EVALUATION
OF
P.L. 480 TITLE II
FOOD AID PROGRAM
IN
CAMEROON

Agency for International Development
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PREFACE

The following evaluation of the Catholic Relief Services (CRS) Food for Peace Title II Program in Cameroon is one of a series of planned long-range comprehensive assessments which has recently been accomplished in the sub-Sahara region of Africa. This evaluation has been directed towards assessing the growing Cameroon program and has included, among its assessment activities, efforts aimed at measuring the nutritional impact of the program on the targeted recipients.

The current CRS Food for Peace Title II Program in Cameroon consists of food distribution through missionary and government Maternal Child Health Centers which are primarily concentrated in the Northwest and Southwest Provinces. Since 1977 the program, focusing on the nutritional needs of pre-school children, has operated under the CRS Growth Surveillance System and has been receiving increasingly larger amounts of commodities over the past few years.

The Office of Food for Peace is most grateful for the cooperation, support, and assistance provided the evaluation team by the USAID Mission, Catholic Relief Services, and the Government of the United Republic of Cameroon. Most important were the helpful mothers and villagers who received the evaluation team and gave so generously of their precious time.

Carolyn F. Weiskirch
Office of Food for Peace

FOREWORD

This report presents the results of the evaluation of the Food for Peace Title II Program accomplished in Cameroon during the five-week period commencing August 17, 1981. The evaluation was carried out by Joyce M. King (Team Leader) and Karen W. Seaton (Nutritionist), consultants to the prime contractor, Systematics General Corporation (SGC), which was selected to accomplish the Cameroon evaluation under contract AID/SOD/PDC-C-0263.

The draft of this report was made available in English in November 1981 and was distributed by the Office of Food for Peace (OFFP) to all concerned agencies. Subsequently, a French translation was prepared in April 1982 and was submitted to the GURC. The OFFP established June 15, 1982, as the deadline for the receipt of comments that would be considered during the preparation of this final report. The SGC consultants have carefully studied all of those comments received and have incorporated acceptance or discussion of the points raised into the body of this final report.

SGC's role in this evaluation has been to provide an evaluation team that could offer the experience and knowledge necessary to produce an effective, independent, and unbiased assessment of the Food for Peace Program in Cameroon. As contractor to the Office of Food for Peace, SGC has provided support throughout the project and during the report preparation stage.

SGC has offered some editing counsel but otherwise has made no attempt to influence the content of this report as written by the consultants. Accordingly, the content, interpretations, and opinions contained in this report, are those of the authors, Joyce M. King and Karen W. Seaton, and convey their finding and impressions and are not necessarily those of SGC, nor should they be attributed to the Agency of International Development.

ACKNOWLEDGEMENTS

Joyce M. King and Karen W. Seaton, Systematics General Corporation (SGC) Consultants, were responsible for the in-country planning, conduct of field work, and the writing of the draft and this final report. Team members for the field work in Cameroon were: Joyce M. King, Evaluation Specialist, SGC Team Leader; Karen W. Seaton, Public Health and Nutrition Specialist, SGC; Randall Thompson, Evaluation Office, USAID/ Yaounde; Mrs. Tessa Epale, Nutrition Service, Ministry of Health, Cameroon; Barbara Ormond, Sub-contractor, Yaounde; and Lucy Entube and Mathilda Ayuk Akat, interviewers in Cameroon. Sam La Foy, Regional Food for Peace Officer provided the summary of the CRS Program in Cameroon (Appendix 12).

Kind assistance was received from the Ministry of Health, Plan and Economy officials, notably Dr. Kessing, Mr. Elias Joe, and Dr. Claudio Schuftan and from Governors, Prefects, Sub-Prefects, Health Delegates, Preventive Medicine Staff, Community Development Staff, Fons; USAID Staff, particularly Mr. Ray Martin and Mr. Bernard Wilder; CRS officials including Dr. Carlo Capone, Mr. Michael Wiest, CRS Director in Cameroon, Kathleen Kelleher, Mrs. Veronique Ada, National Supervisor, Provincial staff, particularly Mrs. Tothy, Mr. Sampson and Mr. Mathias. The team is indebted to MCH Directors and Sisters in charge of clinics, clinic personnel, and mothers and villagers who gave so generously of their time.

Carolyn F. Weiskirch, Project Officer for the evaluation and Nancy Fox of the AID Food for Peace Office, Washington, provided invaluable support and guidance.

Mr. Gary F. Mason, SGC, Manager, Systems Studies Group, provided logistical support to the team throughout the project.

We also acknowledge: Christopher Stevens and the St. Martins Press for the portions excerpted from Food Aid and the Developing World provided in Appendix 6; Randall Thompson for the material provided in Appendices 7 and 8; and Dr. Carlo Capone for the CRS Master Chart shown in Appendix

GLOSSARY

ABS	Annual Budget Submission
AER	Annual Estimate of Requirements
AID/W	AID/Washington
CDSS	Country Development Strategy Statement
CRS	Catholic Relief Services
FFP	Food for Peace
GSS	Growth Surveillance System
GURC	The Government of the United Republic of Cameroon
IBRD	International Bank for Reconstruction and Development (World Bank)
ISC	Interagency Staff Committee
IQC	Indefinite Quantity Contracts
MCH	Maternal and Child Health
MINEP	Ministry of Economy and Planning
MOH	Ministry of Health
NFDM	Nonfat Dried Milk
OFFP	Office of Food for Peace
PASA	Participating Agency Services Agreement
PL 480	Public Law 480
PVO	Private Voluntary Agency
REDSO	Regional USAID Office
RFFPO	Regional Food for Peace Officer
SGC	Systematics General Corporation
USAID	United States Agency for International Development
USDA	United States Department of Agriculture
USG	United States Government
WFP	World Food Program

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EXECUTIVE SUMMARY

A. INTRODUCTION TO PROGRAM AND CAMEROON SETTING

The subject of this report is the evaluation of the Catholic Relief Services Food and Nutrition Program in Cameroon within the context of the MCH network within which it functions.

CRS distributes Title II commodities including cornmeal, oil, and milk powder. The Title II program in Cameroon is a relatively small one in the context of Food for Peace activities in Africa. The volume in Fiscal Year 1981 consisted of 2100 metric tons of food valued at slightly less than a million dollars.

CRS is the sole private voluntary organization that distributes Title II foods in Cameroon. Other international agencies supply free food to the country including the World Food Program. CRS activities only are the subject of this evaluation.

CRS provides Title II food through a network of predominantly government, and some missionary, Maternal and Child Health centers which are concentrated in Anglophone Cameroon.

Prior to Independence, CRS worked out of Victoria in English-speaking Cameroon. Since 1976 the program has focused around the present capital of Yaounde, but the emphasis in operations has continued to be in Anglophone Cameroon. Only over the past few years has CRS been experimenting with increased rations and introduced a standardized education and monitoring system (the Growth Surveillance System) and stated its objective to be that of promoting adequate growth in preschool children. Rations in years prior to FY 1980 were 45.6 kilograms annually per beneficiary. Levels were increased to 51.6 kilograms in FY 1980 and 60 kilograms in FY 1981, the current authorized ration.

Two years ago CRS requested that beneficiaries be increased by 5,000. However, the United States Agency for International Development Mission to Yaounde declined to approve the additional request on grounds that it had no basis for judging the program's effectiveness in terms of nutritional impact. At about the same time the Government of the United Republic of Cameroon (whose contribution to the program in inland transportation alone was $134,000 in FY 1980) was raising questions about the kinds of benefits they were getting from the program.

Cameroon has very real potential for meeting its agricultural needs, and its steady economic growth has been underpinned recently by successful offshore oil drilling, promising self-sufficiency over the next five years and eventual small petroleum exportations. Its leadership strive for the principles of self-reliance. Therefore, both the USAID Mission to Yaounde and the GURC through its Ministry

of Health felt it timely to reassess the need for food donations to be ministered to its people.

The CRS offices in New York, Nairobi, and Yaounde strongly disagreed with undertaking an evaluation at what it considered to be a premature date from their perspective of a program still in its infancy. This position is in strong contrast to the USAID's view that results ought to be demonstrable after 10-20 years of operation in the Anglophone Provinces.

The Office of Food for Peace in AID/Washington chose Cameroon for evaluation not only because of the outstanding CRS request for expansion and the pending USAID decision, but found it appropriate to include the small program in Cameroon within the worldwide evaluation exercise it was mandated by Congress to undertake.

B. SELECTION OF EVALUATION EMPHASES

The interested parties to this Title II evaluation represent a wide range of opinion and perspective, coming from a corps of private and governmental leaders who are all vitally concerned with the scope and results, but in different ways. These are: the Ministeries of the Cameroonian Government; the private and governmental distributors and support network in the country; the CRS field office in Yaounde; CRS regional technical advisers in Nairobi; CRS headquarters staff in New York; USAID in Yaounde; and AID/Washington.

Clearly, all of the individuals representing these different organizations share the common hope that the Title II foods and related services will be delivered efficiently and that they will result in a positive effect on the recipients' health and well-being. This point of agreement should not be lost during the process of evaluation which may seem often to emphasize disparities of viewpoint and the shortcomings or omissions of the acting parties and/or evaluation users.

It is also important to state that many program aspects, such as the management of food logistics by CRS staff in Yaounde, or the many hours OFFP and CRS have devoted to reconciling policy in Washington, will go unreported in this document. Such omissions are the inevitable losses that result from focusing the emphasis of the evaluation on those elements of the program which were found to be most important on the part of a majority of users and, in the final analysis, were ones selected by the evaluation team for priority treatment.

The SGC Consultants respected highly the desirability of giving equal consideration to all users. Accordingly, they made every effort to listen as intently to CRS philosophy as to AID Handbook interpretations of P.L. 480 or the Congressional intent behind the Law, and to respond to GURC concerns as faithfully as to USG priorities. This was not always a smooth course. The team has described the process of obtaining a consensus of user requirements in the first chapter. This "design" or preparatory work constituted a significant piece of the assignment in Cameroon and has merit as "lessons learned" for future evaluative efforts. Though this negotiation phase was highly demanding of time and attention, it fortunately did not detract from the ability of the team to gather ample field data and to offer a careful assessment of the program focused around the following selected points:

- Policy analysis and administrative structure.
- Functioning of the key program components: the food aid package; the Growth Surveillance System; and preventive health services.
- Measurable impacts: nutritional; reaching the needy.
- Assessed outcomes or effects: cost-effectiveness; effect on agricultural production; effect on clinic attendance.

C. HIGHLIGHTS

1. Policy

FFP/AID and CRS policies are inconsistent with respect to recipient criteria and program objectives:

- FFP Guidelines stipulate use of Title II foods for areas of greatest need as defined by level of socio-economic status or nutritional status. FFP Guidelines first give priority to the poorest and most malnourished among eligible vulnerable populations and at the same time recommend that programs are best carried out in preventive health settings. Structured channels of delivery such as MCH in Cameroon are favored by FFP but do not reach the poorest, neediest, and most malnourished.

- CRS delivers food to all families in rural, subsistence areas without regard to poorest and most malnourished. Neither does CRS attempt to target food to the categories defined as eligible by FFP but provides food to "families" and considers the level of rations in the context of adequacy for the entire family.

  FFP has authorized CRS informally to share rations among family members and accepts a trial use of food based on its economic value, but has provided insufficient food per family to attain CRS defined levels and no methodology for assessing the program on this basis.

- FFP and CRS are in disagreement about the possibility of achieving improved nutritional status with food rations at levels calculated for targeted individuals within families. FFP implies that food alone can lead to improved status.

2. Administration

Deficiencies in the administrative fabric are closely related to, or caused by, the lack of agreed program objectives. Notably, contractual commitments, whether implicit or written, which are expected to bind the program together are strikingly absent or incomplete, whether this be the commitment of mothers/parents at the center level or a clarity of objective stated in the CRS contract with the government at the national level.

- The lack of USAID monitoring for the Title II program has resulted in a leadership gap insofar as planning rationally the future for food aid and its progressive replacement, and

- The absence of efforts to integrate food aid planning with USAID strategy.

3. Functioning of Key Program Components

Despite a well managed delivery system, devoted staff in many of the MCH centers and good contributions from the host country, the three key program components were thought to be inadequate: the food aid delivered to families; the CRS Growth Surveillance System (as a monitoring, educational, and contract tool); and the health services provided by the government.

- About 90 calories per child can be expected to be delivered daily; less than 7% of the daily requirements.

- The individual growth chart is not being used effectively as a teaching tool for mothers, nor is it always a reliable record of nutritional status due to problems in filling it out correctly.

- The Master Chart is not serving the purposes for which it was developed -- namely, to monitor composite center/village performance/status for remedial action -- and is utilized at enormous expense to the program and possible detriment to the individual chart/mother counseling time.

- Mothers' knowledge of basic educational concepts and the meaning of the growth chart was minimal, calling into question the general effectiveness of education and counseling providing in the centers.

4. Program Impacts or Outcomes

Among the program impacts and outcomes studied, the team placed priority attention on nutrition impact, or the feasibility of attempting such studies, and the extent to which the program is reaching the needy.

- The nutrition impact data showed that children attending the program have better nutritional status than children who have not had access to a program recently or than children who have just entered the program. These results are not generalizable to the entire program but are valid for the centers studied. Because of self-selection bias, lack of data on other factors affecting nutritional status, lack of longitudinal data and small sample size, the studies do not provide definitive data that the better status is a result of the program.

- Studies for future nutrition impact studies indicate that a design based on sampling program and control sites generalizable to the entire CRS program in Cameroon is not feasible in the Northwest and Southwest. This is because the program has saturated the areas; control villages identified as good matches with a program village were touched by the program to some degree.

- Through the MCH channel of food delivery, the CRS program does not reach the neediest population as defined by socio-economic or nutritional status.

- Program participants who need the program most appear to be marginal users. The attendees who come irregularly (and who constitute a significant percent of total program participants) have demonstrably poorer nutritional status and benefit from less food and fewer services.

5. Overall Recommendations

a. AID and CRS should continue efforts to reconcile differences with respect to beneficiary criteria and food aid objectives. AID should clarify its position on the neediest and most malnourished which are stated priorities for food delivery, indicating how the distributors are to reach them with actual support provided. If this Guideline is unrealistic, the policy should be changed to reach "the neediest and most malnourished within range of health services" or something similar.

b. AID should sponsor a village study where food is distributed and examine both participants and non-participants to learn: why non-participants fail to come; what their socio-economic status is versus the rest of the community; what are the likely effective channels to them; the social problems that inhibit participation in service programs; and the desirability of serving these groups in terms of available resources and cost-effectiveness.

c. Within Cameroon, and other countries with Title II programs, an important step to more effective program evaluation is to obtain a consensus among concerned and cooperating parties on goals and objectives and to determine whether food aid is seen as an interim or long-range program. Phase-out plans, whether for the immediate or eventual future, should be a part of this planning. It is particularly important to decide whether food is intended to be:

- a preventive health program;
- a curative program for the malnourished;
- an income transfer in neediest families/communities; or
- a developmental program for educating mothers and using food either as an incentive for attendance or an economic trade-off for her time.

It is recommended that the concerned agencies in Cameroon -- CRS, USAID, and GURC/MOH -- meet to determine agreed specific nutritional status as well as other objectives they consider desirable and attainable for the program and evaluate the program against those objectives. Otherwise, impact results may be controversial and not serve the consensus of purpose and expectation.

d. In Cameroon, the central governing contract (GURC-CRS) should state the agreed objectives of the program -- which are changed when necessary -- and note the resources to be supplied by both parties. The CRS-MCH center agreement should state those objectives as well to allow for administrative accountability.

e. The functioning of key program elements might be improved immediately and in a cost-effective way by changing the flow of mothers through the clinic to allow for focus on genuine and effective mother counseling. Two ways this might be done are to reduce the number of weighings of older children and give priority to the individual over the Master Chart.

It is further suggested that regular program attendees might be seen less and weighed less frequently than monthly in order to free time for reaching the needy and malnourished.

f. Results obtained in the present studies of nutrition impact are insufficient evidence of nutritional improvement in program children though the trend in that direction is clear. The team wishes to add its judgment that whatever results had been obtained, it recommends that anthropometric studies in isolation are an inappropriate source for making decisions on Title II expansion, continuation or phase-out. This opinion is taken because of the imperfections of existing data, the large expense of collecting valid, scientific data on a representative country sampling and the obstacles for carrying out this exercise definitively, the lack of a sound, comparative framework for judging the most deserving countries for food aid, and the lack of agreed upon tested methodologies to indicate for the satisfaction of all affected that a program is attaining a minimal goal.

It is recommended that the impact reported herein, which suggest a general positive trend that program participants are in better nutritional status than non-participants, not be utilized as conclusive evidence for decisions about terminating or expanding the program. It is recommended that the Mission could use the results as a basis for projecting quantitative nutritional status improvements that might be expected from the program.

g. It is recommended to USAID and AID/W that, given the complexity of determining the cause of results obtained, the program components should be documented for adequacy in Title II evaluations worldwide and in future Cameroon studies. Preferably, a preliminary assessment of quantity and quality of program components should be made prior to allocating funds for wide-scale (expensive) representative studies.

h. The feasibility of further impact studies should be field tested before developing a final design and work scope.

If USAID continues to consider the use of control areas necessary for a definitive nutrition impact evaluation, it is recommended that USAID pursue such a study in the Eastern Province utilizing sites where CRS plans to initiate a program (ethical and incentive considerations thereby dealt with) and undertake a longitudinal study of children as they enter the program. Working in the East has the advantage of good chances for virginal control areas and the disadvantage of the CRS program being relatively new there. It must be noted that the expense of longitudinal studies and the methodological problem of "lost to follow up" are likely to be significant disadvantages.

i. USAID should indicate to the GURC what replacement, if any, it would make in technical assistance if food aid is to be terminated abruptly; likewise, long-range input to replace food aid should be indicated so that available resources for similar or modified programs can be assessed.

ORGANIZATION OF THE REPORT

This final evaluation report opened with an Executive Summary which presents the highlights of the program, the country setting, and the most significant findings and recommendations the authors selected for priority attention with regard to USG and CRS roles in programming and delivering food aid and its utilization by the GURC and value to the Cameroonian recipients.

The first of the four Chapters is a report on the negotiation of evaluation objectives carried out by the team during the first part of their stay in Cameroon. It constitutes a kind of "lessons learned" preliminary chapter, summarizing the problems encountered in reaching a consensus of evaluation priorities and the difficulties of responding fully to all user wishes within strictly defined resource limits.

The assessment begins with Chapter Two on food assistance policy and structure. It covers: development and nutrition activities in Cameroon; the nature, policy and objectives of the Title II program in Cameroon; implementing agreements; personnel and management; and conclusions and recommendations with regard to food assistance policy and administration.

Chapter Three summarizes the evaluation approaches and methodology applied to the field work.

Chapter Four is the team's evaluation of the effectiveness of program components and the impacts achieved.

Documentation in support of this report, such as the SOW work scope, data collection instruments, individuals consulted, copies of agreements and health charts, and special field studies prepared by the team but not intimately relevant to the central document, is provided in the Appendices.

CHAPTER ONE

THE EVALUATION SETTING, USERS AND OBJECTIVES

Chapter One describes the legislative and AID setting for the Cameroon evaluation including contracting procedures for carrying out the work, the planning interaction between the team and evaluation users, and the consensus reached on evaluation objectives.

A. LEGISLATIVE AND AID SETTING FOR EVALUATION

Over the 27 years of its operations, the Food for Peace Program, which is the implementation of U.S. Public Law 480 (PL 480), has changed its initial focus of primarily agricultural surplus disposal to that of combatting hunger and malnutrition and of fostering economic advancement in the developing countries. Today, food aid is authorized under Title II of the Law to:

> "meet famine or other urgent or extraordinary relief requirements; to combat malnutrition, especially in children; to promote economic and community development in friendly, developing areas in order to alleviate the causes of the need for such assistance; and for needy persons and non-profit school lunch and pre-school feeding programs outside of the United States..." (PL 480, Section 201a, page 12.)

Among the programs outlined to meet these goals is the one reviewed in the present report--the MCH program, under which at-risk women and children are eligible but in Cameroon includes only preschool children. The other types of programs designated to meet food aid objectives are: Other Child Feeding, Food for Work, and School Feeding.

On August 3, 1977, the U.S. Congress put into law the requirement that:

> "Beginning October 1, 1978, and at each five-year interval thereafter, the President shall submit to the Congress a comparative cross-country evaluation of programs conducted under Titles II and III. Such studies shall cover no fewer than five countries sampled from the developing regions...and shall assess the nutritional and other impacts, achievements, problems and future prospects for programs under these Titles." (PL 480, Section 408c, page 20.)

In addition to this Congressional mandate, the Food for Peace Office has the usual need for information on specific country program operations. Interest in comparative worldwide evaluations of food aid is heightened by existing and expected budget tightening. Thus, in

1979 the AID Title II Office awarded four Indefinite Quantity Contracts (IQCs) to assist in the development of evaluation methods and in the conduct of evaluations in selected countries. Systematics General Corporation (SGC) was chosen as one of the contractors and was designated to carry out the Cameroon evaluation. Title II evaluations in Africa had been completed by other contractors prior to the Cameroon study in Kenya, Upper Volta and Ghana.

According to the Scope of Work for the Cameroon evaluation (see Appendix 1), the principal objectives were to clarify program goals and to identify ways of improving the program so as to increase benefits to the targeted population. Specifically, the evaluation was expected to: elucidate food aid objectives of the different concerned agencies (GURC, USG, CRS, missionary and Government MCH centers); review and evaluate the Title II MCH program in terms of its fulfillment of planned accomplishments; confirm the validity of program objectives at both the impact and implementation levels; and to recommend any changes in program direction or implementation which could be expected to augment or enhance program benefits. In short, the scope of work called for a thorough examination of the feeding program. It was clear, however, that the scope and methodology could be modified after conferring with other users -- namely CRS, USAID and the GURC. On the subject of nutrition impact, the scope of work mentions no specific requirements, stating only: "It depends on the availability of data. If data are not available, some inferences can be made and some recommendations should be offered for undertaking surveys or studies or for establishing an information system." Though some degree of modification was anticipated, financial resources were not unlimited. Further, because the Cameroon program for OFFP is a relatively small one, funds were not made available for a pre-planning trip to Cameroon, the purpose of which would have been to sort out differences in evaluation objectives, agree on a compromise, work up the design, determine the required resources, and make a preliminary field assessment. Rather, the SGC team was to work out these matters in the initial phase of the five weeks allocated for the Cameroon study.

B. USERS AND OBJECTIVES

1. Priority Objectives

A majority of users gave some priority to the following objectives:

- Learn the nutrition impact on children below six years;
- Learn how effective are the program operations;
- Learn the economic impact of the ration;
- Learn to what degree the program reaches the needy;
- Learn the cost-effectiveness of the program;
- Study the assumptions of the legislation or program theory.

Table I-1 illustrates these objectives and their priority for users.

MAJOR OBJECTIVES FOR THE EVALUATION AND THEIR PRIORITY ACCORDING TO USERS

Objective	Govt. of the United Republic of Cameroon	CRS/ New York/ Nairobi	CRS/ Yaounde	AID/ Washington	USAID Yaounde
Learn nutritional impact on children below age of six	Specifically, effect on the malnourished.				
Priority	High	-	Lowest	High	Highest
Learn how effective are the program operations					
Priority by component					
Management	Highest	-	Highest	Middle	-
Logistics	Highest	-	Highest	Middle	-
Education	Highest	-	-	High	-
Learn economic impact of ration					
Priority					
On family income	-	-	-	High	-
Agric. disincentive	-	-	-	Middle	Middle
Agric. development and self-reliance	High	-	-	-	-
Degree program reaches needy	High	No (all are needy)	No	High	High
Cost effectiveness	High	-	-	High	High
Evaluate assumptions of legislation or program theory					
Priority	-	Highest	Highest	High	-

2. Evaluation Planning and Other User Objectives

CRS Evaluation Objectives

The SGC Consultants had very good and extensive briefings with CRS/New York/Nairobi representatives before departure from the U.S. It must be noted from the outset that CRS headquarters and field offices were opposed to undertaking the evaluation in Cameroon as proposed by OFFP. However, CRS had failed to convince OFFP of their position that the Food and Nutrition Program had not had sufficient time on the ground to be able to demonstrate nutritional impact. The evaluators understood that the question of whether three years was adequate to implement the Growth Surveillance System had been answered by AID/OFFP when they scheduled the evaluations in Cameroon and elsewhere in Africa. (1) Nor did the consultants find anywhere in the CRS literature that the GSS authors had specified a minimal time schedule for implementing the GSS or a scheme of expected progress by segments in a designated time frame.

