



TITLE: MATERNAL CHILD HEALTH EXTENSION:  
PHASE II, PROJECT NUMBER 932-11-580-358

PART I. SUMMARY AND RECOMMENDATIONS

PROJECT DEVELOPMENT TEAM

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Timothy Bork	: Lawyer, AFR/GC
James Franks	: Campus Project Director, UCSC

1. Grantee:

The Governments of Benin, The Gambia and Lesotho.

2. Grant:

A. Total project costs in Benin, The Gambia and Lesotho.

The total cost of both Phase I (FY 71-75) and Phase II (FY 76-79) of the Maternal Child Health Extension project will be approximately \$6.03 million. Funds obligated during Phase I of the project were \$3.664 million, all of which was provided by AID under Title X. Excluding purchase of contraceptives, Phase II funding will be approximately 75% (\$1,370,000) from Africa Bureau and 25% (\$800,000) from Title X. Table I, Page 3 indicates the projected expenditure schedule for Phase II of this project.

B. Amount of AID Assistance.

In late FY 1971 obligated \$1.414 million for the initial two-year funding to this contractor (University of California at Santa Cruz (UCSC) under the original project.<sup>1/</sup> This was followed by an additional \$1.548 million.<sup>2/</sup> to carry Phase I activities through FY 1975.

With this revised PP,\$2,126 million will be required to support Phase II of this project from FY 1976 through FY 1978: an additional \$0.245 million will be for the purchase of contraceptives with Title X funds.

<sup>1/</sup> Another contractor, Organization for Rehabilitation through Training (ORT), operated under the original project in Niger, expending \$744,000 during Phase I. The agreement with ORT has been terminated and all future activities will be limited to UCSC.

<sup>2/</sup> An additional \$34,000 for contraceptives was funded through AID central procurement.

UCSC PHASE I (\$s Millions)

PHASE II (\$s Millions)

	FY 71	FY 72	FY 73	FY 74	FY 75	FY 76 <sup>4/</sup>	FY 76	IO	FY 77	FY 78
Obligation	1.414	-0-	685	-0-	863 <sup>2/</sup>	235.0	469.0	-0-	911.0	747.0
Expenditures	-0-	448	558	753	991 <sup>2/</sup>	235.0				

C. Host Country Contribution.

During Phase I of this project each of the three participating countries contributed approximately 25% of the total project costs as follows:

Total Contribution Translated into \$s  
FY 71-75

Gambia	\$318,800
Benin	227,000
Lesotho	<u>350,000</u>
Total	\$895,800

<sup>3/</sup> Ibid.

<sup>4/</sup> \$.235 Title X funds added in FY 76 to original PROP to carry contract to June 30, 1976.

EXPENDITURE BUDGET SUMMARY

January 1, 1976 - December 31, 1978

U. S. Inputs (\$000)

ITEM		CY 76	CY 77	CY 78	TOTAL
1.	Personnel				
a.	UCSC Personnel				
	Gambia	88.4	75.2	60.1	223.7
	Benin	87.8	76.0	60.9	224.7
	Lesotho	50.0	0	0	50.0
	Home Office	88.4	118.6	124.0	331.0
	Total	314.6	269.8	245.0	829.4
b.	Local Personnel				
	Gambia	.5	.5	.5	1.5
	Benin	4.6	4.8	5.1	14.5
	Lesotho	4.5	0	0	4.5
	Total	9.6	5.3	5.6	20.5
2.	Consultants				
	Gambia	22.5	22.5	22.5	67.5
	Benin	22.5	22.5	22.5	67.5
	Lesotho	24.4	0	0	24.4
	Home Office	11.3	11.3	11.3	33.9
	Total	80.7	56.3	56.3	193.3
3.	Participant Training				
	Gambia	30.0	10.0	10.0	50.0
	Benin	40.0	10.0	10.0	60.0
	Lesotho	9.8	0	0	9.8
	Total	79.8	20.0	20.0	119.8
4.	a. Commodities				
	Gambia	50.4	24.0	42.5	116.9
	Benin	37.5	29.8	29.8	97.1
	Lesotho	15.6	0	0	15.6
	Home Office	7.5	5.5	3.5	16.5
	Total	111.0	59.3	75.8	246.1
	b. Contraceptives				
	Gambia				
	*Oral & Condoms	(30.0)	(30.0)	(30.0)	(90.0)
	Other	5.0	5.0	5.0	15.0
	Benin				
	*Oral & Condoms	(30.0)	(30.0)	(30.0)	(90.0)
	Other	5.0	5.0	5.0	15.0
	Lesotho				
	*Oral & Condoms	(30.0)	0	0	(30.0)
	Other	5.0	0	0	5.0
	TOTAL ORAL & CONDOMS	(90.0)	(60.0)	(60.0)	(210)
	OTHER	15.0	10.0	10.0	35.0

\*Funded through AID central procurement.

		CY 76	CY 77	CY 78	TOTAL
5. Other Costs					
(Includes travel,	Gambia	87.5	67.8	63.3	218.6
transportation,	Benin	66.7	64.1	61.9	192.7
office support,	Lesotho	61.4	0	0	61.4
overhead, and	Home Office	81.9	78.2	73.2	233.3
administrative rate)		<u>297.5</u>	<u>210.1</u>	<u>198.4</u>	<u>706.0</u>
	CY GRAND TOTAL	908.2	630.8	611.1	2,150.1
	plus 10% inflation		63.1	61.1	124.2
	Less Carry Over (Dec.31)	148.0	(56.2)	(0.1)	148.0
	New Funds Required,	760.2	750.1	672.3	2,126.3**
	CP Programmed Amount (FY)	704.0	750		
	Amount to be funded				
	next FY	56.2	0.1		

\*\*This line does not add because of the carryover figures. CP Programmed amount plus CY 78 expenditures adds to total new funds required.

HOST COUNTRY INPUTS \*

1. Personnel Counterparts Drivers Secretaries				
2. In-Country Transportation Service, maintenance, repairs, insurance, petrol				
3. Supplies and Equipment				
4. Participant Training Replacement costs (In and Out-of-country training) Subsistence allowance, training facilities and housing (In-country training)	304.5	200.0	225.0	729.5
5. Housing Maintenance and utilities for one Project Technician (The Gambia)				
6. Operation costs of Training Center (Lesotho)				
Gambia	93.8	100.0	125.0	318.8
Benin	88.2	100.0	100.0	288.2
Lesotho	122.5	-0-	0	122.5

\*In kind contributions of the host countries (including office space, buildings, and land) well exceed the totals above. Written agreements exist between U/SC and the host governments which include the responsibilities of each party's inputs under Phase I. The agreements will be extended to cover Phase II.

### 3. Description and Justification of Project:

#### A. Introduction.

Major health problems of all African countries include very high infant mortality, malnutrition and high incidence of communicable diseases, much of which could be reduced through improved sanitation, proper nutrition and better use of presently available health facilities for MCH/FP services. Frequent pregnancies, inadequate care during pregnancy and delivery, and hazardous cultural practices associated with childbirth and infant care are also major contributors to the high morbidity and mortality of mothers and children as measured by very low average life expectancy. Gambia has a life expectancy of 43 years, and Benin, the lowest of all measured African countries, 37 years. For Lesotho it is 52 years.

The health infrastructure of each country provides at least minimal hospital and public health service to all the major centers of population and each has a beginning network of health centers and dispensaries radiating out from these centers into the rural areas. There is wide variation in the extent of health coverage but in every country large numbers of rural people have no health care except that given by traditional healers and untrained midwives. Mobile services provide infrequent mass immunization against a few endemic diseases. Health services that do exist in the most remote centers are almost entirely limited to the care of the sick; personnel are inadequately trained and unsupervised; and medications and equipment are continually in short supply. Present and projected budget allocations for health provide for a limited expansion of basic health services each year. Health budget statistics are roughly similar to those related in the original PROP: 80% of the health budgets is spent in urban areas and 20% in rural areas, whereas from 80-90% of the people live in rural areas.

This project provides another dimension to AID's total MCH/FP input in Africa in that it approaches the problem at the level of direct services to people. It introduces to them the concept of maternal and child care/family planning as a health service and searches for ways to motivate them to want to change their health behavior as well as space their children. At the same time, it develops feasible ways to extend the local health services through which MCH/FP and nutrition services can be given.

If family planning is accepted as an essential part of basic MCH services, in countries where these health services are just beginning to develop, it will grow with the health services. Also, MCH/FP services will exist, ready to expand as the demand for them increases.

Following the evaluation<sup>1/</sup> of Phase I of this project it is seen that in Gambia, Benin and Lesotho there have been successful MCH/FP delivery systems established in a pilot area of each country. These services have been judged to be reaching mothers and children not previously reached with MCH/FP preventive services and is determined to be feasible in terms of host government projected resources.

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<sup>1/</sup>Report of an Evaluation of the Maternal and Child Health Extension Project in the Gambia and Benin, Hilborn and Williams (May 1975); Lesotho element of project has not formally been evaluated. A cursory evaluation was made in 1975: A Review of the Health Sector of Lesotho, Annex 1, "Comments on UCSC MCH/FP Project Continuation" Oscar Gish et. al. Sept. 29-Nov.8, 1975.

Each Government has accepted the concept of MCH/FP services and begun to incorporate elements of these services, via training of health personnel, into other areas of the country. The time, therefore, seems propitious for the expansion of MCH/FP services into at least two other areas of Benin and The Gambia as envisioned in Phase II of this project. (The program will be phased out in Lesotho; but leaving the GOL/MOH capable of expanding its services within its budgetary and/or personnel constraints.)

B. Project Targets.

(a.1) Goal - This project attempts to be a major factor in achieving the overall program goal of "improving the quality of life of African mothers and children" by demonstrating that MCH/FP services in three African LDCs can provide effective preventive health care and at the same time be affordable by the country.

(a.2) Goal indicators - Infant mortality and morbidity in the three participating countries is generally agreed to be quite high; as an example, in Benin it is reported that there are 150 deaths in the under one year age group per 1,000.<sup>1/</sup> Many of these deaths are preventable, and a reduction of both infant and maternal morbidity and mortality to a significant degree in the improved MCH/FP service area will give a clear indicator that the program goal in part is being achieved.

(a.3) Goal Assumption

(1) Preventive MCH/FP services continue to be a desired component of the health delivery system by the key host country officials.

(2) Improved MCH/FP services will lead to a significant reduction in maternal and infant morbidity and mortality.

(3) Baseline data exists or can be generated for measuring a reduction in maternal and infant morbidity and mortality.

(4) Improved quality of life exists in the ability to control one's fate and in this respect the number of children and size of families affects the well-being of the family.

(b.1) Project purpose The purpose of this project is to find and demonstrate simple but effective ways to improve MCH services including nutrition and child spacing and to extend these services to previously unreached rural population groups without necessitating substantial increases in facilities, personnel or operating costs.

Phase I of this project demonstrated that the project purpose is

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<sup>1/</sup> AID Economic Handbook, Africa 1974

valid and achievable in pilot areas of each of the participating countries. The Phase II target is to replicate improved MCH/FP services in at least two additional areas of each country which will test the Phase I achievements in differing geographic and ethnic/cultural regions of the countries.

(b.2) Goal Indicators

(1) At the end of the project at least three areas (the pilot area and two additional areas) of The Gambia and Benin will have effective MCH/FP services integrated into the existing health delivery system.

(2) The original pilot area of each country will function effectively as a training and demonstration center that will serve as a model to expand services throughout the country.

(3) Host country personnel, at end of project, will be fully prepared to carry out responsibility for delivery of services and training of national health workers, and the Government will assume the major costs for MCH/FP services established.

(b.3) Assumptions

(1) Qualified trainees available; replacements available during training.

(2) Post training positions in expanded areas permit utilization of training.

(3) Expansion of services is feasible and practicable in areas chosen.

(4) Expanded area health staff is sufficiently motivated to expand services.

(5) Host Governments continue to allocate sufficient funds for support of the MCH/FP services.

(c.1) Project Outputs - Although outputs are country-specific (see individual country implementation plans in Part III, "Project Implementation") general targets for all three countries are as follows:

(1) Health status and Knowledge, Attitudes and Practices (KAP) baseline data in the areas of MCH/FP expansion will be collected. (UCSC personnel will participate in development and refinement of relevant health data collection systems with the host country personnel).

(2) After a study of existing basic MCH/FP services provided in expanded areas with local staff, these services will be improved.

(3) The pilot area will be used for short-term training for staff assigned to the expanded area and all appropriate health personnel in the expanded areas will be trained in basic MCH/FP methods.

(4) Volunteers in the expanded areas will be trained and utilized in MCH/FP activities.

(5) Refine and adapt the overall plan for supervision and continuing education of local health workers to the expanded areas.

(6) Where necessary refine and adapt developed health education techniques and materials to expanded areas.

(7) Monitor government integrated supply dispersal system to outlying areas and correct (UCSC recommends correction) where necessary.

(8) UCSC will assist MOH in setting up training programs and professional conferences for all levels of health and health-related personnel.

(9) Develop technical evaluation procedures.

(d.1) Project Inputs - The project inputs will be as follows:

AID will continue its contract with UCSC which will provide field personnel, technical consultants, certain supplies and equipment; participant training and other miscellaneous costs.

Each cooperating country will provide host country personnel costs, physical facilities, certain supplies and equipment, and operations costs.

