>· Mobilized Community and LGA authorities and raised funds to build a PHC in Agodo Community.<br>· Compass has given some equipment to run the PHC.<br>· CC members will provide 20 benches, 20 chairs and 12 tables. |

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| Badagry | Ajara | CC | · Repair of ceiling of Ajara PHC and donation of equipment by Rotary Club at the instance of CC.<br>· Mobilization of community for NIDs; Local Immunization Days and integrated measles campaign.<br>· Monthly stipend contributed and paid out by CC for the maintenance of PHC environment.<br>· Raised N50, 000 each for renovation work in two primary schools.<br>· CC Chairman used his personal motor boat to ferry to and fro children from riverine areas for measles immunization.<br>· Participated in LGA Forum. |
| Badagry | Marina | CC | · Mobilization of community for NIDs, LIDs.<br>· Monitored the renovation of Marina PHC.<br>· Mobilizes community to use the newly renovated PHC.<br>· Advocacy visit to the Akran of Badagry and his Chiefs.<br>· Participated in LGA Forum.<br>· Monitors expenditure of PTA Grants for renovation of Primary Schools. |
| Eti-Osa | Iru-Victoria Island | CC | · Advocacy to LGA Chairman for employment of more Skilled staff for the PHC; renovation of Oriyanrin PHC and provision of 180 pairs of pupils furniture for 3 primary schools. |
| Ibeju-Lekki | Awoyaya | CC | · Advocacy visit to LGA Chairman for the extension of PHC. Towards this, LGA Chairman donated 50 bags of cement @ N65, 000; 1000 nine inches blocks @ N95, 000 and 2 lorry loads of sharp sand @N11, 000.<br>· A community member also donated 200 nine inches blocks @ N19, 000.<br>· An indigene and a member of the Lagos State House of Assembly donated for the PHC: 1 dozen white chairs @ N12, 0 00; 6 benches @ N15, 000; repair of tables @ N5, 000. He has also provided electricity for R.C.M. primary school @ a cost of N50, 000 as well as a bore-hole. |
| Ibeju-Lekki | Ibeju | CC | · Sensitization visits to the LGA Chairman; Religious Leaders and Community LeAders. |
| Oshodi-Isolo | Oshodi | CC | · Monitored the renovation of PHC by COMPASS.<br>· The PHC fence was raised and repaired by the LGA.<br>· A member of the CC donated a Generator.<br>· Participated in LGA Forum.<br>· Mobilizes community for NIDs. |
| Oshodi-Isolo | Isolo | CC | · Mobilizes community for NIDs.<br>· Participated in LGA Forum.<br>· Bore-hole provided for a primary school by LIMCA through the effort of an NGO member of the CC. |
| Kosofe | Ogudu-Ojota | CC | · Monitored renovation of Ogudu PHC.<br>· Organized fund raising event to raise funds to address some health and education issues.<br>· Mobilizes community members for NIDs and Local Immunization Days.<br>· Advocates regularly to the LGA Chairman on health and education Issues. |
| Kosofe | Agboyi-Ketu | CC | · Mobilizes community for NIDs and LIDs.<br>· Facilitated the renovation of Ketu and Agboyi Health Centres.<br>· Facilitated the renovation of Ajelogo Primary School.<br>· Facilitated the construction of a PHC in Ajegunle, a community in Ketu. |
| Lagos Island | City Hall CC covering Lafiaji and Epetedo North | CC | · Mobilizes community for Child Health Week, NIDs and measles Campaign.<br>· Distributed IEC/BCC materials on Exclusive Breastfeeding to community members. |
| Lagos Island | Sura | CC | · Stopped the conversion of PHC into retail shops.<br>· Mobilizes community for NIDs.<br>· Participated in the sale of long lasting ITNs to Clinic Mothers and community members. |
| Lagos Mainland | Iwaya PHC | CC/QIT | · Renovation of two COMPASS schools through CC's advocacy Efforts.<br>· Mobilization of community members to patronize FP and ANC services. There is now increased utilization of services.<br>· Health QIT mobilizes community during child health week and NIDs.<br>· Okada Riders who are members of the CC donated 20 radios to primary schools for the Interactive Radio Instruction programme.<br>· Monitors PTA Grants.<br>· CHPs and Health QIT organized orientation meeting to promote RH/FP and CS issues. Invited representatives of CHPs and CCs from 6 other LGAs.<br>· Production of letter headed paper for the CC by Vice Chairman of Education QIT.<br>· Continuous efforts to leverage resources and funds from community Members. |
| Lagos Mainland | Otto | CC | · Advocacy visit to LGA Chairman led to the release of a total sum of N4, 060, 000. 00 for renovation efforts in COMPASS schools in the Community.<br>· CC succeeded in stopping activities of hooligans at the PHC.<br>· CC has cleaned up the dirty environment of the PHC. |