CRS requested, and OFFP had strongly recommended, that the evaluators take into consideration CRS theories and objectives as well as those in the Title II guidelines, and that the team examine AID assumptions and expectations about food aid along the lines discussed in Whither Title II. (2) CRS/Yaounde also placed a high priority on evaluation of the effectiveness of the management and logistics of the program.

GURC Objectives

When the U.S.-based team members arrived in Yaounde, they discussed evaluation objectives with CRS, the USAID and the Health Ministry representative appointed to be a part of the evaluation team. The team also attempted to see other GURC officials through USAID and CRS channels. Because USAID staff did not have sufficient familiarity with FFP operations and did not know the Government liaison responsible for Title II, the Consultants had little assistance in obtaining an appropriate range of opinion from the Health Ministry on the Title

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(1) The perceived program age in Cameroon was very different for USAID and for CRS. USAID expected impact results after what they saw as 20 years of food aid programs in Anglophone Cameroon. CRS on the other hand saw this history as a current program of only three years age following on a food aid distribution activity of smaller rations without education and surveillance, thereby offering little hope for demonstrating measurable results.

(2) A summary of CRS philosophy on food aid developed by Father Carlo Capone who was the Medical Officer in the CRS Regional Office at Nairobi at the time of the evaluation.

II program. In their comments on the draft evaluation report, CRS revealed that their contact was the Minister of Health and probably correctly observed that the team had not interviewed the prime food aid contact in Yaounde. To learn GURC evaluation objectives, the team relied upon the Health Ministry representative appointed to the team, Mrs. Tessa Epale and Mr. Elias Joe, (who indicated that he spoke on behalf of the Minister of Health, and was identified by USAID as the spokesman to express GURC priority concerns). Mr. Joe asked that the evaluation team include in their assessment: a review of the effectiveness of the CRS and GURC educational program; the influence of the food aid program on clinic attendance; the appropriateness of food aid within the GURC's policy of self-reliance and of terms in the GURC-CRS agreement; the ethics of collecting mothers' fees and the purposes for which they are utilized; and of the CRS vaccination program in the context of MOH policy.

USAID/Yaounde Objectives

Before departing for Cameroon, the team had the opportunity to consult with the USAID Director and two members of the Mission health staff in the U.S. regarding the evaluation objectives. The Director expressed the USAID's desire to give top, and if necessary sole, priority to measuring the nutrition impact of the program. In Cameroon, this priority was reiterated by other USAID staff, along with the priority of analyzing the cost-effectiveness of the program.

All users had indicated some degree of interest in the objective of determining impact on the targeted population, but placed different priority on its importance within the overall Title II evaluation and in deciding how it should be done. The extent of interest ranged from the highest priority accorded it by USAID, to the lowest expressed by CRS/New York/Nairobi who stated emphatically that a nutritional impact should not be expected in Cameroon because rations at the current level of 2:2:1 (3) are inadequate to produce measurable results. (CRS considered the minimum for impact to be 4:4:2.)

A serious problem arose with respect to USAID and SGC consultants' expectations concerning the scope and magnitude of the nutrition impact evaluation. USAID/Yaounde was adamant that results of a scientific study be produced which would be generalizable to the entire program in Cameroon. Health staff had left instructions that this should be accomplished by an anthropometric field study involving a random sampling of five (5) CRS program sites (chosen from among the more than 100 CRS/MCH sites in three Provinces) and a random sample of five (5) villages as controls (from among all villages extant in Cameroon). USAID expected the team to weigh and measure preschool

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(3) 2:2:1 = 2 kilograms of cereal (bulgur, cornmeal); 2 kilograms of NFDM; 1 liter of oil.

children in the 10 selected villages and verify birth dates using a local events calendar for each village which the team would develop. The USAID staff believed at the time of discussion of the work scope, and continues to believe, that this can be accomplished "in a few weeks" under a team of two U.S. members without the benefit of advance planning, selection of sites for study, staff recruitment and training or preparation of questionnaires and testing in the local languages. SGC Consultants gave their opinion that a study of this magnitude could not be accomplished within the time (three weeks in the field) and funds available even if all project resources were devoted to this objective alone. Further, the Consultants had contractual commitments (Appendix 1) as well as obligations to other users to consider their evaluation objectives. Therefore the team proposed to attempt anthropometric studies in two program and control villages, assuming that suitable ones could be identified. The team clarified that results would be specific for nutrition impact in those villages and would not be generalizable to the whole country. The team carried out this task, with study limitations duly noted, and provided the Mission with a full feasibility report on field problems and conditions as guidance for large-scale studies that the Mission said it wished to undertake later on.

This compromise was agreed to after much discussion (one third of the time available to the team in Cameroon was spent proposing different options in Yaounde) and confirmed in a cable shown in Appendix 2. The team completed the tasks agreed upon in the cable and is not aware of other agreements referred to in USAID's response to the draft evaluation.

Many users wanted to know the program's cost-effectiveness. None of the implementing parties--CRS, GURC or USAID indirectly--were considering alternative program component options for which cost comparisons might have been useful. Therefore with time at a premium, the team omitted preparation of a highly detailed cost effective study and made a careful cost analysis along the lines of those made in earlier Title II evaluations and in other types of feeding programs. (4)

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(4) Nutrition Intervention in Developing Countries, Study I Supplementary Feeding, M.A. Anderson, J.E. Austin, J.D. Wray, M.F. Zeitlin, Harvard Institute for International Development. Oelgeschlager, Gunn & Hain, Cambridge, Mass., 1981, pp.170-184.

CHAPTER TWO

ASSESSMENT OF FOOD ASSISTANCE POLICY AND STRUCTURE IN CAMEROON

The Preceding Chapter emphasized evaluation objectives as stated and perceived by the different users. The present Chapter is concerned with Title II policy and program objectives, as stated and perceived by the different organizations involved with Title II.

This Chapter opens with a description of GURC development and nutrition strategy. A brief country setting including a profile of food and cash crop production in Cameroon, rates of malnutrition and nutrition-related problems and a summary of GURC nutrition programs are then followed by a sketch of the organization, budget, program rationale and food components of the CRS/MCH Title II program.

Finally, Chapter Two examines policy guidelines and makes an analysis of the perceived program objectives of the different donor, cooperating and distributing entities and of the contractual agreements and administrative capability affecting program implementation.

At the end of Chapter Two are conclusions and recommendations relevant to policy and administration.

A. DEVELOPMENT AND NUTRITION IN CAMEROON

1. Government of Cameroon Development and Nutrition Strategy

The basic development theme of the GURC Fourth Five-Year Development Plan was the improvement in the standard of living conditions through self-sustained growth. For the five-year period ending in 1981, the GURC allocated 17% of the total investment for agricultural development. Agricultural availabilities and outlook for self-sufficiency are examined below. A second area of emphasis in the Fourth Year Plan was transport infrastructure, a crucial area for alleviating undernutrition problems in Cameroon caused by an inadequate distribution system, and storage capacity. This sector received 25% of the investment budget. Six percent of the national budget went to the health services sector with two-thirds in support of hospitals and curative medicine, and 15% for preventative medicine programs which include funds for rural health centers and mother and child welfare centers. (1)

During preparation of the National Nutrition Survey (from October 1977 to October 1978 when the results were published), an Interministerial

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(1) CDSS, FY 1982, January 1980, p. 25, p. 16.

Nutrition Committee was established by the Ministry of Economy and Planning (MINEP) for the purposes of: ensuring wide support of the Survey; raising nutrition consciousness; and developing a coordinated national nutrition strategy. Follow-up included the holding of a national nutrition planning seminar in which all concerned Ministries participated and the establishment of a Nutrition Advisory Service in the MINEP to which AID provided support.

The Nutrition Advisory Service has worked to improve the GURC's ability to design intersectoral nutrition programs. As the first step in that direction, the Service collaborated with a parastatal consulting firm in the preparation of a food and nutritional analysis. This document entitled Long-Range Food Planning (Plan Alimentaire a Long Terme) was published in February 1981. Its assessment of 95% agricultural self-sufficiency is in accord with predictions made by the World Bank and others. Most food crops in Cameroon are labor-intensively produced, and the Plan Alimentaire urges priority attention to rural infrastructure. The Plan signals the central problem of urban migration which peaked at 8.9% in the seventies and continues to be high though in a leveling-off period. Excessive urban migration creates a double-edged nutrition problem: more mouths to feed in the cities and fewer hands to produce food in the rural areas. By concentrating on rural infrastructure, the GURC hopes further to stem urban migration. According to nutrition planning staff of the Nutrition Advisory Service, Cameroonians at the village level, though not receiving a well-balanced diet and despite undergoing seasonal food shortages caused largely by inadequate storage, are essentially self-sufficient in food crops. At the national level, the Government is fully capable of mobilizing the necessary resources for meeting needs that have been identified by the Nutrition Survey and other studies as pockets of poverty and malnutrition. (Personal communication, Dr. Claudio Schuftan, Nutrition Advisory Service Staff.)

2. Food and Cash Crop Production

Cameroonian agriculture is quite varied, ranging from the extensive cultivation of millet and sorghum in the North to plantation agriculture in the Southwest, and intensive intercropping of several crops in the Northwest and Western highlands. Major food crops include corn, sorghum, millet, and cocoyams. Cash crops include coffee and cocoa grown by individual farmers; cotton and rice promoted through development projects; and vast plantations of tea, pepper, plantains and oil palm. Both the Northwest and the Southwest are major coffee-producing regions.

The Southwest is characterized by a combination of small-holder and plantation agriculture, while the Northwest is almost entirely dominated by small-holder agriculture. Cassava, cocoyams, beans, maize and coffee are, in that order, the most important crops. The diet reflects this range, with corn and tubers predominating. Corn is grown on 80% of

the farms in the Northwest with an average yield of 360 kilograms per capita. Eighty-five percent of this production is consumed on the farm; 15% is sold.

The Northwestern Province has favorable rainfall patterns and fertile soils. The majority of all corn grown in Cameroon comes from this region. However, the population density reflects this high agricultural potential and average farm size (1.22 hectares) is much smaller than the national average (2.0 hectares). Development of this potential is hampered by a severe deficiency of infrastructure in transport and marketing and by a shortage of labor. These problems, combined with inadequate storage facilities, contribute to seasonal variations in supply and hamper increased production. As an example, the index of maize avilability in the Northwest ranges from a high of 131 in June to a low of 84 in October.

Current food crop production satisfies 96% of Cameroon's consumption needs. During the last 10 years, overall food crop production has risen at the rate of 5% per annum with vegetable and plantain production rising at 6.0% and cereal grains at 1.2%. In 1979, the GURC, concerned about rising food prices and shortages in urban areas, requested that the World Bank study these problems. From the report made by the "Agriculture Projects Reconnaissance Mission," the following data on production and estimated demand have been drawn (page 40):

(in thousands of tons)

Crops	Estimated 1978 Production	Estimated Demand 1990	2000
Millet/sorghum	358	430	459
Maize	418	679	907
Rice (paddy)	44	221	378
Plantains	1015	1085	1165
Rootcrops	1223	1360	1493
Groundnuts	167	253	339

It should be noted here that production figures in Cameroon generally are regarded as extremely unreliable. Other estimates for 1978 maize production, for example, range as low as 250.

Consumption estimates are closely linked to production estimates and should therefore be regarded with the same caution. The World Bank report estimated the increase in consumption per capita and the required production to satisfy these needs (Annex 3, page 10):

(In thousands of tons)

	Estimated Consumption (Kg/Year.head)			Necessary Production	
	1978	1990	2000	1990	2000
Cereals	103.6	110.2	115.7	1435	1904
Millet/Sorghum	41.5	34.9	30.0	430	459
Maize	45.9	49.5	51.8	610	794
Rice	6.2	11.6	16.1	221	378
Wheat	10.0	14.2	17.8	174	273
Groundnuts	16.8	18.9	20.4	253	339
Oils/Fats	12.9	14.7	16.4	261	274

Given these estimates, it appears unlikely that self-sufficiency in cereals can be achieved, particularly in rice or wheat. However, as suggested in Long Range Food Planning, increased yields of corn could be exported to finance the increasing imports of wheat and rice. Long Range Food Planning states that the demand for both corn and oil can be covered until 1985/1990 at which time additional production capacity will be required. The IBRD report estimates that 30% of the increased demand can be covered through increased yields and the remainder will have to come from the opening of new cropland. Corn is expected to continue to be the mainstay of Cameroonian agriculture over the long run.

The IBRD report concludes that "overall there is no immediate food deficit problem since, measured in available nutrients, food crop and livestock products provide over 2200 calories and 60 grams of protein per capita per day." (Page 6. The actual figures from the food balance sheet are 2531 calories per day per person and 63.1 grams of protein.) However, there are temporary food deficits for some regions of the country and some segments of the population. Cited by IBRD as the most pressing deficit populations are 1) the Edea-Kribi plantation workers, b) the urban poor, particularly in Yaounde, c) under five-year olds, and d) inhabitants of certain areas in the North and the Eastern forest zones.

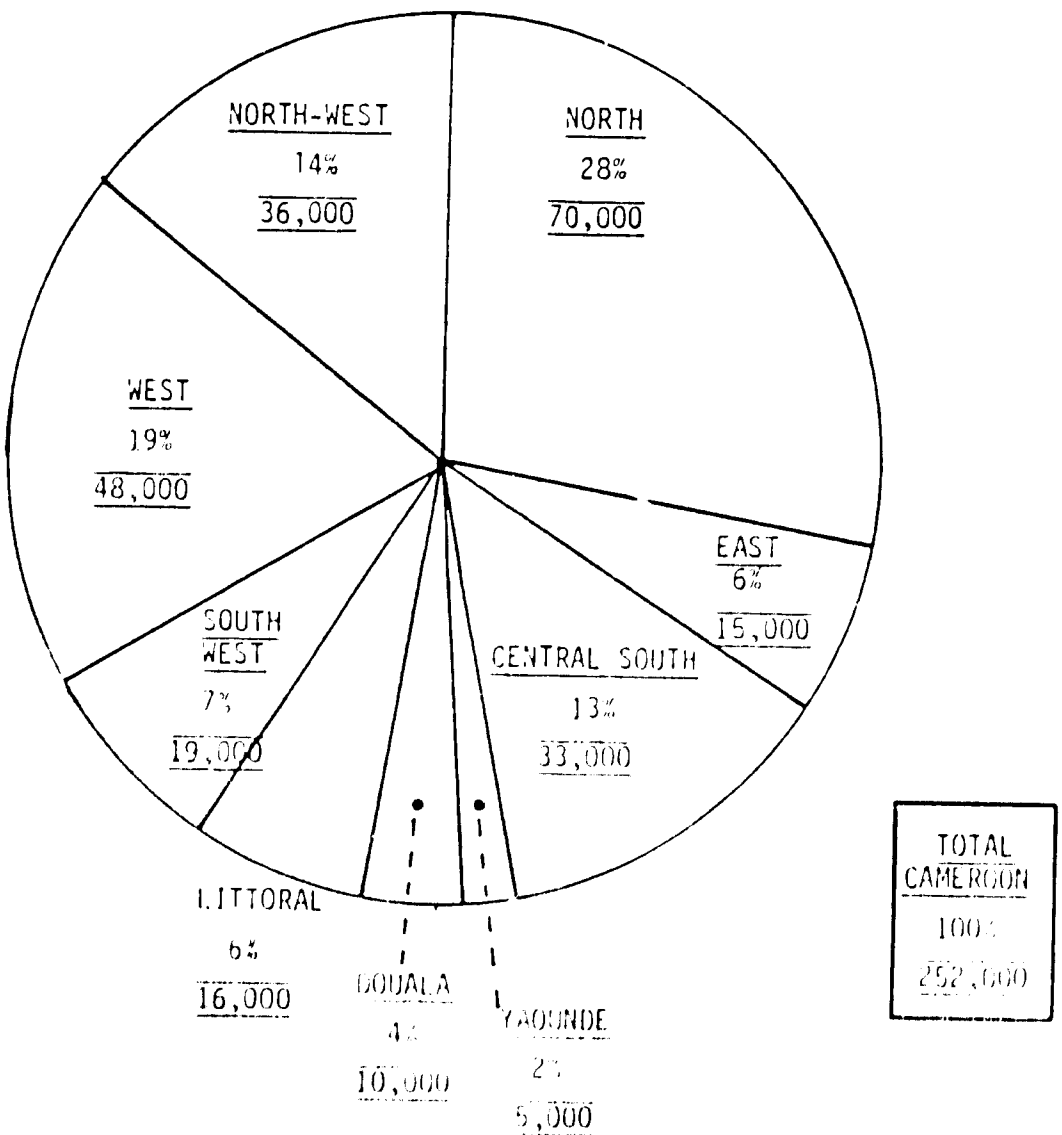
3. The Nutrition Situation in Cameroon

The United Republic of Cameroon National Nutrition Survey contains extensive data on the nutritional status of Cameroonian children according to several anthropometric indicators, by age group, and by ecological zone, milieu, and administrative populations.

The most prevalent nutrition problem in Cameroon is chronic undernutrition, also called stunting and defined as less than 90% of reference median of height for age. 21.1% of Cameroonian preschoolers have chronic undernutrition, or approximately 252,000 children under five years of age. 28% of these children live in the North, 19% in the West Province and 14% in the Northwest. Figure II-1 illustrates the percentages and numbers of stunted preschool children by Province.

FIGURE II-1

Estimated Numbers of Children Aged 3 to 59 Months With Chronic Undernutrition and the Percent Contribution to Total Cameroon



When compared with other sub-Sahara African countries surveyed in recent years, the percentage of children with normal anthropometrics in Cameroon is similar. See Table II-1, showing lowest prevalences of Waterlow's classifications of wasting and wasting plus stunting (acute malnutrition) for Cameroon and Lesotho. Cameron had 0.5% wasting (defined as less than 80% of weight for height) and 0.5% wasting + stunting (defined as less than 80% weight for height and less than 90% of height for age). Prevalence of stunting was at similar levels--in the range of 17-22%--for the West African countries surveyed.

4.7% of Cameroonian preschoolers have mild acute undernutrition (less than 85% of reference median of weight for height). Figure II-2 shows the breakdown for each Province. The largest proportions are in the North Province (54%) followed by Central South (13%) and the Northwest (6%).

21.2% of Cameroonian children were underweight (less than 80% of reference median for weight for age). The North has the highest rate, 27.3%, followed by the West (21.9%) and the Southwest (19.1%).

Approximately 40% of Cameroonian children under five have anemia. Highest prevalence is in the North. Compared with sub-Saharan countries shown in Table II-1, Cameroon had less anemic children than Liberia and Togo but more than Sierra Leone and Lesotho.

USAID has estimated the national infant mortality rate at 165 per 1000 live births with highest rates in the North Province (190/1000). (CDSS, FY 1981)

Survey results indicated that most mothers (90%) breastfeed their infants up to 11 months. However supplementation was highly inadequate. As an example, 30% of infants six to 11 months of age in the North and East Provinces receive mothers' milk with no supplementary foods.

Preschoolers in rural areas experience higher rates of malnutrition than do children in urban areas (23% compared with 13.6%).

The age of greatest risk for all forms of malnutrition is six to 24 months.

4. Etiology of Nutrition and Related Problems of Target Groups

Table II-2 shows factors found by the National Nutrition Survey to be associated with stunting (low height for age). It is cautioned that an association does not necessarily indicate a causal relationship. However, this list of at-risk factors was in positive correlation with the prevalence of stunting, and it constitutes useful guiding data for program targeting.

The anthropometric results of the Nutrition Survey signalled that the

Prevalence of Normal Anthropometrics, Stunting, Wasting and Low Hemoglobin in Preschool Children, from Recent National Surveys, by Country

Country	Children Sampled	% Normal Anthropometrics	% Stunting Only[1]	% Wasting Only[2]	% Stunting and Wasting	% Low Hemoglobin[3]
Nepal	5482	46.5	46.0	3.4	4.1	24.3
Sri Lanka	13396	62.4	29.8	3.8	4.0	NA (Not Available)
Lesotho	1706	76.7	22.4	0.7	0.2	25.5
Egypt	8016	78.6	20.8	0.3	0.3	38.4
Haiti	5353	70.4	23.6	2.9	3.1	33.0
Tunisia	1494	76.3	22.2	1.0	0.5	29.9
Togo	6086	80.7	17.2	1.5	0.6	55.5
Liberia	3733	79.3	19.2	0.8	0.7	62.1
Sierra Leone	4880	74.9	22.2	3.0	1.1	25.0
Cameroon	5689	77.9	21.1	0.5	0.5	38.1

[1] Less than 90% of reference median height-for-age.

[2] Less than 80% of reference median weight-for-height.

[3] Under two years of age: Hemoglobin concentration of less than 10 g/100 ml.
Over two years of age: Hemoglobin concentration of less than 11 g/100 ml.