For budget breakdown see Table I, page 3, and for country-specific information refer to Appendices A, B and C. (See Appendix D, Logframe, for further information.

## PART II. PROJECT BACKGROUND

### 1. Project Background

In June 1971, U.S.A.I.D. contracted with the Regents of the University of California acting through its Santa Cruz campus to conduct the MCH/FP project in the three African countries of Lesotho, Benin and The Gambia. By March 1972, a public health physician, five public health nurses, one health educator and an administrative services officer had been hired, had received orientation training in Santa Cruz and were at their assigned posts in Africa.

During Phase I the project direction was to assist these three

African countries to initiate or improve MCH/FP services in defined pilot areas. This was to be accomplished by the expansion of MCH/FP services to include nutrition and family care education and the provision of contraceptive service. The project operated in existing dispensaries and other health facilities with personnel already on the job supplemented by selected village volunteers. It provided field training, field supervision and clinical supplies required to enable these workers to give minimal but effective MCH/FP services within the limited health resources of the rural areas.

The project developed back-up services (administrative, technical support, logistical) as well as KAP surveys, materials, etc., which are essential to the functioning of each pilot activity. At the end of two years' field experience the pilot activities were evaluated for their technical, economic, social and political acceptability within each country. A UCSC proposal for Phase II was drafted following upon findings of the on-site UCSC/AID evaluation and the recommendations by individual Governments/Ministries of Health concerning replication and expansion of effective MCH/FP activities.

No action was taken on the Phase II draft proposal; funding and project activities will continue to the end of CY 75 under Title X.

In May 1975 an AID/W on-site evaluation of Phase I efforts in the Gambia and Benin was conducted by American Public Health Association.<sup>1/</sup> The team evaluated each of the expected Phase I outputs: (1) the collection of baseline data and improvement of existing services; (2) the development of an MCH/FP training center and health education materials; (3) the development of method of supervision, improved supply system, retraining programs and a method of technical evaluation. Their evaluation conclusion stated that the project goal and purposes are appropriate in lights of the participating countries' stated national health objectives and priorities, and that the majority of Phase I targets are being or have been met and, in many instances, surpassed. The evaluation found that there is government support of the project purposes, which is particularly true at the technical level, where project-stimulated activities are increasingly initiated and carried out by national counter-part personnel.

Upon the basis of evaluative studies and/or progress reports the following are summaries of progress/accomplishments, problems encountered to date and recommendations for the individual countries:

#### The Gambia

##### Progress and Accomplishments

1. A rural health survey was designed and conducted.
2. Project personnel assisted in reinforcing the MCH/FP content in the curriculum of the two health training institutes, as well as training programs for agricultural workers and youth groups.
3. They worked with the pilot area health inspector and his students to include MCH/FP in their village talks - 4 meetings a month reaching approximately 250 people.
4. Improvements in the design and use of clinic records were made.
5. Project personnel assisted in:

<sup>1/</sup> See Footnote Page 6

- a. Group patient teaching by trained personnel.
  - b. On-the-job training of existing personnel.
  - c. Recruiting and training 7 high school volunteers to work in the MCH Clinic and 2 traditional birth attendant volunteers.
  - d. Conducting a two week "Training for Trainers" course.
  - e. Recruiting 3 nurse/midwives for the F.P. training course in the U.S.A.
6. Sixteen senior health personnel completed a two-week "Training of Trainers" course.

#### PROBLEMS

1. Key Ministry of Health personnel changes delayed the start of project activities.
2. Distance between countries made the project's "regional" aspect untenable.
3. Disparity in implementation needs, achievements and possibilities of each country made a single implementation schedule unworkable.
4. The project lacks an adequate evaluation component .

#### Recommendations

1. AID continue to support the project but limit the "region" concept to the Gambia and Benin.
2. Each country be given more autonomy so activities can proceed at their own pace.
3. The life of the project should be extended to give support to agreed upon activities.
4. AID work with the contractor to develop a realistic and mutually acceptable design for end-of-project evaluation.

## Benin

### Progress and Accomplishments

1. Baseline data has been collected on both personnel and their utilization, and on existing preventive health services. It will be used for evaluating project activities and achievements.
2. Local staff are now doing group patient teaching at the MCH Center 4 times a week, reaching approximately 500 mothers weekly. This teaching is now replicated in 3 dispensaries in the Cotonou area.
3. In the first year of the health education program, Family Planning acceptors have doubled and there was a 50% increase in the number of children immunized.
4. A special clinic for women in their first pregnancy has been established, and home visiting to pregnant women and/or mothers with problems has been initiated.
5. New F.P. records have been developed and are in use.
6. Previously trained Trainers conducted short term on-the-job training in health education methods at the MCH Center for 125 health workers.
7. Two physicians and 8 midwives completed special MCH/FP training in the U.S.A.

### Problems

1. Problems precipitated by a recent change in government personnel delayed the start of the project.
2. There is no official government population policy.
3. Coordination, team leadership and country program direction to 3 countries separated by long distances and dissimilarities of needs and possibilities proved unrealistic and difficult to a regional staff of only two.
4. There is no plan for project evaluation.

### Recommendations

1. Extend the project to allow for completion of all agreed upon, on-going activities.
2. Create a new "regional" concept to include only Benin and The Gambia.
3. Allow more autonomy to complement the country's implementation needs and achievement possibilities.
4. Work with the contractor to develop a realistic and mutually acceptable design for end-of-project evaluation.

The Gambia/Benin evaluation team concluded that Phase II plans (as designed in May 1974) are serving adequately to guide project activities during CY 75 but the fact that these plans saw a one-year delay in approval has slowed the tempo of progress toward predicted end-of-project achievement and modifications will be needed in work plan targets and/or time for their accomplishment.

## Lesotho

### Progress and Accomplishments

1. The Tsakholo Health Center established as a model rural center for training all levels of personnel and a demonstration center.
2. Center staff trained in health teaching methods.
3. On-the-job training of existing personnel.
4. Ten volunteers recruited, trained and now teaching in their villages.
5. Six thousand patients received benefits from Center services.
6. Two hundred seventy-five prenatal patients received services and/or health teaching.
7. MOH has been assisted in establishing a health education unit within the Ministry
8. Training courses in health teaching methods conducted for nurses, teachers, students, midwives, economic advisors and others.
9. Family and community health services consolidated.
10. Training of health personnel institutionalized.
11. Studies completed and baseline data collected in KAP and contraceptive utilization.
12. Recording and reporting systems for MCH/FP activities developed.
13. Personnel assigned responsibilities in supervision and management training.
14. New and improved MCH/FP and health education services effectively demonstrated.

15. Health assistants courses improved and expanded with new sections added such as MCH and health education.
16. Health education techniques taught to 13 dispenser trainees.

Problems Encountered

1. Coordination by UCSC Regional staff difficult because Lesotho has not been easily accessible from Benin and the Gambia.
2. Planning preliminary health programs based on need of the people and the community difficult because of unsatisfactory recording.
3. Health education had to be established in its entirety.

Recommendations

1. Phase out project by end of CY 1976.
2. Complete the present on-going training program for nurses.
3. Continue to assist and prepare trained personnel to assume leadership roles.
4. Maintain services of health educator for one year after project is phased out.

## 2. Project Analysis

### A. Economic

As originally conceived the project is designed to study and demonstrate, in several settings (rural and urban, traditional and transitional) that the role of existing local health workers can be expanded to include giving MCH/FP services which will affect the health of mothers and babies. Emphasis is placed on services which can be provided without necessitating substantial increases in supplies or other recurrent costs and on activities which will motivate people to change their own health behavior. The concept of family planning will be introduced as child spacing, a preventive health measure. Overall increase in cost to host Governments will be extremely modest and should not inhibit pilot area activities from being replicated elsewhere in the countries or other African nations.

Alternative approaches had been considered before the original project design, but none seemed as appropriate as those being tested in this project. Such methods as mass campaigns against endemic or epidemic disease, construction of more health care facilities and schools or supplying large numbers of health personnel all placed an eventual severe financial burden upon the country; and none addresses itself particularly to the urgent need to bring about change in the environment and practices within the home via providing MCH, family planning and nutrition services and health education to the rural populations.

### B. Social

The project addresses the high level of preventable illness and death of African mothers and children; large numbers of people unreached by present health services which are largely curative and provided by small numbers of inadequately trained health workers; the widespread cultural and traditional beliefs and practices which militate against changed health behavior; and political and social objection to family planning. Efforts have been made in Phase I to introduce family planning techniques as an integral part of MCH services. After three years of operation the APHA evaluation concluded that MCH/FP Services as a whole, as compared with FP services being offered as a separate health service, are acceptable to nearly all health personnel, readily accepted by African mothers, and make the concept of FP politically possible for African Governments to support.

### C. Financial and Administrative

Health budget and personnel resources in the participating countries are minimal and cannot be expected to increase substantially. The Phase II activities, however, require little increase in either personnel or budget beyond what is already being planned for.

PART III. PROJECT IMPLEMENTATION

1. General Implementing Plan<sup>1/</sup>

Phase II of this project is structured to allow (a) for the program phase-out in Lesotho within one year; (b) the Gambia and Benin programs to proceed in a manner compatible with their individual goals and resources. This implementation plan has therefore been developed in three individual sections (see individual country papers attached).

2. Two public health technicians will be assigned to each participating country. One of the two technicians in each country will be designated as Chief of Party but will begin to function as Associate Chief of Party immediately and assume full duties as Chief of Party within the first nine months of Phase II of project. The individual so designated will have project operational responsibilities and liaison responsibilities with the respective host government supervisory staff in the Ministry of Health. The host government-appointed personnel will be responsible for the project activities, assisted by the contract staff. The counterpart of the designated Chief of Party should be a senior staff member of the MOH, and work in a similar fashion as the Chief of Party, including reporting to the head of this functional area in the MOH.

The present Chief of Party will remain with the teams during the first nine months of Phase II. During this time he will take whatever steps are necessary for the smooth and orderly transfer of his duties and responsibilities to the designated new Chief of Party in each country.

Although the present Chief of Party will be based in Benin, he will visit each country as often as necessary for the continued operation of the project and this orderly transference of responsibilities.

In-country staff members will require some administrative backstopping. Immediate service required will be accomplished by an administrative person, local hire or otherwise. A person designated by UCSC and located in California will provide long-term administrative backstopping for in-country contract personnel.

One Public Health Administrator-Planner (who may or may not be an M.D.) will be physically located in California and act as contract project manager. This person will travel to participating countries when services are required.

3. Health technical advice and consultation may be provided by an AID senior health officer in REDSO/W, Abidjan. An M.D. on the UCSC staff may be required to assist with technical aspects of the project on a part time consultant basis.

The team will assist nationals to implement Phase II of the project which will accomplish the following general results:

- (a) Use the pilot areas as demonstration and training centers for

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<sup>1/</sup> Refer to letter: Dr. Cross to James Franks (UCSC) November 13, 1975.

health personnel throughout the participating countries. The project in Benin will also utilize rural health centers for training purposes.

(b) Replicate improved MCH/FP services (as developed in pilot areas) in at least two additional areas in Gambia and Benin.

(c) All Ministries of Health will have an established method for the supervision and continuing education of personnel giving MCH/FP services.

(d) In all countries, family planning services will be an integral part of well planned MCH services.

(e) By the termination of project activity, the original pilot zones will demonstrate a measurable decrease in maternal and child morbidity and mortality.

## II. Evaluation:

### a) UCSC

Development and implementation of technical evaluation procedures is one of the major responsibilities of the project. Expected project outputs are the basis for the evaluation design for each country and for the total project. Baseline data for each pilot zone has been assembled and is being processed and supplemented by appropriate sample surveys and service statistics analysis. Field visits by U.S. based contract staff will provide opportunity for on-site supervision of data collection and for observation and concurrent evaluation of program methodology and effectiveness. UCSC project staff will be directly involved in the evaluation process through a regular reporting process and participation in the annual review. (UCSC is presently designing a Phase II evaluation design and schedule for AID approval.)

In addition UCSC will provide AID/W with a final report on the Lesotho activity outlining what they learned, what they would do differently, and whether the approach used there could be duplicated in other countries or how it should be modified.

### b) AID

The evaluation schedule will require annual Project Appraisal Reports (PAR's) for each country sub-project; the first PAR to be submitted on or about one year following the approval of Phase II activities. The Par team(s) will include the AID Project Officer, a representative of PHA/POP, a representative of the cooperating country and a member of the UCSC staff. The Project Officer will be the PAR evaluation team leader.

The end-of-project evaluation will be completed by termination of AID funding; there will be an evaluation for each country sub-project. The final evaluation team membership will include representatives of those offices included in the PAR evaluation team; it is suggested that one member of the APHA team that evaluated Phase I of this project be included.

Both the PAR and the end-of-project evaluation teams will be guided and assisted by the Project Evaluation Officer. The Program or Assistant Program Officer will also be involved throughout the evaluation process. The responsible AID country officers will participate in the evaluation.

The Technical Division Chief will become involved as design and implementation issues arise. In addition, depending on the information required or the actions to be assigned, other concerned individuals such as the cooperating country Planning Ministry, or the Mission Controller or the Supply Advisor may need to participate in the evaluation process.

