

PD-AM6-140

(011-020270117)

CLASSIFICATION  
PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE  <b>OUHAM PROVINCE RURAL HEALTH</b>			2. PROJECT NUMBER <b>676-0002</b>	3. MISSION/AID/W OFFICE <b>USAID/YAOUNDE</b>
5. KEY PROJECT IMPLEMENTATION DATES			4. EVALUATION NUMBER (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) <b>FY-80</b>	
A. First PRO-AG or Equivalent FY <b>78</b>	B. Final Obligation Expected FY <b>80</b>	C. Final Input Delivery FY <b>79</b>	<input type="checkbox"/> REGULAR EVALUATION <input checked="" type="checkbox"/> SPECIAL EVALUATION	
6. ESTIMATED PROJECT FUNDING			7. PERIOD COVERED BY EVALUATION	
A. Total \$ _____			From (month/yr.) <b>12/79</b>	
B. LOP \$ <b>1,693</b>			To (month/yr.) <b>2/80</b>	
			Date of Evaluation Review <b>March 6, 1980</b>	

B. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. That the Ouham Province Rural Health Project as described in the PP not be reinitiated.	NA	NA
2. That all goods financed by USAID under this project be officially transferred to the Ministry of Health, or to other donor if the GOCAR cannot maintain equipment, vehicles, nor effectively use other remaining commodities.	Dr. Richard Brown/ Ms. Ann Dotherow	June 1980
3. AID will not support projects in CAR which are fuel dependent until AID is assured that the fuel and other relevant supply problems have been adequately addressed in the design of the project.	NA	NA
4. Future projects involving collaboration between AID technicians and PC Volunteers in CAR should include mutually agreed upon job descriptions for volunteers and assurance of PC willingness to work under supervision as designated by AID.	NA	NA
5. That USAID not design projects in CAR with the intention of developing health systems or management capacity so long as expatriate technicians continue to administer the health system for the entire country.	NA	NA

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS	10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT
<input type="checkbox"/> Project Paper <input type="checkbox"/> Implementation Plan e.g., CPI Network <input checked="" type="checkbox"/> Other (Specify) <u>Re-authorization for a Wells/Ouham project.</u> <input type="checkbox"/> Financial Plan <input type="checkbox"/> PIO/T <input type="checkbox"/> Logical Framework <input type="checkbox"/> PIO/C <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Project Agreement <input type="checkbox"/> PIO/P	A. <input type="checkbox"/> Continue Project Without Change B. <input type="checkbox"/> Change Project Design and/or <input checked="" type="checkbox"/> Change Implementation Plan C. <input type="checkbox"/> Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY/ OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)	12. Mission/AID/W Office Director Approval
SEE ANNEX C Clearances: HNPO:RCBrown PRM:JBWoods A/DIR:FEGilbert [Signatures]	Signature _____ Typed Name <b>James E. Williams</b> Date _____

- |   |                   |           |
|---|-------------------|-----------|
| 6. Until the GOCAR's capacities increase, no programs should be designed for implementation in CAR which require significant counterpart and other GOCAR support of residential U.S. technicians. | NA                | NA        |
| 7. USAID/Y decisions on positive program recommendations made by Ouham evaluation team in their report.   |                   |           |
| a) Develop program for water supply improvement in rural areas. (For indepth info see wells evaluation PES being pouched).  | Dr. Richard Brown | July 1980 |
| b) Study feasibility and possible modalities of a goiter intervention under an OPG to a PVO.  | Dr. Richard Brown | July 1980 |
| c) Investigate possibilities for supporting the development of pro-pharmacies under an OPG to a PVO.  | Dr. Richard Brown | July 1980 |
| d) USAID will not finance reconstruction of the out-patient wing of the Paoua government hospital.  | NA                | NA        |

(PES) PART II

SPECIAL EVALUATION

13. SUMMARY

The OPRH Project was begun in 1977 with the intention of improving the health of people in a remote and impoverished area of the C.A.R. Many unforeseen obstacles precluded the proposed implementation. Among these were a change in government, personnel problems logistical problems and the abrupt termination of the project in mid-1979 by an action of the U.S. Congress. The current evaluation was intended to examine what, if any, parts of the project should be reinstated. The Evaluation Team does not feel that the project as designed, or major parts thereof, should be continued. The project had originally envisioned developing: (1) a health management system, (2) a health education and sanitation delivery system, (3) a health care delivery system, and (4) a vehicle maintenance system. While there apparently was considerable activity in some of these areas, none of these objectives were achieved to any substantial degree. The evaluation team does not disapprove of the project as designed. In fact, it is probable that if the constraints to project implementation had been removed, the project could have made more substantial success. The project was to receive two AID technicians and 10 Peace Corps Volunteers. At the time of this evaluation, all had left the C.A.R. as well as the project, and virtually no project activity was noticeable.