FIGURE II-2

Estimated Numbers of Children Aged 3 to 59 Months with Mild Acute Undernutrition and the Percent Contribution to Total Cameroon

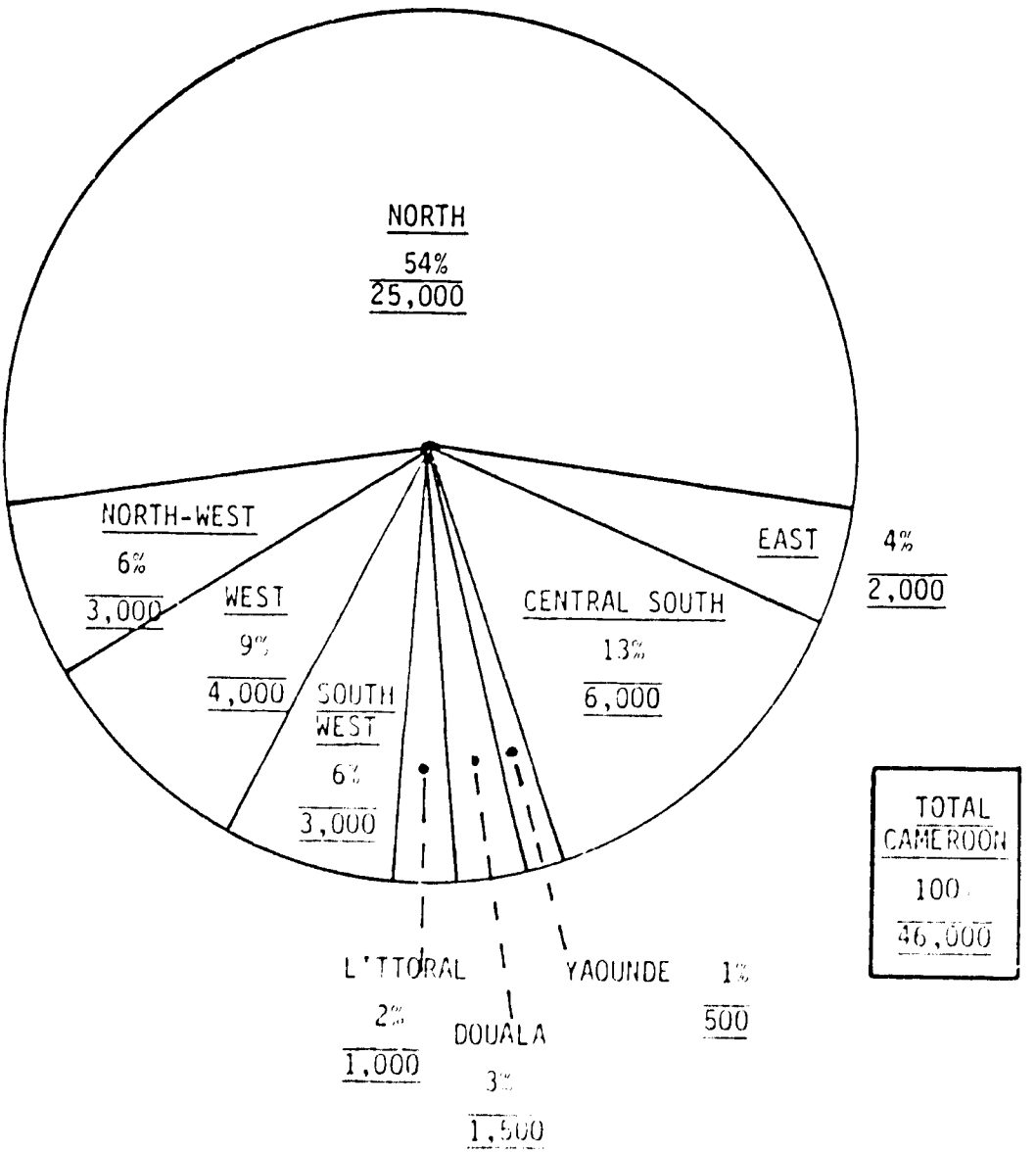


TABLE II-2

1978 National Nutrition Survey, Cameroon

"At Risk" Factors for Stunting

• Demographic	- Household size more than 10 members - High number (i.e. 4+) of dependents (children under (5 years) in household
• Socio-Economic	- Household head a farmer - Household structure traditional or improved - Family owned more cattle, sheep or goats - Someone other than mother cared for the child - Mother illiterate (cannot read French, English or other language).
• Health and Health Service Utilization	- Child not born in a hospital - Child with no birth nor clinic record (i.e. calendar of events or declaration required for age determination). - Recent onset of fever, diarrhea or illness
• Diet	- Child aged 3-5 and 6-11 months receiving no food other than milk - Child aged 6-11 and 12-23 months who receive no family food - Child aged 12-23 months still being breast-fed (assuming inadequate additional foods other than milk) - Children of all ages who receive less number of total energy-containing and protein-rich food groups

population groups that should receive priority in programs to combat malnutrition in Cameroon are as follows, in order of importance:

a. Children between six and 24 months of age;
b. All rural areas in the country;
c. The North Province, followed by the Eastern and Western Provinces;
d. The urban centers of Yaounde and Douala.

5. Government of Cameroon Food and Nutrition Programs

As noted earlier, the nutrition sector has obtained recognition, diagnosed global problems and causes, but is has no budget of its own and offers principally long-term solutions which are to emanate from investments in rural infrastructure. Agriculture and transport are GURC priority commitments. Budgeting for preventive health care lags behind officially-expressed concern for primary health care needs in the rural areas and outreach to isolated regions. There exist at present no elaborated interim action plans or policy, strategy, defined target populations, quantitative objectives or priorities for combatting current, existing malnutrition in the country. Mr. Elias Joe did give an informal MOH opinion that children with a weight-for-age at or above 85% should not receive food aid but rather benefit from other nutrition interventions such as sanitation, wells, etc. This may be an indication of GURC preference for non-food aid attention to its relatively moderate malnutrition problems.

The Nutrition Advisory staff in the MINEP (which will not be supported by AID after this year) have concentrated on laying out a nutrition surveillance system (developing a standardized growth chart based on weight-for-height plus a system for tabulating the information), on training nutritionists and promoting seminars on child growth and development.

Two of the specific recommendations made by the Cameroon National Nutrition Survey team were included in the Report of the Health Committee for the elaboration of the Fifth Five Year Plan (November 1980). A remedial action program against goiter; and preparation of plans for establishment of a national center and seven provincial units for dietetic experimentation and nutrition rehabilitation.

B. THE TITLE II PROGRAM IN CAMEROON: ORGANIZATION, BUDGET, PROGRAM RATIONALE, AND APPROVED RATIONS

1. Organizational Framework

Figure II-3 illustrates the organizational framework of the Cameroon Title II program. Table II-4 on the following page is a summary of

the roles and responsibilities of the different organizations involved with the planning and implementation of the Title II food program in Cameroon.

In AID, the OFFP has responsibility for administering Title II programs. The OFFP also chairs an Interagency Food Aid Subcommittee which is charged with reviewing and approving Title II programs. Food for Peace (FFP) is involved in all aspects of Title II as outlined in AID Policy Handbook 9. In the early years of P.L. 480 assistance, FFP merely provided food donations. Recently, however, initiatives to deliver food aid beyond the reach of existing distribution networks resulted in a centrally funded project called "Outreach." Outreach funds pay for certain logistical costs incurred through efforts to attain the neediest populations which may be outside the normal logistical "reach" of the distributing agency. This funding source was referred to earlier as a "means of improving program effectiveness...for the purpose of concentrating available resources to solve critical development programs in nutrition and health." CRS/New York/Nairobi saw this estimated $9 million grant program of minimal significance for actual needs. The program was considered to be inadequate, short term and limited to expansion, and not intended for program improvements (Interview, New York, CRS Headquarters, August 13, 1981.)

In Cameroon, the USAID Mission formulates the U.S. Government's assistance strategy and annual budget submissions (which are supposed to review and place in context of Mission planning the CRS Title II program). Annually, the voluntary agency submits an Annual Estimate of Requirements (AER), a summary of its food needs for the subsequent Fiscal Year based on numbers of beneficiaries and ration levels, to the USAID for approval prior to sending it to CRS/New York; the Mission in turn sends to AID/W the signed and approved AER along with appropriate reviewing comments. If the USAID disagrees with the program proposed, as has been the case in Cameroon, then the AER goes unsigned until unresolved issues can be settled. Procedures have not been totally consistent over the years as to the resolution of differences at this level. Mission responses to voluntary agencies' food requests have been uneven. The principal reasons for uneven response appear to have been the degree to which the designated project officer in USAID understands the Title II program operations and the prevailing bias of personnel with regard to expected beneficial or deleterious results from food aid.

USAID/Yaounde has no Food for Peace Officer on its staff and according to information available, has preferred not to avail itself of the services provided by the Regional Food for Peace Officer located in the Abidjan Regional AID Office (REDSO). Again, according to limited information available to the team, the USAID personnel who have been called to make judgments on the Title II program scope in recent years have not understood the basic operations of the program or have ever visited a field clinic.

CRS is the sole sponsor of Title II bilateral programs in Cameroon. Ms. Sam La Foy, the Regional Food for Peace Officer, contributed a description

FIGURE II-3

Diagram of Cameroon FFP Title II Organizational Structures & Relationships

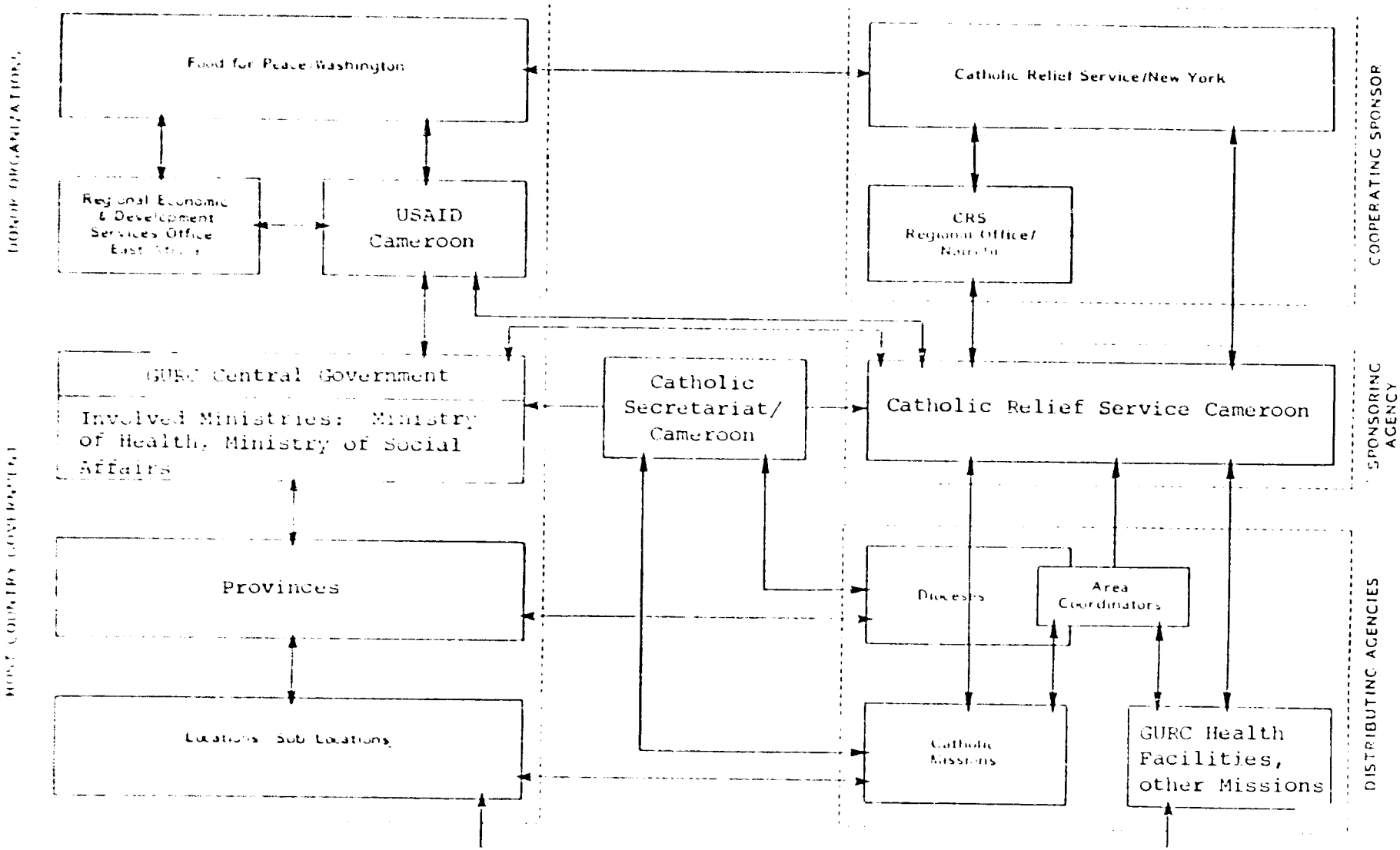


TABLE II-3

SUMMARY LIST OF CAMEROON TITLE II ORGANIZATION ROLES & RESPONSIBILITIES

Organizational Unit	Key Roles & Responsibilities
OFFICE OF FOOD FOR PEACE/AID	- Administer Title II programs - Provide policy guidance - Establish food ration guidelines - Select and approve Title II sponsoring organizations - Prepare Title II budget submissions - Approve and monitor non-food outreach grants - Liaise with Congress and Interagency committee - Review Mission CDSS and ABS submissions - Monitor Title II program implementation - Evaluate impact of Title II programs
REDSO/EAST AFRICA	- Assist USAID/Cameroon with Title II program development upon request - Provide technical advice to USAID/Cameroon upon request
USAID/CAMEROON	- Perform sector assessment - Establish country strategy (CDSS) - Prepare annual budget submission (ABS) - Approve program plan and AER and forward copy to FFP - Endorse program plan and AER and call forward for commodities - Monitor food programs and implementation of outreach grant (in the North Province, no Title II foods)
GOVERNMENT OF CAMEROON	- Sign Country Agreement with CRS (ensures that handling storage and transport costs of goods are financed by GURC, exonerates goods from tax and permits CRS to inspect food operations) - Provide storage facilities, offices, provincial supervisors and staff for MCH distribution centers
CATHOLIC RELIEF SERVICES/ NEW YORK	- Provide policy guidelines to regions & countries - Raise funds - Supervise and monitor field activities
CATHOLIC RELIEF SERVICES/ AFRICA REGION	- Establish regional CRS program strategy & guidelines - Provide technical advice on food programs - Supervise food programs
CATHOLIC RELIEF SERVICES/ CAMEROON	- Produce AER with annual or multiyear program plans - Solicit FFP project proposals and assist with project design - Raise funds - Administer CRS programs - Collect payments from distributing centers - Handle commodity transportation and storage - Supervise commodity use - Keep program records and submit reports
TITLE II IMPLEMENTING AGENCIES	- Manage commodities at distribution site - Execute food aid and education programs - Collect program fees and make payments to CRS - Gather data and submit reports

of the history, administration and management of the CRS program to the evaluation report; it is attached as Appendix 12. CRS/Cameroon is headed by a Program Director. The Title II program staff includes a National Supervisor in charge of the Title II food distribution program which programs 35,000 rations (2) for preschool children at more than 100 centers located principally in the Northwest, Southwest and the Eastern Provinces. Three Provincial Supervisors are in charge of the three Provinces and they are paid by the Cameroonian Government. All personnel in government health centers distributing Title II are paid by the GURC. Personnel in religious centers are supported by churches for the most part.

At the distributing agency level, personnel varied from highly qualified Cameroonian and European nursing professionals, Grade II Cameroonian mid-wives, to nursing aids. Additional staff were employed on distribution days, seconded from nearby health facilities or available through related field agencies such as the Department of Community Development.

2. Budget

The sources of financing the CRS Title II program in Cameroon are discussed in Chapter Four under Cost-Effectiveness. The following inputs are provided by USG, GURC, CRS, and mothers' contributions:

USG:	Title II food Ocean transport Staff for in-country monitoring and planning
GURC:	Inland transport for food Staff for policy and planning at national level Supervisory staff at Provincial level Warehouses and offices for CRS
CRS:	Salary, National Supervisor One-time contribution for program upgrading
Mothers:	Salaries for all project personnel except the National Supervisor and Provincial Supervisors Administrative and program costs

(2) CRS programming utilizes "averaged beneficiaries"; as will be seen further along, actual numbers of beneficiaries are estimated by the team to be greater than the number of "rations" or averaged beneficiaries.

3. CRS Title II Program Rationale (3)

The basic goal of CRS programs within maternal child health settings is to assure adequate growth in preschool children. According to CRS/Yaounde's Operational Plan, Title II food supplements are given to participating families "as a corrective element of the child's diet; as a means of education for the parents; and as an economic aid to the family." CRS considers that all of its beneficiaries need the food assistance since they are from "subsistence" communities. ("Subsistence" communities are defined in CRS literature as those involved in agricultural or pastoral activities who spend a disproportionate amount of their income--85% or more--to satisfy basic food requirements.)

In order for food supplements to reduce the risk of malnutrition among targeted children, CRS believes that the value of the food must raise the family revenue to a level sufficiently high to permit the release of supplementary foods for the child. This is called the level of marginal propensity. According to this economic theory, factors that compete with attainment of the marginal propensity level include: sharing of food with other household members; the relief of nutritional insecurity caused by marginal intakes of the whole family; and sale or exchange of the food supplements for cash, goods or services with non-nutritional purposes.

CRS believes that it can encourage families to give food supplements to the more nutritionally vulnerable young children by making the food aid part of a "contractual assistance package." This package includes: food, nutrition education, and nutrition surveillance. The components, according to CRS, must be provided together to produce the desired results.

Use of the Growth Surveillance System (GSS) described further along, is expected to meet the nutrition education and nutrition surveillance requirements.

According to the guiding principles of the CRS Food and Nutrition Program for Africa, the contractual assistance package should include commitments on the part of the parents and on the part of distributing agency personnel. Under the parental contract, a food supplement, which is in effect a revenue increment for the family, is provided in exchange for parents' agreement to:

- Give the child the food rations or the home equivalents of these foods as an addition to the usual diet so that the child is assured of obtaining adequate food intake

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(3) Information in this section is from CRS field bulletins prepared by Dr. Carlo Capone, Regional Medical Officer for CRS in Nairobi, from an interview which the team members had with Dr. Capone on August 13, 1981, and from the FFP PL 480 Title II Evaluation of the CRS Kenya Program.

for normal growth;

- Keep their children free (through prevention or prompt treatment) of major diseases, infections, parasitic infestation and other nutrition-related illnesses; and

- Agree that the child's rate of growth, as plotted on the Growth Record or Chart, must be adequate and is accepted as proof that they are carrying out the desired feeding and health care.

Under the distributing agency agreement, program workers agree to provide promotional activities which will consist of a "nutrition or general health/household care lesson at every session" and food demonstrations which place "emphasis on the local equivalent of the imported foods so that the children will not suffer if the imported foor supply is ever interrupted or discontinued." (4)

The CRS Operational Plan (YR 1982) states that the progress of children (and therefore the contractual compliance of the parents) is monitored with the Growth Surveillance System; the components of the GSS are:

- Regular monthly attendance by mothers and their children;

- Use of a specially designed growth chart;

- Compilation of a Master Chart which is a record of all weights of participants by center and by month;

- Weighing and recording on the individual chart;

- Interpretation of the weight to the mother;

- Individual advice according to need;

- Provision of anti-malarial and anti-worm medicine by CRS;

- Food supplements.

Dr. Carlo Capone developed the GSS system. The Master Chart is the source of the weight-for-age percentage for the given child's age and weight. The percentile is transferred to the individual Growth Surveillance Chart. One purpose of the Master Chart is to provide a composite nutrition profile for a child population on a given day in a given clinic. Information compiled on the Master Chart includes: the

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(4) Catholic Relief Services/USCC, Cameroon Program, Agreement with Distributing Center, Appendix 6.

number, age group, nutritional status, and location of the children weighed. The Master Chart was intended to separate the nutritional status entries of new enrollees from those of regular attendees. In sum, the Master Chart was to provide health workers with a continuous assessment of the nutritional status levels for groups of children at individual centers and thereby be a tool for program evaluation and planning at the regional and national levels. The child growth charts contain information on the growth progress of individual children over a period of time. The individual card is supposed to be a graphic and easily understood record of child growth for mothers. It also offers continuity of health progress data for mobile families.

4. Authorized Food Rations

The Interagency Staff Committee (ISC) approves specific commodities and ration levels for Food for Peace programs. OFFP sets out "Suggested Maximum Per Capita Rates of Commodity Use" for the different recipient categories in its Commodities Reference Guide. Prior to 1978, the suggested maximum for the MCH category was 3.8 kilograms monthly or 45.6 kilograms annually. These rates were then revised upwards to 4.6 monthly or 55.2 kilograms per beneficiary annually. The current rate of 5.0 kilograms monthly, or 60 annually, was first approved in Cameroon for FY 1981.

The amount and kind of Title II commodity ration, sometimes referred to as 2:2:1, means:

2 kilograms of cereal (bulgur/cornmeal in Cameroon);
2 kilograms of NFDM
1 kilogram of soybean salad oil

The nutritional value for five kilos of cornmeal/bulgur, NFDM and oil is estimated as follows:

Theoretical Daily Availability of Calories and Proteins Per Beneficiary:

	Calories*	Proteins*
Bulgur/Cornmeal	247	6.0
NFDM	242	23.9
Soybean salad oil	295	-
	784	29.9

* Nutritional value of bulgur/cornmeal is estimated at 370 calories per 100 grams and 9 protein grams per 100 grams. (Exact information on cornmeal is not available in Commodities Reference Guide.) Bulgur: 358 calories and 11.2 protein grams per 100 grams. NFDM: 363 calories and

35.9 protein grams per 100 grams. Soybean salad oil, 884 calories, no protein per 100 grams. (5)

In terms of satisfying the average energy requirements of preschool children, the daily ration theoretically meets 56% of these estimated needs. (6)

C. CAMEROON TITLE II FOOD AID POLICY AND OBJECTIVES

Title II foods approved and shipped to Cameroon for Fiscal Year 1981 to meet supplemental needs of 35,000 averaged preschool children in MCH Centers were as follows:

	Metric Tons		CCC Value $000	
	Approved (7)	Shipped (8)	Approved	Shipped
Cornmeal	840	658	n.a.	$ 179.3
Oil	420	417	n.a.	353.4
NFDM	840	741	n.a.	300.5
Total	2100	1816	$ 934.5	$ 833.2

This section of the report reviews the perceived objectives or benefits expected to accrue from the delivery of these foods on the part of the different contributing and participating organizations and offers a setting to explain from whence these expectations flow.

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(5) Commodities Reference Guide.

(6) FAO/WHO Estimated Calorie Requirements for preschoolers: 1400

(7) AID/W Approval, AER, Line 8.

(8) CCC Shipping Records, Yaounde.

1. Office of Food for Peace/AID

In 1954, the 83rd U.S. Congress legislated food aid in the form of Public Law 480 out of the need to dispose of growing American agricultural surpluses. Over the next 20 years U.S. food aid evolved from that initial mechanism to dispose of domestic surplus to a hopefully effective developmental tool in the new, food-short nations. (9) Similar to the purposes laid out by the 1974 World Food Congress (for emergency relief, alleviation of hunger and malnutrition, economic/social development), the provisions that govern the use of Title II state that food will serve developmental as well as humanitarian and nutritional objectives. Food aid is intended "to meet famine or other extraordinary relief requirements; to combat malnutrition, especially in children; and to promote economic and community development...." (Title II, Section 201).

It is further expected in the legislation that "priority shall be given to the extent feasible, to those who are suffering from malnutrition by using means such as a) giving priority within food programs for preschool children to the malnourished children and b) giving priority to the poorest regions of countries." (Section 202, b,3).

AID's Handbook 9 interprets the Law with regard to child feeding in Chapter 10, noting that "Title II commodities...are considered to be a development resource and therefore related to the specific USAID strategy for each country, with the commodities possibly 'augmented with funds and technicians, from AID or other sources, for the purpose of concentrating available resources to solve critical development problems in nutrition and health.'" After noting the desirability of increasing the program responsibilities assumed by the local government with the objective of eventual self-sufficiency, the interpretative provisions specify the expected MCH program components and achievements:

> "MCH projects are established to provide commodities to the vulnerable, high-risk category of women of childbearing age and their children under the age of six...Attempts should be made to reach these groups in terms of poverty and/or nutritional status, thus the effectiveness and extent of delivery systems will need to be carefully considered in planning programs to reach selected target groups. Child feeding projects are to provide nourishing foods needed by those groups along with education for the mothers in nutrition, child care, and related subjects..."

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(9) An excellent summary of how PL 480 evolved from 1954 up to 1966 and through 1977 to the present day, and of its workings and regional emphasis is excerpted from Christopher Stevens' Food Aid and the Developing World and included in Appendix 7.

"...the overall goal is to improve the nutritional status (of vulnerable groups)..."

"...in MCH programs, use of growth charts...may be effectively used to establish a contractual understanding with MCH recipients to assure the desired controlled feeding. In such a project a nutritional education component (which might also include elements of health and/or family planning) should be considered essential. The lack of an educational component would give rise to consideration for discontinuing future support."

(Chapter 10. 10A, 10B, 10B 1.b. and 10B 1.c. (2), Handbcok 9.)

2. USAID/Cameroon Mission

USAID's assistance priorities are indirectly but closely linked to food and nutrition concerns. They emphasize the problems of the rural poor and seek to assist small food producers to increase their production efficiency. Several AID projects aim at increased agricultural food production, others at raising functional literacy rates, and providing agricultural and health training. Projects directly involving nutrition include support for the Nutrition Advisory Service in MINEP (which, however, will not be continued after the current year) and the PL 480 Title II program. USAID shares the GURC's concern that food aid may lead to dependency on the part of recipients and may be unnecessary in light of Cameroon's strides toward self-sufficiency in agriculture and concerns with self-reliance.

USAID's Proposed Assistance Planning Level for FY 1982 is $20 million with 65% allocated to agriculture-related programs. At current prices, Title II commodities will cost approximately $1 million in FY 1982, or less than five percent of the total U.S. assistance to Cameroon.