Both the PAR's and the end-of-project evaluation will be based upon the Phase II targets as given in the respective sub-project Logical Framework; see Appendices A, B and C. Targets, as set in the "Verifiable Indicators" column for project purpose, outputs and inputs, will be compared with assessed project progress at time of evaluation.

The evaluation will also focus on the causative linkages between project input, output and purpose targets.

I. Subproject background

1. Overview

The Gambia is a 7 to 20 mile wide strip of land extending 250 miles along both banks of Gambia River, forming an enclave of about 4,015 sq. miles in Senegal shaped like a crinkled kris. With a population of over 500,000 it has a population density of almost 125 per sq. mile, making the Gambia one of Africa's most densely populated countries. Approximately 85 per cent (425,000) lives in rural areas; annual per capita income is around \$130. The annual population growth rate approaches 2.5 per cent for the country at large, and average life expectancy is estimated from the latest census at 33 years. Infant (0-1) mortality rate of 217/1,000 is high even for Africa. High rural child mortality (1-5 year group) rate of nearly 50 per cent is attributed to Malaria and other parasitic and infectious diseases and the diarrhea/pneumonia complex. (About 90 per cent of rural Gambians above 9-12 months have malaria and some other serious disease). There are two government hospitals, ten rural health centers open, 11 dispensaries, and 40 sub-dispensaries. There are 19 doctors listed (not all of whom function, 75 nurses, and 104 pharmacy/medical/dresser-dispenser staff.

The project pilot area in the Lower River Division serves about 60,000 rural people, with a health center containing 11 hospital beds in Mansa Konko and 7 satellite dispensaries. The health center staff (which includes one nursing sister, two nurse-midwives, a dispenser, a health inspector, a leprosy officer, and eight auxiliaries) make regular treks to provide services at the dispensaries, each of which has a resident dresser. Before inception of the project, the services given were largely curative. Unlike some other African countries, it would appear that Gambian health center personnel are working at full capacity, and new services can be added only by adding staff, using volunteers, or substituting new tasks for old ones. One U.S. technician lives in Mansa Konko and works as the counterpart of the health center sister. They share responsibility for demonstrating the pilot area as the national rural field training center. The second technician and her counterpart are based in the Ministry of Health and make regular supervisory training visits to the pilot area as well as participate in national planning, health training programs and ongoing extension of national health education services to other population groups.

2. National Health Goals and Priorities

The Ministry of Economic Planning and Industrial Development places the highest priority on rural development in the five-year development plan. The health section of the plan stresses the consolidation and improvement of existing rural services and strengthening preventive aspects of health care. To this end, one of the specific objectives is to increase emphasis on Maternal and Child Health Services within the national network. It projects the upgrading of two health centers and three dispensaries per year as well as the expansion of the one provincial hospital. High on the list of health personnel development is the training program for existing auxiliary personnel which the project is assisting. With support of the ministries of economic planning and of health, a national policy to facilitate planned parenthood refers to child spacing and birth avoidance for medical reasons, not family planning per se. The acceptance of child spacing as part of MCH is demonstrated by the expectation that the Gambian government will soon incorporate the Gambian Family Planning Association into the Government Health Program, thus lending its message official sanction and credence.

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### 3. Project Initiation

There are a number of reasons why the project got off to a slow start in The Gambia. This was the only country where the Government-UCSC-AID agreement was required to have approval at a higher level of government than the Ministry of Health. The agreement was not ratified by the Cabinet until project personnel had been in the country several months. Key Ministry of Health personnel changes took place in the interval between design and negotiation of the project and arrival of project staff, and new officials did not automatically assume the commitments of their predecessors. It was necessary to re-interpret project purposes and goals, replan activities, gain new commitments and tool up for implementation. For example, the Government had agreed, during the feasibility study, to provide housing for a U.S. technician in the pilot area (which is a two and one-half to three hour drive over rough roads from Banjul). This commitment had to be accepted by new health officials, money allocated and a house constructed and furnished.<sup>2/</sup> It was one and one-half years before full-time work could begin in the pilot area. In addition, there was lack of understanding and acceptance of the administrative and planning authority of the Gambia based technicians, and local officials were unwilling to make decisions or take action except during the sporadic visits of the field coordinator. A basic misunderstanding, by both UCSC and GOG, about the desired long-term functions of the Ministry of Health based technician and her counterpart was not completely resolved until toward the end of the second project year.

The project staff, however, utilized this long waiting time constructively. In addition to their own orientation and study of the country's health problems and services, they designed and conducted a rural health survey, reinforced the MCH/FP content in the two health training institutions and in training programs for agricultural workers and youth groups, established informal relationships with other donors, and initiated selected project related activities in Banjul as well as in the pilot area.

### 4. Performance and accomplishments

Progress is reported and discussed in relation to each of the project targets during Phase I. <sup>1/</sup>

A rural health survey was carried out during the first project year and the results were tabulated and analyzed at UCSC. The questionnaire, however, was evaluated to be too elaborate and the sample - because of the insistence of the GOG - was far too large in light of the time and resources of the project staff. As a consequence, the survey results do not provide an accurate baseline for project impact evaluation. Recognizing this, the staff has initiated a series of small health center user studies which at this time give the promise of producing effective baseline information.

The existing services in the participating health facilities have been improved. Group patient health education efforts have been established

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<sup>1/</sup> For more detailed information refer to the Hilcorn and Williams Evaluation.

<sup>2/</sup> Funds provided from Population Self Help Funds.

and nearing the end of the Phase I activities, approximately 200 mothers are attending health education sessions each month.

New clinic records, safer techniques and new, easy-to-use equipment have been introduced and are being used effectively. Health problems which had been ignored in the past are being identified and preventive or treatment measures are now being taken.

Child spacing motivation and limited family planning services are now being given as government services through the health facilities. A referral and reporting system has been developed between the health center and referral hospital and transportation is provided to high risk mothers.

Regular bi-weekly training sessions are being held for pilot health center staff and volunteers. MCH/FP training has been provided to pilot area child care supervisors and again to volunteers, who are, by and large, high school or post high school personnel. Only two TBA's have been trained and utilized in a volunteer capacity to date. An auxiliary nurse training program has recently begun and will provide MCH/FP training of all auxiliaries now in government service.

The pilot area is to be used for rural field training and retraining of all health personnel. It is now being used for field experience for basic nursing and health inspector students from Banjul and nursing students from Senegal.

After early lack of success with didactic training efforts, the project staff have developed demonstration and participation techniques applied with locally available materials as teaching aids. A manual of health education lessons for parents is being developed.

A system of project supply recording and dispersal has been completely integrated into the government system.

The project staff has participated in nursing school curriculum revision, they have assisted in an EEC/FAO-sponsored workshop, and have given a two-week course for 16 senior health personnel from a variety of GOG agencies and services.

#### 5. Participant training

Five Gambian health professionals have received participant training in the U.S. under the project to date. These include nurse/midwives in supervisory positions, a public health nurse, and the country coordinator of MCH/FP services who underwent 16 months of training. Four nurse/midwives are to be trained at the UCSC campus in CY 76 with additional training to be scheduled as needs become apparent.

#### 6. Coordination with other donors

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Project technicians have established good relationships with personnel of other donor and non-government agencies. They work particularly closely with CRS and FPA and have actively sought ways to encourage these and other agencies to participate in project activities. The GOG has obtained supplies and commodities for pilot activities from both UNICEF and CRS, and U.S. self-help funds have been used for health center and dispensary renovations. With project initiative, the FPA and Ministry of Health are meeting regularly to coordinate family planning activities. Project staff have participated in an Inter-Ministerial Group on Family Planning, the Pre-school Committee of CRS, the EEC/FAO Rural Seminar in planning for a British supported management project in the Ministry of Health, and they have been told that they will be co-opted when a health planning subcommittee on MCH is established. WHO has just begun operations in the Gambia and is planning for a Basic Health Services project. The WHO Representative assured evaluators of his willingness to collaborate with the project.

#### 7. Government support and commitment

The Government has lived up to nearly all of its commitments as defined in the agreement and, in several instances, has far exceeded them. They have provided counterparts, participants, facilities, personnel and operating costs in the pilot zone, supplies and equipment from CRS and UNICEF, and the Chief Medical Officer, himself, has served as the focal point for project administration. In addition, the Government provides office space in the Ministry of Health, housing for one U.S. technician, and, in the past year, has taken over the salaries of drivers and secretary, postage and office supplies, vehicle maintenance and operating costs, and the handling of all project equipment.

The Acting CMD and other Ministry officials were warmly supportive of the project and expressed their concern that it continue. In a letter to the evaluators the U.S. Charge d'Affaires commented, "To date the project has succeeded in moving the GOG from a position of opposition, first to tacit acceptance and now to one of understanding and active support for the goals of the project - the change has been fundamental and, given at least the time originally projected, should become irreversible."

## II. Implementation Plan, Phase II

### 1. General

The successful pilot efforts, as related in Section I, will be adapted and replicated in at least two other rural areas of The Gambia.

The training center established in the Phase I pilot area will be utilized to train health personnel in the delivery of improved health and FP services in the new area. Gambian health personnel will assume responsibility for training and supervision of national personnel and the delivery of the health services and the host Government will, by end of project, have assumed total financial support<sup>1/</sup> for the project activities (Phases I and II) following

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<sup>1/</sup>See Budget Table, page 8.

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the schedule.

	<u>END PHASE I</u>		<u>PHASE II</u>		<u>1979</u>
	<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	
% Support of project activities	Gambia 25	25	30	35	100%
	U.S. 75	75	70	65	-0-

2. Output and output indicators

Output A. Demographic, health status and KAP data will be collected in each of the areas of expansion.

- (1) A profile of local health practices, utilization rates, public knowledge of existing preventive services will be completed prior to start of other project activities.

Output B. The existing family health services will be studied and then improved.

- (1) There will be a significant increase in utilization of MCH/FP services at the improved health centers, which will result in a decrease of obstetrical wastage.
- (2) There will be a 50% continuation rate among FP acceptors.
- (3) There will be 20,000 people taught about environmental health and malnutrition.
- (4) The transportation, communication and supply systems will be coordinated.
- (5) TBAs (traditional birth attendants) will be trained and utilized in project activities. At end of project there will be approximately 24 TBAs in the improved system.
- (6) The developed health education methods and materials will be refined and adapted (where necessary) to each of the expanded areas.

Output C. Training will be given to health personnel and others.

- (1) There will be 9 health workers trained for 3 mos. in FP theory and techniques 3/yr.
- (2) There will be 32 nurse auxiliaries trained for 18 months in F.P.
- (3) There will be 15 day nursery workers trained for one year in outreach education (5/year).
- (4) There will be 48 TBAs trained in outreach education. (16/center).

- (5) There will be 24 village volunteers trained for one year in outreach education (8/center).
- (6) There will be 45 health center staff (15/center) trained for one year of in-service education.
- (7) There will be 24 area-council-paid nurse auxiliary (8/year) trained for six months in on-the-job training.
- (8) Staff of 4 health centers to attend 2-day orientation program twice a year.
- (9) There will be 4 nurse midwives in FY 76, 2 in FY 77, and 2 in FY 78 to attend a family planning practitioner course.
- (10) There will be 15 graduates of a Training of Trainers program. The overall plan for the training of all health personnel will be refined and adapted, where necessary. Training programs to be incorporated and centers to be utilized include the following:

**Training Centers:**

Mansa Konko  
School of Nursing and Nurse/Midwifery  
School of Public Health  
Teacher training college  
Vocational training center  
Agricultural training center.

**Data Collection and Retrieval System:**

Improved record and referral system.  
An effective record system for MCH/FP in use in health centers.  
A functioning system of collection and analysis of data.

**MCH/FP Division:**

A position identified within the Ministry which is the pivot point for local responsibility for future program development and evaluation of MCH/FP in the country.

**Training Programs:**

OJT for varying levels of health personnel from other health stations and TBAs in:

Health education, family planning counseling, immunization theory and techniques, identification of high risk mothers, identification of high risk infants, village outreach, use of health growth charts, health records and their use.

Family planning training program for nurse midwives.  
Two cycles, 18 months, MCH/FP training program for nurse auxiliaries.

Outreach training programs for:

24 village volunteers  
48 TBAs  
75 Day nursery workers  
20,000 villagers

Training of Trainers program for 15 project and related staff/year.

Output D. A data collection and referral system will be established and/or improved in each health center in the expanded area.

- (1) There will be an effective record system for MCH/FP patients in use in each improved health facility.
- (2) There will be a functioning system of data collection and analysis in the country for data emanating from all improved health facilities.

Output E. A regular method of supervision will be developed for improved health facilities in each of the expanded areas.

The following will be the structure of supervisory responsibilities:

1. The MOH will assign at least 4 administrative level physicians with advanced training in MCH/FP to supervise 5 areas.
2. The supervision of middle level MCH/FP personnel and services will be made the responsibility of one nurse/midwife who is assigned to the office of the Director of MCH at the national level.
3. The supervision of lower level MCH/FP personnel and services will be nursing sisters assigned at the health centers.
4. The supervision of TBAs will be nurse auxiliaries.

Output F. The UCSC team will participate in the training programs and professional conferences (undetermined number) of all levels of health and health-related personnel and provide MCH/FP training as requested.

Output G. A method for technical evaluation of the project activities in the expanded areas will be developed to assess concurrent effectiveness and results at end of project.

A detailed work plan will be developed by UCSC during the first six months of Phase II activities.