#### 14. EVALUATION METHODOLOGY

A. The purpose of this evaluation is to help USAID/Yaounde, GOCAR, and PC/Bangui with a comprehensive evaluation of the project and to make recommendations for possible future health activities.

Evaluation arrangements for the project (PP.p 83) indicate events that could occur during the project which could reflect progress of the project. A number of routine evaluations were prescribed in the PP. The project was last evaluated in November 1978. The present evaluation is a "special" evaluation. The present evaluation is special due to the fact that the project was terminated prior to its completion by an act of Congress. Existing project personnel have disbursed, and the project no longer exists. It is important to note that this evaluation occurred 5 months after official termination of the project. Many activities which may have existed when the project was underway are nowhere in evidence at the present time.

B. The evaluation was conducted by on-site visits, review of appropriate files and documents in USAID/Yaounde and interviews with available persons directly or indirectly related to the project. There was no prescribed study design apart from the guidelines in Yaounde 7255. However, the PES format was used in addition to the TOR provided in Yaounde 7255.

On January 1, 1980 the Ministry of Health was reorganized. What was formerly the Direction de Santé de Base, where the OPRH project was located organizationally and Grandes Endemies were merged into the Direction de Santé Rurale et Grandes Endemies. (See Attachment 1 ).

Responsibility for all health care delivery in the Rural areas of C.A.F. were unified under one Director, the former head of the Grandes Endemies, Dr. Max Nebout. In our interview with Dr. Nebout, he strongly suggested that we go to Bossangoa, where the former OPRH project was headquartered make contact with the Médecin Chef of the Sector, Dr. Hornez and visit the site where 3 dispensaries were built through the project.

The evaluation team travelled by road to Bossangoa. In the company of Dr. Hornez, Médecin Chef, Sector III, we visited villages within a 75 km radius of Bossangoa, the project headquarter. Special attention was given to three villages (Bouanssama, Bossera, Bangayanga) where Dr. Nornez suggested one may see evidence of project activities such as newly built dispensaries, latrines, pro-pharmacies, and project trained secourists. It seemed reasonable to assume that the best examples of project activities would be found within a reasonable distance of headquarters where vehicle, supervisory, and other support services were located. The team did not travel to the remoter sections of the project, area, such as Boguilla where the greatest volume of health education and environmental sanitation measures had been carried out according to the former project manager and Dr. Finlay's report.

