

6310009-021

6310009-02
 PD-AA6-084-81

CLASSIFICATION
 PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol: U-447

1. PROJECT TITLE		2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
Practical Training in Health Education		631-0009	USAID/Yaounde
5. KEY PROJECT IMPLEMENTATION DATES		4. EVALUATION NUMBER	
A. First PRO-AG or Equipment: EV 77	B. Final Obligation Expected: EV 80	Enter the number maintained by the reporting unit (e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY):	
C. Final Input Delivered: EV 82	6. ESTIMATED PROJECT FUNDING	September 1978 March 1980	
	A. Total \$ 4919	REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION <input checked="" type="checkbox"/>	
	B. U.S. \$ 2080	Date of Evaluation: March 25, 1980	
8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR			
A. List decisions and/or unresolved issues (i.e. those items needing further study). NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document (e.g., program SPAR, P.O.) which will present detailed request.		B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED

1. Recommend that the following three objectives be made priority outputs and revisions made in the relevant project documents:

- A. Program of Village Health Committees (VHC's)
 Reduce output from 790 to 375 VHC's
- B. Strengthen program for retaining health and other project related workers

MOH
 UNC
 USAID/Y
 Revisions
 by:
 6/80

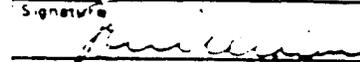
Revised outputs:

- 1. 60 itinerant agents by EOF
- 2. 160 other health workers by EOF
- 3. Teachers in four (4) schools in Mefou and four (4) in Kadey by EOF.

MOH
 UNC
 USAID/Y
 Revisions
 by:
 6/80

(see additional sheets)

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT	
<input type="checkbox"/> Project Paper	<input checked="" type="checkbox"/> Implementation of Plan (e.g., OP Network)	<input type="checkbox"/> Other Specify	<input type="checkbox"/> Continue Project Without Change	<input type="checkbox"/>
<input checked="" type="checkbox"/> Financial Plan	<input checked="" type="checkbox"/> PIC 1	Project Paper	<input checked="" type="checkbox"/> Change Project Design and/or	<input checked="" type="checkbox"/>
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIC 2	Data Sheet (OP)	<input checked="" type="checkbox"/> Change Implementation Plan	<input type="checkbox"/>
<input checked="" type="checkbox"/> Project Agreement	<input type="checkbox"/> PIC 3	Other Specify	<input type="checkbox"/> Discontinue Project	<input type="checkbox"/>

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE: Names and Titles		12. Mission/AID/W Office Director Approve:	
Karen Gricley, COP Evaluation Team (Contract) P.L. Nzeussen, MOH Evaluator Jeannette Teunissen, Contract Evaluator Douglas Palmer, HCO, USAID/Y Theodor Bratrud, Evaluation Officer		Signature  Typed Name: James E. Williams, Director Date: March 25, 1980	

C. Complete development of a program for the Health Sector Institutions.

<p>All ENISFAY, CUSS and OCEAC graduates of one or two academic years have received training in one of the project training sites (Mefou or Kadey).</p>	<p>MOH UNC USAID/Y</p>	<p>Revisions by: 6/80</p>
<p>2. Recommend that the concept of Action Zones (Rayon d'Action) be implemented, where advantageous, to concentrate coverage area (maximum 6 villages per itinerant agent)</p>	<p>MOH UNC</p>	<p>Beginning: 6/80</p>
<p>3. Recommend that a revised logical framework be prepared based on the above recommended changes and all other evaluation recommendations approved by project responsables.</p>	<p>UNC MOH USAID/Y</p>	<p>Done by: 5/80</p>
<p>4. Recommend that the PTHE team (UNC/MOH) prepare an up-dated evaluation plan using the revised logical framework as a base.</p>	<p>UNC MOH USAID/Y</p>	<p>Done by: 8/80</p>
<p>5. Recommend that routine evaluation be done by AID, MOH and UNC in January 1981.</p>	<p>USAID/Y MOH, UNC</p>	<p>1/81</p>
<p>6. Recommend that the Ministry of Health (MOH) provide evidence of funds being provided on a progressive basis for maintaining the following three areas:*</p>		
<p>A. Existing VHC program in the Kadey and Mefou (including vehicle and supervisory support).</p>	<p>MOH</p>	<p>Beginning by: 7/80</p>
<p>B. The program of Practical Field Training with CUSS, OCEAC and ENISFAY.</p>	<p>MOH, CUSS OCEAC ENISFAY</p>	<p>7/80</p>
<p>C. Audio-visual workshop constructed and operational</p>	<p>MOH</p>	<p>7/80</p>

* All fiscal resources necessary to maintain the project to be committed by GURC by the end of AID's contribution to the project.

7. Recommend that the MOH provide a report to USAID/Y of MOH funds allocated and line-item use of these funds for FY 1979/80, as well as for each fiscal year through the remainder of AID's contribution to the project.
- MOH
Provided
by:
6/80
8. Recommend that the MOH hire or assign an audio-visual technician and an artist to the planned Audio-Visual workshop. It is also recommended that the MOH assign the designated A-V technician as a counterpart to the Peace Corps volunteer, working in the MOH.
- Peace Corps
MOH
Assigned
by:
6/80
9. Recommend that core specific health responsibilities (to be defined by the PTHE team - UNC/MOH - be required of all Itinerant Agents (IA's) and Peace Corps volunteers (PCV's) in the project. Core responsibilities of the IA's and PCV's will be different, yet complimentary to each site.
- MOH
UNC
PC
Written
by:
6/80
10. Recommend that the MOH take over all responsibility from UNC to keep account of all expenditures for project training activities, and submit directly to USAID/Y all necessary vouchers/documentation of AID donated training funds. USAID/Y to maintain audit function.
- USAID
MOH
Transferred
by:
5/80
11. a) Recommend that USAID/Y continue to approve per diem and honoraria for training to be specified by the revised project Implementation Plan, to be paid out of project training funds, at 100% of the present GURC rate for 6 months, (July 1 to December 31, 1980) and at 50% for the following 6 months (January 1 to June 30, 1981). After June 30, 1981 the MOH will pay all per diem and honoraria from its regular budget.
- USAID/Y
MOH
Agreed
upon
by:
4/80
- b) Recommend that no AID-donated training funds be used for trainees and participants stationed/living in training area (city, town, village) or used for travel not specifically done for training purposes.
- MOH
USAID/Y
Agreed
upon
by:
4/80

- | | | |
|---|--|---------------------------------------|
| 12. Recommend that the MCH designate one additional technical counterpart for project training and who shall be a staff member of the MOH training division or rural medical division. | MCH | Designated
by:
8/80 |
| 13. Recommend that the MOH, Peace Corps, USAID/Y and UNC take necessary action to maintain continuity of personnel trained and/or designated to work within the framework of the project. | PC
UNC
MOH
USAID/Y | Agreed
upon
by:
4/80 |
| 14. Recommend that USAID/Y consult PTHE team (UNC/MOH) prior to mailing correspondence, affecting the project, to the Ministry of Economic Affairs and Planning and/or the MOH. | USAID/Y | Agreed
upon
by:
4/80 |
| 15. Recommend that the MOH, USAID/Y and UNC reach agreement regarding lines of communication and roles and responsibilities provided in the evaluation document. | MOH
USAID/Y
UNC | Agreed
upon
by:
8/80 |
| 16. Recommend that a Coordinating Sub-Committee of key donor agencies be formed (UNICEF, Peace Corps, USAID/Y, UNC/Y and MOH) to meet periodically regarding PTHE project plans, implementation and evaluation. Results of these meetings are to be presented to the Project Coordinating Committee; if necessary, to the Interministerial Committee. | UNICEF
Peace Corps
USAID/Y
UNC/Y
MOH | To
begin
meeting
by:
6/80 |
| 17. Recommend that funds (\$20,000) budgeted for international training and the remainder of funds (\$30,000) budgeted for Health Education Conferences/International Travel be programmed to send students overseas for long-term training in Health Education. (Long-term defined as from four months to two years.) | MOH
USAID/Y | To be
programmed
by:
7/80 |
| 18. That use of donated construction materials be limited, and that they be used only for public facilities (i.e. schools, health centers, etc) for which work will be provided by local initiative. That U.S. Embassy Self-Help funds be utilized only if they can be channeled more directly through local Cameroonian community organizations. | MCH | Agreed
by:
5/80 |

19. Recommend that the MOH request the Ministry of Finance to investigate a means to affect more efficient passage of audio-visual materials and supplies through customs duty waivers. MOH Requested by: 5/80
20. Recommend that the project maintain community organization efforts in that region of the Kadey where the population is extremely mobile. Every effort should be made by PTHE and MOH field technicians to find an effectual system to reach this population group. To assist in this effort it is recommended that UNC/Chapel Hill propose a short-term (3-4 months) anthropological study of the mobile population of the Kadey. MOH UNC Propose study by: 6/80 Begin new efforts by: 12/80
21. Recommend that the MEDCAM project planners review this evaluation report and consider future integration of PTHE activities, i.e. trained itinerant agents into the MEDCAM project. MOH USAID Univ. of Hawaii Reviewed by: 4/80
22. Recommend that the PTHE team (UNC/MOH) develop a written, viable, long-term (i.e. 5 years) vehicle support system for the VHC program which is to be integrated into the MOH. As part of this plan, the MOH will indicate how it will support and replace vehicles and provide other necessary transportation. UNC MOH UNICEF Plan: written by: 9/80
23. Recommend that MOH, with the assistance of UNC, complete a document, at least one year prior to termination of AID project support, detailing how and at what level the project will continue after the UNC technical assistance ends. This document will address such items as: MOH Document written by: 6/81
- A. Finances
 - B. Vehicle maintenance and replacement
 - C. Supervision
 - D. MOH administrative input
 - E. Training activities
 - F. Role of Itinerant Agents working without PCV's
 - G. Location(physical) of project headquarters

PTHE PROJECT

(631-0009)

MID-PROJECT EVALUATION

(18 Months of Project Activities: September 1978 -- March 1980)

3/27/80

Prepared by: Karen Gridley
P.L. Nzeusseu
Jean te Teunissen

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 - Unplanned Effects
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 - Special Comments or Remarks

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Recommendations

1. That the PTHE Project place top priority on three inter-related outputs: the Village Health Committee Program; the Program of Recyclage for Health and Other Workers; and the Program for the Health Sector Institutions, in order to create a viable field training experience in the Kadey and Mefou for future classes of students from CUSS, ENISFAY and OCEAC.

2. That the Ministry of Health commit, on a progressive basis over a two-year period of time, the fiscal resources necessary for maintaining the following aspects of the PTHE program:

- the existing Village Health Committee Program in the Kadey and Mefou districts (including vehicle and supervisory support)
- the program of Practical Field Training with CUSS, OCEAC and ENISFAY, et. al.