| Ojo | Ojo | CC | · Monitored the renovation of the PHC and mobilizes community to patronize its services.<br>· Mobilizes the community for NIDs.<br>· Increasingly raising awareness on the benefits of Exclusive Breast feeding. |
| Ojo | Iba | CC | · Advocacy to the LGA Chairman led to the completion of a hitherto abandoned Okokomaiko Community Town Hall. The hall is used for health outreach services.<br>· Advocacy also secured a power generating set for Iba PHC; and 500 benches/desks for 10 primary schools.<br>· Mobilizes community for NIDs. |
| Shomolu | Akoka | CC | · Monitored the renovation of PHC by COMPASS.<br>· Mobilizes the community for NIDs and patronage of services at the PHC.<br>· Through advocacy, LGA has provided Ambulance for the PHC; and also;<br>· A 7.5 KVA power generating set.<br>· CC Chairman personally renovated a toilet in the PHC. |
| Surulere | Akerele | CC | · CC members participated in the sales of long lasting ITNs to clinic mothers.<br>· Mobilizes the community for immunization and child survival Programmes. |
| **BAUCHI STATE** | | | |
| Alkaleri | Maternity/Futuk | CC<br>QIT | - Mobilized community for ANC, FP and polio.<br>- Provide water to facility. |
| | Maternity/Gar | CC | - collect IR vaccines from LGA coldstore.<br>- Mobilize community during NIDs/IPDs.<br>- Dug well at facility.<br>- Participated in an LGA Forum. |
| | Model PHC/Yelwan Duguri | CC | - Mobilize community during NIDs/IPDs.<br>- Conduct awareness creation on FP, ANC and NIDs/IPDs.<br>- Participated in an LGA Forum. |
| | Community PHC/Bajama | CC/QIT<br><br><br><br><br>QIT | - Dug well at facility.<br>- Mobilize community for ANC, FP and NIDs/IPDs.<br>- Purchased hand gloves, plastic buckets and fueled generating set at the facility.<br>- Participated in an LGA Forum.<br>- Collect RI vaccines from LGA coldstore.<br>- Organized community in sanitizing the facility. |

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| Bauchi | Domiciliary Clinic/Yelwan Makaranta | CC<br><br><br><br><br><br>QIT | - Mobilized community during NIDs/IPDs.<br>- Sensitized religious leaders on FP, ANC and HIV/AIDS.<br>- Organized community effort in clearing facility of weeds, grasses and liters.<br>- Organized community during award ceremony to honour community members with good health practices which was attended by US Ambassador.<br>- Participated in an LGA Forum.<br>- Addressed issues on IPC and discipline of an erring service provider. |
| | PHC/Tashan Babiye | CC<br><br><br><br>QIT | - Mobilized community during NIDs/IPDs and on FP and ANC.<br>- Building of an Injection/Dressing room in the facility.<br>- Engaged in community dialogues during IPDs.<br>- Participated in an LGA Forum.<br>- Encouraged good IPC between clients and service providers. |
| | Maternity/Tirwun | CC<br><br>QIT | - Mobilized community during NIDs/IPDs on FP and ANC.<br>- Participated in an LGA Forum.<br>- Renovated convenience at the facility. |
| | Clinic/Durum | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Reroofed dispensary to serve maternity needs.<br>- Participated in an LGA Forum. |
| Giade | Maternity/Kurba | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Connected maternity to power source.<br>- Provided blinds to maternity.<br>- Construct toilet at the facility.<br>- Provided benches to the facility. |
| | Maternity/Faguji | CC<br><br><br><br><br><br>QIT | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Provided equipment and other materials to maternity such as beds, mattresses, pillows, BP apparatus and benches.<br>- Dug a well at the facility.<br>- Planted trees in the facility.<br>- A member of the QIT who is an Islamic scholar actively engaged in preaching for the acceptance of immunization, FP/CS and ANC and hospital delivery. |
| | Maternity/Isawa | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery. |
| | Town Maternity/Giade | CC<br><br>QIT | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Provided an iron gate to the facility.<br>- Provided benches. |
| Kirfi | Maternity/Badara | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Utilized LGA Forum in getting additional SP at the maternity.<br>- Participated in an LGA Forum. |
| | Maternity/Bara | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Utilized LGA Forum in getting additional SP at the maternity.<br>- Participated in an LGA Forum. |
| | Maternity/Sharifuri | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital deliVery.<br>- Utilized LGA Forum in getting additional SP at the maternity.<br>- Participated in an LGA Forum. |
| | PHC/Kirfi | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Mobilized community during NIDs/IPDs and on FP, ANC and hospital deliverY.<br>- Utilized LGA Forum in getting additional SP at the PHC, water reservoirs and repaired road leading to the PHC.<br>- Participated in an LGA Forum. |