USAID has not seen opportunities for integrating Title II activities with ongoing programs. Though overall objectives of alleviating nutritional and health needs of the rural population are similar, no practical collaborative efforts are foreseen. The USAID does not see the MCH program fitting into the country development strategy:

"As there is little direct relationship between the Title II food distribution program and other Mission activities, it has not been integrated in the Mission's overall development strategy and program."

(FY 1983 Annual Budget Submission, June 1981, page 14.)

USAID believes that reaching needy people such as hospital patients and malnourished children is a realistic and worthy objective for food aid programs. USAID's viewpoint is that MCH programs targeted at vulnerable groups such as pregnant women and young children without further focus on poorest or malnourished could be valuable provided that they demonstrate nutritional or developmental impact. Even with impact, food aid should not be continued indefinitely but should be designed for eventual phaseout of imported foods. (Response to USAID Check List, Evaluation Office and Population and Health Office, September 1981.)

3. Catholic Relief Services (CRS)

CRS is a voluntary, religious-affiliated organization with headquarters in New York and operations in 70 countries, including Cameroon. CRS is particularly interested in the social aspects of development. The goal of CRS is to help the poor and the hungry, and to provide development and disaster assistance in five program areas: emergency and disaster services; social welfare services; socio-economic development; services to refugees; and food and nutrition. In 1979, CRS expended $241.2 million, or nearly 70% of total funds available, in its food and nutrition and socio-economic development program. CRS' policy is to serve the people in as direct a manner as possible. The agency's concern is with helping people to build institutions that will serve the people rather than to strengthen any and all existing institutions which may or may not serve the people's needs. (10)

CRS Representative Dr. Carlo Capone asked the evaluating team, prior to looking at the Cameroon Title II program, to consider the validity of certain FFP operational guidelines and program expectations implicit in the legislation and explicit in the guidelines. The most important issues were:

> AID has passed on the Congressional mandate to reach the poorest to the sponsoring agencies without providing the financial means or suggested program components to make it feasible. AID expects to deliver nutritional and developmental assistance to the poor by providing Title II foods (at inadequate ration levels) without accompanying funds. (Integration of food aid with dollar assistance is not a way to provide the funds needed for the food aid program objectives.)
>
> AID expects that providing nutritional supplements calculated to meet partial needs of a targeted household member will improve the food consumption and nutritional status of the intended beneficiary. This is an invalid assumption in a

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(10) AID/PCI Food for Peace P.L. 480 Title II Evaluation, CRS Kenya Program. 1980, page III-16.

subsistence household of a developing area stemming from a difference in the marginal propensity for child feeding. Marginal propensity is defined as the percentage of every food aid dollar which is consumed by the targeted child. Margina propensity is much higher in developed countries where it can be assumed that a significant portion of the food distributed will be given to the child as a dietary addition. AID is unrealistic to disapprove of family sharing, ignoring the cultural realities of household food allocations in the developing world.

Food aid is expected to bring about nutritional impact. Yet, except for an undefined nutrition education component, AID guidelines do not require (or provide and suggest) the basic components necessary even to attempt to achieve a nutritional impact.

Given the approved ration levels for Cameroon (5 kilograms monthly), any improvement in nutritional status among the beneficiaries is likely to be due to health or other inputs and not attributable to Title II foods.

Developmental emphasis given by AID to food programs is self-deceiving. Family feeding and relief have been replaced by new MCH and Food for Work programs which are conducted in settings that convey an impression of health, nutrition or development activity when in fact, they are no more than household budgetary supports. Appropriate development emphasis is that of the child's growth for future productivity.

Background on CRS' viewpoint is critical because AID/OFFP has deviated from its guidelines, permitting CRS to undertake an experimental Food and Nutrition Program in Sub-Sahara Africa, based on the premise of family revenue supplement rather than targeted individual supplement. The evaluating team took into consideration both the Title II guidelines and the CRS operating procedures in Africa.

4. Government of the United Republic of Cameroon

While GURC budgetary commitments to nutrition and primary health activities for the rural poor are far from adequate, there is consistent concern on the part of the Government for the social and economic development of Cameroon with equity. The GURC's hope is that increases in rural production can be obtained through the policy themes of self-help (auto-centre) and self-sustained (auto-entretenu) improvement of rural levels of living. An example of this concern was expressed by the GURC, through the Ministry of Health, when they requested the evaluation team to assess the numbers, types and locations of all needy persons in Cameroon so that the Government could examine these requirements. (Time constraints did not permit the team to undertake this assignment.)

Food aid is not mentioned among the long-term components of the Plan Alimentaire and is viewed somewhat negatively even in the short term. There is no policy governing imported free food in the Fifth Five Year Plan, although it is expected that in addition to the Title II MCH program, World Food Program (WFP) will continue to provide free commodities to an estimated 50,000 persons in more than 500 establishments and the European Economic Community (EEC) might supply periodic food supplies as they have in the past for emergency needs in the North.

While there are no GURC stated objectives in writing, it was clear that the Government expects an impact in return for its contributions for inland transport expenses, the time of its MCH personnel who distribute foods and especially in light of the amounts of contributions made by program mothers which are used for program administration support. Through the Ministry of Health, the team learned that the Government considers the program one to assist the needy and malnourished and has expectations for quantitative curative and preventive results.

At Provincial and village levels, the evaluation team heard the opinion that food aid was useful in encouraging preventive care practices. Or, food assistance was seen as particularly useful during short-supply periods especially during pre-harvest times when serious food shortages threatened subsistence farmers as well as the landless. At the national level, however, despite some attempts at maintaining objectivity, officials consistently regarded food aid as stop-gap assistance running the risk of creating dependency on the part of beneficiaries. The image is one of a charity operation which goes against the grain of the Government's reiterated concerns for self-reliance in its peoples. On the other hand, there have been no initiatives to elaborate a phaseout plan which would rationally wean present recipients from the program. The basic reason appears to be that there is still uncertainty about what the program should and does accomplish.

5. Title II Distributing Agents in Cameroon

MCH centers operating in the Northwest and Southwest during the August-September evaluation were carried out by the following kinds of distributing agencies:

	Northwest		Southwest	
	Number	Percent	Number	Percent
Government	27	64	4	11
Government-Council	-	-	11	32
Plantation Estates	-	-	16	46
Missionary	15	36	4	11
(Catholic)	(8)	(19)		
(Other)	(7)	(17)		
Total	42	100	35	100

In addition to these 77 centers administered by the Ministry of Health, private/government-controlled corporations and Missions including Catholic, Baptist, Apostolic, Presbyterian, Full Gospel and Church of Christ, there are a reported additional 30 in the West, Central-South and the East where the majority are under the auspices of village organizations such as the Zones d'Action Prioritaires Intégrés (ZAPI), Priority Integrated Areas of Action, or are social centers attached to the Ministry of Social Affairs.

In the Provinces visited by the evaluation team, the Northwest and Southwest, objectives varied, but all distributing agents essentially provided food with the interest of encouraging greater attendance at the clinic which offered various levels of preventive and curative care. The primary interest was not to reach out to the neediest or most malnourished families from the community, but to offer an incentive for general community attendance of the clinic and to help families through seasonal food shortages.

6. Similarities and Differences in Objectives

Table II-4 on page II-26, II-27, and II-28, is a summary of perceived objectives for the CRS Title II program by AID/Washington, USAID/Cameroon, Government of Cameroon, CRS and distributing agencies.

On the surface, all of the relevant organizations agree on the central objective of improving nutritional status (of targeted, vulnerable groups), although specific quantitative objectives such as amount of improvement desired, target age groups, population groups, etc., go unstated. Moreoever, the separate organizations do not always agree on what components are expected to bring about the unspecified results. The evaluating team found the persistent "misunderstanding" with regard to food aid expectations to stem from conflicting ideas about the company food aid must keep, if any, to produce nutritional impact. The Title II Guidelines leave open the question of whether it is:

- food aid alone
- food aid with the rest of the CRS package of education and surveillance;
- food aid with accompanying components derived from the program with which it is integrated (MCH in Cameroon); or
- the total food program along with other contributing projects of activities

that will "lead to the overall goal of improving nutritional status."

The different agencies also make different assumptions about the quality or intensity of the package delivered to beneficiaries. The FFP Guidelines, for example, do not formally give consideration to the food

dilution that occurs along the delivery chain from the port from which the U.S. food leaves to the targeted preschool child in Cameroon. This problem is treated in the next Chapter and is mentioned but briefly here to clarify this point. Expectations ought rationally to flow from an assessment of the components which include the food ration, other education, counseling and health services provided with the food. The Guidelines estimate that specified quantities of programmed food will meet certain percentages of the nutritional requirements of targeted recipients. USAID/Cameroon then concludes that "x" amount of programmed Title II food per Cameroonian preschool child will result in a correction of his diet which in turn will show a measurable improvement in his nutritional status. Ignored, in the first instance, is the actual intensity of the delivered food component. The intensity is diminished by: reduced or late deliveries of commodities to clinics (that cannot be made up in terms of the targeted child's health status); reduced supply of food to the family because of clinic allocations to beneficiaries that are less than programmed ration levels; further reduction in availability due to low attendance rates; and finally intrafamilial sharing which has been authorized informally by AID in light of cultural realities but not adjusted for in the allocation of rations and most certainly not considered in the estimates of satisfied nutritional requirements of targeted children. Further ignored may be the other necessary components to assure proper biological use of the food delivered to the targeted child--i.e. preventing losses caused by diarrhea, malaria, worms, etc.

Although CRS states in its reports that the agency responds to facilities and areas that wish to participate in the food program, all other parties go on assuming that the Title II food is being delivered to the neediest and most malnourished of Cameroon. These latter assumptions greatly affect the results to be expected from food aid. The Guidelines approach being contradictory on this point, noting the desirability first of reaching the poorest and neediest and then suggesting that for practical purposes, the field programs might more safely be confined to preventive activites. It is important in Cameroon as elsewhere to have an agreement among the parties about what the program priorities are: e.g., preventive or curative? A preventive program can be expected to produce far less dramatic achievements in nutritional status improvements and stands a lesser chance to show impact in comparison with a "control village" than would a curative program for severely malnourished.

D. AGREEMENTS

The intended content of agreements between CRS and the MCH Center, and between the MCH and the mothers, are described under CRS program rationale. In addition to these agreements which are considered crucial to the program's success, CRS has an operating agreement with the Government of Cameroon. The contract currently in effect was signed

TABLE II-4

Summary of Perceived Objectives by Relevant Organization

ORGANIZATION	PERCEIVED OBJECTIVE
AID/Washington OFFP	- Title II foods serve areas and populations of greatest need as defined by level of socio-economic status or nutritional status. Highest priority is given to nutritionally vulnerable groups, especially malnourished children under six years of age and more particularly, under three years of age. - Title II foods, combined with CRS program components and/or components with which the food package is integrated, will lead to an improvement in nutritional status. Education is the most essential accompanying component. - The sponsoring agency (CRS in Cameroon) and the distributing agencies (Mission, CDC and Government MCHs) offer a valid delivery system to the areas and populations of greatest need. - Title II foods are a development resource which should be related to USAID country strategy. - Title II programs have the long-term objective of being carried out without U.S. assistance.
USAID/ Cameroon	- Title II foods serve nutritionally vulnerable populations of Cameroon. (Nutritionally vulnerable include women at risk and young children whether or not malnourished.) USAID has applauded efforts of CRS to move to areas of greater need (the East). - Other program components may or may not be present. USAID believes that Title II foods constitute "a corrective element of the child's diet" and therefore expect that this will result in (measurable) nutritional or developmental impact." - USAID approves the CRS program annually, assuming it to be a valid delivery system to the most nutritionally and economically vulnerable.

TABLE II-4 (continued)

ORGANIZATION	PERCEIVED OBJECTIVE
USAID/ Cameroon (continued)	- The MCH program does not "fit directly into the CDSS." - The Title II program should be designed for eventual phaseout of imported food aid.
Government of Cameroon	- The Title II program should contribute to the country's development. - Other components should accompany food aid, notably adequate education for parents with a view to eventual displacement of imported foods. - Food aid should reach neediest, malnourished under six year old population only. (e.g., when children have a weight-for-age of 85% or better, their families should be served by other nutrition interventions, not food aid.) - Food programs should be geared to eventual phaseout in accordance with the Government's principles of self-reliance and non-dependency. - Except for the growth and development of malnourished children, the GURC does not view food programs as potential developmental resources.
CRS	- Title II foods should help families of preschool children assure adequate growth of children through a program which combines: a food ration representing an economic aid to the family; growth surveillance of children; commitment of centers and mothers through monitoring and promotion fostered by the Growth Surveillance System. - Title II foods have a delivery system to facilities and families that request the program and may not represent "targeted" geographical and population groups. - As sponsoring agency, CRS is responsible only for the delivery of its package including food, demonstrations for its appropriate use, educa-

TABLE II-4 (continued)

ORGANIZATION	PERCEIVED OBJECTIVE
CRS (continued)	tion on local equivalents and use of the growth chart system. Other components with which the program is integrated are outside the purview of CRS. - Title II foods serve children from six months to six years unless there is necessity to "graduate" well children beyond three or four years of age due to the press of business in the clinic. - Title II country and site programs do not have phaseout dates since the rural areas which they serve are at subsistence level. All families are eligible for the program throughout their children's first five to six years of life. - Thus, Title II programs do not necessarily serve areas and populations of greatest need. - Child development is the only meaningful development to which Title II contributes (Dr. Carlo Capone). Contributing to human productivity is more important to countries' development than constructing roads and community works.
Distributing Agencies in Cameroon	- Title II foods encourage larger numbers of parents to frequent the clinic both both curative and preventive health services. - Title II foods assist all families in the community and are especially important in seasons of food shorages.

November 29, 1960, and reconfirmed by Presidential Decree No. 66/DF/186 on April 18, 1966. It provides for:

- Duty free entry of Title II food commodities and other materials imported by the Catholic Relief Services into Cameroon.
- Government responsibility for payment of charges for port-handling, warehousing, transportation, and distribution of supplies.
- Freedom of action for CRS/Cameroon to execute its distribution and supervisory responsibilities.
- The review, inspection, audits, and examination of records by CRS, USAID and other competent personnel.
- The release of adequate and appropriate publicity as to the source of the United States donated foodstuffs.

E. PERSONNEL AND MANAGEMENT

CRS/Yaounde provides training to MCH Center supervisors on appropriate implementation of Title II and CRS objectives. Supervisors attend periodic seminars which have included sessions on how the GSS works, food distribution systems and accounting procedures for food stocks and monies collected.

Most Government MCH clinics are staffed by two midwives. One of these is charged with the responsibility for the Title II distribution and obtains additional help on distribution day from the other midwife or from personnel seconded from nearby health facilities. The regularity and proper functioning of the clinic and food distribution were extremely dependent upon the midwife-in-charge. Her own illness or illness within her family meant shutting down operations in most instances. Though such occurrences were common, no provisional plans existed. Midwives with 2-3 years of training beyond primary school and with some 15 years of experience would receive a Government salary of around $120 - $150 depending upon allowances and deductions. In Mission clinics, the range of persons charged with the distribution program ran from nursing aides to well-trained and highly experienced Cameroonian and European nurses.

The evaluation visit was poorly timed to reflect normal supervision in the two Provinces. No supervisor was on duty in the Northwest. The incumbent had been quite sick for several months. Unfortunately no interim arrangement was made and despite what seemed to be excellent filling in by the warehouse clerk in Bamenda, lack of supervision was apparent in the late submission of reports, stacked up containers in the clinics and perhaps in the failure to solve the longstanding

problem of replenishing the growth chart supply. The supervisor in the Southwest had been on the job only three months and though applying herself effectively, was not able to correct deficiencies in the program that had occurred under a previous reportedly incompetent supervisor.

F. CONCLUSIONS AND RECOMMENDATIONS

1. Policy Analysis Conclusions

a. FFP Guidelines stipulate use of Title II foods for use in areas of greatest need as defined by level of socio-economic status or nutritional status but neither USAID/Yaounde nor AID/W enforce these criteria.

While USAID has praised CRS' efforts to move to needier areas in Cameroon (East), the Mission accepts the concept of free food delivery to eligible vulnerable populations to be sufficient targeting. FFP Guidelines lack clarity on this point, first giving priority to the poorest and most malnourished among eligible vulnerable populations and at the same time, suggesting that programs might best be carried out in preventive health settings.

CRS' criterion is to respond to the requests of MCH centers in rural areas. CRS believes that all rural families in developing countries are at subsistence level and therefore all qualify for food aid.

b. Little thought has been given to how food aid might be used as a developmental tool in Cameroon though the concerned agencies espouse the desirability of "developmental impact." USAID sees no fit of the Title II program in its Country Development Strategy. The Government (MOH) expects the program to serve the malnourished but has no clear food and nutrition policy with delineated role, if indeed there is one, for food aid. Preliminary analytical work on food and nutrition planning has been completed but it is unclear what the next steps are to be in establishing priorities, targeted populations, and quantitative goals.

USAID and GURC would like to see a developmental impact but have offered no proposals on how that is to be achieved. CRS considers the important developmental element to be improved child health which will result in later enhanced productivity.

c. FFP Guidelines stipulate that Title II programs are to be carried out with a long-term objective of being continued without U.S. assistance, but neither USAID/Yaounde nor

AID/W has insisted that CRS program submission include projected phaseover or termination plans. Both USAID and the GURC raise serious doubts about the desirability of continued CRS food distribution but have not decided: a) the best means of ending the program as now operating; b) whether alternative programs are to replace those now in operation; or c) what those programs should be and identification of the resources for them.

CRS believes there will always be a need for the food distributions to provide extra income and education for those populations poorly served by distribution channels or who do not use existing food supplies due to ignorance or lack of motivation.

If phaseout plans are to be promoted, the impetus must come from the USAID and/or the GURC.

d. FFP Guidelines lack clarity as to the level of components that can be expected to lead to the overall goal of improving nutritional status. In addition, OFFP has authorized CRS informally to provide experimental rations which are expected to be shared among family members and which are based on their economic value to the family. There are no articulated objectives or indicators however, in the Guidelines for assessing the program on this basis. CRS' hypothesis of marginal propensity level for supplementing targeted child feeding remains economic theory, without the availability of methodology for evaluation against this objective.

The pleasing and familiar rhetoric of "nutritional impact" may be holding up the designation of other more appropriate goals for food assistance, other objectives that are measurable, and may be frustrating program users with expectations beyond the reach of food assistance.

2. Policy Recommendations

a. OFFP should review realistically what it can hope to accomplish with Title II foods and revise its objectives and guidelines accordingly.

- Take note that most structured delivery channels (MCH in Cameroon) may fail to reach the poorest, neediest, and most malnourished.

- Determine if these neediest groups might best be served through handout operations without the costs and responsibilties of surveillance and evaluation.

- Lower its expectations for "nutritional impact" and base objectives on actual rather than theoretical program components.

- Consider the validity of transferring food to poorer nations as an objective to be measured by calorie and economic value of the food, while relying on voluntary agency channels to ensure delivery to the vulnerable families.

b. OFFP should obtain a workable methodology for testing the income-transfer theories of food aid developed and disseminated by Selowsky, Capone and others as a special assignment rather than including this effort among the myriad tasks assigned to Title II evaluation teams, who must give it short shrift.

c. OFFP, USAID, GURC and CRS might consider the central purpose of the MCH program to be that of educating the mothers/caretakers who are change agents in the program--rather than focusing the program on correcting diets of a small percentage of real or potentially malnourished children. Such a change in emphasis might enhance the likelihood of a developmental impact.

d. CRS may wish to restate program objectives so that they are consistent with the responsibilities it actually assumes, e.g., planning for adequate port facilities for Title II foods, contracting with local firms for distribution to provinces, etc.

e. CRS policy should be made consistent with Title II policy. CRS policy is to open a program where requested rather than seeking to go into areas defined as needy; CRS policy is to feed families and deliver an income supplement rather than to serve nutritionally vulnerable groups.

3. Administrative Conclusions:

a. The USAID/Yaounde has lacked sufficient knowledge of the Title II program to be able to provide reviews and approvals based on other than theoretical information and individual viewpoints.

The Mission has not availed itself of technical advisory services intended for its use through the Regional Food for Peace Office in Abidjan (REDSO).

b. The GURC provides valuable personnel resources to the program in the form of three MOH seconded Provincial Supervisors (Northwest, Southwest and Eastern Provinces) and one

or two MCH staff persons weekly in each center for the food distribution program. The programs, however, are highly dependent on a single individual in charge of food distribution in many centers, seriously jeopardizing the continuity of health and food services to program beneficiaries.

c. Contractual commitments require initiation or restatement at all levels:

- CRS-GURC Contract. The present contract does not have stated objectives, greatly contributing to the present misunderstanding as to what the program is expected to achieve and how far CRS responsibility goes. Likewise the contract does not spell out all of the contributing parties and the uses made of resources.

- CRS-Center Contract. The terms of the CRS agreement with Centers are incomplete (with regard to commitments on education) and less than universally understood. Most MCH Directors could not produce a copy of the agreement nor cite its principal provisions.

- CRS/MCH-Mother/parent Contract. Neither written contracts nor unwritten commitments were in evidence with regard to parent responsibilities for program participation.

4. Administrative Recommendations

a. USAID/Yaounde should appoint a Mission staff person to be the Title II program monitor. Minimal requirements for program knowledge should be visiting three or four clinics annually. The program monitor should confer with the Regional Food for Peace Officer as technically necessary and at crucial program decision points.

The officially designated person should be responsible for working with CRS, GURC MOH officials on evaluation follow-up. This staff member could also assure continuation of the work done by the Nutrition Advisory Committee and invite the collaboration of all parties in developing valid agreed program objectives for the Title II program.

b. USAID might wish to invite AID/W technical assistance to assist periodically, to promote nutrition planning through the stage of developing a food and nutrition strategy and to help guide decision-making as to eventual alternatives (or to have no alternatives) for meeting the void to be left by eventual Title II phaseout.

c. USAID, CRS and the Government of Cameroon appropriate representatives should form a working group to decide on mutually agreed objectives for the program with specific targets to be accomplished, a means of evaluating the program against those objectives, and operating criteria including possible shifting of the program to GURC responsibility for subsequent years. Discussion should lead to a written phaseout plan over whatever the period of time might be agreed. USAID should catalyze these actions and be available for legal counsel with regard to provisions of the CRS-GURC contract.

CHAPTER THREE

EVALUATION APPROACHES AND METHODOLOGY

The preceding chapter assessed food assistance policy and administrative structure. This chapter describes the approaches taken to evaluate key program components and the impacts and outcomes of the MCH/CRS program in Cameroon. Chapter Three provides background on how the team went about examining the actual program components against the theoretical components articulated by CRS and objectives they were expected to accomplish. Chapter Three also describes the methodology employed by the team to evaluate impacts and outcomes of the program. To facilitate reading, the authors have included notes on methodology which are helpful to understanding the results together with the results in Chapter Four.

A. THE METHODOLOGY FOR EVALUATION OF PROGRAM COMPONENTS

Program components which were evaluated were: the food aid package, the Growth Surveillance System and preventive health services. The team evaluated these components through site visits to health clinics. For this analysis of program process, they hoped to visit at least 15% of the clinics with a CRS food distribution program in the Southwest and Northwest Provinces of Cameroon.

1. Pre-field Evaluation Procedure

United States-based evaluation team members met with officials of USAID/Food for Peace/Washington and Catholic Relief Services/New York and Nairobi. The purpose of these visits was to determine objectives for the evaluation and the perceived objectives of the CRS food distribution program in Cameroon. The team received clarification about the CRS Food and Nutrition Policy for Sub-Sahara Africa through discussions with CRS officials in New York. The team met with the USAID/Yaounde director and consulted with two members of the USAID/Yaounde health/nutrition staff in Washington regarding objectives. The checklist questions for FFP/Washington, USAID/Yaounde and CRS/New York officials are shown in Appendix 3 and a list of officials interviewed is given in Appendix 4.