3. Output Methods of Verification and Subproject Assumptions will be given in the Logframe.

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4. <u>Inputs</u>	<u>CY 76</u>	<u>CY 77</u>	<u>CY 78</u>	<u>TOTAL</u>
A. U.S. Inputs (\$000)				
(1) <u>UCSC Personnel</u> ½ Physician Admin. (9 mos.) <u>1/</u> ½ P.H. Admin. 2 P.H. Nurses	88.4	75.2	60.1	223.7
(2) <u>Local Personnel</u> 1 Guard	.5	.	.5	1.5
(3) <u>Consultants</u> 6 man months	22.5	22.5	22.5	67.5
(4) <u>Participant Training</u>	30.0	10.0	10.0	50.0
(5) <u>a. Commodities</u> Audio-visual, Medical equip. & supplies, vehicle/maintenance	50.4	24.0	42.5	116.9
<u>b. Contraceptives</u> <u>2/</u>				
Oral & Condoms	(30.0)	(30.0)	(30.0)	(90.0)
Other	5.0	5.0	5.0	15.0
(6) <u>Other Costs</u> Travel & Transportation, Office Support, Overhead Admin. rate.	87.5	67.8	63.3	218.6
	_____	_____	_____	_____
Total	284.3	205.0	203.9	693.0
Plus 10% Inflation		20.5	20.4	40.9
GRAND TOTAL	284.3	225.5	224.3	734.1

1/ To provide short term consultant services to Gambia as required to train senior technician to assume COP responsibilities prior to termination of PH Adm/Planner position.

2/ Non-add item, funded through AID Central Procurement.

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B. <u>Host Country Inputs</u> *	<u>FY 76</u>	<u>FY 77</u>	<u>FY 78</u>	<u>TOTAL</u>
(1) <u>Personnel</u> 2 Driver/mechanics 1 Social Center receptionist clerk 2 Counterparts				
(2) In-country transportation Vehicle insurance				
(3) Office supplies & related materials	93.8	100.0	125.0	318.8
(4) Participant training replacement costs (in and out of country training) Subsistence allowance, training facilities and housing (in-country training)				

5. Input Methods of Verification and Assumptions will be found in the Logframe.

\*Host country in-kind contributions (including office space, buildings and land) will exceed the above totals.

LOGICAL FRAMEWORK*	PROJECT TITLE MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY: THE GAMBIA
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>***GOAL**</b></p> <p>To improve the quality of life of African mothers and children.</p>	<p>A reduction of preventable maternal and infant/child morbidity and mortality by a significant degree.</p>	<ol style="list-style-type: none"> <li>1. Use sample surveys as provided for in the project implementation.</li> <li>2. Use the project established health status data system.</li> <li>3. Use any available host government data.</li> </ol>	<ol style="list-style-type: none"> <li>1. Family planning (as child spacing) continues to be a desired component of MCH services.</li> <li>2. Improved MCH services will lead to a reduction in morbidity and mortality.</li> <li>3. Vital data exists or can be generated for measuring a reduction in morbidity and mortality.</li> </ol>
<p><b>**PURPOSE**</b></p> <p>(PHASE I: To design and demonstrate simple but effective MCH/FP services that will reach rural populations.</p> <p>PHASE II: To replicate improved MCH/FP services in at least two other areas of the country.</p>	<ol style="list-style-type: none"> <li>1. By the end of the project, at least two areas of the country will have effective MCH/FP services integrated into the existing health delivery system.</li> <li>2. The pilot area (established in Phase I) will function effectively as a training and demonstration center for further MCH/FP service replication.</li> <li>3. Host country personnel will be fully responsible for training and supervision of national personnel and for the delivery of MCH/FP services in the project areas by project end; the host government will assume financial responsibility of the established MCH/FP services</li> </ol>	<ol style="list-style-type: none"> <li>1(a) Clinic/health facilities records.</li> <li>1(b) Supervisors records</li> <li>1(c) Final Project evaluation.</li> <li>2.(a) Training center records of attendance etc.</li> <li>2(b) Follow-up studies on former participant trainees.</li> <li>2(c) Final project evaluation.</li> <li>3 Final project evaluation.</li> </ol>	<ol style="list-style-type: none"> <li>1. Qualified trainees available; replacements available during training.</li> <li>2. Post training positions in expanded areas permit utilization of training</li> <li>3. Chosen areas will prove to be both practicable and feasible.</li> <li>4. The local people will be motivated to accept MCH/FP services.</li> <li>5. The rural health facilities staff will be motivated to upgrade and expand preventive services.</li> <li>6. The host government will allocate that amount of the health budget necessary for the continued support of the MCH/FP services.</li> </ol>

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LOGICAL FRAMEWORK	PROJECT TITLE MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER 932-11-580-358	COUNTRY THE GAMBIA
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>OUTPUTS**</b></p> <p>A. Demographic, health status and KAP data will be collected in each area of expansion.</p>	<p>A. A profile of local health practices, utilization rates, public knowledge of existing preventive services and survey of prevalent diseases will be completed prior to start of other project activities.</p>	<p>A.1 Health facility records and spot surveys.</p>	<ol style="list-style-type: none"> <li>1. Improvement of services leads to increased use.</li> <li>2. Staff training leads to improved services.</li> <li>3. Other donors and governmental departments will cooperate in manpower development.</li> <li>4. Nursing personnel permitted to provide full clinical family planning services.</li> <li>5. Adequate facilities will be provided by cooperative governments.</li> <li>6. Expanded services desirable to governments, clinic staffs and communities.</li> <li>7. Candidates available for training</li> <li>8. Data collection and retrieval system possible.</li> <li>9. Cooperating governments accept the concept and necessity for MCH FP divisions.</li> </ol>

Best Available Document

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GENERAL FRAMEWORK*	PROJECT TITLE: MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY: THE GAMBIA
ARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>OUTPUTS** continued</b></p> <p>5. The existing family health services will be studied and then improved.</p>	<p>B.1 There will be an increase in utilization of MCH/FP services at the improved health centers, which will result in a significant decrease of obstetrical wastage.</p> <p>B.2 There will be a 50% continuation rate among FP acceptors.</p> <p>B.3 There will be 20,000 people taught about environmental health and malnutrition.</p> <p>B.4 The transportation, communication and supply systems will be coordinated.</p> <p>B.5 TBAs will be trained and utilized in project activities. At end of project there will be approximately 24 TBAs in the improved system.</p> <p>B.6 The developed health education methods and materials will be refined and adapted (where necessary) to each of the expanded areas.</p>	<p>B.1 Health facilities records</p> <p>B.2 Health facilities records</p> <p>B.3 Training records</p> <p>B.4 Observation</p> <p>B.5 Training records; observation</p> <p>B.6 Developed methods and materials</p>	<p>Same as above.</p>
<p>6. Training will be given to health personnel and others at the pilot MCH/FP training centers.</p>	<p>There will be -</p> <p>C.1 Nine health workers trained for 3 mos. in FP theory and techniques (3 per year)</p> <p>C.2 Thirty-two nurse auxiliaries trained for 18 mos. in FP.</p> <p>C.3 15 day nursery workers trained for one year in outreach education (5 per year).</p> <p>C.4 48 TBA's trained in outreach education (16 per center).</p> <p>C.5 24 village leaders trained 1 yr. in outreach education (8 per center).</p> <p>C.6 45 health center staff trained for 1 yr. of in-service education (15 per center).</p> <p>C.7 24 area-council-paid nurse auxiliaries trained for 6 mos. of ONJ trg. (8 per year.)</p> <p>C.8 The staff of 4 health centers will attend a 2-day orientation program/center twice a yr.</p> <p>C.9 There will be 4 nurse midwives in FY 76, 2 in FY 77, and 2 in FY 78 to attend an FP practitioner course.</p> <p>C.10 There will be 15 graduates of a trg. of</p>	<p>C.1 - C.10 Participant Training Reports.</p> <p>Trained workers in place and giving service.</p>	<p>Same as above.</p>

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LOGICAL FRAMEWORK*	PROJECT TITLE: MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY: THE GAMBIA
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>OUTPUTS** continued</b></p> <p>D. A data collection and referral system will be established and/or improved in each health center of the expanded areas.</p>	<p>D.1 There will be an effective record system for MCH/FP patients in use in each improved health facility.</p> <p>D.2 There will be a functioning system of clinical data collection and analysis in the country for data emanating from all improved health facilities.</p>	<p>D.1 Observation of record system</p> <p>D.2 Written data</p>	<p>As above</p>
<p>E. A regular method of supervision will be developed for improved health facilities in each of the expanded areas.</p>	<p>E.1 The MOH will assign at least 4 administrative level physicians with advanced training in MCH/FP to supervise 5 areas;</p> <p>E.2 The supervision of middle level MCH/FP personnel and services will be made the responsibility of one nurse/midwife who is assigned to the office of the Director of MCH at the national level.</p> <p>E.3 The supervision of lower level MCH/FP personnel and services will be nursing sisters assigned at the health centers.</p> <p>E.4 The supervision of TBAs will be nurse auxiliaries.</p>	<p>E.1 Observation and supervisory records</p>	<p>As above.</p>

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LOGICAL FRAMEWORK*	PROJECT TITLE: MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY: THE GAMBIA
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>**OUTPUTS continued,,</p> <p>F. The UCSC team will participate in training programs and professional conferences of all levels of health and health related personnel and provide MCH/FP training as requested.</p>	<p>F.1 As reported in UCSC periodic reports</p>	<p>F.1 UCSC reports</p>	<p>Same as above</p>
<p>G. A method for technical evaluation of the project activities in the expanded areas will be developed to assess concurrent effectiveness and results at end of project.</p>	<p>G.1 Evaluation design Developed</p>	<p>G.1 Evaluation design document</p>	<p>Same as above</p>

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PROJECT FRAMEWORK	PROJECT TITLE: MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY: THE GAMBIA
EXECUTIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>INPUTS**</b></p> <p>Contract with UCSC</p> <ol style="list-style-type: none"> <li>1. Field personnel</li> <li>2. Technical consultants</li> <li>3. Supplies and equipment</li> <li>4. Participant training</li> <li>5. Other costs</li> </ol>	<p>See summary budget schedule and individual country budgets. Cooperating governments will support all clinic operational staff, maintenance and counterpart personnel; physical facilities for improved services and incrementally increased portion of supplies and equipment for services. For details see specific country budget schedules.</p>	<ol style="list-style-type: none"> <li>A.1 Personnel in place</li> <li>A.2 Consultants work</li> <li>A.3 Supplies and equipment arrive</li> <li>A.4 Training records</li> <li>A.5 Budget</li> </ol>	<p>(as related to inputs)</p> <ol style="list-style-type: none"> <li>1. Continued funding by USAID</li> <li>2. Continued University of California support for project.</li> <li>3. Incremental financial support by cooperating governments.</li> <li>4. UCSC recruits qualified staff.</li> <li>5. UCSC finds or develops appropriate training programs.</li> <li>6. Host governments provide qualified counterparts.</li> <li>7. Host governments provide appropriate level personnel for participant training.</li> <li>8. Cooperation with other donors.</li> </ol>
<p>Cooperating country</p> <ol style="list-style-type: none"> <li>1. Personnel costs</li> <li>2. Physical facilities</li> <li>3. Supplies and equipment</li> </ol>	<p>See summary budget schedule and individual country budget for host country inputs</p>	<ol style="list-style-type: none"> <li>B.1 Budget</li> <li>B.2 Facilities utilized</li> <li>B.3 Supplies and equipment utilized.</li> </ol>	<ol style="list-style-type: none"> <li>1. The host country will honor its written agreement to provide inputs</li> </ol>

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## BENIN

### I. Subproject background:

#### 1. Overview:

Benin with a population of 2.8 million and an area slightly smaller than Pennsylvania, is one of the most densely populated countries in Francophone West Africa. About 90 percent of the people live in the rural sector, and the population growth rate is estimated as 2.8 percent. Life expectancy is 37 years and the infant mortality rate is reported as 110. As in The Gambia, major causes of infant and child deaths are malaria and other parasitic and infectious diseases, the diarrhea/pneumonia complex and malnutrition. There are less than one physician and four nurses for every 20,000 people. The average annual income is \$80, and the government expenditures for health are just under \$2 per capita, which belies the fact that approximately 80 percent of the health budget is spent for salaries and services to urban areas. The health infrastructure includes general hospitals and "maternities", a network of 200 dispensaries providing curative and some antepartum care, one urban and six rural MCH centers, and mobile endemic disease teams. In addition, there are 11 social centers providing well-child care as well as social services.

In Benin, health officials wanted the project to work with the population in transition from rural areas and traditional behavior to the urban area and the modern world. Pilot areas were located in the Akpakpa quarter of Cotonou, a transitional suburban area of 30,000 people living in small village clusters, and at the Central MCH Center and Maternity Hospital where sick children and complicated maternity patients from Akpakpa are served. Health facilities in Akpakpa include a social center, three satellite village centers and a dispensary. One U.S. PH nurse-midwife technician has worked in Akpakpa with the director and midwife of the social center as her counterpart; and the other U.S. PH nurse worked in the Cotonou MCH Center where a senior midwife was assigned as her counterpart.

The fact that MCH services are fragmented between health and social services has presented problems, and the project has worked in both areas with the goal of influencing integration, at least at the local level.