| Misau | Maternity/Gwaram | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Participated in an LGA Forum. |
| | Health Clinic/Gainan Hausa | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Constructed a shade for women attending ANC.<br>- Participated in an LGA Forum. |
| | Maternity/Misau | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Advocated for generating set with the LGA and was provided to the Maternity.<br>- Participated in an LGA Forum. |
| | PHC/Hardawa | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Participated in an LGA ForuM. |
| Ningi | Maternity/ Balma | CC<br><br><br><br><br><br>QIT | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Provided benches and a power generating set to the maternity.<br>- Advocated with a senator who constructed a borehole with an accompanying power generating set at the facility.<br>- Participated in an LGA Forum.<br>- Utilized LGA Forum in getting additional SP at the maternity.<br>- Encouraged good IPC between SPs and clients.<br>- Provided water to facility prior to construction of the borehole.<br>- Engaged in cleaning the facility and surrounding. |
| | Maternity/Gadar Maiwa | CC<br><br><br><br>QIT | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Construct a well at facility.<br>- Refloored delivery room.<br>- Participated in an LGA Forum.<br>- Engaged in sanitation exercise at the facility and surrounding. |
| | Maternity/Agwarmaje | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Purchased IPT drugs.<br>- Dug a well at the facility.<br>- Involved two TBA members in assisting the only provider at the Maternity.<br>- Participated in an LGA Forum. |
| | Maternity/Kafin Lemo** | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Sponsoring/training identified children in the community to read disciplines in health to man their facility in the future.<br>- Participated in an LGA Forum. |
| | Maternity/Ningi | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Participated in an LGA Forum. |
| | Model PHC/Nasaru*** | CC | - Mobilized community during NIDs/IPDs and on FP.<br>- Provided support to facilitators during IPDs. |
| | Maternity/Masussuka | CC | - Actively involved in mobilizing community during NIDs/IPDs, ANC and delivery with trained providers.<br>- Renovated maternity structure and dug a well.<br>- Participated in an LGA Forum. |
| Tafawa Balewa | PHC/Lere | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Participated in an LGA Forum. |
| | Maternity/Bununu | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Advocated with a senator and leveraged money towards fencing of maternity and building of a toilet.<br>- Participated in an LGA Forum. |
| | Maternity/Dajin | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Participated in an LGA Forum. |
| | Maternity/Tafawa Balewa | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Participated in an LGA Forum. |
| Zaki | Maternity/Sakwa | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Mobilized RI vaccines to facility. |

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| | Maternity/Kafin Larabawa | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Mobilized RI vaccines to facility.<br>- Participated in an LGA Forum. |
| | Maternity/Gurka | CC | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Mobilized RI vaccines to facility.<br>- Participated in an LGA Forum. |
| **NASSARAWA STATE** | | | |
| 1.Keana | 1. Odudu Kwara CC | Central Pri. Sch./PHC Kwara | - The CC advocated for additional SPs. The Chairman tasked us to look out for SPs from anywhere to be employed. Luckily, we got Midwives from Nassarawa Eggon and had submitted their names to him for employment and it was done.<br>- Advocated for additional teachers; 3 have been posted already.<br>- Provide water to facility.<br>- Dug well at school facility.<br>- Visit to Kwara LGA school, by CC Kwara to ascertain educational radio programs. To interact with teachers and PTA.<br>- First Aid and water preservation in school mobilized community for ANC, FP RI, EBF and polio health.<br>- Talk on child nutrition and participate in PD Hearth. |
| | 2. Keana CC | Keana South Pri. Sch. | - Monitor IRI program.<br>- Mobilize community during NIDs/IPDs.<br>- Awakening of peoples' consciousness and philosophy of injecting into the people the power that have been neglected.<br>- Construct toilet at the facility.<br>- Attendance in schools now increased-school children banned from hawking during school hours.<br>- CC advocated to Chairman for change of school uniform in Obene which was considered unattractive and the councilor sponsored the Change.<br>- Have established four standing committees of four members each. The committees are: Advocacy, Mobilization, Finance and Monitoring & Evaluation. |