3. Regarding the PTHE Field Level Program:

a) that the PTHE Project implement the concept of the "Rayon d'Action" (Action Zone) in which itinerant agents and volunteers serve as catalysts for health promotion. This concept creates an emphasis on quality and intensity of contact and interaction within a more concentrated area than outlined by the quantitative focus of the original project paper.

b) that a core of specific health education functions - as defined by the PTHE Team (UNC/MOH) - required of itinerant agents and Peace Corps Volunteers. In addition to these activities, individuals can negotiate with their supervisors to initiate other projects responding to village and health center needs.

4. Regarding AID-donated, MOH-administered training funds:

a) that the MOH keep account of all expenditures for training activities provided under the PTHE project and submit the necessary vouchers/documentation to USAID/Y.

b) that USAID continue to approve use of these training funds for payment of per diem and honoraria at the present GURC rate for the duration of AID's participation. (Exceptions noted in Special Remarks Section on Per Diem)

c) that the USAID/Y Project Manager monitor/verify MOH accounting of project expenditures, and that this responsibility be removed from the UNC technical staff.

5. That the PTHE Project Team (UNC/Y; UNC/CH; MOH) prepare an up-dated evaluation plan for USAID review (preferably using the "logical framework") taking into consideration:

- The revised and new outputs/indicators proposed in this report;
- PTHE field experiences to date;
- Preparation of learning objectives for each level of student health personnel in the proposed field training programs.

6. That the PTHE Team (UNC/MOH) develop a viable long-term vehicle support system for the Village Health Committee Program, integrated into the Ministry of Health and based on suggestions made in this report regarding:

- UNICEF donations of vehicles; parts; training of a mechanic; and/or
- a system for financing purchases of motorcycles/ mobilettes by itinerant agents;
- use of MOH-allocated funds for construction of a garage for repair of motorcycles in the Mafou.

7. That the Ministry of Health designate one additional technical counterpart, preferably from the MOH Training Division or Rural Medicine Division, who can devote 50-60% of time to the PTHE project activities.

8. That the MOH, Peace Corps, USAID/Y and UNC attempt to maintain continuity of personnel specifically trained/designated to work within the framework of the PTHE project for its duration.

9. Regarding lines of communications and designated roles of major donor agencies:

a) That USAID/Y consult with the PTHE team (UNC/MOH collective) prior to mailing correspondence affecting the PTHE Project to the Ministry of Health.

b) That MOH, USAID/Y and UNC reach agreement regarding lines of communication and roles and responsibilities outlined in this document on pp. 25-27 and in Appendix D.

10. Regarding improved coordination of PTHE project:

a) Formation of a coordinating sub-committee of critical donor agencies (UNICEF, Peace Corps, USAID/Y-Project Manager, Chief of Project, and one MOH representative from the PTHE team)

to meet every month regarding PTHE project plans, execution and evaluation. Findings and problems raised are to be presented to the formal coordinating committee.

b) Presentation of PTHE Project issues and reports, as appropriate, before the existing MOH intra-ministerial coordination committee in order to promote horizontal flow of information.

c) To promote vertical flow of information within the MOH and other related ministries:

- Tours be made of the project areas approximately every 2 months by PTHE technicians, other participating donor agencies, and related services/ministries.

- Information discussions be held approximately every 30 days with administrative officials by PTHE team members, including field level personnel. (Especially since the role of préfets and sous-préfets is one of overall coordination of sectoral involvement.)

11. That the Ministry of Health provide an accounting to USAID/Y of MOH funds allocated and disbursed for the PTHE project for the GURC fiscal year 1979/80, as well as for each fiscal year through the remainder of the project period.

12. That an in-house evaluation of the status of the Program for the Health Sector Institutions be scheduled for December, 1980 by USAID, UNC and MOH. Based on evaluation results, consideration be given to extension of the UNC contract in order to ensure that one or two graduating classes from CUSS, ENISFAY and OCEAC, etc al. have experience with the PTHE Project in the Mefou or the Kadey.

13. That monies originally allocated (approximately \$95,000) for upper level health education training and/or conferences be used to implement the Program of Practical Training Workshops for Middle and Upper Level Health Personnel involved in the PTHE Project. (Refer to output No. 8)

14. Regarding development work in the Kadey:

- a) that the PTHE Project maintain community organization efforts in the Kadey, drawing especially on the expertise of the new and experienced UNC Community Organization technician, as part of a process for gathering needed information about the peoples of the region. We refer the PTHE technicians to the theoretical discussion of the problems in the Special Remarks Section.

b) that prior to initiating further development activities in the Kadey (e.g. such as MEDCAM), USAID implement a socio-anthropological study of the area in order to:

- understand the socio-anthropological factors contributing to the current status of underdevelopment, and
- help develop strategies for achieving success of projects.

15. That MEDCAM project planners review this evaluation report and plan future integration of the PTHE-trained "itinerant agents" into the MEDCAM program, particularly in the Kadey districts where the programs will eventually overlap. Experienced itinerant agents could help develop community organizations and could train and/or supervise the residential village health worker envisioned by MEDCAM.

16. That the organizations designated take the following actions essential to the operation of the Audio-Visual Workshop:

- a) MOH: immediate hiring, assignment or transfer of an audio-visual technician and an artist; continue construction on the building site designated.
- b) Peace Corps: placement of a new PCV with appropriate qualifications, as determined by Peace Corps.
- c) Ministry of Finance: investigation of more efficient procurement of audio-visual materials and supplies through customs duty waivers.

17. That use of donated construction materials be limited, and that they be used only for public facilities (i.e. schools, health centers, etc) for which work will be provided by local initiative. That U.S. Embassy Self-Help funds be utilized only if they can be channeled more directly through local Cameroonian community organizations.

PROGRAM EVALUATION SUMMARY (PES): PART II

13. SUMMARY

The Practical Training in Health Education Project is behind schedule in relation to the original project purpose. The mid-term evaluation team assesses the causes for this as follows:

- The original project design was overly ambitious, particularly in attempting to integrate health education curricula into village schools on a national basis. This objective alone could constitute a four (4) year project;

- Unforeseen personnel problems, particularly change of UNC Chief of Project in the first year and delay in replacing the UNC Community Development Technician;

- Problems of communication and differences in project conceptualization among USAID, the contract agency (UNC) and the Ministry of Health (MOH);

- Inadequate administrative support within the project for training activities and for logistical support of the Village Health Committee Program.

Despite early set-backs, the existing UNC/MOH field team has made significant progress toward achieving specific end of project objectives. as follows:

- Formation of an operational coordinating committee composed of the donor organizations, related agencies and ministries, and integrated into the MOH administrative structure for the project.

- Inclusion of MOH health personnel at all levels (national, provincial, departmental and district) in planning PTHE activities and in training of personnel in both the Mafou and Kadey districts.

- Training activities benefitting significant numbers of health personnel at all levels, including the development of a new cadre: the itinerant agent.

- Development of viable health education field training sites in the Mefou for future classes of students from CUSS, ENISFAY and OCEAC.

14. EVALUATION METHODOLOGY

The project paper calls for a mid-term evaluation to be conducted by USAID in order to assess progress to date as measured against the indicators specified in the PTHE project paper and project agreements. The purpose of this evaluation is to assist the Government of Cameroon (GURC) and USAID/Yaounde to make revisions in the project implementation plan as indicated.

The evaluation was conducted by a team composed of three persons:

- a designate from the MOH, Directorate of Statistics and Plan, with experience in evaluation and health education;
- an M.P.H. Health Educator from the U.S. with diverse experiences in health education program administration; and
- a Dutch volunteer with 6 years of field experience in Cameroon in clinical and preventive Maternal and Child Health Care.

The following methods were utilized by the team:

- A. Analysis of available documents regarding the project, including the project paper, project agreement, project reports, the Project Evaluation Summary format (PES), and a MEDCAM project design document. A noteworthy initial oversight was the UNC response to the AID Request for Proposals; that report, however, was made available to the team following the first draft report.
- B. Interviews with appropriate authorities in the offices and agencies involved (individual and group format). (See Appendix A).
- C. Informal surveys in the field (personnel in the health centers - including 20 itinerant agents and volunteers, 15 key members of village health committees, and several randomly selected villagers).
- D. Observation of actual projects and activities in the field, including 20 latrines, ten improved water sources, several animal enclosures and garbage pits, one village health committee meeting, and one school health education session.

In order to evaluate actual progress of the project against projected targets, the evaluation team referred to the Project Paper (PP), the UNC/AID Contract Agreement (C.A.), and the UNC Annual Report (AR). Those documents, plus the technical proposal submitted by UNC to AID in 1978 and the evaluation team's interviews and observations, have served as the basis for comments and recommendations for the future of the project.

It should be noted that the assessment of project status of one output in particular, the Village Health Committees, is based on data reflecting only 12 months of field activity, because of lack of complete data for the 18-month period. This deficiency is primarily due to the fact that field reports must pass through MOH hierarchical channels before reaching the PTHE project staff.

Remarks Regarding the Evaluation Process

All interviews were conducted in French and, because of the composition of the evaluation team, the initial draft report was written in French for translation into English. The evaluation of such projects, using AID's Project Evaluation Summary (PES), would be facilitated by:

- translation of all project documents and the PES forms and instructions into French; and
- allowing adequate time for the evaluation team and also project team members to become familiar with the "logical framework".

15. EXTERNAL FACTORS

There were no major changes in the contextual setting of the project. Nevertheless, several external factors have had an influence on the implementation of the project, with the major effect of slowing output achievement.

Inputs were not supplied on time especially with relation to designation and replacement of project personnel. The original Chief of Party for the project was removed from her position in April 1979 following continued dissatisfaction by donor agencies with her performance in that role. Dr. Darryll Candy, the UNC Community Organization technician, was moved into the role of Acting Chief of Party - later to be named Chief of Party - leaving the technician role vacant. This technician position remained vacant until January 1980 due to delays in recruitment on the part of UNC, and then notification delays of rejection and later of acceptance of proposed UNC candidates by USAID. This represented a loss of approximately 8-9 person-months of technical assistance.

During the 18-month life of the PTHE project, it has had three USAID/Yaounde project managers.

The time required to begin to integrate the project into the MOH structure was underestimated. Among other factors this led to delays in naming counterparts to the project.

There has been a disturbing lack of continuity of personnel in the health centers participating in the PTHE project. Of the 17 health centers involved, only five have had no personnel changes in the past 18 months. Changes have included: 4 changes in chief nurses; 3 changes of itinerant agents; 5 PCV changes, including one transfer and 4 terminations; 1 center with no itinerant agent named as counterpart to the PCV and 2 centers where itinerant agent appointments have not been made. Obviously these losses represent a waste of countless person-hours of training, since most of the training activities to date have focussed on personnel in these health centers. (Refer to Recommendation No. 8)

Significant delays in inputs were due to communication problems between the major donor agencies. In a collaborative effort of this magnitude, it is not surprising that delays caused by the internal workings of three large bureaucracies would lead to strained relations, misunderstandings, and different conceptual approaches.