C. COSTS

Chief, INPO	-	13 M.D.	-	USAID/Y
Chief AF/HN	-	13 M.D.	-	AID/W
P.H.A. DS/HEA	-	13 M.D.	-	AID/W

D. Agencies and Individuals Contacted

1. Minister of Health, C.A.R., Dr. Victor M'Barindi
2. Dr. Max Nebout, Chief of Grandes Endemies, Bangui
3. Director General of MOH, Dr. Mamadou K'Possa
4. Director of Pharmacy, Mr. Delatre
5. Director of Project Coordination, Mr. Dambagoa
6. Assistant Director of Project Coordination, Mr. Coquilleau
7. Ambassador Goodwin Cooke
8. DCM, Mr. Al Fairchild
9. CAR Peace Corps Director, Karen Woodbury
10. Médecin Chef of Grandes Endemies, Sector I, Dr. Claude Guidi
11. Médecin Chef of Grandes Endemies, Sector II, Dr. Hornez
12. Director of Bossangoa General Hospital, Dr. Hornez
13. Former Project Director, Bossangoa, Mr. Modue
14. CAR State Department Desk Officer, Ms. Arlene Render
15. CAR Former Desk Officer, USAID/W, Mr. James Wedberg
16. WHO Representative CAR, Dr. Georges Pinerd
17. Bossangoa - Sous Prefect
18. Bossangoa - Capucine Fathers and Brothers (nine)
19. Bossangoa - Sister Sylvie, Director of Nutrition Program
20. Bossangoa - Sister, Director of Leprosy Program
21. Bouanssouma - Village Chief
22. Bouanssouma - Committee President
23. Bouanssouma - Dispensary Nurse - Secourist
24. Bouanssouma - Pro-Pharmacy Operator
25. Bouanssouma - Superficial Medical/Disease Analyses of 15 villagers
26. Boussera - Village Chief
27. Boussera - Committee President
28. Boussera - Community Development Representative
29. Boussera - Pro-Pharmacy Operator
30. Boussera - Dispensary Nurse - Secourist
31. Boussera - Superficial Medical/Disease Analyses - 10 villagers
32. Boumentana - Village Chief
33. Boumentana - Dispensary Nurse
34. Boumentana - Pro-Pharmacy Operator
35. Boumentana - Community Development Program Representative
36. Peace Corps Desk Officer for CAR - Mr. Pual Rowe, Washington, D.C.
37. Former PCV Rich Bradshaw
38. Former PCV Mary Archung
39. Former PCV Roger Clapp
40. Director of Baptist Mission, CAR
41. Director of Church of Brethern, CAR, Dr. Hawkings
42. Mr. Richard Thornton, Former Project Officer, USAID/Yaounde
43. Mme. Madeleine Nicolle, AID Secretary, CAR
44. Bossembele: Dispensary run by CAR nurse, supported by Church of the Brethern
45. Dispensary run by CAR Government, having a CAR Nurse, supervised by Médecin Chef of Sector I (Bangui)

46. Village of Togho: inspected a government run dispensary; conducted superficial survey to determine most prevalent causes of morbidity and mortality.
47. Mr. Theodor Bratrud, USAID/Yaounde, CAN Coordinating Officer
48. Mr. Frederick Gilbert, USAID/Yaounde, Acting Director
49. Ms. Eilene Oldwine, USAID/Yaounde, Project Manager

15. EXTERNAL FACTORS

It was unforeseen that the behavior of the Chief of State would provoke the U.S. Government first, to embargo the assignment of a direct hire AID Officer to Bangui in September 1977 and, finally, to terminate the project in September 1979. Although the project was designed to function in the context of extreme budgetary tightness, the degree of fiscal weakness and chaos actually encountered was not foreseen. These factors similarly precluded GOCAR from fulfilling its financial obligations to the project.

The inputs were not supplied on time or in the planned amounts. For example, the Chief of Party arrived 6 months after the PCVs. And then only remained 4 months. Waiver for drug procurement consumed 1 year of project time. Furthermore, the contractor for dispensary construction had unforeseen transportation problems, thus significantly delaying the building of these dispensaries.

Additionally after the Physician Chief of Party departed, Dr. Finlay who had originally been assigned the 2nd AID technicians position as health planner based in Bangui for 10 months was asked to become Chief of Project. This meant a constant shuttling from Bangui to Bossangoa and disruption of his health planning and coordination activities being conducted from Bangui.

This action also placed additional responsibilities on Dr. Finlay. Where two AID technicians were operating, the loss of one actually meant that Dr. Finlay was obliged to take up the slack. The November 1978 CAR recommended as a first priority that AID recruit a technician as soon as possible for the Bossangoa position in an attempt to relieve Dr. Finlay of some of his workload.

There were conflicts between AID technicians, between AID technicians and PCV's, between AID technicians and GOCAR personnel as well as and between USAID/Yaounde and PC/Bangui due to differences in public health approaches, program philosophies, management styles and personalities. These differences were severe enough to precluded optimum execution of duties thus affecting project outputs.

Since the project was managed from Yaounde, there were delays in approving funding. There was an AID Program Officer assigned to CAR by AID/W. However, her assignment to CAR was delayed due to political developments in C.A.R. Instead she was posted to Yaounde and shuttled back and forth between Yaounde and Bangui. This factor caused USAID to have no full-time direct hire representative in Bangui and contributed to the overburdening of the project technician in Bangui in that he was confronted with many issues concerning Peace Corps use of AID resources that went well beyond his scope of work. Such issues multiplied because PCV's were assigned to the project before the AID technician in Bossangoa arrived to take up his fulltime assignment.