| | 3. Aloshi CC | Central Pri. Sch./PHC Aloshi | - Conduct awareness creation on FP, ANC ,RI and NIDs/IPDs.<br>- Sensitization of pregnant women on environmental sanitation & use of insecticide treated nets(ITNs Health talk on child nutrition).<br>- Monitoring of routine immunization/FP in health facility Environtal sensitization campaign. |
| | 4. Giza CC | Central Pri. Sch./PHC Giza | - Community mobilization by CCs led to increase in ANC attendance (Agaza in Keana for instance).<br>- Acceptance of CC by community members.<br>- Advocacy visits to LGA officials for support in health and education.<br>- Mobilize community for ANC, FP and NIDs/IPDs.<br>- Purchased hand gloves, plastic buckets and fueled generating set at the facility.<br>- Organized community in sanitizing the facility. |
| | 5. Kadarko CC<br><br>6. Agaza | RCM/PHC Kadarko Central Primary sch. Agaza<br><br>Central Primary/PHC Agaza | - Mobilized community during NIDs/IPDs.<br>- Sensitize community member on FP, ANC, RI and HIV/AIDS.<br>- Organized community effort in clearing facility of weeds, grasses and liters.<br>- Addressed issues on IPC and discipline of an erring service provider. |
| 2.Wamba | 7. Wamba CC | | - Mobilized community during NIDs/IPDs and ANC.<br>- Provision of school desk in R.C.M school .<br>- IPC between clients and service providers.<br>- Sensitization to TBAs and health promoters on maternal and child Survival. |
| | 8. Gbata CC | LGEA Pri. Sch./PHC Gbata | - Mobilized community during NIDs/IPDs on FP and ANC.<br>- Sensitization on exclusive Breast Feeding and mobilization on immunization to come out in mass. |
| | 9. Mangar CC | SDA Pri. Sch./PHC Mangar | - Mobilized community during Market day and on FP, ANC.<br>- Renovate a block of 3 classrooms to serve school needs.<br>- Building health facilities as a result of PDQ process and mobilization activities.<br>- Attendance in schools now increased – school children banned from farms during school hours. |
| | 10. Sisinbaki CC | LGEA Pri. Sch/PHC. Sisinbaki | - Mobilized community on RI ANC and hospital delivery.<br>- Connected maternity to power source.<br>- Provided blinds to maternity.<br>- Construct toilet at the facility.<br>- Provided benches to the facility. |
| | 11. Mararban–Gongon CC | LGEA Pri. Sch. PHC M/Gongon | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Provided equipment and other materials to maternity such as beds, mattresses, pillows, BP apparatus and benches.<br>- Dug a well at the facility.<br>- Planted trees in the facility. |
| | 12. Mama CC | LGEA Pri. Sch.PHC Mama | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital deliverY. |
| | 13. Karu CC | Central Pri. Sch/PHC. karu | - Mobilized community during NIDs/IPDs.<br>- Advocated for generating set with the member of community and was provided to the maternity.<br>- Advocacy visit to traditional rulers & religion.<br>- Attendance in schools now increased.<br>- CC advocated to Chairman wife for seat in health & school which was considered to be a problem and she sponsored.<br>- Provided an iron gate to the facility.<br>- Provided benches.<br>- Paid advocacy visit to LGA chairman for the fencing of the Karu PHC.<br>- Paid advocacy visit to world Bank Project Manager for the sinking of borehole at the premises of Karu PHC.<br>- Have participated in the mobilization exercise on the importance of RI, ORT, EBF and ITN use.<br>- Participated very actively in the dissemination of information for the meeting on IMCI (Integrated Management of Childhood Illnesses) organized by the PHC Department of Karu LGA.<br>- Liaised with Chief of Karu and his ward leaders to mobilize his Subjects.<br>- CC members help in the loading and offloading of equipment transported to designated health facilities.<br>- CC is liaising with health department to see the World Bank. |
| 3 Karu | 14. Kabusu | LGEA Pri. Sch./PHC Kabusu | - Mobilized community during NIDs/IPDs and on FP.<br>- Utilized LGA FT getting additional teachers at the school.<br>- Advocacy visit to the chairman of Karu LGC and the DPHC department Karu LGA Sensitization/orientation meeting on RI, EBF, ORT/SSS and ITN use.<br>- More seats were made by the CC/QIT for health center. |
| | 15. Luvu Madaki CC | LGEA Pri. Sch./ L/madaki | - Mobilized community during NIDs/IPDs.<br>- Pregnant women attended ANC Sensitization/orientation meeting on RI, EBF, ORT/SSS and ITN use.<br>- Molding local blocks to build 1 block of 2 classrooms.<br>- Team spirit of members.<br>- Leveraged 20 bags of cement, sand and gravel from Julius Berger construction company to build more classrooms for the primary/secondary school. |

