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REPORT OF EVALUATION OF REGIONAL PUBLIC HEALTH TRAINING PROJECT (625-11-540-510) CENTRAL WEST AFRICA

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by
Walter Furst
Dr Robert Dyer
Donald Conwell

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Introduction

The evaluation of the Regional Public Health Training Project (625-11-540-510) was requested by the Regional A.I.D. Director in Yaounde. It was his feeling that the project was terminated; as soon as an evaluation was completed the record could be closed.

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Project Evaluation

It has been a difficult project to evaluate for a number of reasons. The design of the project leaves much to be desired; the objectives are still subject to debate and disagreement. The operation of the project has been characterized by divided responsibilities, poor supervision, inadequate documentation, and field staff of questionable competence. With one exception, individuals who participated in the project have not been available to interview. Key individuals in A.I.D./Washington were not in town; the Director of OCEAC and his deputy were away on vacation; the WHO representative in Chad was on vacation; the health education staff at CUSS (Yaounde) were either ill or on vacation. Documentation has been scattered. Preparatory briefing in Washington, D.C. was fragmented and disorganized.

Project History

The project was originated in the late 1960s apparently to fill a political need, i.e., to demonstrate a token American support for these African countries. The initial purposes of the 1969 version of the project were much too comprehensive and ill-defined; they were sharply restricted

by the 1973 evaluation to "introducing public health by means of health education concepts into health training programs at OCEAC headquarters, and into the health services in three demonstration zones", Bimbo (CAR), Farcha (Chad) and M'fou (Cameroon).

Without strong supervision and centralized responsibility at the beginning of field operations in 1971, the project took different courses in the three countries concerned. In Cameroon the emphasis was on community organization to define and solve health problems, and on training of mid- and lower level health personnel at OCEAC. In both Chad and CAR where WHO had organized demonstration rural health programs, the project became the health education component of the larger health center program for provision of health services. The emphasis in these two countries was on health education of a population, health center staff indoctrination in health education, and training and refresher training of health workers, with integration of health education principles and concepts in their training. That the subject context of health education was sanitation, rather than nutrition, infant health, communicable disease control, etc., was probably a matter of happenstance, for a sanitarian was originally recruited to work in Chad and influenced the nature of the program there. Chad and CAR were also involved, to a lesser extent than in Cameroon, in community organization. In OCEAC headquarters, Chad and CAR, there were efforts to develop some health education materials suitable for use with indigenous populations. Seven health educators, two each from Cameroon, Chad and CAR and one from Gabon, were sent to the School of Tropical Medicine in Antwerp for a year of didactic training.

Project Accomplishments

In the three countries approximately 75 health committees were organized in rural villages. Probably less than half of these remain active. The principal activity of the committees was a program of improving springs and wells and building latrines. Records available indicate a total of 40 wells and 374 latrines were built in the three countries. These health committees were organized without relationship to other developmental activities, and in none of the countries were any plans proposed for their continuing support and supervision on termination of the project. Evaluation of their effectiveness is limited because of the lack of baseline data, the operation in the same communities of other factors affecting health status, and the inferior quality of special surveys to determine health status (Cameroon and CAR).

A substantial number of nurses, dispensary attendants, itinerant health workers and other low- and mid-level health workers were provided special refresher training in health education. Likewise many students in the same categories from national training schools supposedly were exposed to field training in health education. It is difficult to evaluate the effectiveness of this training for course curricula were generally not available, the duration of training, the quality of instruction and field supervision were not known, and in many instances logistic problems prevented carrying out the intended programs. Many trainees never got to the field.

Demonstration health center staff education programs were initiated in Chad with apparent continuity, and in CAR only to be discontinued.

In the two demonstration centers in Chad and CAR, extensive efforts at patient education were undertaken. The effectiveness of these activities is dubious, for the quantity and quality of education effort could not be determined, attempts at teaching sick patients are not apt to be successful, especially if the educational effort is not related to their illness. Training aids were frequently in French, requiring verbal translation to tribal language. Much of this training appeared to be lectures, rather than demonstrations. Probably the most effective efforts were in prenatal and well-baby clinics. This form of training appeared to lack focus on the major health concerns, and that carried on in village situations was not associated with the delivery of any personal health service.