One major communication problem led to a delay of 11 months (from June 1978 until April 1979) of a contract modification to release funds from the UNC/Chapel Hill contract to USAID/Yaounde for program expenditures. This meant that much PTHE field staff time was directed away from important initial project activities, such as gathering baseline data in the villages. A review of historical and current communication problems, plus responsibilities and proposed lines of communication appears in the Special Remarks Section on pp. 25-29

An important project assumption dealt with logistical and supervisory support for the Village Health Committee Program. There have been extensive problems with break-downs of the UNICEF motorcycles, lack of garages for repairs, non-availability of parts, and lack of administrative personnel time identified in the project paper to deal with such time-consuming matters. In addition, there has been, and continues to be, a lack of transportation at the departmental level for supervision of the program in the villages.

Important assumptions which continue to operate and which will definitely affect achievement of project purpose are as follows:

- that the Ministry of Health will continue to provide adequate, on-going budget allocations for the existing itinerant agent programs in the Kadey and Mefou districts (See Recommendation No. 2); and

- that a viable health education field experience can be developed in the Kadey, in spite of the diversity and mobility of the population.

The amenability of the population to known community development techniques is also an assumption at the purpose level, important to goal achievement. An in-depth discussion of the problems and challenges posed by working with the peoples of the Kadey appears in the Special Remarks Section, pp. 30-32

An assumption that continues to be important to goal achievement (goal. "To increase the ability of the rural populations and other underprivileged groups to participate in development activities") is that simultaneous efforts will be made by other sectors (especially agriculture, education, civil engineering, etc.) to reach out to rural populations, so that broad socio-economic incentives will exist for organized community development efforts to continue. There is more evidence of this level of development in the Mafou than in the Kadey. Within the project areas, collaborative efforts at both the national and village level are in an embryonic stage, with the Ministry of Agriculture (Community Development), the Ministry of National Education (regarding primary school health education curricula) and with the Ministry of Social Affairs.

16. INPUTS

Inputs are organized according to donor agency and evaluated in terms of quantity, quality and timeliness in relation to the design of the original project paper. Certain issues of timeliness have already been discussed under external factors. These will only be briefly alluded to below.

USAID

<u>Planned</u>	<u>Status as of March 1980</u>
Role Primary resource for long and short term technical assistance.	
In-country training: 10,000 Person/Days	(Untabulated) Person/Days
Money Obligated: \$314,250	\$87,000 spent
<u>Scholarships</u>	
668 Person/Months	(Reduced to projected 96 P/M out of country)
Money Obligated: \$80,000	0 money spent

<u>Health Education Conferences:</u> 4	0 Health Conferences
Money Obligated: \$32,000	\$4,800 spent (international travel)
<u>Mid-Project Evaluation</u>	Contract Negotiated
Money Obligated: \$25,000	\$17,000 spent
<u>Commodities</u>	
3 Vehicles and POL	3 Vehicles and POL
(and maintenance)	(Monies maintenance transferred to contractor)

Discussion:

Input response by USAID is mostly inadequate in terms of timeliness, due in part to communication problems between UNC/Chapel Hill and 3 USAID officers: TRICA/Development Resources/W, the Contracts Office/W and AID/Yaounde.

This led to constraints on two major inputs as mentioned under External Factors:

- The contract modification to release funds from the UNC/Chapel Hill contract to USAID/Yaounde for program expenditures took from June 1978 until April 1979.
- There was significant time delay involved in notifying UNC/Chapel Hill of rejection of the UNC candidate designated as 3rd technician (approximately 3 months) and later a delay in notifying acceptance of the current technician (1 1/2 months).

Two issues of input quality should be raised within the 18-month life of the project. USAID/Yaounde has assigned three different managers to the PTHE project. Lack of continuity of personnel is inefficient and leads to lack of follow-up on important policy issues, commodity orders, etc. This may account for the loss and lack of follow-up on a request for audio-visual workshop materials, causing a delay of several months.

UNC/Chapel Hill/Yaoundé

Role: Contract agency for long term technical assistance

Planned

Status as of March 1980

Yaoundé

1 Chief of Project 48 Person Months	30 Person Months Chief of Project*
1 Training technician 48 Person Months	21 Person Months Training technician

*Includes 12 months personal services contract with Dr. Candy prior to UNC contract.

1 Community Organization technician 48 Person Months	10 Person Months Community Organization
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Total Person Months: 144

Total Person Months: 61

Chapel Hill

1 Administrator (Seaton) 48 P/M	21 Person Months
1 Project Coordinator (Hatch) 16 P.M	7 Person Months
1 Associate Project Coordinator (Stewart) 16 P.M	7 Person Months
1 Assistant Project Coordinator (Islev) 24 P/M	2 Person Months

Discussion:

The original Chief of Party lacked the personal/coordination skills required for the role and functions designated. (It should be noted that responsibility for her selection was shared by USAID/Y and MOH.)

The delay in recruitment of a third technician was due in large part to an inadequate file of qualified technicians for francophone Africa. This led to much time spent in recruitment; (approximately 4 months altogether). Combined with AID delays a total of 3 man-months of Community Organization technician time was lost to the project. It is difficult to measure the impact of this loss. It may be part of the explanation for the inadequacy of community organization techniques for the different groups in the Kadey and why there has been less value placed on process and the teaching/catalyst role of Peace Corps Volunteers and itinerant agents.

The current PTHE team is competent and effective, including the temporary duty employees sent for short-term assignments.

The UNC training technician has had to spend anywhere from 10-35% of her time in the past 18 months on administrative matters involved in disbursement of training funds and maintenance of the fleet of motorcycles for the Village Health Committee, Program. The amount of time required for these administrative functions was not foreseen in the project paper. Since this diverts time of UNC personnel away from technical assistance, it is to be removed from UNC field staff responsibilities. (See below under MOH-Inputs.)

The UNC/Chapel Hill staff has developed an enlarged file of resumes of persons qualified to work in French-speaking West Africa and plans to update this file periodically. The evaluation team assesses that they are capable of providing the necessary technical backstopping for the project.

MOH/Cameroon

Planned

Status as of March 1980

Role: Overall project direction and the provision of MOH personnel for training.

Personnel:

1 Project Director
3 counterpart/technicians
(devoting 50-80% of time)

1 Project Director
2 Technical counterparts

Budget support allocated:

FY 79/80 - 20 million CFA

Budget support received:
(unknown)*

Subsequent Agreement:

Between USAID and MOH in 1978:
identified 1 fiscal person and
1 assistant

1 bookkeeper/administrator

*USAID/Y has corresponded with MOH regarding their budget inputs and is awaiting a response.

Discussion:

Personnel

MOH involvement is spread between one project director, who is the Director of Preventive Medicine and Public Health and therefore extremely busy with other MOH administrative and policy concerns, and 2 technical counterparts. There is a need for an additional technical counterpart.

There was some initial delay in naming the existing two technical counterparts.

The first-designated training counterpart was replaced in November 1979 because she could not meet the time requirements of the post. Nevertheless, she held a position in the Training Division of the MOH. The new counterpart is more accessible, but does not have a position in the MOH Training Division. This raises some concern in relationship to institutionalization of the project at a national level. (This is the rationale for Recommendation No. 7).

The agreement reached between USAID and MOH in 1978 identified 2 MOH fiscal and budgetary persons to account for and disburse all in-country training funds, including signing of checks.

Currently, there is only one person handling these administrative matters. Since accountability still rests partially in the hands of the UNC Chief of Party, UNC technical staff inevitably spend time inappropriately on back-stopping and accounting for these MOH administrative matters. The evaluation team suggests that the current MOH administrative person can satisfactorily manage these fiscal and administrative matters and that the USAID/Y project manager can and should assume the role of accounting for MOH expenditures. (Refer to Recommendation No. 4c.)

* In addition to accountability for training funds, including project funding for per diem and honoraria, this MOH administrative person will gradually take over management of the fleet of project motorcycles. Both of these issues: payment of per diem and honoraria and motorcycle management are discussed in the Special Remarks Section.

Budget Support:

In terms of budgetary support, a total of 20,000,000 CFA (\$100,000) was allocated to the PTHE project for GURC fiscal

fiscal year 1979-80. We do not have an account of how these funds are being used, or what percentage is actually available for PTHE activities. This information should be prepared by the MOH for submission to USAID/Y. (Refer to Recommendation No. 11).

The budget for GURC fiscal year 1980-81 is currently in preparation, but we were not able to obtain any precise budget figures. These will be subject to approval of the National Assembly which meets in May 1980.

The question of the ability of the MOH to absorb recurrent costs of the project following withdrawal of donor inputs seems to hinge on a critical question -- namely, to what degree should this project be replicated nationwide?

The Ministry of Health Project Director perceives PTHE as a pilot project whose End of Project Status will determine motivation for replication nationwide. This question will be discussed with relation to project outputs and purpose, as well as the steps necessary on the part of the MOH to manage the project as external financial resources are withdrawn.

PEACE CORPS

<u>Planned</u>	<u>Status as of March 1980</u>
24 volunteers as field workers	24 volunteers

Discussion:

Key problems with Peace Corps that have arisen are as follows:

- Inadequacy of in-country training (too brief, not practical)
- Initial volunteers assigned to PTHE project arrived prior to its integration at the field level, which led to role confusion by both volunteers and MOH personnel. Some volunteers still feel that their role is too unstructured.
- Lack of continuity of volunteers within project:
 - transfers after one year with no replacements (1), or terminations (4).
 - question of adequacy of 2-year assignments for PTHE project purpose, volunteers are just becoming effective towards the end of their two years. Extensions for one or two years should be encouraged within the framework of pilot projects such as PTHE, perhaps following a brief home leave.

- Results - orientation of certain volunteers. High value is placed on outputs as opposed to process and teaching/catalyst role to promote integration of PTHE activities into Cameroonian MOH. (This approach is reinforced by results-oriented GURC and donor agencies.)

The role of the Peace Corps Volunteer and training qualifications are dealt with specifically in the Special Remarks Section, pp. .

Similar to UNICEF, Peace Corps staff have expressed a desire for more contact and coordination of efforts with the PTHE project team.

WHO

<u>Planned</u>	<u>Status as of March 1980</u>
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One Professor, Scholarships, Consultant Services and Supplies, specifically provided to CUSS.	None
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WHO involvement in the project no longer exists, since the decision was made to develop bachelor and master's degree level health education training at a University in Cotonou.

UNICEF

<u>Planned</u>	<u>Status as of March 1980</u>
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200 Motorcycles	- 25 motorcycles received
Construction materials	- no actual order made for construction materials
Audio-visual materials .	- some audio-visual materials procured

Discussion:

UNICEF initially provided 25 motorcycles for use by itinerant agents and Peace Corps Volunteers. Three itinerant agents currently do not have a motorcycle. Subsequent problems of maintenance of the vehicles and a system for procurement of parts, led UNICEF to refuse additional motorcycles to the project until one of the participating agencies took over responsibility for maintenance.