#### 2. National health goals and priorities

The new Government is reported to be putting great emphasis on rural development. However, APHA evaluators were not able to learn of existence of an operational development plan nor of the priority which is being given to health aspects of rural development.

Health planning has been going on for some time in the Ministry of Health, under the direction of a Chief of Studies and Planning with assistance of WHO.

Several Ministry officials stated that highest priority is being given to preventive and rural health services. This would seem to be borne out by the existence of the WHO Basic Health Services project with its demonstration zone, the training of itinerant workers and home visitors, and a recent major change in Ministry organization which provides for decentralization and coordination of all health services at the district level.

Although Benin has no official population policy, family planning services are given at the MCH Center in Cotonou and the Government has permitted some 30 of its senior health staff to go out of the country for family planning training, presumably with the goal of expending family planning services throughout the country.

### 3. Performance and accomplishments, Phase I, 1972-75

Progress is reported and discussed in relation to each of the project targets during Phase I.<sup>1/</sup>

Minimum health statistics and KAP data were collected in the pilot zone. This baseline data resulted in the refinement of project activities and has been and will continue to be used as a base to evaluate project achievements.

Improvements have been accomplished within the existing health delivery system, resulting in a new program of well-baby services, such as special care of referral for babies at risk. Emphasis has also been given to women in their first pregnancy, and home visits to mothers with problems are beginning. Near the termination of Phase I activities, there has been a 300 percent increase in the number of children brought in for health supervision.

New family planning records have been developed in the participating MCH/FP Center and the collected data revealed that there has been a doubling of family planning acceptors, one year after project staff designed health education materials were put into effect. These efforts have also resulted in a 60 percent increase in the number of parents who have purchased vaccines and have had their children immunized.

On-the-job training has been given to over 125 health workers in the pilot zone. Follow-up indicates that the trainees are using what they learned. More recently a longer course was given to senior personnel. WHO in-country staff have accepted responsibility for continuing education of the health staff.

Although traditional birth attendants (TBAs) were scheduled to be utilized in the improved MCH/FP services, few have been identified and trained during Phase I of the project. Identification of other possible candidates is going on.

A system of supervision has been established insuring guidance for trained staff who are providing the improved services.

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<sup>1/</sup> Refer to report of an evaluation of the MCH Extension Project in The Gambia and Benin, Hilborn and Williams, for more detail.

The project staff has worked with the Ministry of Health to upgrade the supply dispersal system to outlying areas; however, to date, achievements have been limited to integrating management and dispersal of project supplies and equipment into the existing limited government system.

The project staff has participated (as MCH/FP experts) in a variety of professional and community meetings. They have also been asked to assist with theoretical and practical field training in family planning for medical, midwifery and nursing students.

At regular intervals since the inception of the project, U.S. staff and their counterparts have measured progress against activity targets. An overall end-of-project evaluation design will be developed when the Phase II work plan is agreed upon.

#### 4. Participant training

There have been a total of eight Benin health professionals trained at UCSC to date, including the Cotonou Director of Midwifery and Maternity, public health nurses and trainers. In CY 76 an additional 10 participants will be trained at UCSC, including the Academic Director of the National School of Midwifery and the Director of Preventative Medicine who supervises all MCH/FP activities in the country.

#### 5. Coordination with other donors

The UCSC staff has made an effort to coordinate project activities with those of the WHO Basic Health Services project. At the technical level, exchange has been good, but the extent of administrative and planning level coordination has varied with changes in WHO personnel. The present WHO representative received the evaluators only briefly and indicated his willingness to work with project personnel when the Government takes the initiative in bringing this about. Project staff has successfully collaborated with staff of other agencies--the CRS, FAC, CIDA, UNICEF, Peace Corps, church missions, and the FPA. The UNDP has almost no health input in Benin (WHO works quite independently), but it is interesting to note that even without a development plan, UNDP aid to Benin is increasing. A \$5 million grant was made this past six months for personnel and petrol costs.

#### 6. Government support and commitment

Since its independence in 1960, Benin has had 10 different military and civilian governments. The present Government's preoccupation with establishing itself firmly, and the many recent policy and personnel changes at all levels, make it difficult to assess potential commitment for this or any other project. At the Ministry of Health, the focal point for project planning and administration has changed several times. Now it is through the Directors of Preventive Medicine and Social Affairs to the Permanent Secretary. Project staff seem to

have free access and good relations with these decision makers. All three of them expressed to the evaluators their support for the project and their desire to see it continue. The Permanent Secretary said priority was to be given to extending preventive services to the rural areas and he wished to use personnel trained at UCSC and simple and replicable equipment furnished by the project. Last year's Phase II planning was done with a different group of officials and replanning had been postponed, but the Permanent Secretary assured the team that it would be held the following week.

The Government has kept the commitments made in the Phase I agreement and, in several instances, has surpassed them. Counterparts were assigned, pilot area services and personnel made available, and staff were released for participant training. In addition, they have taken over the salaries for two counterparts and two drivers, supplemental salaries for two additional counterparts, and a portion of vehicle maintenance costs. They have established a central health education office and plan to provide the project with office space there. They are working with project staff now on plans to integrate project vehicles and supplies and equipment into government transport and storage and dispersal systems.

Commitment to project purposes and program has increased markedly at the technical level. Project counterparts and their immediate supervisors are enthusiastically assuming leadership in the carrying out of ongoing programs, initiating additional innovations and, most importantly, in negotiating with top officials for project continuation and expansion. The Professor of Obstetrics/Gynecology at the Medical School and Director of the Nursing and Midwifery School is also strongly supportive.

## II. Implementation Plan, Phase II:

### 1. General

The successful pilot efforts, as related in Section I, will be adapted and replicated in at least two other rural areas of Benin.

The training center established in the Phase I pilot area, as well as selected rural sites, will be utilized to train health personnel in the delivery of improved health and FP services in the new area. Health Personnel of Benin will assume responsibility for training and supervision of national personnel and the delivery of the health services and the host government will, by end of project, have assumed total financial support<sup>1/</sup> for the project activities (Phases I and II) following the following schedule:

<sup>1/</sup> See budget table on last page.

	<u>End of Phase I</u>		<u>Phase II</u>			
		<u>1975</u>	<u>1976</u>	<u>1977</u>	<u>1978</u>	<u>1979</u>
% Support of project activities	<u>Benin</u>	25	25	30	30	100%
	U.S.	75	75.	70	70	-0-%

2. Outputs and Output Indicators

A. Demographic, health status and KAP data will be collected in each of the areas of expansion.

(1) A profile of local health practices, utilization rates, public knowledge of existing preventive services, and information regarding prevalent diseases will be completed prior to start of other project activities. Results of a Cotonou-based postnatal pediatric follow-up project of 1,000 primiparas will have been compiled.

B. The existing family health services will be studied and then approved.

(1) There will be a significant increase in utilization of MCH/FP services at the improved health centers which will result in a decrease of obstetrical wastage.

(2) There will be a 50% continuation rate among FP acceptors.

(3) There will be 20,000 people taught about environmental health and malnutrition.

(4) The transportation, communication and supply systems will be coordinated.

(5) TBAs (traditional birth attendants) will be trained and utilized in project activities. At end of project there will be approximately 60 TBAs in the improved system. And a TBA demonstration program will exist in Akpakpa and its satellite social centers.

(6) The developed health education methods and materials will be refined and adapted (where necessary) to each of the expanded areas.

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C. Training will be given to health personnel and others at the pilot MCH/FP training center or at other areas.

- (1) There will be 79 midwives trained in MCH/FP (59 in-country and 20 out of country. These 20 will be tutors.)
- (2) There will be 6 doctors trained in MCH/FP (5 in-country, who will be supervisors for the 4 areas; and 1 out of country to specialize in surgical procedures. One will train in Montreal to have access to French language training.)
- (3) There will be 1 senior level nurse/midwife trained in MCH/FP (out of country.)
- (4) There will be 24 nurses trained in MCH/FP (in-country).
- (5) There will be 1 assistant social worker trained in MCH/FP skills (out of country).
- (6) There will be 80 medical students from the University Medical School trained in MCH/FP techniques (in-country).
- (7) There will be 60 TBAs trained in outreach education.

The overall plan for training of all health personnel (developed in conjunction with MOH) will be refined and adapted, where necessary, in conjunction with the voluntary agencies.

All training programs will include MCH/FP and Nutrition Training and centers to be utilized include the following:

- a) On-the-job training for varying levels of health personnel at Cotonou PMI and Akpakpa Social Center.
  - b) Department of Medical and Paramedical Education (DEMP) of University of Benin using integrated MCH/FP/NUT curriculum.
  - c) Rural health team training program in the Government of Benin Basic Family Health Services Scheme.
  - d) Professional training program in FP at the Maternite Universitaire.
  - e) DEMP of University of Benin rural training facilities.
  - f) Field training centers at district Social Center and its satellite clinics.
- D. A data collection and referral system will be established and/or improved in each health center in the expanded areas.

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- (1) There will be an effective record system for MCH/FP patients in use in each improved health facility.
- (2) There will be a functioning system of clinical data collection and analysis in the country for data emanating from all improved health facilities.

E. A regular method of supervision will be developed for improved health facilities in each of the expanded areas.

The following will be the structure of supervisory responsibilities:

- 1- The MOH will assign at least 4 administrative level physicians with advanced training in MCH/FP/NUT to supervise the 4 areas.
- 2- The supervision of middle level MCH/FP/NUT personnel and services will be made the responsibility of the Director of Preventive Services.
- 3- The supervision of the TBAs will be by nurse/midwives assigned to rural social centers and maternities.

F. The UCSC team will participate in training programs and professional conferences of all levels of health and health-related personnel and provide MCH/FP training as requested.

G. A method for technical evaluation of the project activities in the expanded areas will be developed to assess concurrent effectiveness and results at end of project.

A detailed work plan will be developed by UCSC during the first six months of Phase II activities.

3. Output Methods of Verification and Subproject Assumptions will be given in the Logframe.

4. <u>Inputs</u>	<u>CY 76</u>	<u>CY 77</u>	<u>CY 78</u>	<u>TOTAL</u>
A. U.S. Inputs (\$000)				
(1) <u>UCSC Personnel</u> $\frac{1}{2}$ Physician Admin. (9 mos.) <sup>1/</sup> $\frac{1}{2}$ P.H. Admin. 2 P.H. Nurses	87.8	76.0	60.9	224.7
(2) <u>Local Personnel</u> 1 Driver/Messenger 1 Guard 1 Secretary	4.6	4.8	5.1	14.5
(3) <u>Consultants</u>	22.5	22.5	22.5	67.5
(4) <u>Participant Training</u>	40.0	10.0	10.0	60.0
(5) <u>a. Commodities</u> Audio-visual, Medical equip. & supplies, vehicle/maintenance	37.5	29.8	29.8	97.1
<u>b. Contraceptives</u>				
Oral & Condoms <sup>2/</sup>	(30.0)	(30.0)	(30.0)	(90.0)
Other	5.0	5.0	5.0	5.0
(6) <u>Other Costs</u> Travel & Transportation, Office Support, Overhead, Admin. rate.	66.7	64.1	61.9	192.7
Total	264.1	212.2	195.2	671.5
Plus 10% Inflation		21.2	19.5	40.7
GRAND TOTAL	264.1	233.4	214.7	712.2

1/ To provide short term consultant services to Benin as required to train senior technician to assume COP responsibilities prior to termination of PH Adm/Planner position.

2/ Non-add item, funded through AID Central Procurement.

B.	<u>Host Country Inputs</u> *	<u>FY 76</u>	<u>FY 77</u>	<u>FY 78</u>	<u>TOTAL</u>
1-	<u>Personnel</u>				
	2 Driver/mechanics				
	1 Social Center receptionist/clerk				
	2 Counterparts				
2-	Incountry transportation Vehicle insurance				
3-	Office Supplies & related materials				
		88.2	100.0	100.0	288.2
4-	Participant training replacement costs (in and out of country training)				
	Subsistence allowances, training facilities and housing (in- country training)				
5-	Input <u>Methods of Verification</u> and <u>Assumptions</u> will be found in the Logframe.				

\*Host country in-kind contributions (including office space, buildings and land) well exceed the above totals.