Of the several manuals developed at OCEAC, only two have been published. "Education pour la Sante appliquee aux Communautes Rurales" has been printed and wide distribution is intended. Of the several mimeographed manuals and those in manuscript, "Health Education for School Teachers", prepared by a Peace Corps volunteer, appears the best. Those on preparation and testing of health education materials are not well designed or rigorous. Locally prepared health education materials (posters, flip charts, slides, flannelograms) appear of limited usage, and nowhere did we find material that was convenient, practical and suitable to conversion for village use by village health workers. The production of health education materials aspect of the project, although carried on at a great expenditure of time, effort and money, appears to have produced very little of lasting value.

Of the seven health educators trained in Antwerp and destined to be counterparts for U.S. health educators working on the project, we had an opportunity to interview four. One from Gabon and one from CAR assigned to the Ministry of Planning and Statistics and the unassigned trainee from Cameroon were not available. There were varying degrees of satisfaction in their didactic training at Antwerp from useful to not practical.

Of the six trained health educators in Cameroon, Chad and CAR, one is as yet unassigned, one is working as an administrator in a clinic, one in a Ministry other than health, and three (one in each country) are in health education-related activities. The one in Cameroon has the greatest potential for usefulness from his position in the Ministry of Health; the one in Chad has managed to maintain and operate a health education program in Farcha without good supervision and administrative support. The one in CAR is of dubious usefulness, for most of his time is spent other than at Bimbo, and his work there is limited in amount and quality, and he seldom gets to the villages. He was described by several sources as a poor teacher.

Criteria for the original selection of these trainees were not known (and probably were never established) and there appeared to be no contractual obligation on their part to return to the health field, or on the part of the sponsoring government to employ them in health education-related situations. No systematic evaluation of their didactic training was undertaken and their performance since returning has not been reviewed and evaluated.

Evaluation of project-supported technicians working on the project at its termination is inconclusive for only one was available for interview, and that was for a limited time and contrary to his wishes.

Both technicians who were working during the last year of the project were either not aware of, or chose to ignore, the recommendations made by the 1973 evaluation teams. The one in CAR frankly quoted the project purpose of the 1971 PROP as her directive. Both were involved in too many diverse activities without hope of accomplishing the work proposed, both appeared to be working in an operational capacity, rather than as consultants, and the operations although related to national government health services are not really a part of them, according to Ministry of Health officials in both CAR and Cameroon. They worked without benefit of professional consultation or close supervision. Neither technician prepared a plan for continuation of project activities by the host government at the termination of the project, nor participated with the host government in a joint evaluation, as specified by the job description and duty statements in their contracts with A.I.D. Neither technician appeared fully capable of discharging the responsibilities assigned to them. The technician in CAR was reported to have personality conflicts with indigenous workers, worked independently of them on her own program, which was terminated by time constraints rather than accomplishment.

End of Project Status

Project end products are practically impossible to measure quantitatively and their effectiveness is at best a subjective estimate.

OCEAC's participation in the project from the beginning has been a matter of convenience, a fiction designed to meet A.I.D.'s requirements for a regional project. Aside from some personal interest on the part of the Director, some participation in trainee programs, their contribution has been minimal. There is no increased capacity to provide leadership in and support for health education training (no specially trained health educator remains on the staff), there are no plans or resources for the continuation of the two international conferences on health education which have been held; no resources for development and management of the 1000-volume library which has been developed, or for the translation, circulation and distribution of library and health education materials. The lasting effects of the project in OCEAC are negligible.

Perhaps one of the most successful, although very intangible aspects of the project, has been the introduction of health education concepts to both the top policy and management level of Ministries of Health and to operational-level health workers in health centers and dispensaries. They are aware of health education as an important methodology in health services, but whether the means of integrating health education into all aspects of health service programs are known or understood is another matter. Whether or not health education activities will continue as a part of health services, especially in the face of pressures for clinical services, and the lack of Ministry of Health participation in project development and execution, is uncertain and can only be

measured at some more distant time. The fact that a health education component in the Farcha demonstration zone program has been maintained in the face of great obstacles (lack of administrative support, lack of material resources, absence of supervision and professional consultation) is an encouraging sign.