Procurement of construction materials from UNICEF has proved difficult because their procurement mechanism requires orders of large quantities. The PTHE project needs these materials

on a limited and infrequent basis and has never submitted a collective order due to problems presented by storage.

Future inputs to the PTHE project by UNICEF are somewhat dependent on their negotiations in May 1980 with the Ministry of Health to develop a more global plan for health. UNICEF will continue to contribute commodities and services to the PTHE project, particularly if the zones selected by UNICEF for health programming overlap with the PTHE project districts.

Following discussion with UNICEF, the evaluation team perceived willingness to donate the following:

- additional motorcycles or mobylettes
- monies to train a mechanic to repair motorcycles
- motorcycle parts

UNICEF's willingness to contribute to the project seems to be related to their involvement with project planning, and an increased desire to be able to measure the impact of their inputs.

CUSS

Planned

Faculty support

Status as of March 1980

Faculty available for consultation

Discussion:

Given the change in upper level training plans by WHO, it now appears that CUSS inputs will be primarily in joint planning with PTHE of field training activities for 4th year medical students and CESSI students.

Although original plans for training health education bachelor and master's level students have changed, it seems that UNC/Chapel Hill could collaborate with CUSS, potentially through guest appearances, when UNC faculty visit Yaoundé. (Also refer to proposed Output No. 8, p. 19)

CIDA

Planned

Status as of March 1980

Faculty Support to CUSS

None

As a result of the change in WHO's plans, CIDA has no direct role in the project at this time.

OCEAC

Planned

Status as of March 1980

Facilities

Facilities provided for 1st 18 months of project. Office equipment was inadequate.

Consultant Services

No consultant services, except perhaps informally at the field level.

Training Program for field level workers

No training of field workers

Discussion:

The role of OCEAC has changed from that identified in the original project paper. It has not provided training for field workers. In fact, 15 OCEAC workers received training in the November 1979 workshop sponsored by PTME. Future OCEAC students should have an opportunity to be involved in the field training programs of PTME.

17. OUTPUTS

Output 1 Program of Village Health Committees (PP)

Quantifiable Indicator Set

Status as of Sept 1979

788 Village Health Committees (PP)

97 Village Health Committees Established

Discussion:

The original target set in the Project Paper of 788 villages was unrealistic.

The UHC Technical Report targets 500 Village Health Committees (VHC's) at the end of four years. The evaluation team believes this is still too ambitious, given that the total number of itinerant agents is only 63 for the four year project period. Each itinerant agent should work in an average of 6 villages (a total of 378) to allow for in-depth organization and a smaller radius of action. (Refer to Role of Peace Corps Volunteer and Itinerant Agent, on p 35).

According to the evaluation indicators identified in the project paper plan for Village Health Committees (p. 68) the revised formula would appear as follows:

$$\frac{\text{No. of committees formed}}{\text{Total no. of villages targeted}} \times 100 = \% \text{ of output}$$

In this instance then:

$$\frac{97}{378} \times 100 = 26\% \text{ total output achieved}$$

The current percentage of output achieved for 12 months of field activity is acceptable given problems with inputs and assumptions. Also, it is expected that the number of committees organized will increase more rapidly during the latter half of the project.

The evaluation team recommends the following indicators of success for future use:

Recommended Indicators:

1. 378 VHC's be established by September 1981, of which 80% will be active. (Refer to Appendix B for criteria of an active, i.e., effective, VHC.)

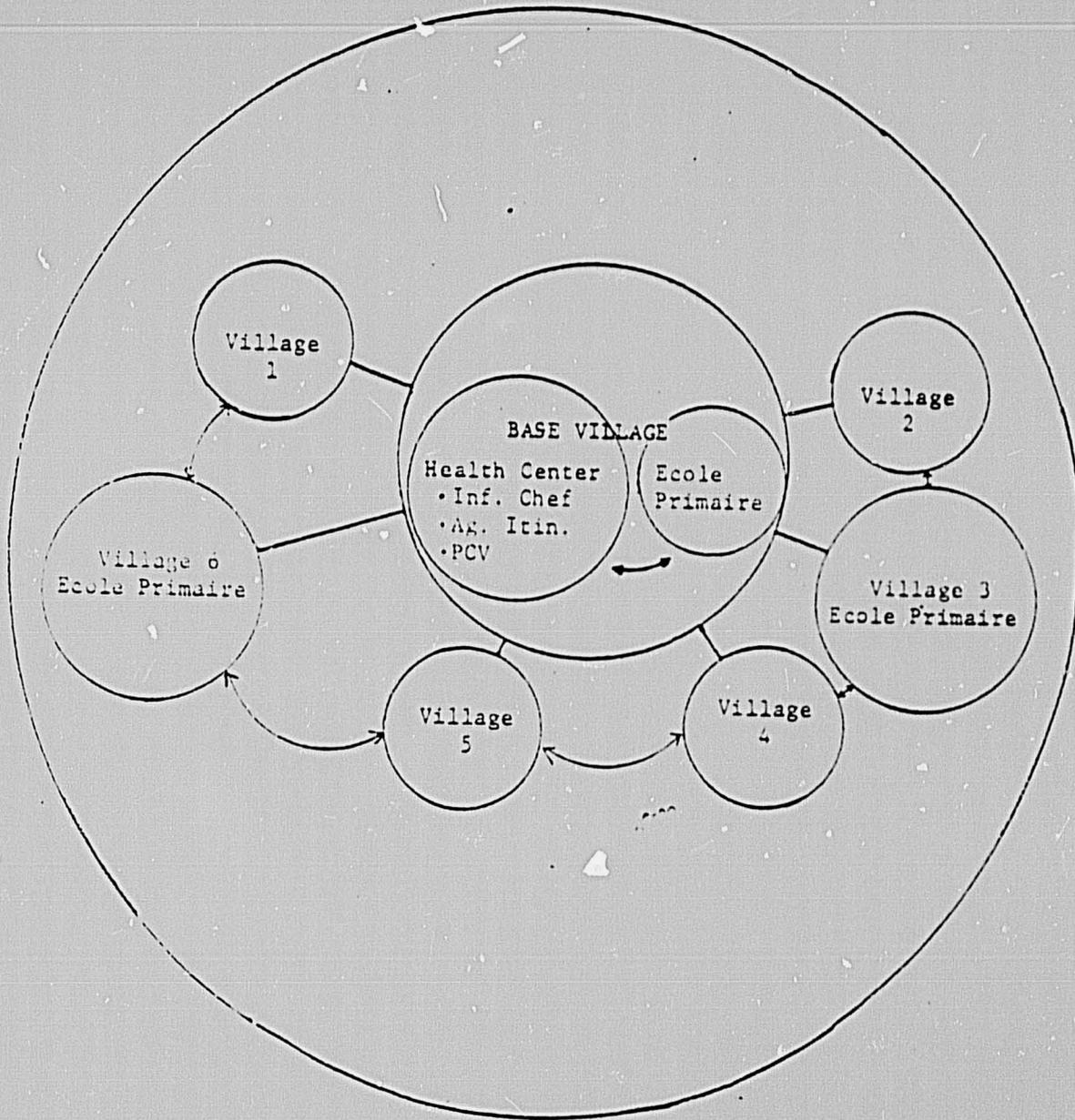
- a. _____ VHC's in the Kadey of which _____% are active.
- b. _____ VHC's in the Mafou of which _____% are active.

This will allow for evaluation of the overall effectiveness of committees as identified in the project paper by the following formula:

$$\frac{\text{No. of effective committees formed}}{\text{Total No. of committees formed}} \times 100 = \% \text{ effectiveness}$$

* To be determined by PTHE Team.

"RAYON D'ACTION" OF ITINERANT AGENT AND PCV



The rationale for the concept of the "rayon d'action" is to focus on a center and move outwards, drawing strength from 1) the diffusion of new ideas from towns to villages, 2) creating a smaller geographical area for the itinerant agent and PCV to work in, so as to be somewhat less reliant on motor-cycles, repair and fuel and 3) to increase the interactive effects between villages, villages and schools, health center and schools

Since there is such a difference in the socio-organizational nature of the populations in the Kadey and the Mefou, it would be helpful to separate the data from these two regions.

Output 2: Program of Teacher In-Service Training (PP)

<u>Quantifiable Indicator Set</u>	<u>Status as of March 1980</u>
511 Primary School Teachers Trained	89 teachers have been contacted/interviewed 0 teachers actually trained Plans negotiated for in-service training of primary school teachers in mid-1980.

Discussion:

This output is behind schedule. The evaluation team considers the original output too ambitious given the project duration and existing resources.

We proposed a revised output:

Revised Output 2: Health Education Program for Primary Schools Initiated

Recommended Indicators:

2a. Health education curriculum developed and piloted in 4 schools in the Kadey and 4 schools in Mefou districts by September 1981.

2b. School Health Education Subcommittee functioning and effective, as evidenced by:

- regular meetings
- regular attendance of all participants
- production of useful and feasible policy and technical recommendations

Output 3: Program of Recycling for Health and Other Workers (PP)

<u>Quantifiable Indicators Set</u>	<u>Status as of March 1980</u>
a. 120 field level workers trained (PP)	18 itinerant agents trained
b. 160 health and other workers recycled	117 health center personnel recycled and 35 other workers recycled

Discussion:

Re 3a: 120 itinerant agents is an unrealistic indicator. The evaluation team, in conjunction with the UNC staff, arrived at the number of 63 itinerant agents as a realistic four-year target.

Using this figure in the formula for effectiveness, the training of 18 itinerant agents means achievement of 28% of total output. The evaluation team still considers this inadequate in light of the importance of this output to an effective field site experience for students.

Re 3b: the high percent of recyclage of health and other workers (i.e. 95% of total output) demonstrates a shift in focus in output nature and priority, which the evaluation team would reflect in re-conceptualization of the project output as follows:

Recommended Output 3:

Program of Educational Activities Organized for Entire Health Center Team, to include:

- a. recyclage of health personnel (including team concept)
- b. follow-up visits to health centers by PTHE personnel

Proposed Indicators:

a. 63 itinerant agents and 160 health workers "effectively" retrained by September 1981. "Effectively trained" workers will be defined as those utilizing training as indicated by increases in their health education activities. (Refer to Appendix C). Records should be kept of number of training session contacts with each health worker.

- Health Center Team Meetings held regularly (Appendix C)

b. Five follow-up visits by PTHE team members per year to each health center.