LOGICAL FRAMEWORK*	PROJECT TITLE MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY: BENIN
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>**GOAL**</b></p> <p>To improve the quality of life of African mothers and children.</p>	<p>A reduction of preventable maternal and infant/child morbidity and mortality by a significant degree.</p>	<ol style="list-style-type: none"> <li>1. Use sample surveys as provided for in the project implementation.</li> <li>2. Use the project established health status data system.</li> <li>3. Use any available host government data.</li> </ol>	<ol style="list-style-type: none"> <li>1. Family planning (as child spacing) continues to be a desired component of MCH services.</li> <li>2. Improved MCH/FP services will lead to a reduction in morbidity and mortality.</li> <li>3. Vital data exists or can be generated for measuring a reduction in morbidity and mortality.</li> </ol>
<p><b>PURPOSE**</b></p> <p>(Phase I: To design and demonstrate simple but effective MCH/FP Services that will reach rural populations.</p> <p>Phase II: To replicate improved MCH/FP services in at least TWO other areas of the country.</p>	<ol style="list-style-type: none"> <li>1. By the end of the project, at least TWO areas of the country will have effective MCH/FP services integrated into the existing health delivery system.</li> <li>2. The pilot area (established in Phase I) will function effectively as a training and demonstration center for further MCH/FP service replication.</li> <li>3. Host country personnel will be fully prepared to carry out responsibility for training and supervision of national personnel and for the delivery of MCH/FP services in the project areas by project end; the host government will assume financial responsibility of the established MCH/FP services.</li> </ol>	<ol style="list-style-type: none"> <li>1(a) Clinic/health facilities records.</li> <li>1(b) Supervisors records</li> <li>1(c) Final project evaluation</li> <li>2 (a) Training center records of attendance etc.</li> <li>2(b) Follow-up studies on former participant trainees.</li> <li>2(c) Final project evaluation.</li> <li>3(a) Final project evaluation</li> <li>3(b) Staff assigned</li> <li>3(c) Government budgeted for continuation of services.</li> </ol>	<ol style="list-style-type: none"> <li>1. Qualified trainees available; replacements available during training.</li> <li>2. Post training positions in expanded areas permit utilization of training</li> <li>3. Chosen areas will prove to be both practicable and feasible.</li> <li>4. The local people will be motivated to accept MCH/FP services.</li> <li>5. The rural health facilities staff will be motivated to upgrade and expand services.</li> <li>6. The host government will allocate that amount of the health budget necessary for the continued support of the MCH/FP services.</li> </ol>

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LOGICAL FRAMEWORK	PROJECT TITLE MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY BENIN
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>OUTPUTS***</b></p> <p>1. Demographic, health status and KAP DATA will be collected in each area of expansion.</p> <p>2. The existing family health services will be studied and then improved.</p>	<p>A.1 A system of standard records will be established to determine prevalent diseases, state of malnutrition, FP acceptors, etc. A spot survey will compile a profile of local health practices, utilization rates, and data on public health knowledge of existing preventive services.</p> <p>B.1 There will be an increase in utilization of MCH/FP services at the improved health centers, which will result in a decrease of obstetrical wastage.</p> <p>B.2 There will be a 50% continuation rate among FP acceptors.</p> <p>B.3 There will be 20,000 people taught about environmental health and malnutrition.</p> <p>B.4 The transportation, communication and supply systems will be coordinated.</p> <p>B.5 TBAs will be trained and utilized in project activities. At end of project there will be approximately 60 TBAs in the improved system.</p> <p>B.6 The developed health education methods materials will be refined and adapted (where necessary) to each of the expanded areas.</p>	<p>A.1 Health facility records and spot surveys.</p> <p>B.1 Health facility records</p> <p>B.2 Health facility records</p> <p>B.3 Training records</p> <p>B.4 Observation of supply records</p> <p>B.5 Observation of training records.</p> <p>B.6 Developed methods and materials.</p>	<ol style="list-style-type: none"> <li>1. Cooperating governments accept the concept and necessity for MCH/FP divisions.</li> <li>2. Expanded services desirable to governments, clinic staffs and communities.</li> <li>3. Adequate facilities will be provided by cooperative governments.</li> <li>4. Candidates available for training.</li> <li>5. Nursing personnel permitted to provide full clinical family planning services.</li> <li>6. Staff training leads to improved services.</li> <li>7. Improvement of services leads to increased use.</li> <li>8. Other donors and governmental departments will cooperate in manpower development.</li> <li>9. Data collection and retrieval system possible.</li> </ol>

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PROJECT FRAMEWORK	PROJECT TITLE MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY BENIN
EXECUTIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>AGU FP'S continued</p> <p>Training will be given to health personnel and others at the pilot MCH/FP training centers and (in Benin) at rural training centers.</p>	<p>C.1 There will be 79 midwives trained in MCH/FP (59 in-country and 20 out-of-country.)</p> <p>C.2 There will be 6 doctors trained in MCH/FP (5 in-country and 1 out-of-country)</p> <p>C.3 There will be 1 senior level nurse/midwives trained in MCH/FP (out-of-country)</p> <p>C.4 There will be 24 nurses trained in MCH/FP (in-country).</p> <p>C.5 There will be 1 assistant social worker trained in MCH/FP skills (in-country).</p> <p>C.6 There will be 80 medical students from the University Medical School trained in MCH/FP techniques (in-country)</p> <p>C.7 There will be 60 TBAs trained in outreach education.</p>	<p>C.1 - C.6 Training records</p>	<p>as above.</p>
<p>Data collection and referral system will be established and improved in each health center of the expanded areas.</p>	<p>D.1 There will be an effective record system for MCH/FP patients in use in each improved health facility.</p> <p>D.2 There will be a functioning system of clinical data collection and analysis in the country for data emanating from all improved health facilities.</p>	<p>D.1 Observation of record system</p> <p>D.2 Written data</p>	<p>As above.</p>

Best Available Document

LOGICAL FRAMEWORK	PROJECT TITLE MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY: BENIN
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>**OUTPUTS continued</p> <p>E. A regular method of supervision will be developed for improved health facilities in each of the expanded areas.</p>	<p>E.1 The MDH will assign at least 4 administrative level physicians with advanced training in MCH/FP/NUT to supervise the 4 areas.</p>	<p>E.1 Observation and supervisory records</p>	<p>as above</p>
<p>F. The UCSC team will participate in training programs and professional conferences of all levels of health and health related personnel and provide MCH/FP training as requested.</p>	<p>F.1 As reported in UCSC periodic reports</p>	<p>F.1 UCSC reports</p>	<p>as above</p>

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LOGICAL FRAMEWORK	PROJECT TITLE: MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY BENIN
NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>**OUTPUTS continued</b></p> <p>G. A method for technical evaluation of the project activities in the expanded areas will be developed to assess concurrent effectiveness and results at end of project.</p>	<p>G.1 Evaluation design developed</p>	<p>G.1 Evaluation design document</p>	<p>As above</p>
<p><b>INPUTS**</b></p> <p>A. Contract with UCSC</p> <ol style="list-style-type: none"> <li>1. Field personnel</li> <li>2. Technical consultants</li> <li>3. Supplies and equipment</li> <li>4. Participant training</li> <li>5. Other costs</li> </ol>	<p>See summary budget schedule and individual country budgets.</p> <p>Cooperating governments will support all clinic operational staff, maintenance and counterpart personnel; physical facilities for improved services and incrementally increased portion of supplies and equipment for services. For details see specific country budget schedules.</p>	<ol style="list-style-type: none"> <li>A.1 Personnel in place</li> <li>A.2 Consultants work</li> <li>A.3 Supplies and equipment arrive</li> <li>A.4 Training records</li> <li>A.5 Budget</li> </ol>	<p>(as related to Inputs)</p> <ol style="list-style-type: none"> <li>1. Continued funding by USAID</li> <li>2. Continued University of California</li> <li>3. Incremental financial support by cooperating governments.</li> <li>4. UCSC recruits qualified staff.</li> <li>5. UCSC finds or develops appropriate training programs.</li> <li>6. Host governments provide qualified counterparts.</li> <li>7. Host governments provide appropriate level personnel for participant training.</li> <li>8. Cooperation with other donors.</li> </ol>

PROJECT FRAMEWORK

PROJECT TITLE:  
MATERNAL/CHILD HEALTH EXTENSION

PROJECT NUMBER:  
932-11-580-358

COUNTRY:  
BENIN

OBJECTIVE SUMMARY

OBJECTIVELY VERIFIABLE

MEANS OF VERIFICATION

IMPORTANT ASSUMPTIONS

INPUTS\*\* continued

- o Cooperating country
- 1. Personnel costs
- 2. Physical facilities
- 3. Supplies and equipment

See summary budget schedule and individual country budget for host country inputs.

- B.1 Budget
- B.2 Facilities utilized
- B.3 Supplies and equipment utilized

- 1. The host country will honor its written agreement to provide inputs.

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## LESOTHO

### I. Subproject background:

#### 1. Overview

Lesotho is roughly the size of the American State of Maryland, covering 11,716 square miles. The country is largely mountainous and completely surrounded by the Republic of South Africa. Its boundaries were determined politically without regard to the country's potential viability as an independent entity. Three fourths of the country is covered by foothills and mountains of the Drakenberg Range, rising to 11,000 feet above sea level. The remaining one fourth is lowland, 5,000 - 6,000 feet in altitude. The lowlands comprise only one sixth of the country's total area but support about 50% of the population and produce most of the agricultural crops.

In 1975 the de jure population of Lesotho was estimated (based upon 1966 census data) to be 1,180,000. 17% of the population is under the age of five, and fully 40% under fifteen. Females comprise approximately 57% of the de facto population; males 43%. This imbalance is primarily the result of a great number of males being employed in South African mines outside of the country.

Related to the migration of the country's young men is the rapid decline in output of agricultural crops. Between 1950 and 1970 the output of all grains fell by 41%. During that same time period the country's population grew by about 45%. Over 95% of the population live outside the six designated urban areas. The only relatively significant urban center is the capital.

Lesotho's per capita income is estimated at U.S. \$120 per year. A study of the deployment of the labor force in Lesotho in 1970 found that of a total population of over one million, only 216,000 were "adequately employed" (defined as earning R150 per annum). There were 640,000 dependents, and almost 300,000 either inadequately employed or unemployed. Of the 216,000 "adequately employed," 70% were engaged outside the country, and about 10% each in the indigenous modern sector, the indigenous rural non-farming sector, and the indigenous farming sector.

The economy has been growing at about 6% p.a. However, in 1972 imports were ten times greater than exports (during the first five years after independence imports were equivalent to about one-half of gross domestic product).

The birth rate is 37 per 1,000 and death rate 15 per 1,000, resulting in a rate of natural increase of 2.2% per annum. Life expectancy at birth is put at 52 years and infant mortality at 106 per 1,000.

The pattern of disease in Lesotho is similar in nature to all LDCs in that it is shaped primarily by low incomes, inadequate diets, and very limited access to clean water for the mass of the population which lives in rural areas. Although there is no nationwide disease incidence data system, hospital records give an indication of the disease pattern: approximately 20% of the admissions and 25% of the outpatient attendances were for infectious and parasitic diseases; approximately another 20% of admissions and outpatient attendances were related to the respiratory system. As in other African countries, the bulk of the disease in Lesotho is readily preventable.

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Typhoid outbreaks can be serious due to the high case fatality rate. Tuberculosis and venereal diseases are very serious problems and may be on the increase, although it is difficult to be certain due to under-reporting. Nutritionally related diseases are also frequently diagnosed, as are influenza and measles. However, malaria, schistosomiasis, trypanosomiasis and onchocerciasis (the "tropical" diseases) do not occur in Lesotho.

## 2. The Health Care Delivery System

(a) Organized health services in Lesotho fall into two basic categories: government services under the Ministry of Health, which follow the British (colonial) pattern; and non-governmental services provided by mission groups of several Christian denominations.

Government health services are hospital centered, although a number of clinics are now operated by the Government as attached or remote administrative dependencies of the hospitals. Government hospital distribution and health services administration in general follow the boundaries of administrative districts, which were politically determined and have little to do with such other factors as transportation, markets, etc. The Ministry of Health is a highly centralized organization, but currently there is interest in decentralization to the district level.

Mission health services in Lesotho were initiated in the nineteenth century and expanded slowly until the 1940's when they began to grow rapidly, especially in the form of hospital development. Further growth and expansion of the church-related health services has been primarily hospital-based, although a number of clinics are operated by the various mission hospitals. Until very recently when the Private Health Association of Lesotho (PHAL) was organized, there had been essentially no coordination of the various church-related health programs.

(b) During FY 1974/75 the Ministry of Health was scheduled to absorb 7.5% of the total government recurrent budget, or R1.3 million. In FY 1975/76 the health budget showed a significant increase to a total of R2.0 million. This figure represented an increase of 57% (R733,000) over the previous year. However, about half that increase represented a massive "once only" increase in wages, and the recurrent budget of the Ministry of Health is devoted almost entirely to urban-based hospital services, as follows for 1975/76: hospital services 84%, public health 8%, and administration 8%.

(c) The Ministry of Health is aware that there will not be doctors in most of the country's clinics and health centers for many years to come, if ever. Doctors' skills are not required for the adequate diagnosis and treatment of the vast majority of patients seen in Lesotho's outpatient facilities. The Ministry is therefore very interested in improving the diagnostic and treatment skills of nurses. At present, in spite of a lack of training in diagnosis and treatment, nurses in most of the rural non-hospital clinics must diagnose and treat patients. Neither the Ministry of Health nor the missions at present make use of nurse-practitioners or other paramedical personnel - although WHO and AID have made proposals to the MDH for training. The realities of Lesotho's health problems, health services resources, and population distribution make use of adequately trained paramedical and auxiliary personnel the only possible solution to the problem of providing appropriate, adequate and accessible health services for the rural population.

(d) The GOL has drawn up its second National Plan, covering the years 1975/76 - 1979/80, which states its health objectives to be the improvement and expansion of health services in the rural areas of the nation, and the strengthening of preventive/protective health services. The plan explicitly "places a much greater emphasis on rural services" than did the first, and allocates R1,250,000 for rural clinic development. In order to strengthen the capacity of the clinics to provide services, a new cadre of nurse-practitioners will be established. They will also work in the outpatient departments of the hospitals. The plan also indicates, in a way that was absent in the first, more specific intentions with regard to health education, environmental sanitation, and maternal and child health and child spacing. The plan target is to reduce the rate of population increase from 2.2% to 2.0% annually. The number of doctors and other professional level health workers will be increased. In addition, in contrast to the first plan, provision is made for the training of nurse aides.