A substantial number of lower- and mid-level health workers have received additional training in their professional fields, with some health education components included in that training. The success of this effort cannot be measured, for we lack pre- and post-training evaluations; little information on the quality of instruction, content of training programs, the extent of field training is known. There was no opportunity to observe the performance of these individuals in their working environments.

Only in Chad is a project-trained health educator carrying on effective demonstration zone activities as a result of the project, and in none of the countries is there any indication that these activities (integration of health education into all aspects of health services) are conducted beyond the demonstration zones. In Cameroon, the Ministry of Health is requesting support for a new project to extend the community organization aspect and practical training of health educators to other areas.

No summarization of training methods and techniques by OCEAC was prepared, for dissemination to member countries, and there is no evidence that any of the training materials, other than several manuals, have been distributed (and these by A.I.D., Yaounde).

The community health committee movement has been started in each of the three countries, particular Cameroon. The absence of plans and resources for their continuing support and supervision is a matter of serious concern. The failure to associate them with other aspects of rural community development is faulted by Ministry of Health officials in Cameroon and CAR. The capabilities of these committees to improve health facilities (wells and latrines) has been demonstrated in villages, but their ability to maintain them, and to assume responsibility for the development of other health services is yet to be tested.

There are no significant perceptible changes in health information, behavior or health status in test populations of the demonstration zones. Some observers have felt there is an improvement in health practices in a number of villages, but we found no objective evidence, and improvement in health status is not measurable in the absence of good baseline data, adequate special surveys and agreed-upon indices of health status.

There are no plans or resources for the continuation of the two international conferences on health education held under OCEAC auspices. The conferences were obviously enthusiastically received, but were criticized for the lack of participant involvement in their planning.

In summary, the greatest values of this project lie in its introduction of the health education concept to health workers in three countries, the training of a small group of national counterparts, and most of all in the negative lesson from the conception, development, operation and evaluation of this project.

The Project in Retrospect

In looking at the project retrospectively there are at least three areas where mistakes were made,--situations which should be examined for the lessons that might be learned from them. The first of these is in the concept of health education, the second the relationship and understandings with the host government, and finally the project itself--its design, objectives, resources, operation and evaluation. All three of these areas are closely related, overlapping in some details and requiring careful consideration of their interrelationships.

Concepts of Health Education and the Health Educator

From the public health administrator's point of view health education is not an end in itself, but a means for attaining a goal,--a change in understanding, attitudes or behavior which produces a positive action. This appears to have been recognized in the design of the project, but not in the execution.

The health educator is supposedly taught how to teach and train, and how to develop and use the tools for these purposes, to understand human behavior and the learning processes, leadership identification and training, group dynamics, and community organization. Their knowledge of subject areas of public health and preventive medicine is secondary, and they frequently need to resort to technical consultants for such information. Few are equipped to make special surveys and collect data with rigorous precision, or to evaluate and interpret such data.

Several flaws emerge in the conceptualization and operation of this project. The first is that the health educator is a "jack of all trades", sufficient unto himself. Except in the early stages of the Chadian project, the health educators were without professional subject matter consultation.

No limited target populations were selected, little specific information was made available to selected high priority groups. The shotgun approach of trying to instruct everyone in all aspects of health, without follow-up and re-stimulation appears to characterize patient education in Chad and C.A.R.

Too frequently the role of the health educators on the project appeared to be that of giving particular subject matter, rather than instruction in how to teach and train. They lost sight of their role as teacher and consultant in health education, assuming operational responsibility,--probably because the nature of their role was not initially emphasized sufficiently, because of the lack of supervision, and an absence of host country counterparts at times made it necessary to assume operational responsibilities,--which weren't carefully focused.

The other matter of concern is the failure to associate and relate health education to the giving of a personal health service, though frequently patients appeared to be "talked at" without consideration of their needs and interests. In village situations health education appeared to be an end unto itself, and not associated with service.

A common gimmick in advertising is the "give-away". Clinic records in Chad showed the very sharp peaks in clinic attendance occurred on days when small bars of soap and baby food supplements were distributed. Here, also, the most consistent clinic attendance was in the well child and prenatal clinics where a desired perinatal service was delivered, and the educational effort directed to the immediate interests of the mother.