Output 4: Program for the Health Sector Institutions: CUSS, ENISFAY and OCEAC. (PP)

Quantifiable Indicators Set

Status as of March 1980

100 mid-level student nurses trained (PP) 0 trained

<u>Quantifiable Indicators Set (cont)</u>	<u>Status as of March 1980</u>
400 Professional level CUSS (and CESSI) students trained (PP)	0 trained; 80 to be trained in April 1980
313 ENISFAY students trained (PP)	0 trained
10 ENISFAY Faculty trained (PF)	2 trained in November 1979 Seminar

Proposed Indicators:

- a. ____* ENISFAY students will have completed ____* weeks PTHE field experience by September 1981.
- b. ____* OCEAC students will have completed ____* weeks PTHE field experience by September 1981.
- c. ____* CUSS students will have completed ____* weeks PTHE field experience by September 1981.
- d. ____* Other (to be identified) will have completed ____* weeks PTHE field experience by September 1981.
- e. ____* ENISFAY faculty will have received ____* hrs. of training by September 1981.

Discussion:

It is in this output that the project is most significantly behind target, although the PTHE team has established communication with the appropriate authorities regarding the PTHE Project and its proposed relationship to the institutions' various activities. (Refer to further discussion under End of Project Status, p.).

Output 5: Develop an appropriate operational framework for the major participating agencies to plan, carry out and evaluate the practical system of health education activities. (UNC contract)

<u>Quantifiable Indicators Set</u>	<u>Status as of March 1980</u>
No indicators specified for success of this activity in PP or UNC contract.	a. An interagency coordination committee composed of the following core agencies has met every six months to date (i.e. in June 1979 and December 1979):

* Target numbers to be established by PTHE Team.

Status as of March 1980 (cont)
Core Agencies: CUSS, ENISFAY,
OCEAC, Peace Corps, UNICEF,
USAID, Ministries of National
Education and Agriculture.

b. An inter-ministry sub-committee (Health and Education) was formed in December 1979, charged with the development of a health education program in the primary schools. It has met 3 times; in Jan, Feb and Mar 1980.

Recommended output indicators for the Coordinating Committee:

- regular meetings (every 6 mos.)
- regular attendance by core agencies
- production policy and technical recommendations
- adherence to role as adopted in first formal session (Refer to Appendix D)

Discussion:

The Coordinating Committee established within the Ministry of Health has facilitated coordinating between related Ministries and other donor agencies.

Two donor agencies, the Peace Corps and UNICEF have indicated a need for more frequent or a different kind of interaction with the PTHE staff to maximize coordination at the field level.

The two specific instances of lack of communication or coordination which the evaluation team witnessed were at the provincial and departmental levels:

- Personnel in the Office of Health Education at the provincial level in the Kadey were not familiar with or involved in PTHE field activities.

- CARE, an American organization, provides construction materials to villages in the Kadey (under the auspices of the Civil Engineering Service of the Ministry of Agriculture). Its efforts are not coordinated with the PTHE Village Health Program at the field level. Because CARE provides free construction materials to villages, its approach tends to undermine the "local materials" approach of PTHE.

Many of these coordination problems derive from the slowness of communication within the hierarchical structure of the Ministry of Health.

In order to improve coordination among critical donor agencies the evaluation team formulated Recommendation No. 10.

Output 6: Provide an evaluation strategy for the entire project.

Quantifiable Indicators Set

Status as of March 1980

No indicators of success identified in UNC contract, particularly End of Project Status indicators

The UNC technical report written in 1978 identifies objectives, indicators of success and a timeline for project implementation.

No revision or update which allows for assessment of progress (Refer to Recommendation No. 5)

The team recommends that the PTHE project team prepare a revised evaluation scheme for AID review (preferably using the logical framework) based on revised outputs and indicators, and on PTHE experiences to date.

Output 7. Keep account of expenditures by documentation of all training provided under this project and submit to USAID/Yaounde the necessary vouchers.

Discussion:

The evaluation team suggests that this is not an output but rather an activity analogous to other management functions to be performed by an appropriate administrative agent. (also refer to Recommendation No. 4a.)

The evaluation team also proposes two additional outputs (No. 8 and No. 9) as important to project success.

Output 8: Program of practical training workshops organized for middle and upper level health personnel involved in the PTHE project.

Quantifiable Indicators Suggested:

- 20 middle and upper level MOH personnel involved in PTHE project will receive a 2-4 weeks training in preventive health education by UNC/Chapel Hill staff by September 1981. (In Yaounde or Chapel Hill)

The evaluation team recommends that the monies originally allocated for upper level health education training and/or conferences (approximately \$95,000) be used for this output, with the dual purpose of:

- providing an opportunity for MOH curative personnel to gain greater knowledge of a preventive approach, and
- involving UNC/Chapel Hill faculty in more experiential technical role.

Proposed Output 9: Audio-visual workshop constructed, equipped and operational

<u>Quantifiable Indicators Suggested:</u>	<u>Status as of March 1980</u>
a. An audio-visual workshop will be operational by October 1980 staffed by three technically trained personnel:	Although never identified as a formal output, inputs have been provided by the MOH and USAID for this output.
1 PCV specialist (communication)	Status is assessed as follows:
1 Cameroon specialist (photographer)	
1 Cameroon artist	
b. _____ posters will be produced by September 1981	- construction of facility begun, but progress arrested by MOH and MIN. of Finance
c. _____ brochures will be produced by September 1981.	- some materials stocked
	- essential equipment and supplies still not received
	- current PCV technician to leave by May 1980.

Due to the problems with inputs for the audio-visual workshop, the evaluation team developed Recommendation No. 15.

18. PURPOSE

"To develop and implement a nationally coordinated practical training system of health education activities responding to the needs of rural populations and other under-privileged groups in Africa. Initial project activities will take place in the Kadey and Mefou districts of Cameroon."

<u>End of Project Status 1 (EOPS)</u>	<u>Status as of March 1980</u>
1. Coordination by MOH of practical training programs conducted by CUSS, OCEAC, and ENISFAY (as stated in PF).	1a. The MOH is fulfilling its obligation of overall coordination and liaison among project participants.

Indicators to be determined by PTHE team.

Status as of March 1980 (cont)

1b. The practical training program is established with CUSS. (30 students will be placed in the field in April 1980.)

1c. Negotiations between PTHE team and other institutions are in process.

Recommended EOPS:

1a. Continued effective operation of Inter-Agency Coordinating Committee and Subcommittees.

1b. Field training (using the PTHE sites in Kadey and Mefou) integrated into the programs of the various schools.

End of Project Status 2:

2. Integration of Health into other socio-economic programs in the village (as stated in PP).

There is evidence of collaboration between health workers and other sectors.

- primary school personnel
- community development personnel (Ministry of Agriculture)
- personnel from the Ministry of Social Affairs

Recommended EOPS:

2. Health projects undertaken in collaboration with other sectors by September 1981.

_____ * in the Kadey

_____ * in the Mefou

* to be established by the PTHE team.

End of Project Status 3

Status as of March 1980

3. Modification of educational objectives by institutions (in EOPS No. 1) to match reality of village life. (As stated in the PP).

No known change in curriculum to date

Recommended EOPS:

3. "Expanded" practical health education curriculum in training programs of CUSS, CESSI, EMISFAY and OCEAC by September 1981. (Expanded needs to be defined/developed by the PTHE project).

End of Project Status 4

4. Continuous reassessment of project impact on villages - of services provided (as stated in PP)

Remark: This type of measurement can be attained more quantifiably at the output level, i.e. number of active village committees, projects completed, etc.

Discussion:

Although behind schedule as mentioned in the project summary, the PTHE team is making significant progress in terms of establishing a nationally coordinated training system of health education activities - with an initial base in the Mefou and Kadey districts of Cameroon. The project has remained very true to the plan set out by the original project paper, which was an excellent base document.

The evaluation team suggests that strong emphasis be placed on Output No. 1 (the Village Health Committee Program), the revised Output No. 3 (the Program of Recyclage for Health and Other Workers) and Output No. 4 (the Program for the Health Sector Institutions), in order to create a viable field training experience for future classes of students from CUSS, EMISFAY, OCEAC, and other schools. Learning objectives need to be established for each level of health personnel involved so that field experiences can be evaluated.

The team also proposes that an in-house evaluation of the status of the Health Sector Institutions Program (USAID/UNC/MOH) be scheduled for December 1980. Following the status report from this evaluation consideration should be given to extending the project contract as appropriate to allow for two or three graduating classes of each institution to have experience with PTHE program in the Mefou or Kadey. This will allow for gathering feedback from students on the part of

the PTHE team and the faculty of the various schools. This feedback period will be critical to program improvement, and will provide the necessary impetus for sustaining the program over time. (Refer to Recommendation No. 12).

It is deemed quite likely by the evaluation team that these three outputs (Nos. 1, 3 and 4) together will lead to a field training system for health education which can be maintained by the MOH, especially because of minimal recurring costs.

Currently, field training costs for CUSS (including CESSI) students are provided by the Ministry of Education, and field training costs for ENISFAY and OCEAC students are provided by the Ministry of Health.

ENISFAY students already participate in established field training experiences. It seems reasonable that many of the students could be transferred to the PTHE sites - if not to the Kadey, then at least to the Mefou sites.

One aspect of the project that differs from the original design involves the expected preparation of master's level students in health education. As indicated, WHO changed the base of this training from Cameroon to Benin. Thus, it is still available to french-speaking West Africans seeking advanced study in health education.

The project paper originally predicted possible extension of the PTHE project nationwide. This idea preceded plans for MEDCAM, which to some extent pre-empts and conflicts with plans for extension of the PTHE project. Consequently, the evaluation team suggests that the establishment of viable field training programs for CUSS, ENISFAY and OCEAC in the Mefou and Kadey districts, coordinated by the Ministry of Health, can stand alone as the critical measurement of project success.

19. GOAL

"To increase the ability of the rural populations and other underprivileged groups to participate in development activities."

Despite the fact that the goal is both global and complex, visible progress is being made in the Mefou. Organization of the population into active committees is taking place, and these committees have undertaken projects which will contribute to an improvement in health status (i.e. latrines, improved water sources, animal enclosures, garbage pits, etc).

In the Kadey, by contrast, certain phenomena suggest that innovative community development approaches will be needed to deal with the diversity and mobility of the population, as discussed in the Special Remarks Section, pp.

In addition, the activities undertaken by the committees are primarily limited to environmental problems related to health. It is hoped, nonetheless, that this organizational format will constitute a solid base for the implementation of other GURC-based community activities intended to promote self-reliance in the rural areas.

20. BENEFICIARIES

Despite extensive and intensive efforts to establish direct casual relationships between specific health/environmental aid projects in rural areas and improvement in health or socio-economic status of the population, no such linkages have been proved by experts in the field.

The PTHE project was specifically conceived as an effort to improve an overall environmental situation, which is recognized as a prerequisite to improving the health and quality of life of rural populations.

The evaluation team conjectures that the most significant, long-term benefits of this project will result from the "spread effects" of training students for later health education work all over Cameroon.

21. UNPLANNED EFFECTS

The development of a team spirit at the level of the health center is an important unplanned effect of the project, as a result of training experiences shared by all the personnel and of the integration of activities of the itinerant agents with those of other health center staff members.