2. Field Evaluation Procedure

In Yaounde, the two United States team members were joined by a USAID staff member, an MOH designated participant and a recruited health worker resident in Cameroon to make up an evaluation team of five members. The team also recruited and trained two Cameroonian women as interviewers. The evaluation team and officials of USAID, GURC, and CRS in Yaounde met to discuss objectives for the evaluation and perceived objectives of the CRS food distribution program in Cameroon. A list of the individuals interviewed is given in Appendix 4 and the checklist questions are shown in Appendix 3.

3. Field Protocol

In the field, the team made or attempted to make protocol visits with the Governor of each Province or the Secretary General; Divisional Prefects and/or Sub-Prefects, Delegates of Public Health, Chiefs of Preventive Medicine, Bishops, and CRS Supervisors. Those individuals interviewed are listed in Appendix 4.

4. Selection in Yaounde of Villages for Site Visits

A list of all operating centers by Province was provided by CRS/ Yaounde. The team drew a random number for each center (by separate Province) which became its priority ordering for visit. The random list for Southwest is shown in Table III-1 and for the Northwest Province in Table III-2.

5. Coverage by Province

The team set as a minimum goal the visit of 15% of the centers in the Southwest and Northwest Provinces. In the Southwest, 11 centers out of 35 (31%) were site visited for attempted process evaluation. A process evaluation was completed on 7 centers (20% coverage). Reasons for not completing process evaluations were: the center was closed on distribution day (midwife ill or away); or the team was inaccurately informed as to the clinic day. In the Northwest, visits to 11 centers were attempted, and because the road was impassable to one center, process evaluation was completed for 10 of the 42 centers in the Northwest. This constitutes a coverage of 24%.

No centers in the Eastern Province were visited because of: lower priority for USAID; uncertainty of available vehicles for travel; and time constraints for hiring and training a second team of interviewers for the Francophone area (Southwest and Northwest Provinces are Anglophone).

TABLE III - 1

Random Assignment of All Centers

Where CRS Distributes Title II

Food in Southwest Province

1 - Eyang
2 - Tole Tea
3 - Victoria
4 - Eyomojok
5 - Bokwango
6 - Banga - Bakundu
7 - Lobe P.M.I.
8 - Mudeka
9 - Supe-Mbakwai
10 - Mukonje
11 - Mokondange
12 - Tali
13 - Konye
14 - Buea Council
15 - Muea
16 - Bimbia
17 - Mbonge
18 - Bwinga
19 - Mbeta
20 - Idenau
21 - Mpundu CDC
22 - Nyasosso
23 - Kendem
24 - Missellele
25 - Moliwe
26 - Meanja
27 - Kembong
28 - Buea P.M.I.
29 - Kombone
30 - Tombel Health Center
31 - Kurume
32 - Debumsha
33 - Manyemen
34 - Tombel
35 - Bangem
36 - Muyuka
37 - Isongo
38 - Lysoka (Dorcas Luke)
39 - Mamfe P.M.I.
40 - Iiko P.M.I.
41 - Fiango 3 Corner
42 - Likomba
43 - Ekondo-Titi
44 - Bojongo

TABLE III - 2

Random Assignment of All Centers

Where CRS Distributes Title II

Food in Northwest Province

1 - Widikum
2 - Mbengwi
3 - Mbot
4 - Bamessing - Ndop
5 - Nso P.M.I.
6 - Shisong
7 - Jakeri
8 - Banso
9 - Mbiame
10 - Misage
11 - Belo - Kom
12 - Wum P.M.I.
13 - Santa
14 - Nkumkov
15 - Bali Catholic (New)
16 - Tatum
17 - Djottin Noni
18 - Oku-Elak
19 - Ndu Tea Estate
20 - Bangolan
21 - Bambui
22 - Njinikom (Catholic)
23 - Befang
24 - Bafut (Catholic)
25 - Nkambe
26 - Ndop-Baba I (Catholic)
27 - Mbem
28 - Bali (Catholic)
29 - Gusang
30 - Mbingo (Kom)
31 - Ndu Council
32 - Mankon
33 - Bafment
34 - Fundong-Mb.
35 - Nkor
36 - Bossa
37 - Guka
38 - Jikijem
39 - Pinyin
40 - Mbam-Nkum
41 - Bamumbu
42 - Kedjom Keku
43 - Andek Ngie

6. Centers Visited

In the Province, the clinic days when food distribution occurred were identified by the CRS representative for the 20 clinics at the top of the random list. Priority was given to visiting clinics which distributed food on a day of the week that the team was in the area and which figured among the top 20 on the random list. If the center operations were suspended or had not turned in master charts and food reports to the provincial office for the last four months, it was not considered for a visit. Three centers in the Southwest were closed when the team arrived because the midwife in charge was sick or away. There were also occasional inaccuracies in the information received at the national and provincial levels concerning clinic day. The centers visited or reasons for those not visited are listed in Table III-3 for the Southwest and Table III-4 for the Northwest Provinces.

Figure III-1 is a map of the United Republic of Cameroon. Figure III-2 shows the location of all CRS centers in the Northwest and Southwest Provinces. Figures III-3 and III-4 illustrate the centers by Province and show centers visited for evaluation of program process components and nutrition impact on feasibility studies.

7. Representativeness of Sample

Of the top 20 centers chosen at random for site visit, two centers in the Southwest (Eyang and Tali) and one in the Northwest (Widikum) were not visited because of impassable roads. They were reported to be inaccessible because of the rainy season. The team attempted to reach Widikum and found that indeed the road was impassable. Since truly inaccessible centers were not included in the sample, the data are reflective of the accessible clinics. However, the majority of CRS distribution centers are located on main roads (accessible). See Maps in this chapter. Thus, the data gathered are representative of the majority of the program.

Compared to isolated centers, the accessible ones are probably better off for having better reach to services, roads, resources, and education. As an illustration, children attending the Widikum Center had twice the levels of low weight-for-age of other centers in the Northwest. Therefore, data on program components discussed in Chapter Four are likely biased in favor of the program. That is, results are better overall for the program than would have been the case had the three inaccessible centers been included.

8. Data Collection

The following instruments were developed for the evaluation of program process components in accordance with objectives:

TABLE III - 3

CENTERS VISITED OR REASONS NOT VISITED
IN SOUTHWEST PROVINCE

Center	Visit Status
1 - Eyang	R+D+F
2 - Tole Tea	OK
3 - Victoria	OK
4 - Eyomojok	D+F
5 - Bokwango	OK
6 - Banga - Bakundu	OK
7 - Lobe P.M.I.	T
8 - Mudeka	OK
9 - Supe-Mbakwai	P
10 - Mukonje	OK
11 - Mokondange	Attempted M+S
12 - Tali	D+S+R
13 - Konye	P
14 - Buea Council	P
15 - Muea	OK
16 - Bimbia	T
17 - Mbonge	S
18 - Bwinga	Attempted - M
19 - Mbeta	P
20 - Idenau	P
24 - Missellele	Attempted - M
42 - Likomba	Attempted - E

Key: OK - Visit completed
S - Clinic operations suspended
R - Road inaccessible
D - Master Data not turned in
F - Food Reports not turned in
T - Team not in area on clinic day
P - Team visiting centers having higher priority or doing protocol visits on clinic day
M - Midwife away or sick
E - Error in information concerning clinic day

TABLE III - 4

CENTERS VISITED OR REASONS NOT VISITED
IN NORTHWEST PROVINCE

Center	Visit Status
1 - Widikum	R
2 - Mbengwi	T
3 - Mbot	T
4 - Bamessing - Ndop	E
5 - Nso P.M.I.	OK
6 - Shisong	OK
7 - Jakeri	OK
8 - Banso	P
9 - Mbiame	T
10 - Misage	OK
11 - Belo Kom	P
12 - Wum P.M.I.	P
13 - Santa	OK
14 - Nkumkov	P
15 - Bali Catholic	OK
16 - Tatum	OK
17 - Djottin Noni	T
18 - Oku-Elak	OK
19 - Ndu Tea Estate	S+D
20 - Bangolan	T
Other	
42 - (formerly) Akum-Bagangu	Attempted S
24 - Mankanikong (Mobile Clinic from #24)	OK
24 - Bafut Catholic	OK
28 - Bali Catholic	OK

Key: OK - Visit completed
S - Clinic operations suspended
R - Road inaccessible
D - Master Data not turned in
F - Food Reports not turned in
T - Team not in area on clinic day
P - Team visiting centers having higher priority or doing protocol visits on clinic day
M - Midwife away or sick
E - Error in information concerning clinic day

Figure III-1 Map of Cameroon

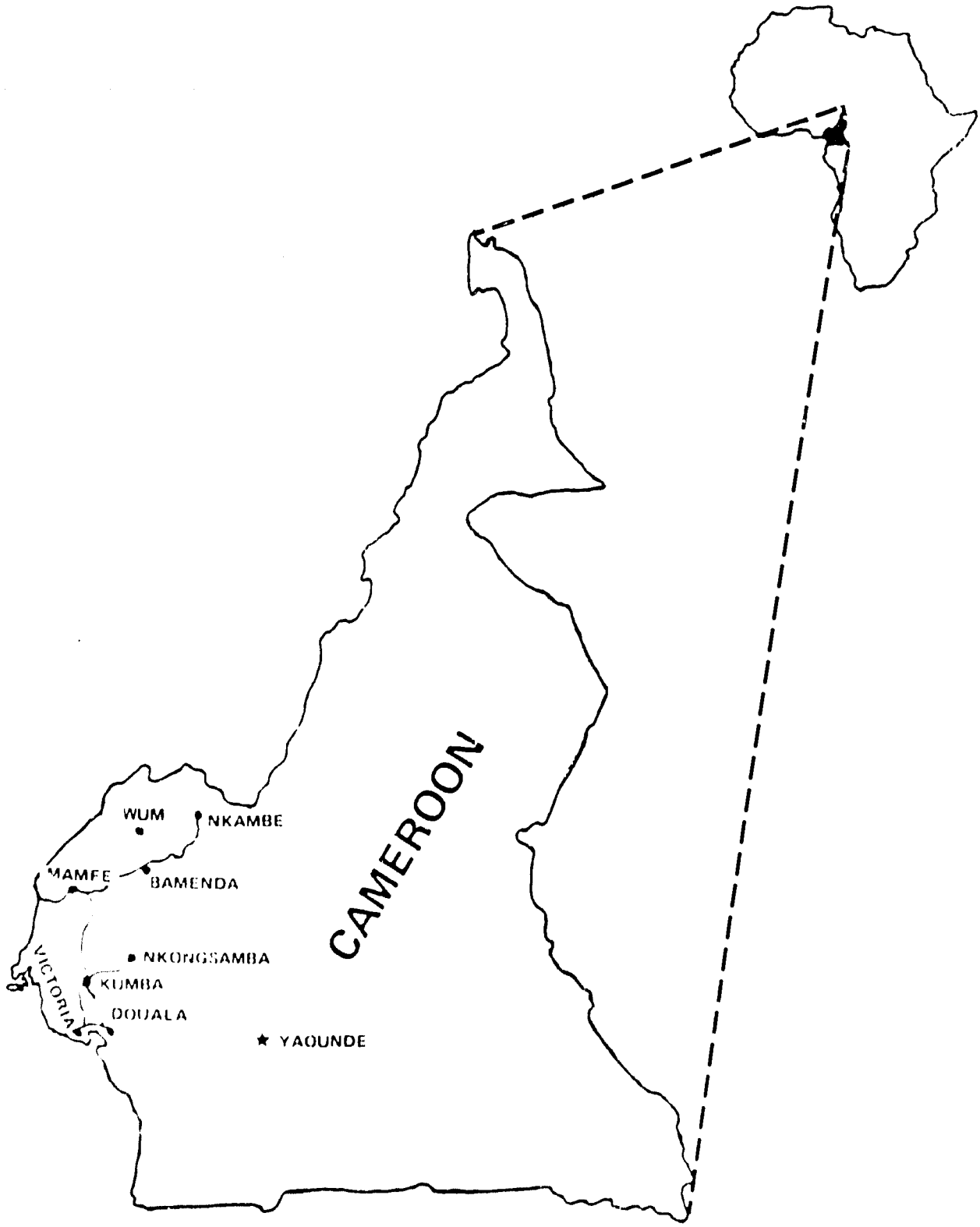


Figure III-2 Location of CRS Centers in Northwest and Southwest Provinces

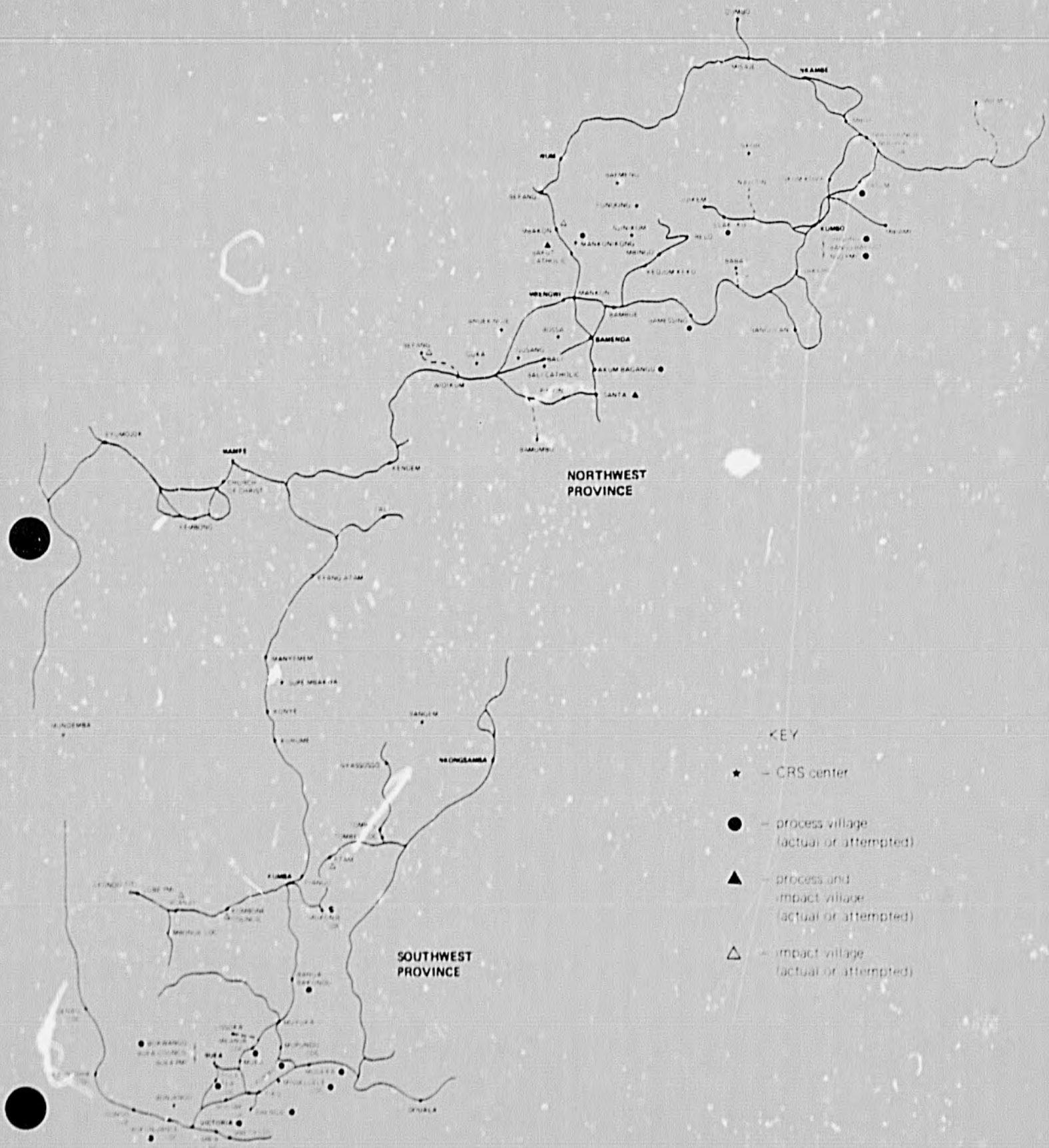


FIGURE III-3

Location of Centers with a CRS Food Program in the Northwest Province. Map Shows Centers Visited for Evaluation of Program Process Components and Nutrition Impact or Feasibility Studies.

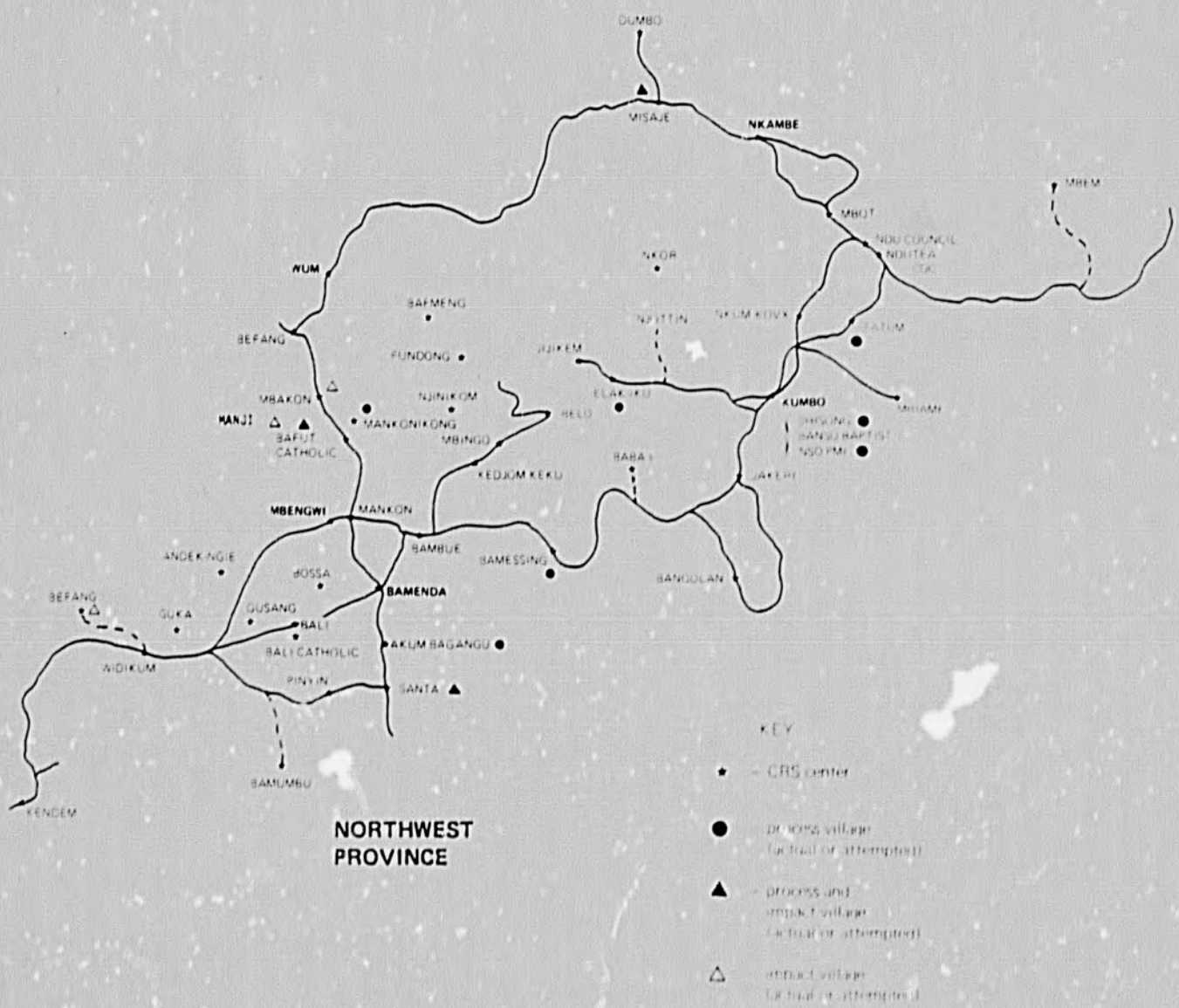
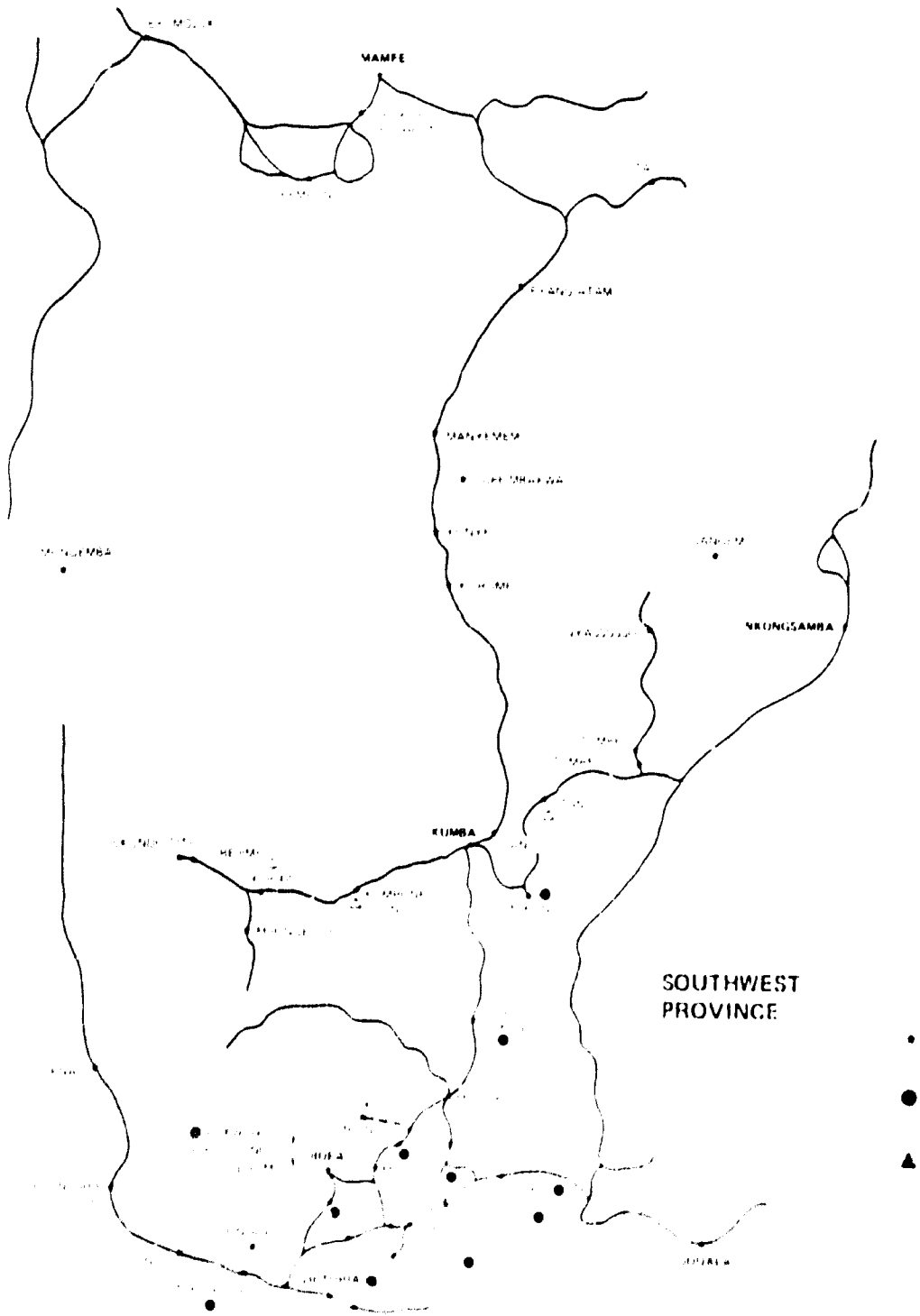


FIGURE III-4

Location of Centers with a CRS Food Program in the Southwest Province. Map Shows Centers Visited for Evaluation of Program Process Components and Nutrition Impact or Feasibility Studies.



