

7300348-②  
PD-AAF-587-B1

EXISTENCE OF DESIGN DOCUMENT (PROP) QUESTIONABLE

PROJECT APPRAISAL REPORT (PAR)

7300348-3  
Mr. [Signature]

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1. PROJECT NO. 730-11-530-348	2. PAR FOR PERIOD: July 1970 TO : May 1972	3. COUNTRY Vietnam	4. PAR SERIAL NO. 730-72-018
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5. PROJECT TITLE

Public Health Services

PD-AAF-587-C1

Mr. [Signature]

6. PROJECT DURATION: Began FY 67 End FY 1976	7. DATE LATEST PROP NA	8. DATE LATEST PIP June 30, 1970	9. DATE PRIOR PAR NA
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10. U.S. FUNDING	a. Cumulative Obligation Thru Prior FY: \$ 4,542,000	b. Current FY Estimated Budget: \$ 1,355,000	c. Estimated Budget to completion After Current FY: \$ 1,539,000
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11. KEY ACTION AGENTS (Contractor, Participating Agency or Voluntary Agency)

a. NAME	b. CONTRACT, FASA OR VOL. AG. NO.
Republic of Korea (Medical Team)	AID-2903
International Rescue Committee	AID-3078

\* Does not include \$310,000 in commodities procured under project #330.

I. NEW ACTIONS PROPOSED AND REQUESTED AS A RESULT OF THIS EVALUATION

A. ACTION (X)			B. LIST OF ACTIONS	C. PROPOSED ACTION COMPLETION DATE
USAID	AID/W	HOST		
X		X	<p>Mission approval of KOPHAP team extension through December 31, 1972. ADLD requested extension of this contract in order to meet urgent medical program needs precipitated by the recent NVA invasion.</p> <p>Request pending approval in the office of the Mission Director.</p> <p>(Extension was approved by Mission Director prior to June 30, 1972, and contract was extended.)</p> <p><u>Note:</u> Tab A to this PAR is a brief historical account of the project.</p> <p>Clearances:                      A. E. Farwell, ADLD: _____ Date _____                      Dr. W. D. Oldham, ADPH: _____ Date _____                      W. S. Lefes, ADPROG: _____ Date _____                      J. E. Roberts, ADPROG: _____ Date _____                      Ernest Kanrich, ADPROG: _____ Date _____</p>	June 30, 1972

D. REPLANNING REQUIRES	REVISED OR NEW:	<input type="checkbox"/> PROP	<input type="checkbox"/> PIP	<input checked="" type="checkbox"/> PRO AG	<input checked="" type="checkbox"/> PIP/T	<input type="checkbox"/> PIP/C	<input checked="" type="checkbox"/> PIP/P	E. DATE OF MISSION REVIEW
								June 6, 1972

PROJECT MANAGER: TYPED NAME, SIGNED INITIALS AND DATE	MISSION DIRECTOR: TYPED NAME, SIGNED INITIALS AND DATE
Merril M. Shutt, M.D., Chief PH Branch	G. J. [Signature]

**II. PERFORMANCE OF KEY INPUTS AND ACTION AGENTS**

A. INPUT OR ACTION AGENT	B. PERFORMANCE AGAINST PLAN							C. IMPORTANCE FOR ACHIEVING PROJECT PURPOSE (X)				
	UNSATISFACTORY		SATISFACTORY			OUTSTANDING		LOW		MEDIUM		HIGH
	1	2	3	4	5	6	7	1	2	3	4	5
1. Republic of Korea (Medical Team)					X							X
2. International Rescue Committee				X				X				
3.												

Comment on key factors determining rating

1. Republic of Korea
  - a. Establishment of regional laboratories to provide disease confirmation on timely basis.
  - b. Improved effectiveness of *CVM* disease surveillance and control.
2. IRC
  - a. Monitor refugee situation and recommend appropriate actions to local authorities.
  - b. Increased effectiveness of MCH programs.