It is also interesting to note that the relatively better communication and transportation structure in the Mefou has perhaps facilitated a competitive, results-oriented village health committee program. Lack of communication and transportation in the Kadey seems to make village competition less of an issue.

In the Kadey, the lack of curative medical supplies is so acute that departmental physicians seem somewhat more receptive to a preventive approach than their counterparts in the Mefou, who have more resources at their disposal.

22. LESSONS LEARNED

When undertaking a project that involves national coordination, a thorough assessment should be made of the infrastructure required to support the project. In the instance of this project no such study was undertaken. Both transportation and communication infrastructure are inadequate; this particularly hampers achievement of project success in the Kadey.

Long-range implications of short-term projects (i.e., a 4-year project) should be examined carefully during preparation of the project paper, especially when it concerns preparation of a new category of health worker. Establishment of health personnel categories should be part of long-range plans for the Ministry of Health.

In this particular project, we see the development and in-service training of a special category of health worker that should probably not be integrated as such into the curriculum of the national training school of "aides soignantes", especially as it does not fit into the plans identified for this category of worker by the MOH and in the MEDCAM project.

The MEDCAM project proposes to retrain the "aide soignant" as a primary health care worker who will supervise - from a base in the health center - the activities of health workers who reside in the villages. The special training of existing itinerant agents need not necessarily be lost to MEDCAM, and some MEDCAM curriculum changes for the "aide soignant" may develop out of the PTHE project experience. (refer to Recommendation No. 15, p. iV).

Choosing the least developed area of a country for development efforts is appropriate and is in accordance with AID and USAID/Yaounde strategy. The implications of this choice, however, should be carefully examined in seeking to establish realistic indicators of project success. It would also be advisable, prior to initiating further development activities in the Kadey, to invest time and money in a socio-anthropological study of the region in order to:

- understand the socio-anthropological factors contributing to the current status of underdevelopment, and
- help develop a strategy for achieving project success. (Refer to Recommendation No. 14).

Development of people, resources, organizational structures, and even changes in a single attitude, take a long time. In this project, we saw a direct correlation between visible project achievements and length of time and continuity of people in the field.

23. SPECIAL REMARKS

A. Scope of Work Question: assess project communication between/ among UNC Chapel Hill, UNC field team, AID/W, USAID/Yaounde, MOH, Peace Corps, and other donors.

Historical Problems of Communication:

According to UNC/Chapel Hill, there were initial communication problems between UNC/Chapel Hill and USAID/Washington, and a lack of clarification of the roles of the Contracts Office and the AFR/Development Resource Office vis-a-vis the PTHE project. This accentuated the initial budget transfer problems. These communication problems appear to have been resolved.

Initial communication problems between UNC/Chapel Hill and the UNC/Field Team have been improved immeasurably by once-a-week telephone calls. Indirectly, this appears to have improved communication between UNC/Chapel Hill and USAID/Yaounde. Occasional calls are made directly from UNC/Chapel Hill to USAID/Yaounde.

Current Problems of Communication:

There are still problems of communication between USAID/Y, UNC/Y and the MOH. To a certain extent, confusion exists between USAID/Y and UNC/Y because of different concepts of the PTHE "team". When UNC Field staff refer to the PTHE team, they are referring to the total MOH/Cameroon and UNC staff collective.

UNC field staff feel that USAID/Y really sees PTHE team as meaning the UNC field staff only, and that AID's tendency is to only deal with the UNC technicians.

On the other hand, the USAID/Y Health, Nutrition & Population Office (including the project manager) feels that when they refer to the PTHE team, they are referring only to the MOH staff, not the UNC technical advisors, who are seen as short term inputs to the overall project.

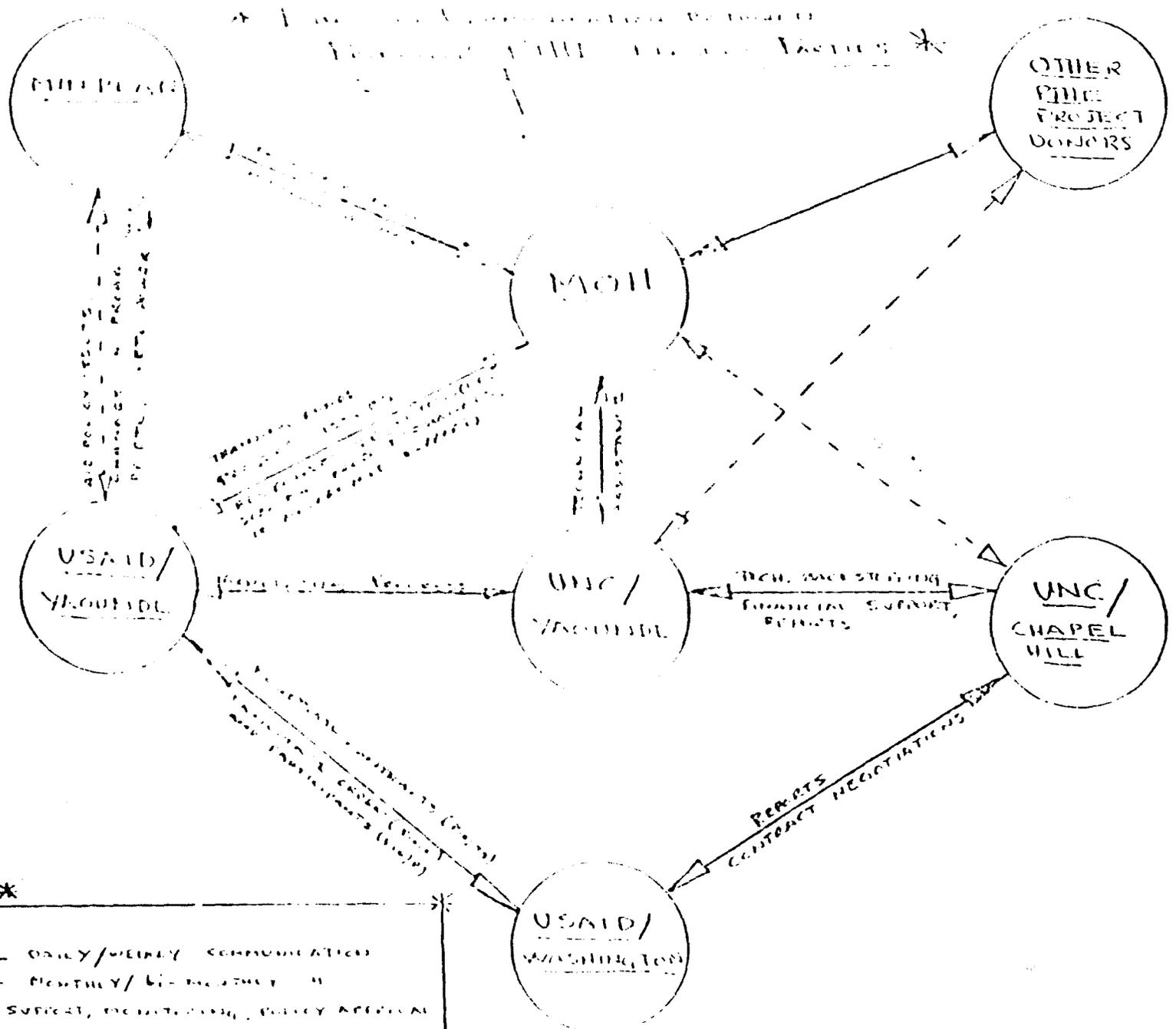
The evaluation team believes this problem can be resolved if

- 1) the project manager is involved in a regularly scheduled meeting involving a UNC technician and a MOH project representative (refer to Recommendation N° 10a) and

- 2) the PTHE team (i.e. UNC/MOH collective) is consulted by USAID/Y before correspondence affecting the PTHE project is mailed from USAID/Y to the Ministry of Economic Affairs and Planning and/or the Ministry of Health. (Refer to Recommendation N° 9a).

A recent (February 1980) letter from the Ministry of Health to the Director of USAID/Yaounde requests clarification of the role of AID/W and USAID/Y within the context of the project.

The following list of functions represents the team's assessment of this relationship, based on comments from both USAID/Y and the UNC field staff.



*** KEY ***

- ONLY/DAILY COMMUNICATION
- - - - MONTHLY/BI-MONTHLY
- ⇄ SUPPORT, IDENTIFYING, POLICY APPROVAL
- ⇨ REPORTING RESPONSIBILITY

f) USAID/Y communicates AID/policy to, and seeks approval from, Ministry of Economic Affairs and Planning on use of all AID donated funds to the project. USAID/Y initiates and seeks approval from AID/W for any project agreement amendments, changes in the project paper, and amendments to the UNC contract. A policy now established by GURC is that USAID/Y is to clear AID policy and agreements through the Ministry of Economic Affairs and planning which will then accordingly clear these internally with the MOH. This internal communication often doesn't take place. The MOH does have the power to veto USAID proposals and policies.

Part IV of the original project Paper defines the specific administrative responsibilities of the MOH, the coordinating committee, the MOH project Director, the Chief of Project and the U.S. Contract Institution. These are still valid. For ease of reference, they appear in Appendix D.

The following diagram (p. 38) attempts to illustrate the lines of communication and responsibility of the major donor agencies.

Current Problems of Communication with Other Donor Agencies

Both Peace Corps and UNICEF have expressed the sense of not being adequately involved with PTHE project activities, even though they are contributing agencies. It is clear that the Coordinating Committee, which meets every 6 months; does not satisfy the level of communication needs of these two agencies. (Refer to recommendation n° 10).

Diversity

Problem description

Villages visited by the evaluation team, like kette, Boubara and Kambele-Chantier are populated by several ethnic groups, all of which seem quite conscious of their differences.

Although the evaluation team did not have sufficient time for profound study, nor the necessary professional capabilities, the differences observed within each village (language, customs, level of development, lifestyle, daily occupations) do raise doubts as to considering a village a community. Although the different groups have difficulties in understanding each other's languages, the current PTHE approach seems to consider each village a community.

The evaluation team recommends a community approach rather than a village approach. This will necessitate 1) determining what communities make up these villages/regions 2) studying these communities, and 3) applying a community organization approach based on the findings. In a later phase, when the several groups are actually actively participating in development efforts, it might be possible to group them in order to promote a common development effort. This seems rather a question of generations than one which is achievable within the time set for the project.

Mobility :

Problem description :

Many people (mainly Baya) practising tobacco culture spend only three consecutive months per year in a fixed location, which is called their "village".

Perhaps another type of agriculture reducing mobility should be promoted.

As to the Bororos, a suggestion could be made to follow or visit them where they are, as well as to promote involvement of the agricultural sector for development of cattle-raising procedures in a fixed location. (cf. Ranch near Betare-Oya - World Bank). This would require a settlement project. As to the mobility of the traders, we do not know enough at this point to propose any recommendation/

C. Scope of Work Questions: Discuss project funding for per diem and honoraria

At the time of this evaluation, all per diem and honoraria for Cameroonians involved in PTHE project activities are paid for out of the AID-donated training budget administered by the MOH Project Director.