- Questionnaire for Clinic Personnel;
- Observation Checklist;
- Evaluation Survey Questionnaire for Mother/Caretaker;
- Growth Card Data Extraction Form;
- Form for Calculation of Mother's Fees, Empty Container Fees, and Growth Chart Fees; and
- Form for Calculation of Monthly Ration per Recipient and Range of Beneficiary Attendance over four month period.

These instruments are shown in Appendix 3.

The instruments were field-tested in the first centers visited in the Southwest Province. Adjustments were made to forms in the field from results of field testing. When new questions were added, results were tabulated only for centers at which the new question was asked. The centers where the question was not asked were eliminated from the data universe. Field testing prior to use in the field was desirable but not possible in the Yaounde area because the Yaounde is in the Francophone area.

Tables III-5 and III-6 summarize the number of supervisor and mother/caretaker interviews conducted, of observation checklists completed, and individual growth cards analyzed in the Northwest and the Southwest Provinces. United States and Cameroonian team members interviewed 18 supervisors, completed 12 clinic observation checklists, and compiled data from 647 child growth charts. Two especially trained Pidjin-speaking Cameroonian women on the team interviewed a total of 119 mothers/caretakers. Instruments used for interviews are shown in Appendix 3. Except for mothers/caretakers of children in the program who are anonymous, the persons interviewed during the conduct of this evaluation are listed in Appendix 4.

9. Note on Methodology for Evaluating Economic Value of the Food Aid Package

CRS believes that an essential component of a potentially effective program is an economically significant amount of food provided to the household of the targeted beneficiary on a regular basis (Whither Title II). CRS has stated that the Title II ration distributed in Cameroon is not sufficient to increase family income to a level of "marginal propensity for child feeding" -- i.e., is not of sufficient economic significance to the family so that the level of family income permits giving more food to the preschool child than previously. The team attempted its own assessment of the economic benefits the Title II food provides to families.

TABLE III - 5

Centers Visited in Northwest Province With Numbers of Interviews, Observation Checklists and Growth Card Studies

MCH Center	Priority by Random Number	Supervisor/ Worker Interview	Observation Checklist	Number of Mother Interviews	Number of Growth Card Studies
Widikum	1	Attemped-P	-	-	-
Bamessing	4	yes	Attempted-E	-	-
Nso P.M.I.	5	yes	yes	12	116
Shisong	6	yes	-	8	26
Jakeri	7	yes	-	-	-
Misage	10	yes	-	-	-
Santa	13	yes	yes	27	156
Bali Catholic	15	yes	yes	11	21
Tatum	16	yes	yes	17	-
Oku-Elak	18	yes	yes	-	59
Bafut Catholic	24	yes	-	-	169
Akum-Bacangu	42	Attempted-S	-	-	-
Mankani Kong	Mobile Clinic From #21	yes	-	-	-
TOTAL Accomplished for Northwest		11	5	75	547

Symbols: S - Clinic Operation Suspended
P - Road Impassable
M - Midwife away or sick
E - Error in information concerning clinic day

TABLE III - 6

Centers Visited in Southwest Province with Numbers of Interviews, Observation Checklists and Growth Card Studies

MCH Center	Priority by Random Number	Supervisor/ Worker Interview	Observation Checklist	Number of Mother Interviews	Number of Growth Card Studies
Tole Tea	2	yes	yes	3	20
Victoria	3	yes	yes	6	-
Bokwango	5	yes	yes	7	-
Banga-Bakundu	6	yes	yes	11	70
Mudeka	8	yes	yes	5	10
Mukonje	10	yes	yes	-	-
Mokondange	11	Attempted-M & S	-	-	-
Muea	15	yes	yes	12	-
Bwinga	18	Attempted-M	-	-	-
Missellele	24	Attempted-M	-	-	-
Likomba	42	Attempted-E	-	-	-
TOTAL Accomplished for Southwest		7	7	44	100

Symbols: S - Clinic Operation Suspended
R - Road impassable
M - Midwife away or sick
E - Error in information concerning clinic day

United States based team members studied background materials on how to assess the economic value of food aid (Selowsky, etc.). They also asked for guidance on an appropriate methodology from Dr. Carlo Capone and Mr. Michael Wiest of CRS, Dr. Marcelo Selowsky of the World Bank, Mr. Gary Smith and Ms. Charlotte Miller of USDA, Dr. Phillips Foster of the University of Maryland, and other economists and professionals working on food aid.

The team concluded that no field-tested methodology exists at the present time to assess within the short periods allocated to Title II evaluations evaluations of the economic impact of food aid at the family/community level. However, the following questions were studied in a preliminary effort to understand the economic value of Title II rations in Cameroon: the market value of the ration and the value of the ration as perceived by the family.

B. EVALUATION OF PROGRAM IMPACTS OR OUTCOMES

1. Nutrition Impact/Feasibility for Future Studies

a. Introduction

The team carried out three types of anthropometric studies intended to assess nutrition impact or to lay the groundwork for further studies. These were:

- Study of Children in a Program and a Control Village

  The purpose of this study was to determine if the CRS food distribution program has had an impact on the nutritional status of children in the village studied. The study design was to compare the nutritional status and factors related to status of children in a program and a control village.

- Study of New Entrants and Program Participants

  The team compared the nutritional status of children just entering the program with the status of children of the same age who have been in the program for a year.

- Feasibility for Future Nutrition Impact Study

  The purpose of this study was to assess field conditions for a larger study of nutrition impact to be carried out by USAID at a later date. Design aspects tested were: identification of and field considerations for control villages, ethical considerations, and feasibility of the call-out sampling technique. The methodology for this study is discussed in Chapter Four.

b. Ethical Considerations for All Impact Studies

Two major ethical considerations were consent of the community to be studied and reimbursement to the community and/or individuals for time. The team questioned anthropologists, CRS, and GURC on these issues. CRS/Y requested that no material reimbursement be provided either to clinics or individuals distributing or receiving Title II funds.

In respect to all studies, particularly ones involving non-program mothers and children, the team requested and received consent for study of local communities of the following persons:

- Governor of the Province;
- Prefect of the Division;
- Chief of Preventive Medicine;
- Delegate of Public Health (attempted but not always accomplished because he was not in office); and
- Regional Fon and Village Fon (Chief).

The team is extremely grateful to these persons for their support and interest in the evaluation project.

Reimbursement was provided to communities and individuals as follows:

- Program participants were provided the weight measurement for plotting on their growth card.
- Non-participants were provided a letter explaining the purpose of the project and were given the weight and height measurements on the date taken.
- Height measuring equipment was donated to the Santa clinic.
- Referral to clinic for two malnourished children was provided.

The team was not fully satisfied with the arrangement utilized, feeling it would have been preferable to offer both an adequate reimbursement (for time taken from mothers/caretakers) and an adequate incentive for greater participation. The issue of "incentives" for participation is discussed in greater detail in Chapter Four, Section D, Feasibility for Future Nutrition Impact Study.

2. Nutrition Impact: Study of Program and Control Village

a. Criteria for Selection of Program Village

The program village must meet the following criteria at site visit:

- Have three basic elements of CRS nutrition package at least 1-1/2 years: food ration, growth chart, and education services.
- Records of food deliveries indicate no recent major disruptions.
- Must be accessible by four-wheel drive vehicle.
- Program village must have a matching control village (matching defined below).
- Village size no larger than 3,000.

b. Criteria for Selection of Control Village

The criteria for selection of the control village were as follows:

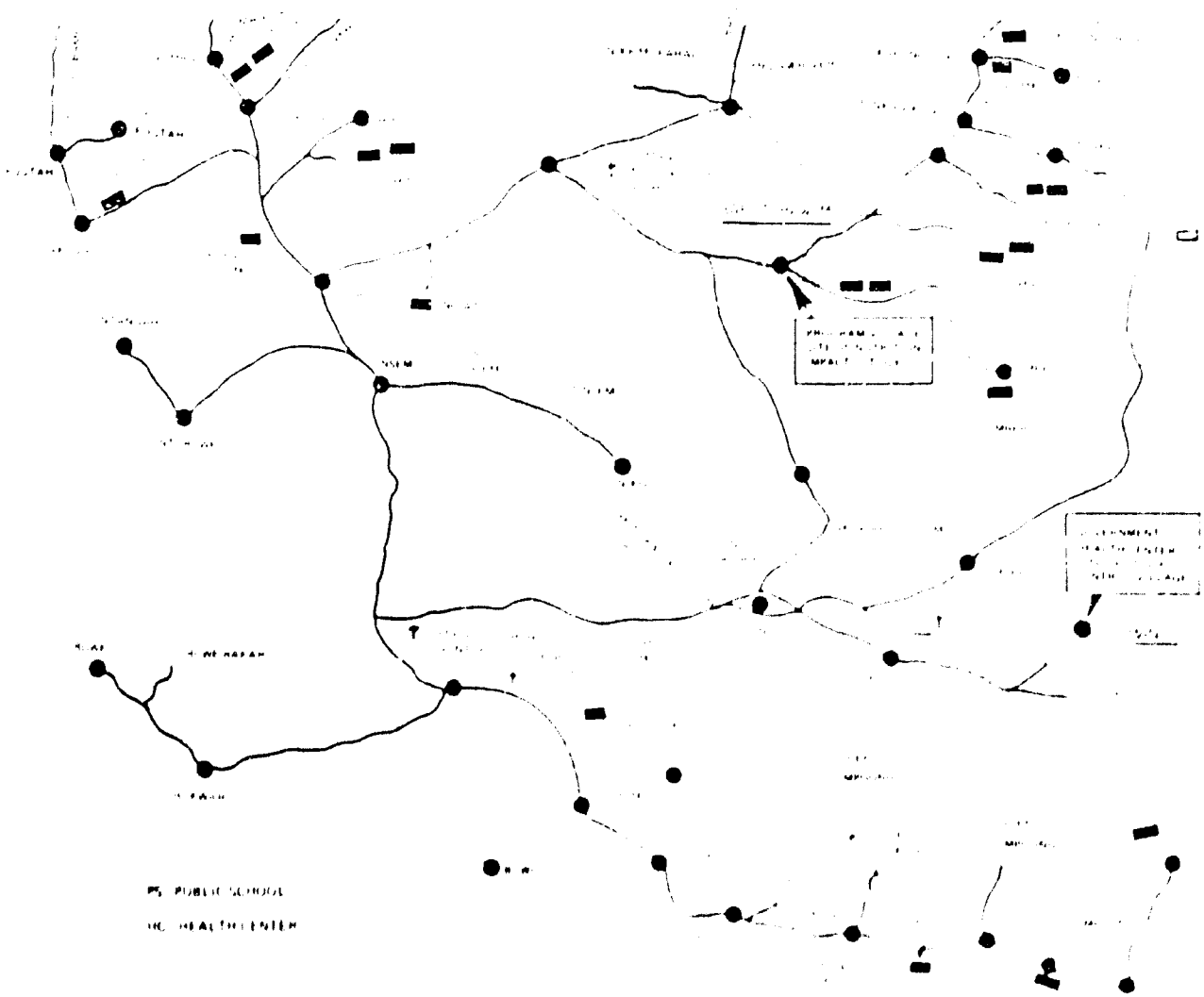
- Village has no other food distribution program and is not located in easy range of another program village which mothers might attend for food distribution.
- Village size about 3,000.
- Same distance from major roads and towns, same tribe, socio-economic status, occupation, level of health services, source of water, and sanitation facilities.
- No current or recent epidemics in village.

c. Villages Chosen for Study

The program village selected for the study was Bafut - Bawum, and the control village selected for the study was the village of Manji. These villages are located in the greater Bafut area in the Northwest Province (see Map, Figure III-5).

FIGURE III-5

Map Showing Location of Nutrition Impact Study of Program and Control Villages in the Bafut Area



d. Sample Selection for Program/Control Village Study

Two methods of sampling were considered for the program/control villages. One method is called population-based sampling. This method is recommended by the United States Center for Disease Control, Atlanta, Georgia (Simplified Field Assessment of Nutritional Status in Early Childhood: Practical Suggestions for Developing Countries. Miller, D.C., Nichaman M.Z., and Lane J.M.: Bull. World Health Org. 55: 79-86, 1977) and was used in the Cameroon National Nutrition Survey.

This method is most desirable because it reflects the nutritional status of the community at large. The procedure is to map a geographically defined area and sample very "nth" home for data collection activities to achieve the desired sample size. Time is required to map the area, to go on foot from home to home, and to follow-up those not at home at the time. This method was not attempted because of the short period allocated for field work.

The second method considered was the "call-out" technique. All children in the village are requested to come to a central place for measuring. If the village is small and the sample size large relative to numbers of children under six years in the village, the nutritional status of the village can be described. This technique was tested in the control village of Manji with the help of the Fon of the area to bring people out. It was the consensus of the anthropologists and other advisors consulted by the team that the Fon (Northwest) or Chief (Southwest) would be the most effective means of obtaining cooperation of mothers/caretakers not receiving food distributions. It is desirable to conduct a study of a subgroup using the house-to-house technique described above to determine how representative of the community are the children who come to the call-out. This was not feasible because of the following:

- The time required for mapping was not adequate.
- Weight and height equipment was not portable or appropriate for correct measurement-taking in dwellings.
- According to on-site advisors (Fon, Fon's messengers, health officials), mothers could be expected to be in their homes only on "rest days" which occurred every eight days. Sundays following church were more likely prospects than non-rest days for finding mothers at home although Sundays were considered to have less chance of success.
- The only other time it was thought that mothers might be found at home was at night. Time was not adequate to stay in the area long enough to test these hypotheses.

The study sample for the program village included all children attending Bafut Mission Clinic for the food ration from Bafut-Bawum on the regular clinic day. The study sample for the control village included all children under six in Manji. The Fon requested them to come to the Manji Government Health Center for measuring and interview. Time and resource constraints prevented the team from conducting a house-to-house subsample to determine how representative were the populations coming to measuring sites in both program and control villages. This is discussed in greater detail in Chapter Four, Feasibility for Future Nutrition Impact Study.

e. Data Collected: Program/Control Study

The team carried out measurements of height, weight, and arm circumference of children for this study. Table III-7 illustrates the level of data collection. The team made 256 measurements of weight, 138 of height, 263 of arm circumference, and conducted 139 interviews of mothers for analysis of comparability factors. The Impact Questionnaire was used for these interviews to assess factors related to the nutritional status in program and control villages. It is shown in Appendix 3.

f. Data Collection Procedures: Program/Control Study

Clinic services were assessed in using the Supervision/Worker Questionnaire in Appendix 3.

Weights were taken using a CRS clinic scale lent for use in all impact studies. Children were weighed unclothed to the nearest 10 grams. Height was taken using a meter stick attached to the wall and headboard designed by Dr. R. Brown, formerly of USAID/Yaounde. Height measurements were taken to the nearest .5 cm. Arm circumference measurements were made by marking or estimating the midpoint of the left arm in a relaxed position and using the Zerfas tape for measurement. Difficulties were encountered in acceptability of the arm circumference measure. In these cases the right arm was measured. Arms were not relaxed at all times as desired.

Weights and heights were each taken by one person for the duration of the impact studies to ensure consistency. Due to long waiting times for mothers, it was difficult to standardize each data collector by taking measurements twice at a later time. Arm circumference measurements were taken predominantly by one person; this person was assisted by a second to expedite the measuring process when necessary. Due to lack of an extra three team members plus the recumbent board, lengths were not taken of children under two years.

Weight, height, and arm measurements were recorded by a third person.

TABLE III - 7

NUMBERS OF MEASUREMENTS MADE OR TABULATED FOR NUTRITION IMPACT STUDIES

Village Studied	Number of Weight Measurements Made or Tabulated	Number of Height Measurements Made	Number of arm Circumferences Made	Number of Mother Interviews for Analysis of Comparability
Bafut - Bawum - Program Village	163	81	170	91
Manji - Control Village	93	57	93	48
8 NW and SW Villages - New Entrants/ Participants Study of Growth Cards	196	--	--	--
TOTAL	452	138	263	139

Children were calmed and mothers asked to help by a fourth person.

Growth card data were collected by a fifth person.

g. Age Determination: Program/Control Study

The following techniques were used to determine age:

- Date of birth as recorded by the clinic on the growth card was accepted as the source of data for age.
- Most birth dates were known to the clinic from the birth records of the maternity section where the mother delivered or from the birth certificate (observed).
- Some birth dates were estimated by the clinic; most of these were estimated when the child was an infant and were presumed to be accurate within approximately three months.

h. Data Analysis: Program/Control Study

The data analysis phase was accomplished as follows:

- Calculations of age, weight-for-age, height-for-age, and weight-for-height percentiles were made using the Anthropometrics program for the Texas Instruments-59 designed by Theodore Ahlers. The team is indebted to Dr. Ahlers for lending this program for the duration of the project.
- The Ahlers Program uses 50th percentile, sex-combined "Harvard Standard" values as reference. It uses continuous functions modelling Harvard Standard Growth curves dervied by John Hitchings in Child Nutrition in Rural Kenya, Central Bureau of Statistics, Ministry of Economic Planning and Community Affairs, Republic of Kenya.
- Comparison of program to CRS growth cards: the CRS Master Chart values for 60th, 80th, and 100th percentiles for ages 6, 12, 24, and 48 months to the Ahlers Program values at those points revealed variations within 1.2% of the CRS Master Chart values.

i. Adequacy of Program Village: Bafut-Bawum

Regular CRS program components were present (food ration, growth chart and weighing, education). However, most mothers had the Cameroon government growth chart rather than the CRS growth chart. The clinic director stated that three mothers from Manji (the control) usually attended the Mission for food distribution. One from Manji attending on the Tuesday of the team visit was removed from analysis.

j. Appropriateness of Control Village: Manji

The Manji Government Health Centre services appeared to be comparable to the Mission services, but had no food distribution program. However, it was learned that a Presbyterian Center, which currently provides nutrition rehabilitation for about 20 children in the greater Bafut area, had formerly had a food distribution program serving Manji. CRS stated that the Presbyterian Program had been discontinued in May 1980. Therefore, the Manji area had been without a food distribution program for 15 months. Since Manji was otherwise comparable to Bafut - Bawum, and this was the only area identified without a food program for a defined period of time, it was decided to carry out the nutrition impact study using these villages. Further, no other suitable program/control pair had been identified. However, it must be remembered that a prior food distribution program in the control village is a limitation of the study.

2. Methodology for Study of New Entrants/Participants

This study was carried out using individual growth cards. The methodology was as follows:

- Data were collected from the growth cards of children attending a clinic on a food distribution day.
- Cards were taken in order of presentation at the clinic. Since two or three clinics were sometimes visited on one day, data on cards of all children attending one clinic on a day were not taken.
- The data collection instrument used is shown in Appendix 3. Table III-8 shows the clinics at which data were collected.
- Data extracted from the growth cards were weight measurements, at various points in time, date of birth, and clinic determination of weight percentile. The team calculated weight percentiles and age from clinic data using the Ahlers program. The team tabulated 196 measurements of weight and age for this study.

TABLE III-8

SITES OF COLLECTION OF GROWTH CARD DATA

Clinic	Province
Elak Oku Health Center	NW
NSO PMI	NW
Santa Health Center	NW
Bafut Mission	NW
Shissong Mission	NW
Tatum Mission	NW
Bali Catholic	NW
Mudeka Health Center	SW
Banga Bankundu Mission	SW
Tole Tea CDC	SW

- Age was determined as described in Section 2g.

3. Reaching the Needy

The procedure for determining the degree to which the CRS food distribution is reaching the needy was to:

- Assess CRS policy on the needy;
- Determine MCH clinic policies regarding the needy;
- Analyze criteria for attendance at a clinic; and
- Describe the status of the needy and coverage.

The methods used for these studies are discussed in Chapter Four. However, the team notes here that an additional study to measure the nutritional status of non-participants in the program did not meet the purposes for which it was undertaken. The team carried out measurements for this study and learned that only program participants had come to the measuring site. The team offers recommendations for questions which need answering regarding the needy in Chapter Four.

4. Effect on Agriculture

The team consulted agricultural economists working with the Ministry of Agriculture in Cameroon, Dr. Theodore Ahlers of Boston University and Dr. John Schamper (USDA staff member on a PASA assignment in Cameroon), concerning methodology and data sources to answer this question. Both experts said that collecting data to determine the effect of Title II foods on local production would entail several years and extensive resources. The two economists with a wealth of experience in Cameroon and other countries gave their best judgment on the question of what effects, if any, Title II foods delivered to Cameroon are likely to have on agricultural production among subsistence families.

5. Methodology for Other Impacts/Outcomes

Methodologies for other studies are described in Chapter Four.

CHAPTER FOUR

THE CATHOLIC RELIEF SERVICES TITLE II PROGRAM IN CAMEROON: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This chapter presents data, findings, conclusions, and recommendations which are separated into studies of the functioning of program components and the assessment of program goals and outcomes.

Program components which were evaluated were:

The Food Aid Package
The Growth Surveillance System
Preventive Health Services

Program goals or outcomes which were evaluated were:

Nutrition Impact
Reaching the Needy
Cost Effectiveness
Effect on Agriculture
Other Impacts and Benefits

A. THE FOOD AID PACKAGE

1. Ration Dilution: How Much of the Food Ration Reaches the Child?

a. Introduction

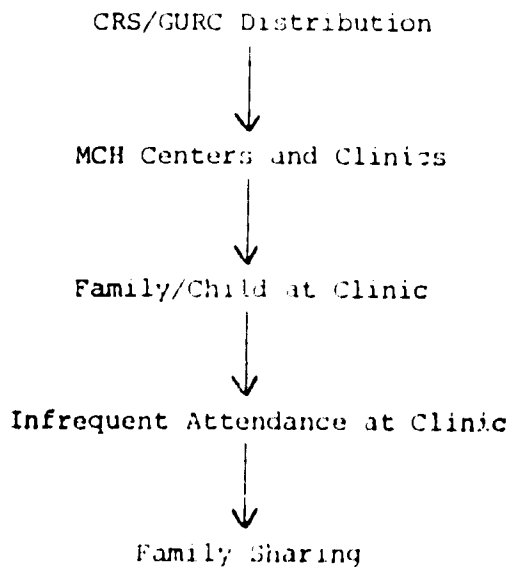
This section presents data for calculation of amount of ration delivered to a preschool child by the CRS Title II food distribution program in Cameroon. No direct data are available which show the amount of food delivered to the recipient -- i.e., the clinic records or the individual growth charts do not show how much food was given at each visit and family sharing is not accounted for. The team therefore chose to study ration dilution at the different levels where reductions occurred -- i.e., in amounts distributed in Cameroon; in amounts delivered to clinics; in amounts delivered to beneficiaries in "ration packages"; and in amounts available within the family unit.

Figure IV-1 summarizes points through which the Title II ration must pass to reach the program beneficiary. Data collected from CRS national, provincial, and MCH clinic records will be presented in this section to provide insight into the question of how much less of the intended five kilograms of ration probably reaches the child. These data are presented with the goal of developing realistic

expectations of what Title II is and is not, and of what Title II might be expected to produce in terms of benefits for the poor, needy and malnourished.

FIGURE IV-1

DELIVERY OF THE TITLE II RATION TO THE CHILD: SOURCES OF "DILUTION"



b. Distribution from CRS/GURC to MCH Clinics

The first study was an analysis of distributions by CRS/GURC to MCH clinics for a one year period made from the Recipient Status Reports dating from April 1980 and ending in March 1981. These Reports, which are prepared monthly in Cameroon by CRS, are based on the reported average number of beneficiaries and the amounts of foods actually distributed.