4. PARTICIPANT TRAINING	1	2	3	4	5	6	7	1	2	3	4	5
				X							X	

Comment on key factors determining rating

Training and performance on the job of returned participants is satisfactory. Three sanitary engineers on job with MOH. 24 third-country trained staff in MOH. Deficiency in language facility continues to adversely affect participant selection. Tighter screening procedures now used by MOH has helped early identification of candidates for English language training. 9 MPH participants returned and are working with MOH.

5. COMMODITIES	1	2	3	4	5	6	7	1	2	3	4	5
					X						X	

Comment on key factors determining rating

Effectiveness in use of vehicles, insecticides, training films and materials, and water-supply commodities for health facilities, sanitary hamlets, etc. is satisfactory. Adequate maintenance and availability of spares are less than satisfactory, however.

6. COOPERATING COUNTRY	a. PERSONNEL	1	2	3	4	5	6	7	1	2	3	4	5
						X							
	b. OTHER				X								X

Comment on key factors determining rating

- a. Establishment of corps of public health technicians and assistants to hamlet level is proceeding slowly. In-country training facilities are now beginning to turn out large numbers of required staff.
- b. Accuracy and reliability of statistics used for surveillance and control are unsatisfactory. Some of this is due to minimally trained diagnosticians at the local level and some is due to lack of statistical training.
- c. Skills in planning and implementation of effective control programs (sanitation, health education, school health, quarantine services, etc.) requires additional upgrading. Inadequacy of pay and allowances is detrimental to maintaining trained staff.

7. OTHER DONORS	1	2	3	4	5	6	7	1	2	3	4	5
					X				X			

(See Next Page for Comments on Other Donors)

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II. 7. Continued: Comment on key factors determining rating of Other Donors

1. Improved MCH related activities (WHO) (UNICEF)
2. Strengthening control program through provision of vaccines (Canada)
3. Establishment competent quarantine service (WHO)
4. Training of personnel for PHT and PIAT Corps (WHO)
5. Improvement of TB and VD program (WHO)

III. KEY OUTPUT INDICATORS AND TARGETS

A. QUANTITATIVE INDICATORS FOR MAJOR OUTPUTS		TARGETS (Percentage/Rate/Amount)					
		CUMU- LATIVE PRIOR FY	CURRENT FY		FY 73	FY 74	END OF PROJECT
			TO DATE	TO END			
1. Integrate Public Health Technicians (PHT) into MDH system to provide services at district and province level. (3 yr course) (50 graduates p.a.) (min. req. about 1,000)	PLANNED	-	-	-	50	50	200
	ACTUAL PERFORMANCE						
	REPLANNED						
2. Integrate Public Health Assistant Technicians (PIAT) into MOH system to provide services at district level. (1 yr course) (annual outputs)	PLANNED	75	50	100	100	100	575
	ACTUAL PERFORMANCE	75	50				
	REPLANNED						
3. Assign trained chiefs of services and Director of Public Health Directorate. (trained at MPH level in US) (annual outputs)	PLANNED	15	5	5	2	2	24
	ACTUAL PERFORMANCE	9	-				
	REPLANNED			-	2	2	13
4. Produce and distribute health educational posters on various public health programs. (annual outputs)	PLANNED	600,000	120,000	200,000	1.5 mil.	1.5 mil.	6.8 mil.
	ACTUAL PERFORMANCE	600,000	110,000				
	REPLANNED			300,000	625,000	700,000	3.8 mil.
5. Produce and distribute health education pamphlets on various programs. (Radio and TV shorts are prepared for the media and aired at least once a week)	PLANNED	750,000	250,000	300,000	500,000	700,000	3.7 mil.
	ACTUAL PERFORMANCE	750,000	134,000				
	REPLANNED						
6. Conduct formal school health education program in elementary schools. Number of School.	PLANNED	-	4	75	150	150	675
	ACTUAL PERFORMANCE	-	4				
	REPLANNED						
7. Established sanitary hamlets.	PLANNED	141	40	100	100	100	583
	ACTUAL PERFORMANCE	83	40				
	REPLANNED			40	100	100	523