### 3. MCH/Extension Project

The outputs (CY 1971-1976) of project activities in Lesotho were:

(a) The Tsakholo Health Center was fully established as a model rural health center for training where all levels of health and related personnel can participate in rural basic health services which integrate health teaching and child spacing.

(b) The staff at the Tsakholo Health Center will have been trained in health teaching methods and identification of high risk mothers. Staff includes two nurse-midwives, health assistant, health aide, driver, public health nurse.

(c) Ten volunteers will have been recruited and trained and will be doing simple health teaching in their villages.

(d) Six thousand patients seeking service at the Tsakholo Health Center will have benefited from improved services and from health teaching.

(e) Two hundred and seventy-five prenatal patients will have benefited from improved services and from health teaching.

(f) A Health Education unit will have been established within the Ministry.

(g) Health teaching methods will have been documented.

(h) The following will have attended training courses which include health teaching methods:

60 government nurses; 5 Catholic Relief nurses; 40 teachers;  
62 student nurses; 18 student midwives; 25 economic assistants.

(i) Twenty-seven health professionals from Lesotho have received participant training in the U.S. They are in place and functioning as supervisors and teachers (multiplier effect), and are now accepting responsibilities and providing health services to people to the extent that UCSC and AID can discontinue their assistance by end of 1976. A senior medical officer is presently in training at UCSC. He will assume duties of the country coordinator MCH/FP services upon return to Lesotho. This will provide a high level, well trained physician to administer the country program. Any additional training that may be needed in the future can be supplied by the already trained professionals.

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In A Review of the Health Sector of Lesotho, Annex 1, "Comments on UCSC MCH-FP Project Continuation,"\* the health sector review team stated:

"Expansion and improvement in the MDH's MCH and family planning services has been stimulated by the MDH - University of California at Santa Cruz - MCH Child Spacing project, which began in 1972 with USAID financing. The project has included a demonstration center at Tsakholo in Mafeteng District, a counterpart training component, and a health education component. A maternal record developed under the project is being used nationwide. The demonstration unit has become a training center for the country. No further out-of-country training of nurse MCH-FP practitioners is planned at present, but MCH-FP skills will be included in the mid-wifery and basic nursing curricula in order to make them widely available without requiring a special cadre of workers. The health education efforts have resulted in the incorporation of health and health education courses in several teaching institutions, including the National Teachers College. The multiplier effects of the latter change are expected to be substantial."

The review team, however, stated that,

"...in the absence of significant increase in the capacity of Lesotho's health services to reach the mass of the population it is unlikely that any categorical health program, let alone one in the difficult area of MCH and family planning, can go further at this time than has this one. It is also important to recognize that although Lesotho is desirous of having improved MCH/FP skills in all its health workers, it does not believe that separate categories of MCH/FP workers will be the most efficient way at this time for improving services in these areas. A very significant number of nurses have already received MCH/FP training abroad and except in very special circumstances there can be little justification for any more such activity. By now the institutional capacity for such training within Lesotho should exist, and in fact does, and those who have trained abroad should now take responsibility for the organization and carrying out of the country's MCH/FP training and other related needs."

## II. Implementation Plan

### 1. General

It was the recommendation of the health sector review team and is the decision of AID/W to phase out the Lesotho component of this project at the end of CY 1976.

The general objectives for the one-year phase-out of project activities in Lesotho will include: a) to assist the Ministry of Health in integrating and institutionalizing MCH/FP and health education activities which it has initiated and demonstrated through the project, and b) to provide continuity of effort between the MCH/Extension project and the new MCH and PHAL projects proposed in the PRP being developed.

\* A draft report prepared by Oscar Gish, Eugene Boostrom, James Franks and Rodney Powell for the period September 29-November 8, 1975, for the American Public Health Association in contract with AID.

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2. The purpose and purpose indicators include:

a) Purpose -

- (1) Consolidate and institutionalize family and community health services at Ts'akcholo to the extent possible and transfer all responsibility to national personnel early enough to assure a smooth transition.
- (2) Provide continuity of effort between the MCH/Extension Project and the new MCH and PHAL projects proposed in the PROP being developed.

b) Indicators -

- (1) By the end of the project (end of CY 1976) the GOL will have the technical capability for extending MCH/FP services throughout its facilities.
- (2) The pilot area, Ts'akcholo (established during Phase I) will function effectively as a training and demonstration center for further MCH/FP or related health activities replication.
- (3) Host country personnel will be fully prepared to carry out responsibility for training and supervision of national personnel and for the delivery of MCH/FP services in the project areas by project termination; the host Government will assume financial responsibility for and integrate necessary project activities into the government structure - integration to include:
  - (a) MCH/FP and health education teaching activities
  - (b) Records system
  - (c) System of supervision
  - (d) Administrative functions -
    - 1) Vehicle maintenance, service, petrol
    - 2) Salaries; drivers, supply officer, secretaries
    - 3) Provision of supplies: office and programs
    - 4) Integration of petty cash system

3. Output and output indicators will be:

Output A. The four following studies will be completed and incorporated into localized planning and teaching programs.

- 1) Knowledge, attitudes and practices (KAP)
- 2) A survey of contraceptive acceptors

- (3) Model village study
- (4) Study of village leaders

Indicators

- A.1 The four studies will include data, analysis and interpretation.
- A.2 The completed studies will be made available to GOL and AID, and used in health planning and teaching.

Output B.

Family health services at Tsakholo, two neighboring clinics in Scott hospital region, and two MOH MCH expansion areas will be expended.

Indicators

- B.1 Model village; data will be analyzed, implementation and evaluation plan will be developed, program will be implemented and incorporated into field training.
- B.2 MCH/FP services will be expanded to two other government health centers (Malalea, Thabana-Morena)
- B.3 Five community health volunteers will be identified and trained in basic health motivation and preventive health concepts one each at Tsakholo, Boiketsiso, Mphaki, Malalea and Thabana-Morena.
- B.4 A system of supervision of volunteer health motivators will be demonstrated.
- B.5 Two demonstration area nurses will be trained locally in expanded teaching and nurse practitioner skills.
- B.6 School health programs will be demonstrated at one school and incorporated into field training.
- B.7 Community health aide training at Tsakholo will be developed.
- B.8 Training needs will be supported and equipment and supplies provided to four expansion clinics.
- B.9 To the extent possible family and community health services at the pilot area will be consolidated and institutionalized and responsibility transferred to local personnel.

## Output C.

Training will have been given to health personnel and others at the pilot MCH/FP training center and at other rural locations.

The Rural Health Training Center will be staffed and in full operation to provide all levels of health manpower with training to prepare them for rural MCH and health education activities.

## Indicators

- C.1 11 PHN's and 40 government nurses serving in rural areas will have received training in organization, implementation and supervision of MCH services including health education, nutrition and family planning.
- C.2 250 student teachers, 6 pupil health assistants, 10 pupil dispensers, 28 pupil econ. extension workers, 20 student nurses and 38 vocation school teachers will have received training in health education and motivation.
- C.3 MCH/FP practitioner training will be localized.
- C.4 GOL will have assumed full responsibility for training programs at the Tsakholo Center.

## Output D.

The GOL MOH will have assumed full responsibility for health education services.

## Indicators

- D.1 All personnel trained out-of-country through this project will have returned to designated responsibilities commensurate with their MCH/FP training.
- D.2 Health education activities will be consolidated and integrated into MCH program.
- D.3. A plan will be established for future health education activities.

## Output E.

The routine MOH records and data collection system in health statistics will reflect basic means of monitoring ongoing MCH/FP activities in the country including health education.

**Indicators**

- E.1 A system for continued provision of MCH related health records will be developed.
  - E.2 Official (health statistics) data collection system in MCH services will be developed.
  - E.3 Use of data in planning and implementation of MCH/FP services will be taught.
  - E.4 Responsibility for monitoring system will be localized.
  - E.5 Data system will be evaluated and modified for continuation by local personnel.
  - E.6 Health education outputs will be statistically documented.
4. Output methods of verification and subproject assumptions are given in the Logframe.

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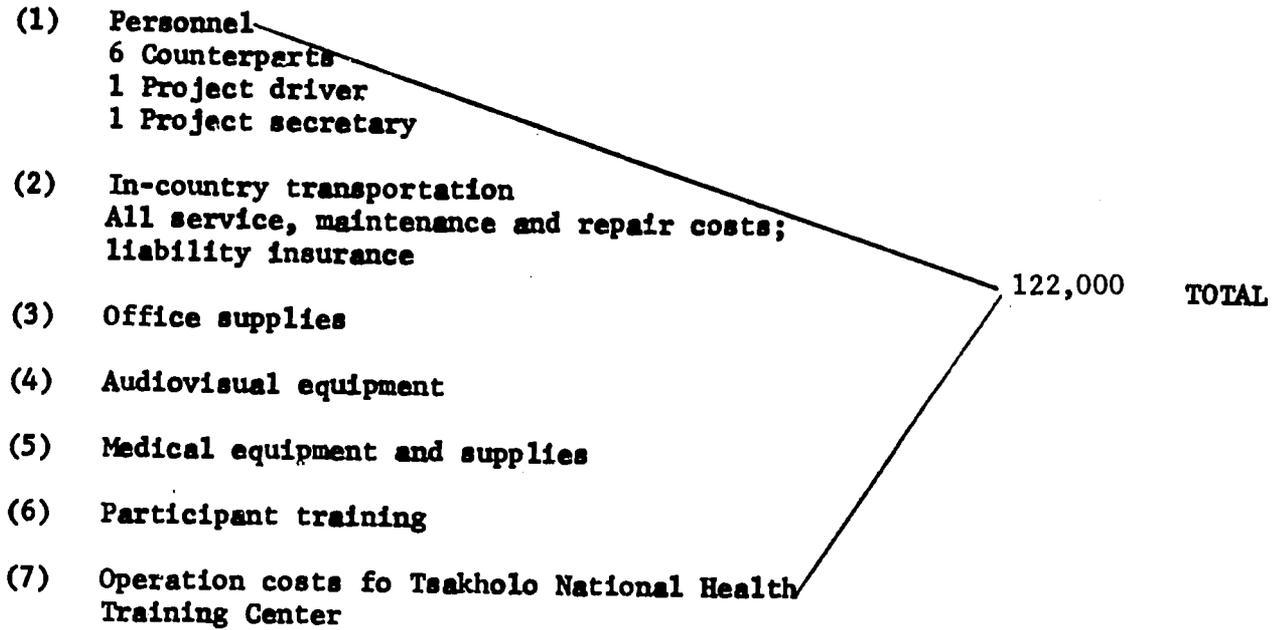
<u>5. Inputs</u>	<u>CY 76</u>
A. <u>U.S. Inputs</u> (\$000)	50.0
(1) <u>UCSC Personnel</u>	
1 P.H. Nurse	
1 P.H. Educator	
(2) <u>Local Personnel</u>	4.5
2 Secretaries	
2 Driver/Messengers	
(3) <u>Consultants</u>	24.4
9 Man Months	
(4) <u>Participant Training</u>	9.8
MCH/FP Country Coordinator	
6 Man Months	
(5) a. <u>Commodities</u>	15.6
Medical equipment	
materials & supplies	
b. <u>Contraceptives</u>	
*Oral & Condoms	(30.0)
Other	5.0
(6) <u>Other Costs</u>	61.4
Include Travel &	
Transportation, Over-	
head & Admin. Rate	
	<hr/>
TOTAL	170.7

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\*Funded through AID central procurements

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B. Host country inputs (Lesotho)\*

- (1) Personnel
    - 6 Counterparts
    - 1 Project driver
    - 1 Project secretary
  - (2) In-country transportation
    - All service, maintenance and repair costs;
    - liability insurance
  - (3) Office supplies
  - (4) Audiovisual equipment
  - (5) Medical equipment and supplies
  - (6) Participant training
  - (7) Operation costs fo Tsakholo National Health Training Center
- 122,000 TOTAL
- 

6. Input methods and verification and assumptions will be found in the Logframe

\*Host country in-kind contributions (including office space, buildings and land) well exceed the above total.

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FRAMEWORK\*

MATERNAL/CHILD HEALTH EXTENSION

PROJECT # 932-11-580-358

LESOTHO

NARRATIVE SUMMARY

OBJECTIVELY VERIFIABLE INDICATORS

MEANS OF VERIFICATION

IMPORTANT ASSUMPTIONS

**\*\*GOAL\*\***

To improve the quality of life of African mothers and children.

A reduction of preventable maternal and infant/child morbidity and mortality by a significant degree

1. Use sample surveys as provided for in project implementation.
2. Use the project established health status data system
3. Use any available Host Government data

1. Family planning as child spacing) continues to be a desired component of MDH services.
2. Improved MDH/FP services will lead to a reduction in morbidity and mortality.
3. Vital data exists or can be generated for measuring a reduction in morbidity and mortality.

**\*PURPOSE\***

Consolidate and institutionalize family and community health services at Ts'akholo to the extent possible and transfer all responsibility to national personnel early enough to assure a smooth transition.

Provide continuity of effort between the MCH/Extension Project and the new MCH and PHAL projects proposed in the PROP being developed.