Table IV-1 shows the extent of continuity and evenness in monthly distributions. The overall average delivery of ration was good for the year, standing at 92.3% of the programmed amounts for the "averaged beneficiaries." However, there was considerable unevenness, ranging from 0% in June 1980, possibly because double rations had been distributed in the preceding month. Likewise a high of 166% delivered in February 1981 was preceded by a low of 38%, presumably making up for low food supplies in the previous month. The beneficiary range is from a low of 18,132 in May 1980 to a high of 32,381 in October 1980 and does not follow a pattern of steady increase, but is rather characterized by significant irregularities.

c. Distribution from MCH Centers to the Family/Child

The second study was made with data obtained at the provincial level on foods delivered to 20 centers in the Northwest and 20 centers in the Southwest during the months of March through June 1981. Tables IV-2 and IV-3 show calculations of the percentage of the 2:2:1 ration distributed. These figures were based on clinic records showing actual numbers of beneficiaries per actual amounts of food distributed. Therefore, the percentages in the tables give a realistic assessment of amounts actually provided.

These tables show that the amount of each commodity and of the total package delivered is frequently less than intended. The pattern for some centers is very erratic and may be influenced by factors such as irregular deliveries to the clinics and widely varying numbers of children who attend from month to month (this is documented in section E, Reading the Needy, of this report), which results in distribution of a smaller ration so that all may receive some.

Overall, there is a delivery rate of 83% of the programmed ration to beneficiaries.

TABLE IV - 1

Title II Foods Distributed by Catholic Relief Services in Cameroon, For One Year Period, April 1980 to March 1981, by Month, by Commodity, by Beneficiary as Assumed by Averaged Numbers and by Pounds and Kilograms.

	Pounds Distributed					Beneficiaries			
Month	Cornmeal	Bulgur	NFDM	Oil	Total	Number	Pounds per	Kilograms per	% Ration (1)
Mar 1981	45,450	57,150	100,440	38,854	241,894	29,725	8.1	3.7	74
Feb 1981	113,700	59,200	170,198	102,460	445,558	24,302	18.3	8.3	166
Jan 1981	2,500	57,600	31,750	4,258	96,108	23,652	4.1	1.9	38
Dec 1980	-	167,950	81,000	38,762	287,712	26,873	10.7	4.9	98
Nov 1980	-	171,100	74,862	20,420	266,382	28,432	9.4	4.3	86
Oct 1980	-	114,800	90,742	30,723	236,265	32,381	7.3	3.3	66
Sep 1980	-	119,950	83,932	14,276	218,158	28,941	7.5	3.4	68
Aug 1980	-	211,600	71,624	61,030	344,254	28,629	12.0	5.4	108
Jul 1980	-	65,450	162,866	59,367	291,683	32,103	9.1	4.1	82
Jun 1980	-	23,100	297,616	84,777	405,493	NA *	0	0	0
May 1980	-	96,800	311,822	47,494	456,116	18,132	25.2*	11.4*	228*
Apr 1980	-	184,700	-	90,691	275,391	26,583	10.4	4.7	94
Totals	161,650	1,333,400	1,476,852	593,112	3,565,014	27,250 (Average)	10.2 (Average)	4.6 (Average)	92.3 (Average)

(1) Ration = 5 Kilograms

* We assume that double rations were given in the preceding months as the May figures suggest.

Source: Recipient Status Reports

TABLE IV - 2

Calculation of Foods Distributed per Beneficiary, March, April, May and June, 1981 and Average for Four Month Period from Distribution Report Data Compiled on Randomly Selected Centers in the Northwest and Southwest Provinces.

(In Percentage of Planned Rations per Beneficiary)

NORTHWEST PROVINCE

AMOUNT IN PERCENTAGE OF RATIONS DISTRIBUTED TO BENEFICIARY

Center	OIL					BULGUR AND CORNMEAL					NONFAT DRY MILK					All Commodities Average
	Mar	Apr	May	June	Avg	Mar	Apr	May	Jun	Avg	Mar	Apr	May	Jun	Avg	
Widikum	80	90	50	50	68	85	90	105	50	83	75	85	105	10	69	73
Mbengwi	110	110	110	110	110	105	105	105	205	130	50	95	55	100	75	105
Mbot	30	80	3	110	56	105	105	0	105	79	105	105	105	105	105	80
Bamessing	40	na	na	na	40	270	na	na	na	270	125	na	na	na	125	145
Nwo	110	110	na	110	110	100	105	na	100	102	20	0	na	100	40	84
Shisong	60	220	30	90	100	85	80	95	60	80	75	75	105	55	78	86
Jakiri					na					na					na	
Banso	60	110	60	90	80	80	95	95	260	133	40	70	50	185	86	100
Mbiame	130	130	130	70	115	0	95	95	70	65	100	95	115	95	101	94
Misaje	110	na	na	110	110	130	na	na	100	115	90	na	na	95	93	106
Belo Kom	na	na	80	80	80	na	na	0	50	25	na	na	0	35	18	41
Santa	0	90	30	110	58	105	210	195	170	170	0	80	35	105	55	94
Nkum Kov	na	10	20	10	13	na	0	0	0	0	na	25	20	50	32	15
Bali Cath.	100	110	na	100	103	100	140	na	65	102	115	80	na	100	98	101
Tatum	10	0	0	110	30	50	50	85	85	68	20	50	55	40	41	46
Djottin	70	4	0	60	34	70	50	120	80	80	80	95	85	40	75	63
Elak Oku	na	110	100	110	107	na	115	115	115	115	na	55	59	80	65	96
Ndu	100	100	120	110	108	90	100	85	105	95	90	70	90	105	89	97
Bafut	30	na	60	110	67	20	na	75	95	63	35	na	50	95	60	63
Total Averages					77					99					73	83

TABLE IV - 3

Calculation of Foods Distributed per Benficiary, continued.

SOUTHWEST PROVINCE

Center	OIL					BULGUR AND CORNMEAL					NONFAT DRY MILK					All Commodities Average
	Mar	Apr	May	Jun	Avg	Mar	Apr	May	Jun	Avg	Mar	Apr	May	Jun	Avg	
Eyang	136	0	0	0	34	100	0	0	0	25	105	0	0	0	26	28
Tole Tea	130	130	130	110	125	135	35	0	65	59	95	90	95	65	86	90
Victoria	130	130	130	130	130	95	105	120	10	83	100	100	100	na	100	104
Bokwango	97	0	0	78	44	105	110	105	105	106	100	0	0	80	45	65
Banga Bakundu	82	94	79	90	86	130	115	115	30	98	110	95	85	75	91	92
Lobe	0	130	120	0	63	110	170	100	105	121	105	95	105	110	104	96
Mudeka	130	70	130	130	115	105	100	105	145	114	47	0	100	0	37	89
Mbak Supe	60	40	118	110	82	70	145	0	70	71	25	105	0	70	50	68
Mokondange	120	130	130	130	128	160	205	185	90	160	170	80	90	100	110	133
Tali	0	0	0	110	28	0	0	0	105	26	0	0	0	110	28	27
Konye	na	na	na	0	0	30	30	0	0	15	120	120	0	0	60	25
Buea	120	100	150	100	118	80	70	45	35	58	75	85	45	40	61	79
Muea	110	50	120	70	88	105	105	30	55	74	100	100	75	60	84	82
Bimbia	130	130	130	130	130	110	160	105	45	105	110	110	40	0	65	100
Mbonge	130	130	110	110	120	210	210	210	105	184	110	110	105	55	95	133
Mbela	120	130	150	110	128	155	80	0	105	85	100	100	0	115	79	97
Idenau	130	130	130	120	128	105	135	90	15	86	110	60	0	0	43	86
Munkonje	0	130	130	110	93	0	0	0	105	26	0	0	0	110	28	49
Total Averages					91					83					66	80

d. Effect of Infrequent Attendance on Amount Received

The third significant factor causing the family/child to receive less than the intended amount of ration over time is the actual attendance rate at the clinic. The programmed amount of ration (1981) is 60 kilograms per family/child annually. However, the mother who attends two months or six months out of twelve receives only 10 or 30 kilograms, respectively, for the year. A significant percentage of children are irregular attendees, as is shown in Table IV-4.

This table shows the attendance rates of 278 children who were in the program for a year or longer: 56% of children attended for 7-12 months per year; 44% attended six times or less during the year Therefore, assuming a 60% attendance rate on the average, only 40% of the monthly ration goes to the family.

e. Family Sharing

Family sharing of the ration is a factor assumed to occur but not usually given concrete consideration when assessments are made to determine the nutritional, economic or other impact to be expected from the program. Table IV-5 shows data collected by the team regarding this from interviews with mothers: 80-85% said the ration was shared in the family.

GURC data show that the average family size is 6.4 in the Northwest and 5.8 in the Southwest. Further information to support the notion of family sharing is the fact that commodity foods are not child-specific foods. Data in section B, Preparation of Commodity Foods, further support this point. Therefore, the ration which the child receives is about one-sixth (1/6th) of that programmed.

f. Calculation of Ration Delivered to Child

Table IV-6 shows the calculated caloric availability from the ration to the preschooler after reductions occur from sources described above.

Starting with a caloric availability of 1,165 per day (assuming an average of 1.4 rations per family), this amount is diminished to 93 calories or 6.6% of the child's needs after adjustment for 80% distribution from centers, 60% attendance rate and sharing among a family of six.

g. Conclusions: Ration Dilution

Program recipients frequently receive dramatically less than the prescribed amount of ration because of reductions which occur along the food delivery chain, less than 100% attendance rates, and family sharing. This amount is estimated at 6.6% of the daily caloric needs of the preschool child.

TABLE IV - 4

ATTENDANCE RATES FOR CHILDREN ENTERING THE PROGRAM AT LEAST ONE YEAR AGO*

	Number of Children	Average Months in Attendance	Percent of Children
	80	11	29%
	76	8	27%
	74	5	27%
	48	2	17%
Total	278		100%

* Based on growth card data from 4 clinics in Northwest and Southwest provinces.

TABLE IV - 5

CONSUMPTION OF THE TITLE II RATION AS REPORTED BY MOTHERS/CARETAKERS INTERVIEWED BY TEAM*

Consumer(s) of the Ration Indicated By Mothers/Caretakers	Oil n=115	Milk Powder n=114	Cornmeal n=113
Whole Family	85%	80%	83%
Only Children	15%	18%	15%
Only Adults	0%	2%	2%

* Source: Interviews by team. Instrument in Appendix 3.

TABLE IV - 6

CALORIC VALUE OF RATION AVAILABLE TO THE TARGETED PRESCHOOLER
DAILY AVAILABILITY

One ration - five kilograms monthly

Caloric value[1] available per day	832
Cornmeal:	247
NFDM:	242
Oil:	295
Average ration per family	1.4 [2]
Theoretical calorie availability per family	1165
Average percent of ration delivered in Centers - 80% of programmed ration	932
Availability to family, based on 60% attendance rate to Centers	559
Availability to child, based on family size of six[3], one ration for one preschooler	93
Caloric needs[4] of preschool child	1400
Percent of requirements met with Title II ration delivered to preschooler	6.6%

1 Cornmeal, 370 calories per 100 grams; NFDM, 363 calories per 100 grams; and soybean oil, 864 calories per 100 grams. (Latter two values from the current Commodity Reference Guide; cornmeal is an estimate.)

2 From mother questionnaires, the average number of children was 1.4 (120 mothers in Northwest and Southwest, 60% received one ration, 35% received two rations, and 5% received three rations.)

3 Average family size: in Northwest, 6.4; in Southwest, 5.8.

4 FAO/WHO estimated caloric requirements.

2. Economic Value of the Ration to the Family

a. Introduction

As discussed elsewhere in the report, CRS theorizes that the economic value of the ration to the family is essential for accomplishment of nutritional goals. While CRS does not consider the Cameroon ration to be of sufficient value to reach those goals, Dr. Capone requested that the team evaluate the economic value.

Since a field-tested methodology to assess the economic impact of the ration at the family/community level was not available, the team collected data to assess the market value and the value of the ration as perceived by the family.

b. Market Value of the Ration

The team asked the question: What is the value of equivalent food in the market if Title II foods are sold?

Ascertaining the market value of the ration is a theoretical exercise when the food is not being sold by the family for cash income. Until the food is sold, it is unfounded to assume that the ration is worth a calculated "cash value."

Based on 114 interviews with mothers and our own observations in markets, it does not appear that Title II commodities are being sold per se; the team observed that oil was being used for cooking deep-fried products that were on sale in street markets.

Table IV-7 shows the calculated cash value of a ration delivered to a family (1.4 rations; one ration = 60 kilograms annually of cornmeal, NFDM and oil in a 2:2:1 ratio). The calculations are based on prices paid for cornmeal, powdered milk and soy oil in a Northwest market. The market value of other equivalent commodities is provided for reference in Appendix 10. The market value of the 60 kilogram yearly ration is 42,852 CFA or $194.78.

Factors that affect what is finally received by the family include: the average number of rations the family gets and the percent of the ration that is delivered to the Center and then distributed. The cash value of the ration delivered to the family is 28,796 CFA or $130.89. As a percent of family income, this amounts to 16%.

Powdered milk accounts for 77% of the calculated cash value of the ration. Our observations did not confirm that this commodity is being sold or that it is perceived as a particularly valuable food. Therefore, while the ration appears to have a high cash value based on market prices for powdered milk, it does not in fact have a high value unless and until it is exchanged for cash.

TABLE IV - 7

MARKET VALUE OF RATION AVAILABLE TO FAMILY IF SOLD

Ration	Value, Per Year CFA	Dollars*
Cornmeal, 2 kg (146 x 2 x 12)	3,504	15.93
Powdered milk, 2 kg (1375 x 2 x 12)	33,000	150.00
Benedita soy oil, liter (529 x 12)	6,348	28.85
	42,852	194.78
Average ration per family 1.4 Theoretical availability/family	59,992	272.69
Average percent of ration delivery at Center, year, 80% (Table IV-2 and IV-3)	47,994	218.15
Availability based on 60% attendance rate	28,796	130.89
Average income per capita, 1980, Northwest[1]	30,000	136.36
Average income for family of six	180,000	818.18
Percent of family income	16.0%	

1980 Exchange Rate: 220 CFA = $1.00

[1] Source: GURC Ministry of Agriculture.

It can be speculated that the use of powdered milk as a commodity may actually have a negative economic impact on the family. All powdered milk sold in Cameroon is imported from Europe and is very expensive. (One kilogram of powdered milk costs 2,750 CFA or $12.50.) Our data show that powdered milk is most frequently added to tea, usually consumed only by adults; 18% of the mothers interviewed said that they bought other powdered milk when they ran out of Title II milk.

c. Perceived Value of the Ration

When queried as to the commodity(s) which attracted the largest numbers of participants to Centers, the clinic personnel answer was overwhelmingly oil. Reasons given were taste preference over other oils and the economic value of the oil for use in a small family food business. Street vendors in the Northwest were frequently observed selling fried cakes made of various flours. Soy oil has the right properties for the deep frying of these products while palm oil does not. Soy oil may be of economic benefit to the family for this reason.

Logically, the economic value of the ration to the mothers must be at least greater than the 140 CFA average paid per mother (1.4 rations average, 100 CFA per ration) plus the cost in time that the mother must spend in the clinic on the day of ration distribution. Placing a cash value on the ration using these variables is extremely difficult.

d. Conclusions: Economic Value of the Ration

The economic value of the ration would be potentially significant if it were sold. The estimated ration value would be 16% of annual family income if it were sold. However, since it does not appear that it is being sold, one must conclude that the value is something less than this percentage.

The ration ingredient constituting the largest part of the calculated market value (77%) is powdered milk. Since it did not appear that any of the commodities (including milk) was being sold, the economic value to the family was probably far less than the calculated value.

The potential for a negative economic impact of NFDM exists because 18% of mothers interviewed purchased NFDM when they ran out, and NFDM is extremely expensive.

3. Recommendations: The Food Aid Package

a. AID/CRS/GURC should re-evaluate assumptions that the programmed amount of ration, 2:2:1, is delivered regularly to a defined group of preschool children.

b. Studies of nutrition impact should include documentation of amounts of ration distributed to the family over time and account for the factor of family sharing. The very small estimated quantities received by the child in Cameroon make any conclusions about improved status due to increased food intake highly questionable.(1)

c. USAID and the GURC should consider whether the economic benefits to subsistence families represent a valid objective and if so, seek ways to direct the program to families at greatest economic need, or families in transition to developmental activities who require food while, say, awaiting new harvests.

d. A field-tested methodology is needed to evaluate in greater detail the economic value to the family and the economic impact of the ration on the community.

B. The Growth Surveillance System

1. Use of the Growth Chart to Monitor Child Nutritional Status

a. Introduction

The individual child's growth card is the cornerstone of the CRS Food and Nutrition Program. The card is essential as a record of the child's growth and nutritional status over time. For the record to be valid, the card must be used properly by clinic personnel. This involves a number of steps, some of which are complex tasks under the best of circumstances. In the clinic setting, they are even more difficult because of the press of time to weigh large numbers of children as quickly as possible, concern for the discomfort of crying children, and of mothers' waiting time.

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(1) Not all studies agree with us. The notable exception is a carefully supervised distribution program in Tamil Nadu, reported by Cantor & Associates who found marked improvements in children receiving only 66 calories daily.

This section shows the data collected on the teams' observations and studies of steps important to use of the growth card as a tool to monitor child nutritional status: weighing, recording the weight and plotting on the chart, availability of birth dates, and calculation of age. This data collection instrument, the "Observation Check List," is shown in Appendix 3. The three growth cards in use in the clinics (CRS, GURC, Morley Road to Health) are shown in Appendix 9. The full report of a field study of problems clinics have in use of the charts and an analysis of chart designs which aid and abet errors is found in Appendix 8.

b. Weighing

Weighing was carried out at all clinics visited on a food distribution day. Children were usually weighed with clothes on, and sometimes with shoes. Reading of the scale by clinic personnel was usually within an acceptably accurate range, e.g., to the nearest 100 grams. This reading was accurately transferred to the chart.

c. Recording the Weight and Plotting the Percentile on the Chart

The team observed that weight was always recorded onto cards, but not always plotted onto charts. When this happens, the nutritional status of the child remains unknown.

For use of the CRS chart, recorders must go to a second chart, the Master Chart, to get the child's weight percentile (using the age and weight measurement). Personnel appeared to carry out correct plotting of the Master Chart but then either (1) returned the percentile incorrectly to the child's card, or (2) did not return the percentile at all to the chart (some clinics). In these instances, the use of the chart is invalidated for education, monitoring health status or as part of a contractual commitment from the mother for weight gain. The team observed that the importance of the correct individual chart plotting appeared to be neglected for the higher priority of completing the Master Chart.

Marking of the percentile on the child's chart frequently took place in another room without the mother's presence or at a table far away from the weighing procedure, so that the opportunity for communication and explanation was completely missed.

The CRS Operational Plan (FY 1981) states that the child's weight is interpreted to the mother. In 12 observation visits, this was not observed by any team members.

d. Availability of Birth Dates

The basis for age ascertainment was valid. Ages were either taken from a birth certificate or from midwives' registers of birth. Without these sources, the mothers' estimate was accepted. It was possible for the team to know which dates were estimates because only the month and year were recorded for estimates. The level of known birth dates was 80% or higher, as determined from growth card and impact studies (reported in Nutrition Impact Section).

e. Calculation of Age

Correct calculation of age (quantifying in months) essential for correct assessment of nutritional status, appeared to be an enormous problem for clinic personnel. Age calculation is difficult, even in the best of circumstances, and clinic personnel compute age in months under the pressure of a busy clinic/food distribution day. Thus, the opportunity for error is great.

The problem of age calculation and analysis of common types of errors in using the charts was studied in detail by an evaluation team member; results of this study are provided in Appendix 9. To summarize this study, there were four common types of errors, all of which resulted in an underestimation of age. The effect of this is that the child will appear to be in better nutritional status than s/he actually is. Clinics would be less able to target malnourished children for special attention and results of evaluations could be biased because of this. Team evaluation of this problem was limited to a description and analysis of these problems and a subjective estimate of how widespread these errors were. Therefore, the team cannot estimate the magnitude of impact of this problem at this time. Errors seemed to stem from: incorrect calculation of age at the first visit which was perpetuated at succeeding visits, confusion as to calculation and recording caused by use of the Morley, GURC, and CRS charts all at once, and problems in understanding the difference between other charts which have ascending good health paths on them by age and on CRS flat good health paths. Also, the Morley chart requires that spaces be left for missed months in order to place accurately the current nutritional status. The CRS chart does not require leaving spaces.

f. Conclusions: Use of the Growth Chart

All clinics weighed preschool children on food distribution day according to the CRS plan.

The individual growth chart as a tool to monitor the child's nutritional status was sometimes ineffective because the chart was not used correctly. The team's impression was that errors in its use were widespread and potentially significant; however, the team did not collect

quantitative data on the magnitude of the problem system-wide and therefore cannot comment on the impact of these factors on this report or on the validity of program components.

Completion of individual charts appeared to be neglected for the higher priority Master Chart.

The team did not observe that clinics used the individual chart as a visual tool for mothers.

2. Use of the Master Chart for Program Planning

a. Introduction

According to CRS, the Master Chart is intended to pinpoint geographic areas of need, centers with high levels of malnutrition, and to demonstrate seasonal problems. For clinics, it is intended to give a visual picture of the nutritional status of the children seen on a given day. The Chart is intended to be useful through a system of feedback from national to provincial to clinic level. The Master Chart is shown in Appendix 9.

The CRS Operational Plan (FY 1981) states that the Master Chart "permits one to readily evaluate the program's impact."

It is important that the program derive some tangible benefits from the Master Chart because of its enormous cost to the program. Completion of the Master Chart requires no less than one-person day of work at every food distribution session throughout the program.

b. Use of the Master Chart

We did not find evidence of feedback being provided from national to provincial levels or from provincial to clinic levels, regarding Master Chart data findings.

The Master Data are only partially used by CRS at the national level. Preliminary studies of numbers and percent malnourished were begun, but not tabulated and distributed to clinics. Master Data for centers by province were not on file in Yaounde, having been sent to Nairobi "for analysis."

Compiled Master Data by percentile categories for a four month period were available in the provincial offices. Southwest and Northwest Provinces reported having just begun to compile these data since March 1981. However, the crucial step of calculating the percent below 80th percentile (from numbers of children compiled) had not been taken.

Therefore, particular centers with extraordinary levels of malnutrition were not identified and targeted for further investigation and perhaps special attention. For example, of the top 20 centers chosen at random in the Southwest, the team calculated that Mokondange had 43% of children below 80% weight for age (March 1981), while other centers had 20% or less. In the Northwest, Widikum had especially high rates, in excess of 40% malnourished (March-July 1981). Seasonal trends, which must be identified by plotting the percent malnourished each month, had not been identified. Plots of Master Data made by the evaluation team for 20 randomly chosen centers in the Northwest (Figures IV-2 and IV-3) show an apparent seasonal problem in malnutrition. There was a rise in rates of malnutrition in May in a number of Northwest Centers for the four-month period studied.

At the clinic level, many did not have summaries of their own data; others had only recently begun to keep a record of the numbers of children falling into percentile categories on a monthly basis for their own month-to-month comparison purposes.

c. Conclusions: Use of the Master Chart for Program Planning

The Master Chart is not currently serving the purposes for which it was intended. It is not used at the national or provincial levels to pinpoint geographic areas of need, identify seasonal problems, or allocate resources to areas of need.

The Master Chart appears to be of minimal benefit to personnel in MCH centers. Even if centers could actually make some practical use of the data on percent malnourished, it is not clear (a) that this information must be obtained at the cost of one person-day every clinic day, or (b) that it is worth this cost to the entire CRS food distribution program, and (c) that the Master Chart is necessary to acquire this information.

Plotting on the Master Chart was a time consuming task which appeared to reduce contact with mothers and to interfere with marking the percentile on the mother's cards.