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### III. KEY OUTPUT INDICATORS AND TARGETS

A. QUANTITATIVE INDICATORS FOR MAJOR OUTPUTS		TARGETS (Percentage /Rate /Amount)					END OF PROJECT
		CUMU- LATIVE PRIOR FY	CURRENT FY		FY 73	FY 74	
			TO DATE	TO END			
8. Trained sanitary agents in MOH to install and repair hand and electric pumps.	PLANNED	78	-	-	-	-	78
	ACTUAL PERFORM- ANCE	78	-				
	REPLANNED						
9. Trained water supply personnel assigned to hamlets. (third country training) (these were Rural Health personnel who were given in- service training).	PLANNED	24	10	10	5	-	39
	ACTUAL PERFORM- ANCE	24					
	REPLANNED						
10. Trained sanitary workers assigned to hamlets. (Rural health workers given in-service training).	PLANNED	400	-	-	-	-	400
	ACTUAL PERFORM- ANCE	400	-				
	REPLANNED						
11. Trained water plant operators assigned to province (course given by water Direct- orate in cooperation with MOH)	PLANNED	30	-	20	40	40	210
	ACTUAL PERFORM- ANCE	30	-				
	REPLANNED						
12. Established sanitation services or bureaus.	PLANNED	32	5	7	7	8	54
	ACTUAL PERFORM- ANCE	32	7				
	REPLANNED						

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### III. KEY OUTPUT INDICATORS AND TARGETS

B. QUALITATIVE INDICATORS FOR MAJOR OUTPUTS	Comment:
1. Accurate/reliable statistics generated and used for control programs and planning purposes.	1.0 Advisors working with counterparts to implement existing reporting system on timely basis. Statistics not reliable at this time -- sporadic reporting, incomplete series, and unreliable records are major problems. NIS providing assistance to MOH to improve health statistics system.
2. Upgrade health services in 31 selected provinces and metropolitan areas in all phases of Public Health activities.	2.0 Advisors phased out in 16 provinces already sufficiently self-reliant. US advisory assistance primarily to medical personnel and Medicin Chef. FY 72 target date for full pull-out of medical advisors from all provinces.
3. Refugee health status continuously monitored for medical requirements in disease outbreaks, health needs, etc.	3.0 One advisor troubleshooter throughout country. Advises Medicin Chef and others. Illustrative work activity: unconfirmed reports of large numbers of deaths investigated. Organized local resources to set up clinic to treat disease outbreak, etc.
4. Establish competent quarantine services at all ports of entry in South Vietnam (total 6 ports).	4.0 Two ports have reliable services - Saigon and Vung Tau. US advisors support activity through reporting incidence of disease in environment immediately surrounding ports of entry. WHO checks on violations of international regulations and also provides advisory services for establishing port procedures.
5. Established improved curricula in NIPH courses for Public Health technicians. (USAID provides advisory input when requested by both NIPH and WHO.)	5.0 In cooperation with WHO and MOH staff, special course work in nursing, environmental sanitation, health statistics and community health are now a part of the NIPH curriculum.
6. Establish long-term health plans in each province.	6.0 Twelve provinces have submitted plans as of June 1972. The MOH four-year health plan has identified broad goals as guidelines to provinces.

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### III. KEY OUTPUT INDICATORS AND TARGETS

#### B. QUALITATIVE INDICATORS FOR MAJOR OUTPUTS

#### Comment:

#### Outputs (Environmental Sanitation)

7. Install packer type garbage trucks and dump trucks in major provinces and cities throughout South Vietnam.

7.0 41 new packer type garbage trucks assigned to 16 locations as follows: 1 each in Pleiku, Bien Hoa, Chau Doc, An Giang, Sadec, Vung Tau, Dalat; 5 in Gia Dinh, and 15 in Saigon; 2 each in Binh Dinh, Phu Yen, Khanh Hoa, Dinh Tuong, Phong Dinh, Hue and Da Nang.