16. INPUTS -

PLANNED

ACTUAL

AID Technical Services

72 Man Months long-term T.A.

28 Man Months  
- Dr. Reilly was terminated  
from project.

12 Man Months Short-term T.A.

5 Man Months (est.)  
- Mrs. Reilly  
- Jon White

20 Man Months Short-term training

Same training was done but not  
quantifiable.

124 Man Months Long-term training

None

COMMODITIES

Vehicles, medical equipment, POL

All arrived

CONSTRUCTION

25 Health Posts constructed/repaired  
5 Health centers constructed

5 buildings completed -  
Three of these were inspected  
and found to be satisfactorily  
built. They were being utilized  
as intended.

PEACE CORPS

10 PCV's

2 Mechanics

Not more than five PCV's on  
location

8 Health Workers

At one time.

INPUTS

<u>PLANNED</u>	<u>ACTUAL</u>
<u>GOCAR</u>	
Basic Health Office, Bangui	Provided
Technician House, Bossangoa	Provided
Clinical Services	Provided
Training of Secourists	(a) Clinical program with microscopy instruction - 3 conducted. (b) Pro-pharmacy program - 1 conference conducted
Drugs	N/A
Commodities	N/A

As mentioned earlier, commodity delay and untimely technician arrival and departure seriously hampered successful implementation of this project.

17. OUTPUTS

The four outputs of this project are listed below with evaluation team observations on each.

1. A prefectural administration system for support and supervision of rural health planning and evaluation.
  - a. The project was to have developed health planning and evaluation manuals. None were ever developed during this project.
  - b. Baseline surveys and disease incidence data in addition to development of a Prefecture Base Data Collection system was to have been conducted and set up respectively.

Mrs. Reilly's evaluation of the health problems of the population of Bossangoa provided baseline demographic data for the project. This was done as part of the AID short-term technical assistance to the project. The report was useful in that it furnished helpful information on reference diseases by which the project could later be evaluated. There were no follow-up studies undertaken which could be compared with Mrs. Reilly's baseline data.

- c. Health plan for Ouham developed - The evaluation team found no evidence of one having been established.

2. A system for the delivery of village level health education and rural sanitation.

- a. Sixty active village health committees were envisioned in the P.P. Dr. Finlay reported that (Sept. 1979) "More than 100 village health or development committees have been formed with more than 80 described as active." The evaluation team was unable to confirm or deny this statement. However, in 3 villages visited by the team (Bouanssouma, Boussera and Bangayanga), there had been no village committee meetings within the past six months since the project had been terminated. These were among the villages in which committees had been reported. Apparently committee activity was unrelated to dispensary activity in these three villages.

- b. Fifty primary schools with health education being a part of the curriculum was planned.

Finlay (Sept. 1979) reported that "Health curriculums have been introduced and are known to be functioning in only 10 schools of Ouham and Basse-Kotto at this stage of the project. Teachers from more than 50 schools, however, have been introduced to the adopted Togo health curriculum and are in possession of a copy of this curriculum. This curriculum has not yet been officially adopted by the Ministry of Education in Bangui.

- c. A distribution system for health education materials would be established.

Health education materials were obtained. An attempt was made to distribute these materials to various health workers in the villages. Although a system was being evolved for the distribution for these materials, the project was terminated before this could be effected (Finlay, 1979).

3. A system for delivery of village level health care services

- a. 1,000 traditional birth attendants and healers were to have attended MCH workshops.

The evaluation team saw no workshops in session, nor did it meet with known workshop participants. However, Finlay reports that at least 50 people attended these workshops (Finlay, 1979)

which were conducted by a PCV in Bongoila. As the evaluation team did not have the opportunity to visit Bongoila, we are unable to comment further.

- b. 20 Villages Health Care Agents (VHCA) identified by the community and trained in prototype training.

5 VHCA underwent training in Bongoila. (Finlay, 1979). They were chosen by the community.

4. A system for vehicle maintenance, 10 mechanics trained

1 mechanic and 2 apprentices received on-the-job training at the Bossangoa rural health services garage. The evaluation team did not see any evidence of a system for vehicle maintenance.