Currently, the PTHE project employs the system criteria and scale of payments for per diem currently developed by GURC for payment of personnel from its own fund. The known exceptions to this rule within the PTHE project have been: (1) a slightly larger supplement to "aides soignants" brought to a trained session in Yaounde on a once-a-year basis in order to cover actual costs of board and room; and (2) per diem paid to personnel for outside training (outside of their town or village).

Several questions have been raised during the investigation of this issue by the team, and need further study and dialogue between the Ministry of Health and USAID/Y, particularly since these issues affect MEDCAM, a project requiring significant and re-training and additional MOH supervision capacity. We propose the following questions:

1. To what extent does the MHH pay per diem and honoraria to its own personnel?

room and are considered very dangerous by several volunteers. Repair facilities for motorcycles are no adequate in either the Kadey or Mefou, and spare parts are difficult to obtain. Finally, all of these problems have meant that PTHE technicians have had to spent an inapporpriate amount of their time on vehicle maintenance. A new amendment to the project agreement will transfer approximately \$8,000 from AID to the MOH for maintenance of PTHE motorcycles. The PTHE staff assesses that this sum will cover the existing motorcycles for a six-month period.

This still leaves major questions unresolved, both for the remainder of the project period and for the epricd following withdrawal of IAD funds.

The evaluation team proposes a combination of solutions to this problem

Recommendations regarding PTHE Motorcycles and their maintenance.

Short Range Plan

. Encourage UNICEF to continue donations of motorcycles and/or mibilettes and spare parts for itinerant agents and Peace Corps Volunteers.

. Use the \$8,000 to be allocated to MOH for maintenance of vehicles of itinerant agents for the next six months, then recommend thta MOH provide a monthly supplement to the iti-nerant agent on a on-going basis.

. Repair system : Refer to Garage below.

Long Range Plan

Develop a personal credit system for the purchase of motorcycles and mibilettes. The itinerant agents will buy their own motorcycles in order to carry out their job func-

The Volunteer can also help organize health education activities and hygiene projects in the health centers or schools in the base village (which serves as the center of the zone of action) and in the smaller villages. (Refer to Recommendation N° 3b).

The evaluation team recommends that the PTHE project implement the concept of the "rayon d'action" (zone of action) where itinerant agents and volunteers serve as catalysts for health promotion. (Refer to diagram on p.24)

Emphasis will be on quality and depth of contact and interaction within a more concentrated area, as opposed to quality of separate villages contacted in a more superficial fashion, as conceived in the original project paper.

Currently itinerant agents and volunteers sometimes travel long distances to reach villages quite remote from the health center, often missing villages that are much closer in or not noticing possibilities within one's own personal "quartier". Sometimes it is easier to facilitate change in the smaller villages than in the towns, and certain villages are definitely more receptive to change than others, so that the "rayon d'action" is to be used as a conceptual model, not as a rigid plan of action.

With regard to training requirements for Peace Corps Volunteers, the evaluation team proposes the following:

. that health volunteers destined for the Cameroon have contact with- PTHE staff from UNC/Chapel Hill prior to departure so that volunteers can select to work in the project.

. that in-country training include:

1) practical traing in

- community organization techniques (including personal evaluation in terms of process and catalyst role.
- health education
- environmental hygiene

2) discussions with MOH personnel, PTHE staff, plus volunteers and itinerant agnets currently working in the project.

3) field visits to health centers, villages and primary schools_

In terms of qualification of Peace Corps Volunteers within the PTHE project, it would be desirable to select persons with the following characteristics:

- . background in community organization, general social sciences or communications
- . interest in and ability to speak languages (French and a 2nd dialect)
- . liking to work with people - basically social
- . self motivated
- . flexible, with a good sense of humor.

In terms of language training, learning French in training is essential, but techniques for learning local dialects

Appendix A

Persons Interviewed by the Project Team

USAID/Yaounde

- Dr. Richard C. Brown, Health Officer
- Mr. Douglas Palmer, Project Director to Practical Training in Health Education (PTHE)
- Mr. T.E. Bratrud, Jr. Evaluation Officer.

Ministere de la Sante Publique

- o Direction de la Medecine Preventive et l'Hygiene Publique
 - Dr. M'BAKOB Jacques-Rene, Directeur (et Directeur du Projet (PTHE))
 - Mr. JOE Elias, Chef de Service de l'Education Sanitaire
 - Dr. NDJIKEU Edmond, Chef de Service Adjoint de l'Education Sanitaire (member of PTHE Team)
 - Mr. NGOKA Jean, Chef de Service d'Hygiene et Assainissement
- o Direction de la Sante
 - Dr. ATANGANA Simon, Directeur
 - Mr. TCHOUMBA Ignace, Chef de Service de la Formation et du Perfectionnement
- o CUSS (Centre Universitaire des Sciences de la Sante)
 - Dr. NCHINDA Thomas, Co-ordinator of fourth year medical students

Ministere de l'Education

- Mr. NTOKO Wilfred, Chef de Service des Affaires Pedagogique et de la Formation
- Dr. TANGYIE Shu, Medecin de Service Sante Scholaire et Universitaire

KADEY

- o Bertoua
 - Dr. MOUCHILI Daniel, Délégué Provincial de la Sante Publique de l'Est
 - Dr. DAME Emmanuel, Chef de la Section Provinciale de la Medecine Preventive et de l'Hygiene Publique de l'Est

ZAPI

- Mr. AKANGANA Ndigie
- Mdm. BETOKNWELL Irene
- o Batouri
- Dr. NKOPCHIEU KOPSI Pierre, Chef de Service Départemental de la Santé Publique de la KADEY
- Dr. ONNA WEYI Pierre, Chef de la Section Départementale de la Médecine Préventive et Rurale de la KADEY
- Mr. KAIKO Michel, Adjoint au Chef de la Section Départementale de la Médecine Préventive et Rurale de la KADEY

MEFOU

- o Yaounde
- Dr. BCMBA NKOLO Denis, Délégué Provincial de la Santé Publique du Centre-Sud
- Dr. ZE MENA Pierre, Chef de Service Départemental de la Santé Publique de la MEFOU
- Mr. MEDJOTO Martin, Chef de la Section Départementale de la Médecine Préventive et Rurale de la MEFOU

Peace Corps

- Ms. Kathy TILFORD, Health Coordinator
- Seven Peace Corps Volunteers

UNICEF

- Ms. FISCH, Responsible for Project Inputs

UNC/YAOUNDE

- Dr. Darryl CANDY, Chief of Party
- Ms. Nancy MCCHAREN, Technician for Training
- Mr. Michael DAVIES, Technician for Community Organization
- Ms. Geni ENG, Research Assistant, Training Specialist temporarily assigned from UNC/Chapel Hill to address school health education program
- Ms. Marilyn WESTPHAL, temporary technician in charge of training

UNC/CHAPEL HILL (Interviewed by Karen Gridley only)

- Dr. John HATCH, Co-ordinator of PTHE Project
- Dr. Guy STEUART, Associate Co-ordinator of PTHE Project
- Mr. Paul SEATON, Administrator of Project

Associated Research Assistants and Faculty:

- Mr. Robert CONSTANTINO
- Dr. Tony WHITEHEAD
- Dr. Joyce KRAMER
- Dr. Preston SCHILLER

MEDCAM Design Team (Interviewed by Karen Gridley only)

- Dr. Eugene Boostrom, Principal Co-ordinator
- Mr. George Jamieson, Consultant
- Ms. Lindsay Robinson, Consultant

Appendix B.

Draft Criteria for Active Village Health Committee

Comité Actif: (Propositions)

Critères à Pointer

Réunions générales

nombre par trimestre: _____

assistance:

_____ 10 personnes
_____ entre 10 et 15 personnes
_____ plus de ;5 personnes

participation:

combien de personnes prennent
la parole au cours des réunions? 5 personnes _____
entre 5 et 10 _____
10 personnes _____

Réunions du comité

nombre par mois _____
assistance _____

Projets en cours (en chiffres)

Autres (à préciser)

latrines _____
points d'eau _____
fosse à ordures _____
enclos pour bêtes _____

Projets achévés (en chiffres)

Autres (à préciser)

latrines _____
points d'eau _____
fosse à ordures _____
enclos pour bêtes _____

Contacts - Liaison (oui ou non)

Contact prise avec:

Service de l'AHP _____

Service du Génie Rural _____

Service du développement Communautaire _____

Directeur de l'Ecole Primaire _____

M. Sous-Préfet _____

Autres services ou organismes (à préciser):

(Tels que: ZAPI

CARE

CRS

SODECOA

SOCODER

CDF-STC

Volontaires Hollandais

Etc.

Appendix C.

DRAFT EVALUATION FORM - PTHE 3-27-1980

Period From _____ to _____

Health Center _____ Méfou Kadey

Staff: Chief Nurse _____

Itinerant Agent _____

Peace Corps Volunteer _____

Auxiliary Midwife _____

Janitor _____

Others _____

Total number of villages normally served by this health center: _____

1. Health Center Action	1st Mo.	2nd Mo.	3rd Mo.
1. <u>CONTINUING EDUCATION</u>			
a. Health Center staff hold planned, regularly scheduled meetings for the purpose of improving their roles and the Center's services.			
b. Continuing education activities are sporadic and done through individual contracts as the need arises.			
2. <u>PATIENT EDUCATION</u> (Individual)			
a. Prevention oriented messages mostly.			
b. Treatment oriented messages mostly.			
3. <u>MATERNAL AND CHILD HEALTH</u>			
a. Prenatal services			
b. Post-natal services			
4. <u>DIDACTIC HEALTH INSTRUCTION</u>			
a. Staff prepare and present health talks to patients on a regular basis.			
b. Health talks are presented sporadically.			
5. <u>HEALTH FACILITIES</u>			
a. Latrine is available and regularly maintained.			
b. Clean water source is available and regularly maintained.			
c. Latrine construction is underway.			
d. Water point improvement is			

II. COMMUNITY ACTION (To be completed for each Village)

1. Name of Village _____

Total Population _____

	1st Mo.	2nd Mo.	3rd Mo.
a. Leaders identified and contacted			
b. Social diagnosis and power structure analysis done for a village.			
c. Committee formed in a village dealing with health issues regardless of who organized the committee.			
d. Committee formed and with one environmental/sanitation outcome or product for the village.			
e. Committee formed and with one more environmental/sanitation outcomes or products, for the village.			
f. Committee formed and with one agricultural/nutrition outcome or product for the village.			
g. Committee formed and with one more agricultural/nutrition outcome or product, than last month for the village.			
h. Primary school director contacted			
i. School with operating health curriculum.			
j. School having liaison with a community project.			
k. School with operating PTA.			
l. School latrine is available and regularly maintained.			
m. Clean water source is available to school and regularly maintained.			
n. School with environmental and/or sanitation project underway.			
o. School with agricultural and/or nutrition project underway.			