7.1 20 dump trucks assigned to various provinces and Saigon; and

7.2 30 dump surplus packer type garbage trucks assigned to all other provinces with exception of: Phu Bon, Hung Duc, Binh Tuy, Kien Tuong, Go Cong and An Xuyen.

7.3 Trucks placed on basis of need, available funds and labor and maintenance capability, cooperation of GVN officials and political impact.

8. Established National Water and Sewerage Control laboratory.

8.0 Facility constructed in 1963. In 1970 laboratory was placed under direction of NIPH and its services were expanded to include training, water quality control, water chemistry, sewerage research, air pollution, bacteriology and nutrition studies.

8.1 Its staff includes: 1 medical doctor, 3 chemists, 3 lab technicians, and 2 laborers.

9. Established guidelines for National Plague Control Program.

9.0 Developed in 1963 following Vung Tau epidemic. Program now provides for dusting, vaccinations, clean up, rodent control, etc., for entire province or other area that reports incidence of the disease.

10. Water pumps and piping provided by MOH to establish community water supply systems.

10.0 200 hand pumps provided to Ministry of Health of which 100 were installed in 1966. 180 are installed to date and the remaining 20 have been scheduled for installation. (See output number 8, page 4, for trained manpower requirements)

11. Established pilot potable water systems.

11.0 Established potable water systems for resettlement projects in Vinh Long and Bien Hoa provinces.

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III. KEY OUTPUT INDICATORS AND TARGETS

B. QUALITATIVE INDICATORS FOR MAJOR OUTPUTS	Comment:
12. Established sanitary hamlets throughout country.	<p>12.0 Establish sanitary hamlets with following improvements: 1) privy for houses, 2) safe water supply, 3) garbage disposal, 4) all residents tested and treated for parasites, 5) drainage system, 6) children vaccinated and 7) all other improvements for environment;</p> <p>12.1 Two pilot sanitary hamlets constructed in Tay Ninh and Phu Yen provinces in 1966/67.</p> <p>12.2 In 1971, 141 hamlets selected and 123 improved under the above criteria. 100 hamlets per annum programmed for 1972-1975.</p>
13. Established sanitation services or bureaus in all provinces and 10 major cities by 1975 per PM decree #130, 1971 (bureaus in province capital cities with less than 50,000 population; services in the larger ones).	13.0 By 1968 there were 20 provinces with sanitation services or bureaus. By 1971, 32 provinces and Saigon had established a sanitation service or bureau. Management responsibility is MOI's, with technical input by MOH.
14. Established a public health nurse program at the national level in Vietnam.	<p>14.0 Pilot effort started July 1967 with two PHN advisors assigned to two provinces to work with the GVN chief of public health services.</p> <p>14.1 In Nov. 1967, number of nurses increased to 19. (Only 16 positions were filled at any one time of which 5 were nurse-wives)</p> <p>14.2 Expanding Public Health programs to increased number of people. MCH programs expanded.</p> <p>14.3 Established program for publicizing available services, not as yet formalized.</p> <p>14.4 Established administrative and supervisory procedures at province and district levels. Not as yet formalized.</p> <p>14.5 Established improved nursing techniques in rural health facilities.</p>

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**III. KEY OUTPUT INDICATORS AND TARGETS**