18. PURPOSE

"The purpose is to develop a health management capacity at the prefectural level together with a central support system in the capital capable of planning administering, training for, and executing a program of rural health education, sanitation and basic village health care." (PP).

Based on our evaluation, the EOPS conditions are not an adequate description of what is achievable in this project given the framework within which the project was implemented. The purpose can never be achieved. In fact, given the seeming attenuation of the basic health services function in the recent Ministry of Health reorganization, the project at present is further away from the purpose than when it first began.

The Direction de Santé de Base has been moved into a new joint Directorate with Grandes Endemies with the Direction in the hands of the Grandes Endemies management structure. The Directorate is dominated by French technicians, under a French management system, both at the Central and at the Ouham Prefectural levels. Therefore, the attempted improvement of a health management capacity in C.A.R. by Central Africans has not materialized. This is not a fault of the project.

The following four conditions were to have been achieved by the end of the project:

1. Health activity integrated with those of other sectors

Health activity of the OPHP was being integrated with the Education Sector as evidence by collaboration in Health Education curriculum development at the primary school level. The environmental sanitation and community organization aspects of the project were carried out with the help of community development field workers. Integration with the Agriculture and Public Works sector has been contemplated but not effected.

2. OPMOH personnel demonstrating competency in performing functions

In the three villages visited by the Evaluation team, and also in the opinion of the Médecin-Chef of Sector III, Dr. Hornez, the secourists seemed to demonstrate competence commensurate with their training. No measure of competence is stated in the PP. The mechanics appeared to be functioning adequately. (They repaired our car!)

3. MOH decides to replicate this management system in other provinces

Finlay does not report on whether or not the MOH's intends to replicate the OPHP Management system in other provinces. The Minister of Health and Dr. Nebout gave no indication to the evaluation team of their desire to have the OPHR replicated.

Dr. Nebout indicated that rural primary health care is a high priority of the CAR government. He recommended attacking high infant mortality by the extension of P.M.I. centers and by an extended vaccination program. Health education for better nutrition and hygiene also figured in his plan. Actual requests for assistance were first for drugs, curative and preventive.

The second request was for health educational material. The third request was for assistance in means of transport. Other requests were for material assistance for curative health programs in Bangui.

4. Village communities are engaged in addressing their own priority health problems

We did not find any evidence to support this statement apart from the functioning pro-pharmacies. Finlay reports that "this engagement is a question of level. With 88 village health committees in only two sous-prefectures, much discussion is being given to local health problems. The impression is, however, that village health activities are still being seeded from above and that latrine campaigns, stream improvement, and request for pro-pharmacies would not be forthcoming without the continual prodding of commune-based securists and CD agents."

19. GOAL/SUBGOAL

The ultimate program goal toward which this project is aimed is the achievement of active participation on the part of the rural population of Ouham Prefecture in community development. The Subsector goal is development of an integrated health care delivery system.

These goals were to be measured using these four criteria:

1. Reduced prevalence of debilitating disease.

There is no verifiable evidence that debilitating diseases were reduced in prevalence.

2. Increased activity of villagers in health and other development activities.

Finlay reported that there is increased health and development activity. Such activity is difficult to quantitate. The evaluation team counted 2 functioning pro-pharmacies as evidence of activity. Mr. Richard Thornton, the former USAID/Y Project Manager, stated (February 14, 1980) that "most village activity was taking place around Boguila," where the team did not visit.

3. Amelioration of the village environment.

Villages of the project area do not appear to have a better environment.

A cursory examination of dispensary medical records in Bouanassouma, Bossera and Bangayanga indicated no difference in disease prevalence as compared to prevalent diseases listed in dispensary records of two villages (Tobgo' and Dodoupa) in Bossembele which is outside the project area.

It is interesting to note that Dr. Reilly proposed that a latrine-use survey be conducted, but this was never done. Such a survey would have helped to quantify changes in village environment.

4. Village health committees active in community development. There was no indication that 3 villages visited by the evaluation team had committee meetings in the past 6 months. These 3 villages were close to Bossangoa, project headquarters, (within 75 kms) where one would assume that project stimulated activities would be strongest. Finlay, on the other hand, reported more than 88 active health committees in Ouham. Records of these village committees were not found.

#### 20. BENEFICIARIES

The direct beneficiaries of this project were to be the traditional birth attendants (TBA's) and village level health care agents (VLHCA's) working in the Ouham Prefecture in the R.C.A.