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| | 16. Kodape CC | LGEA Sch./PHC Kodape | - Mobilized community during NIDs/IPDs.<br>- Have closely monitored the renovation of Awwaliyya Islamiyya School Mararaba Gurku.<br>- QIT education did a minor fund raising through letters in collaboration with CC and also embark on intensive follow–up before something was realized. |
| | 17. Masaka CC | Pilot Pri. Sch./PHC Masaka | - Mobilized community during NIDs/IPDs.<br>- Advocacy in getting additional SP at the PHC, water reservoirs and repaired road leading to the PHC. |
| | 18. Uke CC | Central Pri. Sch./PHC Uke | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Constructed a shade for women attending ANC. |
| 3. Kokona | 19. Dari CC | | - Mobilized community during NIDs/I ANC.<br>- Advocated for generating set with the LGA and was provided to the maternity Meeting of CCs, and CC&QITs, advocacy visit to traditional rulers & religion.<br>- Sensitization on Girl Child enrolment.<br>- Attendance in schools now increased children banned from going to city for Job.<br>- The CC takes inventory of parents whose wards are not going to school and sensitize them on the need for the children to be educated.<br>- We were also able to advocate for additional 2 teachers. |
| | 20. Garaku CC | LGEA Pri .Sch./PHC 1 Garaku | - Mobilized community during NIDs/IPDs.<br>- Global 2000 iniative funded by Jimmy Carter Foundation donated cement to the community for the construction of over 100 toilets.<br>- More seats were made by the CC/QIT for health centre.<br>- The CC/QIT has sensitized the community to know that the PHC is for them and also raised awareness on various health issues: EBF, RI, FP,ANC during church service.<br>- There is increased patronage in ANC, delivery and immunization services |
| | 21. Marke | LGEA Sch./PHC Marke | - Mobilized community during NIDs/IPDs ,RI, EBF , ANC and hospital delivery.<br>- Provided benches and a power generating set to the maternity.<br>- Advocated with a senator who constructed a borehole with an accompanying power generating set at the facility.<br>- Utilized advocacy in getting additional SP at the school.<br>- Encouraged good IPC between SPs and clients.<br>- Provided water to facility prior to construction of the borehole.<br>- Engaged in cleaning the facility and surrounding. |
| | 22.Tatara CC | LGEA Sch./PHC .Tatatara. | - Mobilized community during NIDs/IPDS.<br>- Construct a well at facility.<br>- Refloored delivery room.<br>- Engaged in sanitation exercise at the facility and surrounding. |
| | 23. Gurku Toni | LGEA Sch./PHC Gurku Toni | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Purchased IPT drugs.<br>- Dug a well at the facility.<br>- Involved two TBA members in assisting the only provider at the Maternity. |
| | 24. Bokoko CC | LGEA Sch./PHC Bokoko | - Mobilized community during NIDs/IPDs EBF,, ANC and students Enrolment.<br>- Sponsoring/training identified children in the community to read disciplines in health to man their facility in the future.<br>- Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery.<br>- Mobilized community during NIDs/IPDs and on FP.<br>- Provided support to facilitators during IPDs. |
| 4. Akwanga | 25. Gudi CC | CMS Pri. Sch./PHC Gudi | - Actively involved in mobilizing community during NIDs/IPDs, ANC and delivery with trained providers.<br>- Monitor the school & health facility renovated after PDQ process.<br>- Attendance in schools now increased – school children banned from hawking during school hours. |
| | 26. Ungwan – Zaria CC | RCM U sch./PHC U.- Zaria | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery. |
| | 27. Kurmin – Tagwaye CC | RCM K/Tagwaye and Akwanga Islammiya K/Tagwaye | - Mobilized community during NIDS/IPDs.<br>- People were mobilized to take action on their own.<br>- Crisis resolved (socio-political tussles in Kurumi Tagwaye) – with PDQ process, they were able to resolve their differences and started meeting together of which a health facility was built.<br>- Molding local blocks to build heath facility.<br>- Team spirit of members (health and education).<br>- Building health facilities with their efforts and which made mobilization activities realizable. |
| | 28. Andaha CC | Andaha South & Andaha North Pri. Schs. | - Mobilized community on hospital delivery. |
| | 29. Nunku CC | LGEA Pri. Sch/PHC. Nunku | - Mobilized community during NIDs/IPDs and on FP, ANC and hospital delivery. |
| | 30. Akwanga CC | Central Pri. Sch PHC. Akw. | - Mobilized community during ANC.<br>- Mobilized RI vaccines to facility. |