B. QUALITATIVE INDICATORS FOR MAJOR OUTPUTS	Comment:
	<p>14.6 Mobile health teams are organized in every province to conduct immunizations. Additionally, immunizations are given at fixed health facilities.</p>
<p>15. Established regular scheduling of immunizations for schools, orphanages and high-incident areas.</p>	<p>15.0 Mass immunization programs in the past. Currently, selective reactive immunization programs are carried out as required.</p> <p>15.1 Smallpox vaccination is a pre-school requirement.</p> <p>15.2 TB (B.C.G.) testing and vaccination provided to newborn children included about 160,000 of the 400,000 newborn children in 1971.</p> <p>15.3 Mobile health teams are organized in all districts in country. Teams include 1 to 6 persons each. Teams conduct immunization, health education and some treatment work. PIATS are members of teams - 123 graduates are fulfilling this role in their respective districts. Teams visit hamlets about once a month according to planned schedules. Teams also assist in any special control campaigns conducted in their particular area.</p>
<p>16. Established referral system for laboratory specimens.</p>	<p>16.0 The diagnosis of disease and follow-up of communicable disease now formalized by procedures used in provinces.</p>
<p>17. Established programs for school health education and health services.</p>	<p>17.0 Specific plan now requires vaccinations for children at certain ages, standards of sanitation for public institutions, etc.</p>
<p>18. Establish procedures for teaching home visit techniques</p>	<p>18.0 Included as a part of curriculum for NIP health technician's course.</p>

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III. KEY OUTPUT INDICATORS AND TARGETS

B. QUALITATIVE INDICATORS FOR MAJOR OUTPUTS	Comments
<p>19. Established maternal and child health clinics with integrated family planning services.</p>	<p>19.0 Approximately 700 villages (about one-third of the total) have MCH programs, most of which require upgrading, in addition to about 200 districts and 44 provinces.</p> <p>19.1 Eight of the 200 districts have independent family planning services, and 24 of the 44 provinces have family planning services in cooperation with MCHs.</p>
<p>20. Develop teaching guides for health education.</p>	<p>20.0 Manuals/education for health have been prepared and distributed to secondary school teachers. Material for normal school teachers now in preparation. Both manuals are now being expanded to include first-aid skills and the newly instituted school health programs; and the teacher-training courses are being revised to incorporate the newly added activities. MOEd and MOH are cooperating on the activity.</p>

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IV. PROJECT PURPOSE

A. 1. Statement of purpose as currently envisaged. 2. Same as in (PUS)  Yes \_\_\_ No

To develop a GVN capability to prevent and control disease.

B. 1. Conditions which will exist when above purpose is achieved.	2. Evidence to date of progress toward these conditions.
<p>1. GVN capable of planning, organizing and implementing national prevention/control programs without external assistance.</p> <p>Criteria: Adequacy in planning human resources, commodities, orientation of local population, training, reporting requirements, etc.</p>	<p>1.0 A 4-year GVN/MOH health plan has been prepared, but its assessment of priorities and allocation of resources need improvement. While MOH has manifested its interest in planning and organizing national programs, it lacks appropriately trained staff.</p> <p>1.1 Marshalling commodities, orientation of local population, and reporting requirements are the least satisfactory aspects of Ministry's capability.</p> <p>1.2 A national plague program is now a part of MOH plans and policy. Program response is good.</p> <p>1.3 A water and sewerage control lab is functioning: it tests and evaluates samples submitted by localities and makes recommendation on any necessary measures to be taken.</p> <p>1.4 A national medical reporting system is functioning but results to date are still poor. Lab specimens are sent to national level for diagnosis. Province and local staff are unable to provide accurate diagnosis and timely reporting of data to MOH.</p> <p>1.5 Epidemiological service is functioning and MOH experts plot incidence of disease as basis for spraying and dusting program schedules. Lack of sufficient and reliable data constitutes a major shortcoming in the service.</p> <p>1.6 An established and functioning National Health Education Service (NHES) is providing educational material and publicity to MOH health programs. Director is well qualified. A staff of 2 with MPH training is currently able to meet GVN requirements. Currently, US commodity assistance continues to provide most of the supplies needed. GVN is expected, however, to provide for all of its needs after FY 74</p>