The indirect beneficiaries of this project were to be the rural population of Ouham Province, an estimated 350,000 persons, who would benefit through improved health status.

- Although the project was clearly designed to benefit the rural poor, there is no evidence to demonstrate that they are better off than before the project started.

#### 21. UNPLANNED EFFECTS

1. Dr. Nebout was impressed with the two way radio communications network set up by the project. He indicated that he would pursue the possibility of installing a radio in each of the Grandes Endemies Sectors.
2. The bicycles furnished to the secourists provided mobility so that he could carry out health education activities in surrounding villages. This mobility, in one instance which we noticed, caused the secourists to be away too long from the village where the dispensary was located and annoyed some villagers. It was Dr. Hornez's opinion that bicycles afforded the secourists a mobility that was in fact detrimental to the project since they tended to leave their posts all too frequently.

#### 22. LESSONS LEARNED

1. A project in such a desolate, remote area, without an infrastructure and stability in government cannot survive.
2. A project so dependent on gasoline and kerosene has a high probability of failure.

3. A project which explicitly demands the presence of technical experts cannot survive if timely arrival schedules are not adhered to.

4. An expatriate technician intensive project, e.g. health education, will not have a good chance of success in C.A.R. at present.

23. SPECIAL COMMENTS OR REMARKS

A. Recommendations:

1. That the Ouham Province Rural Health Project as described in the PP not be reinitiated.

2. That all goods financed by USAID under this project be turned over officially to the Ministry of Health to be used, as appropriate, by the Directorate of Santé Rurale et Grandes Endemies.

3. Future collaboration between AID/PC in CAR should include mutually agreed upon job descriptions for volunteers and assurance of PC willingness to work under supervision as designated by AID.

4. Prior to providing AID support and given the chronic fuel shortage in Bangui and CAR, AID not support projects which are fuel dependent until AID is assured that the fuel problem can be ameliorated by steps positively identified in advance.

5. That USAID not design other projects in the CAR with the intention of developing health systems or management capacity so long as expatriate technicians continue to administer the health system of the entire country.

B. Optional Projects for Consideration:

1. The evaluation team recognizes the importance of access to safe water and the inherent effects such access has in improving health. We support the provision of safe water to the Ouham and Ouham-Pende Provinces, if not

to all CAR. This action would probably have more beneficial effects on health for more people than any other health project activity AID could support at this time in CAR.

2. The pro-pharmacy aspect of this project has merits that could be explored for possible AID support. A PVO, possibly the Catholic Fathers in Bossangoa or the Protestant Church of the Brethern may be suitable to undertake activity of this sort.