In the field of community organization, wells and latrines were built when cement was provided for covering them. Village health committees

died of attribution, when motivation was not stimulated and incentive to work was lacking, illustrating again the need to provide an associated service.

In summary, in projects where health education is concerned as a way to improve health services, the role of the health educator must be more clearly defined than in this case, the means by which he discharges the role carefully defined (with careful distinction between consultant and teacher on the one hand, and operator on the other), and his activities associated with a desired personal health service in the community. Careful focus on specific high priority subgroups of the population is to be preferred to "shot-gun" community education. For this reason, a specific segment of preventive medicine (sanitation, infant health, nutrition, communicable disease control, etc.) would appear to be a better goal than "improving health services" in general. In all three countries, target populations were selected for professional education,--teachers, nurses, etc., but in every instance the range of activities was too great for the time and capacity of the staff. As a result admirable plans which were developed were never executed, periodic evaluation was lacking, breakdown in availability of resources not reported. Much of this results from lack of supervision and failure to involve the host governments.

Relationships to the Host Government

In the discussion of the project with representatives of the Ministries of Health, particularly in C.A.R. and Cameroon, one is impressed with the astuteness of their observations and the frankness and objectivity of their comments. In most instances the spokesmen are highly competent,

well trained and capable individuals, whose opinions are worthy of serious consideration.

In both Cameroon and C.A.R., the project was regarded as an A.I.D. activity superimposed on their health services with the tacit approval of the Government. They had little or no part in its planning and development, and felt it unrelated to national heatlh plans and priorities. They had not been deeply involved either in planning or operation, and felt little responsibility for failure to meet national commitments of personnel and materiel. They recognized the inadequacies of a data base for use in evaluating project accomplishments, and admitted they were unprepared to assume responsibility for those aspects of the project which were regarded as worthwhile.

I believe our observations confirmed the majority of the allegations as essentially correct. But even if only one or two are assumed legitimate, they represent serious oversights in project negotiations and relationships with the host country. It is not the purpose of this discussion to point the blame for these omissions (they are probably shared by all parties concerned for project responsibilities were initially so divided that no one party was fully accountable), but rather to try to identify the reasons for them.

Certainly the initial technical negotiations on a health project are correctly conducted with representatives of the Ministry of Health. But the Minister of Health does not have the responsibility for integrating them with other aspects of rural development (economic, transportation, communication, education, agriculture, etc.) which the governments seem to desire, and does not have authority for binding financial commitments.

My knowledge of the workings of foreign ministries is admittedly fragmentary, but it is respectfully suggested that once the division of responsibilities and obligations of the host country, the donor agency and any other parties involved are clearly and completely determined, then that agency of the host country, be it the Ministry of Planning, or Finance or Foreign Affairs, which has authority to commit the national government be asked to approve the agreement and accept the commitments of the host country.

Whether the motivation of the United States in providing project assistance is political, humanitarian or something else, there are several aspects of inter-country negotiation which merit special attention. In the desire to obtain administrative approval of the proposal, the resources of the host country are overestimated and overstated. (In the case of this project, the entire budget of O.C.E.A.C. was listed as a contribution to the project.) It is unrealistic to believe that a health delivery system, already badly lacking in structure below the ministerial level, without mid-level administrative skills to utilize existing resources, and heavily overburdened with the provision of crisis-type medical care,--it is unrealistic to assume such a system can take on additional preventive health programs without supplementation of their existing resources, both personnel and materiel.

It is probably oversimplification to state that A.I.D. has two alternatives for project support. It can go into a country where invited, conduct a demonstration project in toto (providing everything but the consumer) for a predetermined period of time, and then depart with a "see what we did"--a useful service serving political and humanitarian goals for a given time period, which may have helped to tide the host government over a period of crisis. There are no expectations of host government involvement or eventual

assumption of the successful aspects of the project. At best it provided a service and perhaps served as an educational experience for both host and A.I.D.