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<p>B. 1. Conditions which will exist when above purpose is achieved.</p>	<p>2. Evidence to date of progress toward these conditions.</p>			
<p>2. Internationally quarantinable disease-rate reduced to, and maintained at, 1965 levels:</p> <p>(The 1965 base year represents incident-rates whose control is deemed within the manageable capability of GVN resources)</p>	<p>Plague and cholera is endemic to South Vietnam. Reasonably low rates exist currently, but still not at 1965 levels.</p> <p>Plague - still remains high in comparison with 1965 rates of infection.</p> <p>Cholera - about at 1965 level and its control is deemed satisfactory at this time.</p> <p>Yellow fever and smallpox - do not exist in Vietnam at this time.</p>			
<p>3. Upgraded health services in provinces and metropolitan areas in all phases of public health activities. Self-reliance is the final result sought, to enable medicine chiefs and other medical personnel to respond to health problems with dispatch.</p>	<p>3.0 Province-developed plans, following central guidelines, include realistic programming for immunization, surveillance and reaction to serious preventable diseases. This is the first year that thoughtful, structured health planning by provinces and cities was realized.</p> <p>3.1 Most local medical clinics in all provinces have trained staff able to apply simple laboratory test procedures and methods for lab specimens. Most, however, are unable to confirm results for important diseases (plague, enteric diseases, TB, etc.) and are directed to send samples to regional and central labs for disease confirmation.</p> <p>3.2 Garbage collection and disposal programs are in effect in most provinces and cities. Operation and maintenance of trucks is satisfactory due to reasonable compliance with agreements reached prior to delivery of trucks. Evidence of maintenance performance is based on infrequency and rapidity of field complaints on inoperative equipment.</p> <p>3.3 A national program for establishing sanitary hamlets is functioning. As of CY 1971, 125 hamlets, about 1% of the total hamlets in the country, were improved.</p>			

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A. Statement of Programming Goal

To improve the quality of life and well-being of the populace and help increase productivity

B. Will the achievement of the project purpose make a significant contribution to the programming goal, given the magnitude of the national problem? Cite evidence.

Yes. A viable public health institutional structure, accessible to most of the population, can check the spread of disease and prevent infection from pathogenic organisms. Child-care clinics providing routine medical services can prevent the debilitating effects of many childhood disorders. The benefits of a sound public health program are fully realized only in the long run, however, and, while considered an essential step toward the goal, the project is expected to have only modest impact by June 1976.

Tab A

SUMMARY BACKGROUND ON PROJECT

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Public Health Svcs.  
730-11-530-348

The entire concept of preventive medicine and public health is essentially a product of western medicine. Even in the most developed nations it has traditionally taken Herculean efforts over decades to establish good public health programs. Attentions (and, also, budgets) have been directed primarily at the more spectacular and dramatic area of curative medicine. It is no surprise to find the same attitude prevailing in this, or any other, developing nation. The input during the French period was primarily in the curative field; it was they who initiated the central provincial hospitals, and later district facilities. Training was directed at curative medicine primarily. During the Diem regime, a major break-through occurred with the introduction of the Malaria Eradication Program, which was one of the most effective in the world, until manpower and money were shifted to the war effort, and decline in security hampered the operation in the mid-1960's.

The upsurge in war activities beginning in 1964-65 precluded much response to significant public health programs by the Ministry, but the Ministry did continue to develop administrative mechanisms to approach various public health problems. To more closely reflect the MOH structure, USAID/ADPH was reorganized and the Public Health Services Project was established in 1967. Its major thrust was institution-building, i.e., assisting the MOH increase its capability to plan, implement and evaluate public health programs in Vietnam. At that time, there were on-board advisors in sanitation, health education and preventive medicine (malaria advisors served under a separate project until mid-1972).

In 1968, public health nurse advisors, previously assigned to the Nursing Branch, were brought under the project.

Family Planning/Maternal and Child Health was added in 1969. In 1971 Family Planning was made a separate project, but MCH advisory effort remained with the Public Health Services project.

An important accomplishment of the project, perhaps not fully reflected in the progress reported in the PAR, has been the interest, participation and commitment to sound public health concepts that have been generated at all levels of the Ministry of Health