1. By the end of the project, end of CY 1976 all existing rural health delivery service areas will be providing MCH/FP services.
2. The pilot area, Ts'akholo (established during Phase I will function effectively as a training and demonstration center for further MCH/FP or related health activities replication.
3. Host country personnel will be fully prepared to assume responsibility for training and supervision of national personnel and for the delivery of MCH/FP services in the project areas by project termination; the host government will assume financial responsibility for and integrate necessary project activities into the government structure:

Integration to Include:

- (A) MCH/FP and health education teaching activities.

GOL has developed plans for assuming full responsibility for:

- 1(a) Budget
- 1(b) Personnel
- 1(c) Final Project evaluation.
- 2(a) Training center records of attendance, etc.
- 2(b) Follow-up studies on former participant trainees.
- 2(c) Final project evaluation
- 3 Final project evaluation.

1. Qualified trainees available; replacements available during training.
2. Post training positions in expanded areas permit utilization of training.
3. Chosen areas will prove to be both practicable and feasible.
4. The local people will be motivated to accept MDH/FP services.
5. The rural health facilities staff will be motivated to upgrade and expand preventive services.
6. The host government will allocate that amount of the health budget necessary for the continued support of the MCH/FP.

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PROJECT NUMBER: 932-11-580-358	PROJECT TITLE: MATERNAL/CHILD HEALTH EXTENSION	PROJECT TITLE: MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358
COUNTRY: LESOTHO	OBJECTIVELY VERIFIABLE INDICATORS	PURPOSE INDICATORS (CONTINUED) (b) Records system (c) System of supervision (d) Administrative functions 1) Vehicle maintenance: service, petrol 2) Salaries: drivers, supply officer, secretaries 3) Provision of supplies: office and program 4) Integration of petty cash system	IMPORTANT ASSUPTIONS
NARRATIVE SUMMARY			

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LOGICAL FRAMEWORK	PROJECT TITLE MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER 932-11-580-358	
NARRATIVE SUMMARY(OUTPUTS)	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>A. the four following studies will be completed and incorporated:</p> <ol style="list-style-type: none"> <li>1. Knowledge, Attitudes and Practices (KAP)</li> <li>2. Survey of Contraceptive Acceptors</li> <li>3. Model Village Study.</li> <li>4. Study of Village Leaders.</li> </ol>	<p>A. 1. The four studies will include data analysis and interpretation. 2. The completed studies will be made available to GOL and AID, and used in health planning and teaching.</p>	<p>A. 1 Completed survey documents. A. 2 Surveys in use.</p>	<ol style="list-style-type: none"> <li>1. Expansion of services leads to increased use.</li> <li>2. Staff training leads to improved services.</li> <li>3. Other donors and governmental departments will cooperate in manpower development.</li> <li>4. Nursing personnel permitted to provide full clinical family planning services.</li> <li>5. Adequate facilities will be provided by cooperative governments</li> <li>6. Expanded services desirable to governments, clinic staffs and communities.</li> <li>7. Additional candidates available for training.</li> <li>8. <u>National data collection and retrieval system possible.</u></li> </ol>
<p>B. Family health services at Tsakholo, two neighboring clinics in Scott hospital region, and two MOH MCH expansion areas will be expanded.</p>	<p>B. 1. Model village; data will be analyzed, implementation and evaluation plan will be developed, program will be implemented and incorporated into field training. 2. MCH/FP services will be expanded to two other government health centers (Malalea, Thabana-Morena) 3. Five community health volunteers will be identified and trained in basic health motivation and preventive health concepts one each at Tsakholo Boiketsiso, Mphaki, Malalea and Thabana-Morena. 4. A system of supervision of volunteer health motivators will be demonstrated. 5. Two demonstration area nurses will be trained locally in expanded teaching and nurse practitioner skills. 6. School health programs will be demonstrated at one school and incorporated into field training. 7. Community health aide training at Tsakholo will be developed. 8. Training needs will be supported and equipment and supplies provided to four expansion clinics. 9. To the extent possible family and community health services at the pilot area will be consolidated and institutionalized and responsibility transferred to local personnel.</p>	<p>B. 1. Model village program operational. 2. Services available at.... 3. Training records 4. Project reports 5. Training records 6. Project reports 7. Training records 8. Project reports 9. Project reports</p>	<ol style="list-style-type: none"> <li>9. GOL will utilize all trained health personnel in expanded MCH/FP delivery system.</li> </ol>

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LOGICAL FRAMEWORK*	PROJECT TITLE: MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER 932-11-580-358	COUNTRY: LESOTHO
NARRATIVE SUMMARY(OUTPUTS)	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>C. Training will be given to health personnel and others at the Pilot MCH/FP training center and at other rural locations. *The rural health Training Center will be staffed and in full operation to provide all levels of health manpower with training to prepare them for rural MCH/FP and Health Education activities.</p>	<p>C.1. 11 PHN's and 40 government nurses serving in rural areas will have received training in organization, implementation and supervision of MCH services including health education, nutrition and family planning. C.2. 250 student teachers, 6 pupil health assistants, 10 pupil dispensers, 28 pupil econ. extension workers, 20 student nurses and 38 vocation school teachers will have received training in health education and motivation. C.3. MCH/FP practitioner training will be localized C.4. GOL will have assumed full responsibility for training programs at the Tsakholo Center.</p>	<p>C. 1.Training records 2.Training records 3.Project reports 4.Project reports</p>	
<p>D. The GOL MOH will have assumed full responsibility for health education services.</p>	<p>D.1. All personnel trained out of country through this project will have returned to designated responsibilities commensurate with their MCH/FP training. 2. Health education activities will be consolidated and integrated into MCH program. 3. A plan will be established for future health education activities.</p>	<p>D. 1.MOH Employment Records 2.Project reports 3.Plan written</p>	

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LOGICAL FRAMEWORK*	PROJECT TITLE: MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY : LESOTHO
NARRATIVE SUMMARY(OUTPUTS)	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p>E. The routine MOH records and data collection system in health statistics will reflect basic means of monitoring ongoing MCH/FP activities in the country including health education.</p>	<p>E. 1. A system for continued provision of MCH related health records will be developed.            2. Official (health statistics) data collection system in MCH services will be developed.            3. Use of data in planning and implementation of MCH/FP services will be taught.            4. Responsibility for monitoring system will be localized.            5. Data system will be evaluated and modified for continuation by local personnel.            6. Health education outputs will be statistically documented.</p>	<p>E. 1. MOH Records.            2. Statistical reports.            3. Project reports            4. Project reports            5. Project reports            6. MOH Records</p>	
<p><b>*INPUTS* (\$000)</b>  <b>*AID:</b>            1. UCSC personnel            2. Local hire            3. Consultants            4. Participant training            5. Commodities            6. Other costs            7. Contraceptives**</p> <p>*See Project description -- for budget item breakdown.            **Non-add. funded through AID central procurement.</p>	<p>See summary budget schedule and individual country budget.</p>	<p>1,2,3. AID and contractor personnel records.            4. AID and GOL training records.            5. AID procurement records.            6. UCSC Records.            7. AID/PHA/POP records.</p>	

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LOGICAL FRAMEWORK	PROJECT TITLE MATERNAL/CHILD HEALTH EXTENSION	PROJECT NUMBER: 932-11-580-358	COUNTRY: LESOTHO
<p><b>**INPUTS** (Continued)</b>  <b>GOL:</b>            1. Personnel (Including Counterparts)            2. Vehicles            3. Office supplies and equipment            4. A-V Equipment            5. Medical supplies and equipment            6. Participant training            7. In-country training</p>	<p>See budget summary schedule and individual country budget for host country inputs.</p>	<p>1-7 GOL MOH and training site records</p>	<p>1. Budget projections not significantly reduced.            2. Qualified consultants available as required.            3. Supplies and equipment will arrive on a timely basis.</p>
<p><b>WHO ( And Other Donors)</b>            1. Laboratory services and medical supply dispersal system            2. Training</p>	<p>1. The services and system are established.            2. The training is provided.</p>	<p>WHO and other donor records</p>	<p>4. WHO and other donors have agreed to support project purpose.</p>

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## UCSC OFFICE

The UCSC office provides project back up support and training. Past activities have included:

1. Organizing and implementing training courses at the UCSC campus.
2. Coordinating with other institutions to provide training that is not available at UCSC.
3. Recruiting, orienting, and placing new project staff.
4. Evaluating the programs and submitting semi-annual reports.
5. Providing administrative backup to project personnel in Africa.
6. Accounting project expenses and negotiating with AID/W.
7. Purchasing and shipping project materials and supplies.

It is anticipated that future activities will consist of the same functions at approximately the same levels. Although the project will be terminated at the end of CY 76 in Lesotho activities in the Gambia and Benin will at the same time be expanded.

Home Office Inputs

	<u>CY 76</u>	<u>CY 77</u>	<u>CY 78</u>	<u>TOTAL</u>
A. <u>U.S. Inputs</u> (\$000)				
(1) <u>UCSC Personnel</u>	88.4	118.6	124.0	331.0
1 Project Director				
1 Asst. Proj. Director				
.....				
.....				
1 Secretary, full time				
1 Secretary, ½ time				
Student employees pt.time				
(2) <u>Consultants</u>	11.3	11.3	11.3	33.9
(3) <u>Commodities</u>	7.5	5.5	3.5	16.5
Equipment, Materials, and Supplies				
(4) <u>Other Costs</u>	81.9	78.2	73.2	233.3
Travel, Transportation, Office Supplies, Overhead, Administrative rate				
	_____	_____	_____	_____
Total	189.1	213.6	212.0	614.7
Plus 10% Inflation		21.4	21.2	42.6
Grand Total	189.1	235.0	233.2	657.3

JUN 16 11 25 AM '76

ACTION MEMORANDUM FOR THE ACTING ADMINISTRATOR

JUN 20 1976

THRU: ES

FROM: AA/PPC, Philip Birnbaum *Ashah*

Problem: We need your approval to Revision No. 3 of the Maternal Child Health Extension Project No. 698-11-580-358 which will authorize commencement of Phase II and extend the project through FY 1978. The project appears in the FY 76 Congressional Presentation for African Programs at page 218.

Background: The project began in FY 1971 and has been carried out by the University of California at Santa Cruz in Gambia, Benin and Lesotho. The purpose of the project is to find and demonstrate simple but effective ways to improve maternal and child health services including nutrition and child spacing and to extend these services to previously unreached rural populations without a substantial increase in facilities, personnel or operating costs. There has been an evaluation of Phase I which indicated that in spite of a slow start, the project purpose is valid and achievable in pilot areas.

Phase II of the project, which is covered by this revision, will begin now and last through FY 1978. The purpose is to replicate improved maternal child health services in at least two other areas each in Gambia and Benin in order to test Phase I achievements in diverse geographic and cultural regions of the countries. The Lesotho activity will be phased out of this project in December 1976. This revision will require authorization of \$2.1 million from FY 1976 through 1978; an additional \$245,000 will be provided in centrally funded Title X commodities. The project has been managed by the Office of Population. By joint agreement, the Africa Bureau assumed responsibility for the project in FY 1976.

There are no major issues in this PP. There are a number of operating decisions which must be resolved with the Contractor and the AID overseas offices. Illustrative of minor decisions which need to be made are phasing out some of the field personnel, increasing the responsibility of the host governments for project operations, reducing home office support costs and local costs. We propose to resolve them through clearance of the PIO/T which we will be processing as soon as project approval is obtained.

At the time of project approval in FY 71 the 25 percent cost sharing requirement of the FAA section 110(a) did not apply. Nonetheless, contributions by the host countries amounted to 23 percent of the total cost of the project, see PP, page 2. On an individual basis only Benin's contributions (18%) fell below the 25 percent mark.

In Phase II improved maternal child health services will be replicated in at least two additional areas each in Gambia and Benin. This will involve training an increased number of host government health personnel in maternal child health practices in a greater number of government furnished facilities. Consequently, the host countries' activities and contributions to the project will be increased, and will amount to at least 25 percent of the total cost of the project. A written assurance to this effect will be obtained from each country as part of the UCSC agreements with the host governments.

Recommendation: That you approve the attached PP Revision No. 3 of the Maternal Child Extension project.

Approved: John E. Munday

Disapproved: \_\_\_\_\_

Date: 6/11/76

Attachment: a/s

Drafted: AFR/RA: PA Struharik: gg: 6/4/76

Clearance:

- AFR/DP: RGHuesmann NA Date: 4/4/76
- AFR/SFWA: DShear (Draft) \_\_\_\_\_ Date 5/12/76
- AFR/DR: PLyman (Draft) \_\_\_\_\_ Date 5/11/76
- AFR/ESA: RThompson (Draft) \_\_\_\_\_ Date 5/14/76
- PPC/DPRE: JWelty (Draft) \_\_\_\_\_ Date 5/12/76
- PHA/POP: JMassie (Draft) \_\_\_\_\_ Date 5/10/76
- AFR/DR: EBCross (Draft) \_\_\_\_\_ Date 5/6/76
- PHA/POP: RTRavenholt (Draft) \_\_\_\_\_ Date 5/10/76
- GC/AFR: EADragon EAD Date 6/4/76
- GC: CLGladson CL Date 6/9/76
- AFR/RA: EDConroy ED Date 6/4/76
- AA/AFR: DSBrown \_\_\_\_\_
- PPC/DPRE: AHandly A Handly Date 6/9/76