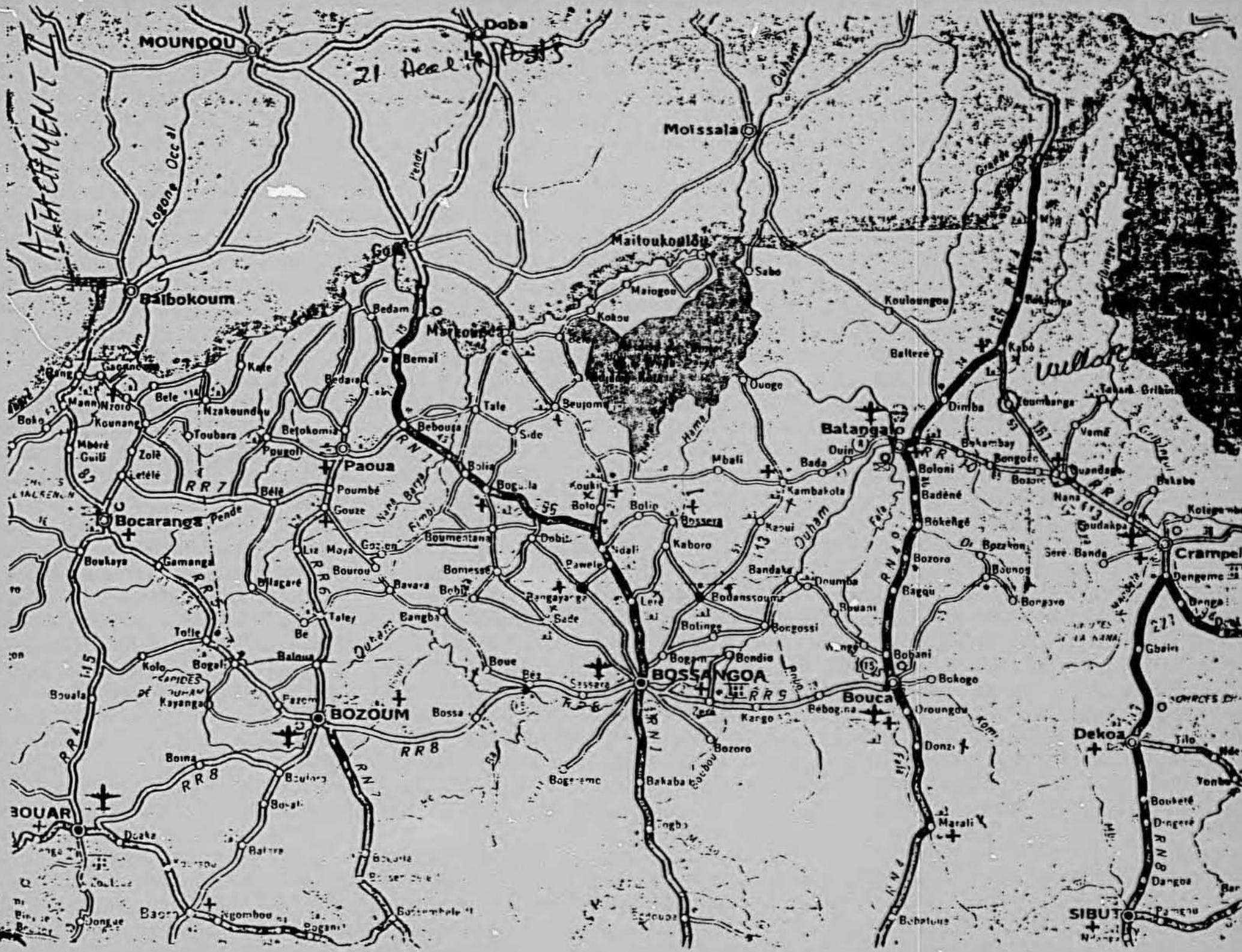
3. AID should consider supporting, through the Service des Grandes Endemies a national goiter eradication campaign. Our observations and some available statistical notes indicate that there is a 25 to 43% prevalence of goiter in Northern CAR. The technology for such a campaign is well known. Such programs have been successfully carried out in Zaire, Bolivia and parts of New Guinea. The Chief of the Grandes Endemies is willing to add this component to their existing program. No American presence would be absolutely necessary for the success of this project. On the other hand, an American team could carry out the project and give it high visibility.

4. The Catholic Fathers in Bossangoa have requested financial assistance to reconstruct the outpatient department which burned down in 1978, at the Poua government hospital. This may be a feasible effort for AID support which has possibilities of minimizing AID direct hire or other American personnel in CAR while at the same time assisting in the development of the CAR Primary Health Care System. The ancillary question of a few simple dispensaries for rural outreach coupled with pro-pharmacy support could also be considered as part of the total funding support.

## APPENDIX C

### TEAM MEMBERS:

1. Richard Brown, M.D., M.P.H.  
Chief, Health/Nutrition/Population Office  
USAID/Yaounde
2. Thomas Georges, M.D., M.P.H.  
African Bureau  
Director, Health, Nutrition Office  
AID/Washington
3. John McEnaney, M.P.A.  
Public Health Advisor  
Development Support Bureau  
Office of Health  
AID/Washington



ATTACHMENT II

21 Aerial Posts

MOUNDOU

Doba

Moissala

Balibokoum

Maitoukoullou

Bocarang

Paoua

Balanga

BOZOU

BOSSANGO

BOUAR

Bouca

Dekoa

SIBUT

Logone Occal

Ouham

Willak

RR 7

RR 8

RR 9

RR 8

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**ORGANIGRAMME DU MINISTERE DE LA SANTE PUBLIQUE,  
DES AFFAIRES SOCIALES, DE L'ORGANISATION DE  
L'EDUCATION SANITAIRE ET DE LA PROMOTION  
HUMAINE**

ATTACHMENT K