The other alternative is a cooperative project, within the realistic capacities and resources of the host, supplemented by such skills and materiel from A.I.D. that there is hope of the host eventually being able to provide. A.I.D. supplements host resources for a limited time and to a limited extent with planned take-over built into the project from the start. A.I.D. provides expert consultation and training, and the host country operates the project. This approach involves a greater sense of host country participation from the beginning, and the risk of failure if the host is unable to live up to their commitments, or A.I.D. fails in the provision of the supplemental services and technical assistance and materiel required.

In the case of this second alternative it is unrealistic to expect the host country to take-over the project "lock, stock and barrel" at the end of the designated time period. It is much more realistic to plan (from the project's conception) for a gradually phased transfer of responsibility, so the host country is not hit at the termination of the project with a total responsibility which it cannot hope to assume. This is particularly true of materiel and financial support. For example, there is agreement from the start that A.I.D. will supply 100 percent of the required resources in the first project year, eighty percent in the second year <u>after</u> the host country has expended their twenty percent support, sixty-forty sharing in the third year, forty-sixty in the fourth, and twenty-eighty in the final year. This involves a commitment and sharing from

the beginning of the project which requires country contribution before A.I.D. assists and prepares for eventual complete take-over of the successful aspects of the project. Such a plan, of course, is a possibility only where there are national resources to participate, and would not work in a country like Chad, where the first alternative is the only choice.

Many of the failures in the project under review here could have been obviated by a national acceptance and commitment beyond the Ministry of Health, involving the agencies authorized to make planning and financial commitments. A more careful delineation of the responsibilities of the parties concerned, mutual agreement on responsibility for closer supervision and periodic joint evaluation will assure a project administration in which the deficiencies are noted in time, and not permitted to continue to the extent that they jeopardize the goals. Finally, I have seen little evidence on the part of A.I.D. to terminate a project when necessary.

The criteria for evaluation of this project have not been realistic, in light of the lack of a reliable national data base. Morbidity, mortality, natality and population statistics are practically non-existent, and those that do exist are subject to question by reason of the way they are collected, reliability of diagnosis, completeness of reporting and accuracy of tabulation and analysis. Service statistics are probably equally unreliable except in a few selected instances, which are not representative of the country.

If sophisticated standards of evaluation are to be applied, special provisions must be built into the project for the mechanisms for collection, tabulation and analysis of the required data. Such data collection and analysis are not a responsibility commensurate with the usual levels of skill of project technicians such as employed on this project,--as they amply

demonstrated! One possible suggestion is the involvement of a competent health statistician, with research design experience, in the design and review of the project proposal.

Another factor which complicates successful evaluation is the wide range of variables operating in demonstration areas. There seems to be a tendency on the part of host governments to select demonstration areas which are atypical of national circumstances (i.e., suburban rather than rural, comparatively overstaffed, etc.), inclined to suit the conveniences of staff, transportation and communication, and where multiple demonstrations are going on. In the current project, none of the demonstration zones were truly rural, and in the M'fou area of Cameroon, the medical school, CUSS, had extensive health services and teaching programs in operation.

Although evaluation is a major component of project design, the elements involved are such that their consideration should be a part of the inter-country discussions and agreements.

Finally, although there were extensive commitments to academic training in the present project, there appear to be no written inter-country agreements on the subject, no criteria for selection of trainees, no statement of country obligation to employ the trainee in an appropriate capacity on completion of training, and no statement of the trainee's obligation to return and serve for a specified time in the country from which he came. This is still another area where inter-country agreements should be documented during project negotiations.

Project Design and Implementation

The third area in which the present project should be carefully examined for the negative lessons it illustrates is project design and operation.

So much has been written and said about the objectives of this project that further discussion is redundant. Initially, the objectives were too broad; after revision they were still subject to different interpretation. Suffice it to say, the simpler the objective the easier it will be to reach a mutual agreement on meaning. The temptation to include multiple objectives to make the project more appealing is to be avoided, for it increases the opportunities for misunderstanding, increases the resources required, diffuses operational efforts and complicates evaluation.