III. LIAISON

	1st No.	2nd No.	3rd No.	
1. Other agency personnel only contacted for work with PTHE. List by title:				
a. _____				
b. _____				
c. _____				
d. _____				
e. _____				
2. Other agency personnel contacted and involved with work of PTHE. List by title:				
a. _____				
b. _____				
c. _____				
d. _____				
e. _____				
3. Other health centers contacted to work with PTHE. List by Health Center name:				
a. _____				
b. _____				
c. _____				
4. Other health centers contacted and involved with work of PTHE. List by Health Center name:				
a. _____				
b. _____				

Appendix D.

From Project Paper: Practical Training in Health Education,
dated March 29, 1977

PART IV. IMPLEMENTATION PLANNING

A. Administrative Arrangements

Overview

As indicated in Figure 1, Project Organigram, the primary responsibility for the PTHE will be assumed by the Minister of Health/Cameroon through a coordinating committee consisting of representatives of those agencies or other ministerial departments involved with the PTHE Project. Additionally, the Minister of Health/Cameroon will assign a Project Director who will have responsibility for direct supervision of project staff and related project activities. The RDO/Y will participate as a member of the Coordinating Committee.

The Project will be staffed full-time by three AID-sponsored technicians, one of whom will be designated Chief of Project. The AID-sponsored technicians will be provided through a contract with a U.S. based university or other contract institution. The Chief of Project will be responsible to AID for the on-going daily management of all project activities and will report directly to the Project Director. The MOH will provide three technicians to the project. All project technicians will assist the Chief of Project. The WHO will provide one technician who will have teaching responsibility at CUSS. The entire Public Health Department of CUSS including one CIDA technician will participate in the project.

The primary implementing agencies for this project are OCEAC, CUSS, Peace Corps, and ENISFAY. Each will have a significant responsibility for providing training and personnel resources for the project. Each agency, through a designated project representative, will work directly with the Project Director to coordinate PTHE project activities.

B. Specific Project Administrative Responsibilities

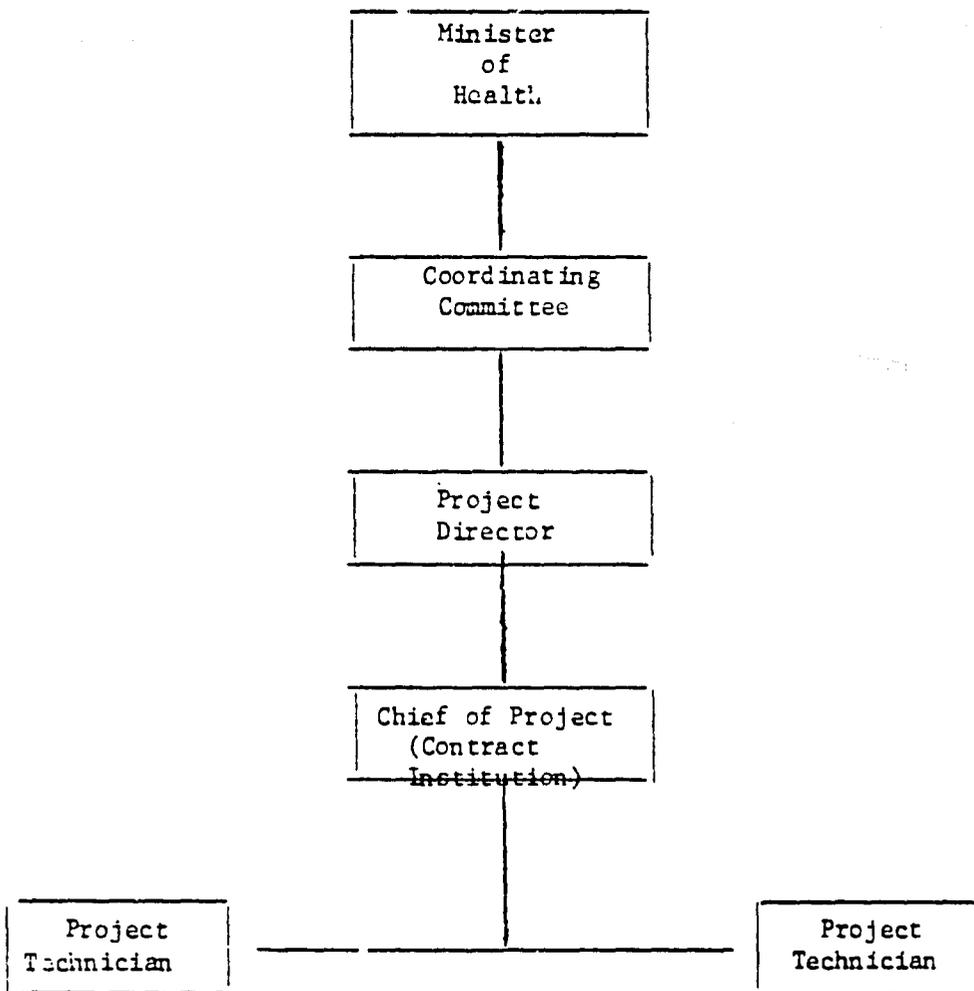
Minister of Health

The Minister of Health or his designate representative will assume overall responsibility for establishing policies regarding project activity. Specific responsibilities include:

1. Assuring the coordination and liaison among project participants, including other Cameroonian Ministries.
2. Planning, convening meetings of the coordinating committee and serve as staff to the coordinating committee.

IV - A Figure 1.

PROJECT ORGANIGRAM



3. Assigning a representative of the Ministry of Health as Project Director to the PTHE Project.
4. Negotiating Project Agreements with relevant participants.
5. Arranging for periodic MOH/C Project Progress Reports.

Coordinating Committee

The Coordinating Committee will have the major responsibility for advising the Minister of Health on policy matters regarding aspects of the PTHE Project. The Coordinating Committee, through its President, a representative of the Ministry of Health, reports directly to the Minister of Health. Specific responsibilities include:

1. Meeting periodically to assure the continual coordination of the PTHE Project activities.
2. Recommending needed PTHE Policies to the Minister of Health.
3. Reviewing and evaluating PTHE Project progress.
4. Providing input for the development of PTHE project plans.
5. Assuring that individual committee members are fully informed regarding PTHE Project activities.
6. Organize sub-committees as needed for the project.

Project Director

The Project Director will be a staff person designated by the Minister of Health to implement and coordinate the project, and will have direct supervisory responsibility for the project technician staff. Specific responsibilities include:

1. Supervising the implementation of the PTHE Project activities in a manner consistent with policies established by the Minister of Health.
2. Providing leadership to the project staff in planning, designing, and evaluating project activities.
3. Assuring that required MOH administrative procedures are followed.
4. Providing administrative liaison between the PTHE Project and the existing administrative structure in the pilot zones.
5. Assuring that required MOH Project records are maintained, and that needed project reports are prepared.
6. Acting as President of the Coordinating Committee

Chief of Project

The Chief of Project will be one of the three AID-financed technicians. His nomination must be approved by the Ministry of Health and AID. Under the Project Director, the Chief of Project will be responsible for the execution of the project in accordance with the objectives of the PTHE project as stated in the Project Paper. Specific responsibilities include:

1. Assisting the Project Director with the planning, design, evaluation of project activities. (See pps. 17-21 for description of project activities)
2. Implementing project activities in accordance with policies established by the Minister of Health and Coordinating Committee.
3. Contributing substantial technical expertise to the teaching and research activities of the project.
4. Providing supervision and administrative support to other project technicians.
5. Providing liaison between the contracting organization and the project.
6. Preparing necessary project reports including those documents required as part of the AID contract process.
7. Assisting the Project Director with liaison activities regarding the Coordinating Committee, by serving as the non-voting committee executive director.

U.S. Contract Institution

The U.S. contract institution in cooperation with the MOH will assume administrative responsibility for the logistics and support of the AID-sponsored technicians staff and related project training activities. Specific responsibilities include:

1. Recruiting, selection, and dismissal of project technician staff.
2. Providing logistical and technical backstopping for the technician staff.
3. Providing short-term technical assistance to the project when required.
4. Handling the logistical support for participant training activities including payment of travel, per diem and tuition.

Appendix E.

Recommendations from UNC Annual Report on the PTHE Project dated September 1979

V. R E C O M M E N D A T I O N S

NOTE: These summary recommendations are those emerging directly from the current report and most are amenable to more or less immediate action. There are further more general technical and professional recommendations which are not elaborated in the report and therefore not included in the list below. It has been decided to raise these with the Evaluation Team as they probably warrant discussion in some depth.

A. Technician Qualifications:

All three technicians should have skills and knowledge in community organization, administration and training in addition to his/her own specialty. Day to day implementation require versatile technicians who can fill in for each other. Given the Project work load, and its geographical distribution, the COP must contribute to both community organization and training activities. This will have the advantage of keeping her in close touch with the reality in the field. (IV UNC Personnel page 24).

B. Local Hire: There is a need for a translator on an item to item basis (IV UNC Personnel page 24).

C. TDY: Two TDY's should be in the field Nov. 1979 and the community organization technician and a TDY in January 1980. (IV UNC Personnel page 24).

D. Training Counterpart Availability:

We urge a meeting of Ministry of Health officials and COP to negotiate time and responsibility for this Counterpart. (IV C. MOH page 32).

E. Recruitment of Itinerant Agents:

The possibility of recruiting other health personnel rather than only nurses aids as itinerant agents should be studied. (II A. Health Personnel page 5).

F. Internal Coordination of Services in the Ministry of Health:

In order to systematize Project contact and collaboration with different services within the Ministry of Health, the possibility of establishing a coordinating body which would meet regularly should be considered. This meeting would provide a clearing house for requests for help from these services to PTHE, clarification of activities in those services and the hierarchy in the field, involvement of other Ministry of Health services in PTHE activities. (IV C. MOH page 32).

G. Coordinating Committee:

At the meeting, the coordinating committee could organize subcommittees to make recommendations on school health programs, administration of Ministry vehicles and interministerial collaboration in visual aids production. (III.C.C. page 23).

H. Motorcycles:

A system of maintaining and financing the motorcycles should be established within the Ministry of Health not only to allow the technical team more time for programming but also to ensure smooth transition of motorcycle responsibilities to the Ministry. (II. Logistics page II).

I. Construction Materials:

Criteria for the use of outside materials (e.g. UNICEF, US Embassy Self-Help) should be established to order to accomplish Project goals without compromising long range self-reliant development. (II. A. Construction Materials page 12).

J. Visual Aids Production Center:

The Ministry of Health needs to take action on problems of space for the workshop and the counterpart technician for the Peace Corps Visual Aids technician. (II. C. Visual Aids Production Centre page 20).

K. Peace Corps In-Country Training:

The Ministry of Health and PTHE team should have more input into the planning and training design for Peace Corps Volunteers. (IV. C. Peace Corps page 34).