Demonstration projects tend to become idealistic, rather than realistic, ignoring the resources of the country and from the start are not suitable for replication. In both Chad and C.A.R., the Farcha and Bimbo experiments were so atypical, so expensive and so overstaffed that they could never provide a model for delivery of health services elsewhere. Granted they provided a better than average quality of care for the communities they served, they were not realistic as training centers or as models of a system to be replicated.

These two demonstrations, as previously noted, point to the need for a more realistic assessment of the circumstances under which care is to be provided, and of the resources available, or potentially available from the host country. The tendency has been to expect too much; when it

is not forthcoming, the objectives of the project are not satisfied. In the present project, the inability to keep vehicles operational and the failure to provide fuel for them prevented visits to outlying villages for support of village health committees, did not provide for supervision and teaching of recently trained village health workers, and field training never materialized, for trainees could not be transported to the training sites.

Overestimation of the host's and third party's contributions, and underestimation of the nature and extent of resources required have also characterized this project. The lack of provision of a means of keeping vehicles operational, the absence of paper for duplicating machines, ribbon for typewriters, simple materials for demonstrations are all examples of the minutia that affected the quality of training.

Previous mention has been made of two other significant deficiencies in design,--the failure to recognize the inadequacies of the available data base for the project, and the impractical nature of some of the criteria for evaluation.

Although not a part of project design per se, site selection plays an important factor in determining the success of the project, and the replicability of demonstrations. Convenience to urban areas negates the concepts of rurality, and the practice of multiple projects in the same area introduces variables which complicate evaluation.

In the face of the complicated project review system which A.I.D. employs, the suggestion of still another review is open to question. But nowhere in the review process is the project subject to review by an independent group of qualified professionals. Use of the N.I.H. Study Section

mechanism could well provide a form of criticism presently lacking. For instance, a health education project could be subjected to study and criticism by a small group, all familiar with the international scene, of a public health M.D. administrator, a public health statistician, a cultural anthropologist, several health educators and an administrative officer familiar with management record keeping, accounting, purchasing, etc. A.P.H.A. might try this practice on an experimental basis to see if it proves worthwhile before suggesting it on a larger scale. Whatever the cure may be, there is no question of some inadequacies in the present review system. I have suggested that perhaps economists are not the professionals to be concerned with human resource development!

Project Operation

Deficiencies in the operation of this project were discussed in detail in the 1973 evaluation. Many persist and others have been added.

A few simply listed are personnel inadequate for the job requirements; little or no supervision resulting in too much attempted, little accomplished; failure to involve indigenous personnel in project operation; absence of joint host--A.I.D. evaluation and reporting periodically; absence of periodic professional consultation for field technicians; inadequate record keeping and documentation; and failure to make provisions during the last year of the project for continuation of the successful aspects by the host country upon completion of the project.

Summary

This evaluation has been difficult, and neither satisfying or satisfactory, for many reasons previously noted. Among them are the

concept and design of the project itself; inadequate data and poor documentation; failure to observe some of the 1973 recommendations for closer supervision, limitations of scope of work and improved administrative practices; impossible criteria for evaluation; inability to interview key participants and observers of the project.

The timing of the evaluation was unfortunate; the composition of the evaluation team can be faulted for failure to include an internationally experienced health educator. And finally, evaluations are frustrating, for there is no apparent mechanism for feedback of the action taken on the evaluation report, both from A.I.D. to the contractor (A.P.H.A.), and from the contractor to the consultant. One appears to be working in a vacuum.

That this project has been almost a total failure is apparent from the reaction of the host countries, the failure to provide any form of continuing activity (other than a new project proposal from Cameroon), the absence of documentation of methods and practices which might be applicable elsewhere, the lack of identifiable impact of training; the absence of any significant change in O.C.E.A.C.'s training leadership; the failure to provide for continuing international health education conferences; and little evidence that health education has made any impact beyond the demonstration zones. On the positive side a health education component has been continued in the health services at Farcha, in Chad; at least three of the health educators trained at Antwerp are working appropriately in their home countries, and the concept of village health committees has been applied, although it is too early to evaluate their effectiveness.

Probably the greatest value of this project lies in the lessons learned from the negative aspects. Whatever the reason for future health projects,--whether political, humanitarian or otherwise, there is a need for a higher standard of concept and design, operation, and evaluation than is apparent in this activity.