3. Education Effectiveness

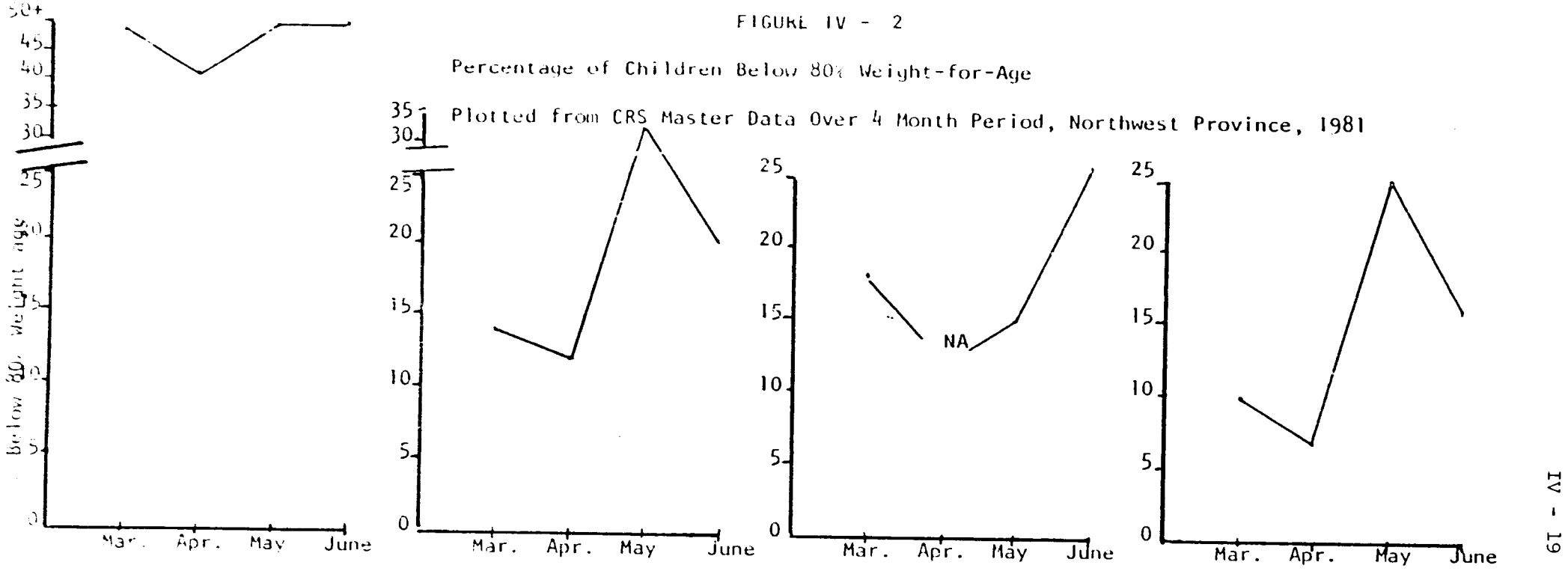
a. Introduction

Education of mothers is another essential component of the CRS Food and Nutrition Program. Education of mothers is intended to provide the link between child health and the growth card and Title II commodities. To determine the effectiveness of the education program, the team interviewed CRS officials extensively and reviewed CRS documents to determine the specific concepts which were taught.

FIGURE IV - 2

Percentage of Children Below 80% Weight-for-Age

Plotted from CRS Master Data Over 4 Month Period, Northwest Province, 1981

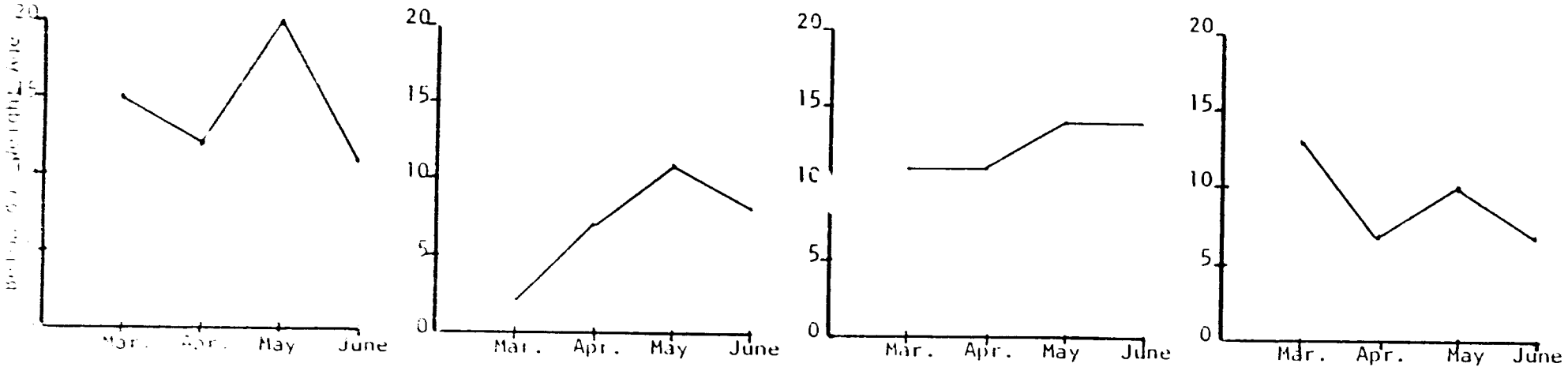


WIDIKUM
Attendance Range 215-315/mo.

SANTA
Attendance Range 208-756/mo.

BAFUT
Attendance Range216-400/mo.

NDU TEA
Attendance Range 142-256/mo.



MBOT
Attendance Range 122-409/mo.

DJOTTIN
Attendance Range 815-1320/mo.

NKUM-KOV
Attendance Range 149-377/mo.

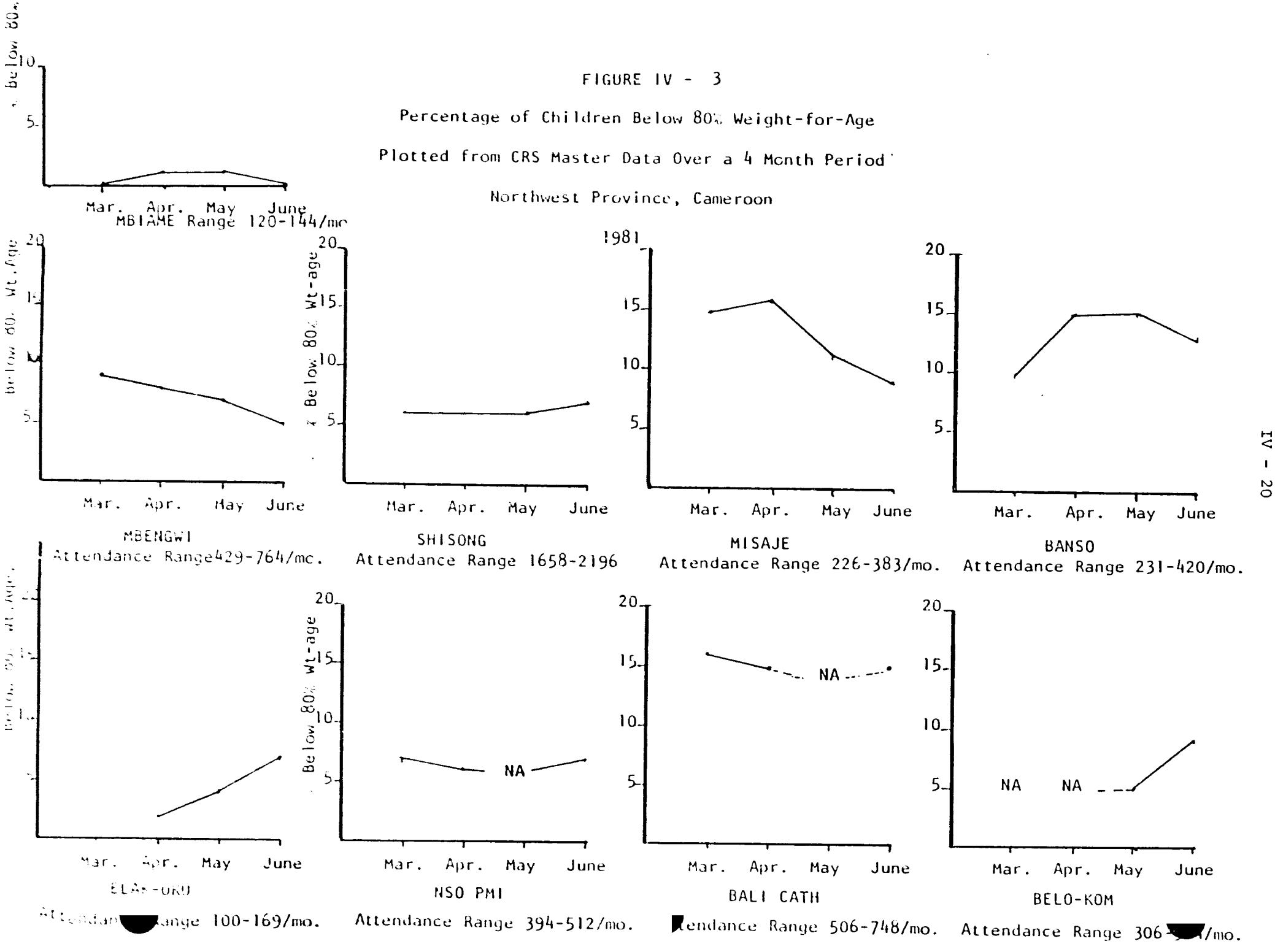
TATUM
Attendance Range 173-291/mo.

FIGURE IV - 3

Percentage of Children Below 80% Weight-for-Age

Plotted from CRS Master Data Over a 4 Month Period

Northwest Province, Cameroon



Then, the team assessed the effectiveness of teaching these concepts by:

- Analyzing the written agreement between CRS and centers regarding the teaching of these concepts;
- Asking clinic personnel what they taught mothers;
- Observing what personnel taught mothers; and
- Asking mothers what they knew about these concepts.

The team also reviewed the methods by which the educational messages were delivered. Thus, mothers' knowledge of concepts is the last step in a chain of events, shown schematically in Figure IV-4. Steps in the chain and evaluation methods used at each phase are summarized in this Figure.

Additionally, at the request of the GURC, the GURC health education program was reviewed. Thus, mothers' knowledge of prevention and treatment for common illnesses was evaluated.

This section of the report will trace the implementation of specific objectives through each of the steps in the chain (Figure IV-4) leading to mothers' knowledge. First, the evaluation methodology will be reviewed, then objectives and program methods described and finally accomplishment of these objectives assessed.

b. Notes on Methodology

The overall scheme for analysis of process components was described in Chapter Three. The team utilized open-ended questioning techniques to ask and then probe for information and knowledge of the 17 MCH supervisors and 116 mothers/caretakers who were interviewed. There were 12 observation checklists completed. Clinics chosen for visit by the team were randomly selected and mothers interviewed were also randomly selected.

CRS raised the question that the responses of new enrollees should be distinguished from the responses of those who have participated in the program for some time. The team completed additional analyses to provide a description of the population interviewed with regard to amount of time in program. Table IV-8 summarizes this information. Eighty percent (80%) of mothers interviewed reported that they came to the clinic monthly; 20% came less often than that. Clinic records showed that the average percentage of new enrollees in the clinics where mothers were interviewed was 7%. Attendance rate studies using growth cards in these clinics revealed that 31% of the children studied were in the program for 1-6 months. From these data, the team concludes that the percentage of new mothers interviewed may range from

FIGURE IV - 4

STEPS IN A CHAIN LEADING TO THE MOTHERS' KNOWLEDGE OF CONCEPTS AND EVALUATION METHODS USED AT EACH STAGE

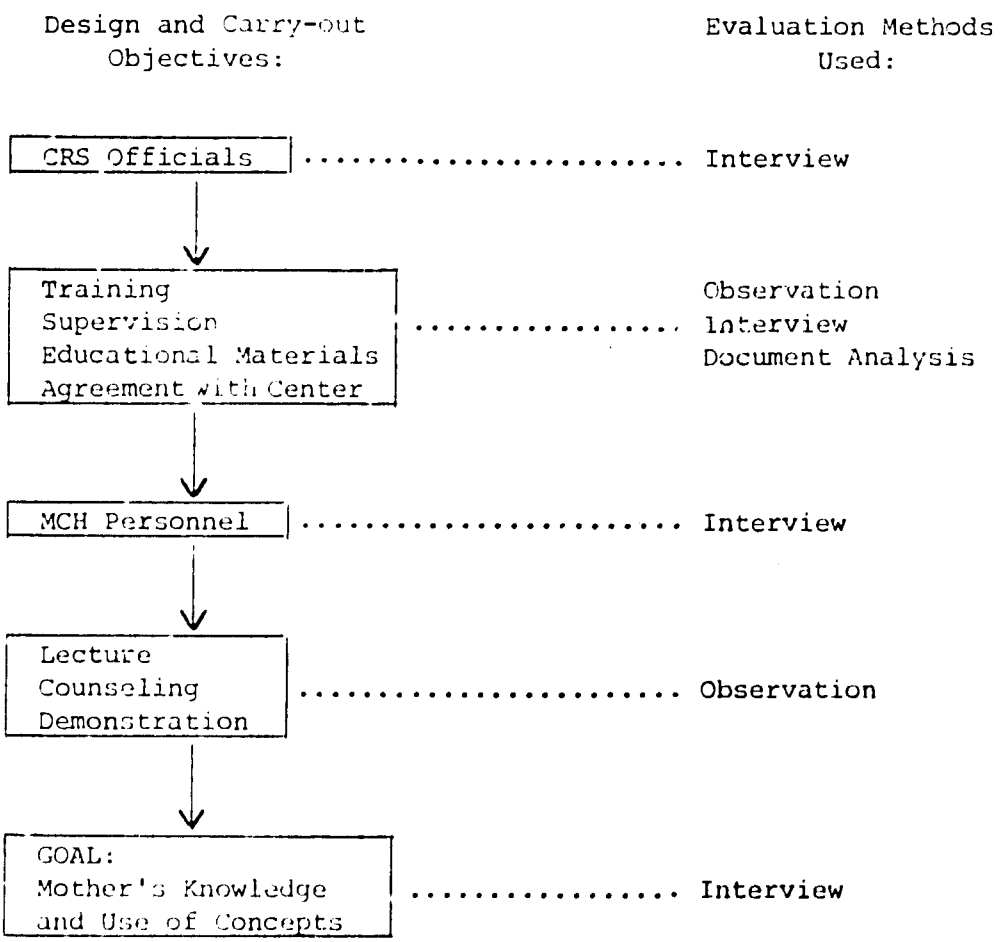


TABLE IV - 8

SUMMARY OF DATA TO DESCRIBE TIME IN PROGRAM
OF MOTHERS INTERVIEWED FOR THE EDUCATION EVALUATION

Data Source	Sample Size	Results
Team Interviews of Mothers	116 Mothers	80% responded that visits to clinic were monthly 17% reported visits every other month to clinic 3% reported participation less than every other month
Monthly Distribution Reports of Title II Foods Filed by Clinics	11 Clinics	New children per month Total participants (averaged for 4 months) Clinic — New Bali Catholic — 1% Shissong — 5% NSO PMI — 5% Tatum — 8% Santa — 10% Bo Kwango — 3% Muea — 10% Banga Bakundu — 12% Victoria — 18% Mudeka — 6% Tole Tea — 1% Average New - 11 clinics = 7%
Growth Cards - Team Studies of Attendance Rates	593 Cards	31% of children in Program 1-6 months

7% to 31% of the sample. Since new mothers are part of the total population, the team believes they should be represented in the sample. When percentages of mothers in excess of 7-31% lack knowledge of particular concepts, the team concludes that objectives have not been accomplished.

c. Program Objectives and Methods

Objectives of the education program as stated and written by CRS were as follows:

Growth charts. Charts are used as educational tools or visual aids by interpretation of colors and directions of the percentile line. Advice is given if the child is in a certain area on the card. The following are explained: meaning of green area (healthy area), meaning of yellow (malnourished) area, meaning of decline from green to yellow and ascent from yellow to green, proper actions to take if child is in the green and yellow areas.

Concept of equivalents. Mothers are taught: to identify local foods which are substituted for commodities and to "reimburse" the child using local foods for the extra amount of protein, fat or carbohydrate food if the commodity is put into the family pot.

Preparation of commodities. Mothers are taught to prepare the commodities in the following way:

oil: fry or add to foo-foo
cornmeal: add milk powder and water and boil into a pap (baby food) or prepare as foo-foo
milk powder: add as powder to pap or foo-foo corn mixture.

Contractual agreement with mothers to help the child grow. Health workers explain to mothers that they must make a commitment for the child to grow. Mothers are expected to follow instructions of the health worker to feed the child with Title II food or its equivalent, to give prescribed medications, obtain vaccinations, and to follow instructions for treatment of diarrhea, etc.

The GURC (MOH) does not have stated health education objectives or standard manuals at present; it is expected that subject matter for health education messages will be adapted to the prevention and treatment of seasonal and local problems. Therefore, the team asked mothers general questions about water hygiene, general hygiene, three food groups, medicines, how to cook and child care.

CRS uses the following methods to implement the educational program:

- Training of directors at periodic seminars in educational objectives;

- Communication of concepts about the growth card and child progress to individual mothers through counseling;
- Delivery of a health or nutrition lesson during every food distribution clinic;
- Provision of a health education manual which explains the basis of the program to all centers and additional materials at training seminars;
- Provision of growth charts and master charts to centers which will be used for education of mothers and center monitoring;
- A written agreement with MCH centers.

MCH personnel use these methods to deliver the program to mothers:

- A lecture at every clinic on health and nutrition principles;
- Counseling of mothers whose children have special needs; and
- Cooking demonstrations on use and preparation of Title II foods.

d. Organization of Objectives

In the following sections of the report, the level of accomplishment of each educational objective will be assessed. That is, the report will focus on how each step in the chain shown in Figure IV-4 contributes towards accomplishment of the objective. In this way, the team hopes to clarify points where the system is or is not working to achieve stated objectives.

e. The Growth Chart: Use as an Educational Tool

CRS-MCH Center Agreement. This agreement (Appendix 5) does not contain any provisions regarding this objective.

Clinic Directors. Sixty-five percent (65%) of directors responded that they taught mothers about the meaning of colors; 57% replied that they taught the meaning of a declining or ascending line on the chart (some of them taught both, some only one concept). One hundred percent (100%) replied that they explained reasons for growth failure and gave advice for its treatment and prevention.

As Observed by the Team. During the 12 observation visits, clinic personnel were not observed either explaining the chart to an individual mother or explaining the chart to a group of mothers. The team members were aware of the abnormalities their presence might have caused, and made no conclusions with regard to the educational capability or performance by clinic personnel.

Mothers' Knowledge of Growth Card Concepts. When asked about the particular growth chart they had with them (whether CRS new chart or GURC chart), 66% of the mothers did not know the significance of the green or healthy area, and another 3% thought it meant nothing. Questioned about the yellow area signifying poor nutritional status, 70% of the mothers either did not know its meaning or thought it meant nothing. When asked about the causes of growth failure (green to yellow on CRS chart), 65% of the mothers did not know of any, 25% thought that the child did not eat enough, and 10% thought the child was ill. Questioned about an ascension on the chart from failing to good health (yellow to green), 67% of the mothers did not know causes; of those answering correctly, some said the child was eating right (25%), and others said the child was getting well and being healthy (8%).

Asked about clinic advice given when the child was failing (in yellow), 60% of the mothers said they were told nothing and 11% did not know. Only 26% stated that they knew they must give more food to the child or take the child to the clinic. Asked about advice given when the child was normal, 61% said they were told nothing, another 12% did not know, and 27% correctly understood that their child was healthy due to giving it food.

If one assumes that 30% of the mothers were new or had had very little exposure to the education, findings of 60-70% of mothers not knowing the concepts intended is very high.

These findings are summarized in Table IV-9.

f. The Concept of Equivalents

CRS-MCH Center Agreement. This objective is referred to in the Agreement. It states that:

> During each food demonstration, emphasis will be placed on the local equivalent of the imported foods so that the children will not suffer if the imported food supply is ever interrupted or discontinued.

The reason stated above for teaching the local equivalent food does not relate to the objectives of correct substitution of the local food for the child or the concept of reimbursement of local food to the child.

Clinic Directors. All of the directors gave the correct local equivalents for Title II foods. The team asked what amount of food was to be given to the child in order to determine if the concept of reimbursement was being taught. None of the queried directors indicated they taught the amounts of food to be given to the child.

As Observed by the Team. During 12 observation visits, the concepts of local substitution and reimbursement to the child were not discussed during the health lesson or in counseling. Again, the team assumed that these failures might be due partly to the team's visit on a misrepresentative day or the effect of their presence on the regular routine.

Mothers' Knowledge of Equivalents. All mothers named a correct local equivalent for cornmeal and oil. When questioned about substitutes for powdered milk, the mothers placed at the top of the list other milk, followed by other powdered milk, with only 5% naming other protein sources, and 3% indicating there were not local equivalents.

These findings are summarized in Table IV-9.

g. Preparation of Commodities

CRS-MCH Center Agreement. The agreement does not have any provisions regarding teaching the correct preparation of commodities.

Clinic Directors. All of the center directors knew the correct preparation of cornmeal and oil; 35% said they taught mothers to prepare powdered milk as a drink; 50% said milk should be made into a paste and added to tea; 86% said they taught mothers to add milk powder to cornmeal (some gave more than one answer). When asked if children drank tea, the directors responded in the negative. Two directors volunteered that they were following CRS instructions in not teaching mothers to prepare milk as a drink for children because it might cause diarrhea.

As Observed by the Team. A cooking demonstration observed in one center showed the correct preparation of all three commodities.

Mothers' Knowledge of Preparation of Commodities. All mothers gave the correct use for oil; 72% used the cornmeal for foo-foo and 28% for gruel/pap (specifically infant food). When asked about the use of powdered milk, 74% said they added it to tea; another 17% said they mixed it with a liquid, and only 8% said they mixed it with pap or gruel.

These findings are summarized in Table IV-9.

h. Contractual Agreement with Mothers.

CRS has not yet attempted to implement this component of the Growth Surveillance System.

i. GURC Health Education

Clinic Directors. Directors stated that the content of the health lesson would vary and depend on the needs of the community.

As Observed by the Team. The team observed that a wide variety of preventive health topics were dealt with in the health lessons, probably too many in sessions that were too long.

Mothers' Knowledge of Preventive Health Concepts. When questioned about different categories of health education which included water hygiene, general hygiene, local food equivalents, three food groups, medicine/clinic, how to cook and child care, mothers first mentioned areas about which she had information. She was then probed for "recognition" of the subject. Areas in which she mentioned knowledge in order of highest to lowest were general hygiene (70% mentioned), how to cook (38% mentioned), medicine/clinic (37% mentioned), and water hygiene (32% mentioned). Probed for recognition, the mothers recognized the following in descending order: three food groups (71% recognized), local food equivalents (67% recognized), and water hygiene (59% recognized).

j. CRS/GURC Education Methods

CRS-MCH Center Agreement. The agreement states that:

> A nutrition or general health/household care lesson will be included in every session of the pre-school program.

Clinic Directors. Directors reported that a training seminar had been held about four months ago in the Northwest and a large seminar several months previously regarding the GES system. All directors reported that counseling was provided to mothers of failing children. Ten percent (10%) of the directors queried answered that they had seen the CRS health education manual. However, several directors produced materials given out at a recent seminar. Most answered that their source of information for lectures was their midwifery training. One director reported that health lessons were never given because the mothers needed to get to the fields.

As Observed by the team. Mothers were not once provided counseling regarding actions they must take if the child does not grow. A health lesson was provided at all centers visited except one; the reason given was that mothers do not have time and must return to the fields.

Flipcharts available in the two centers made visual reference to the growth chart, but concepts conveyed were not comprehensible to the team. They were not observed being explained to groups of participants. Supplying growth charts was a problem. Centers visited in the Southwest appeared to have sufficient CRS charts. However, the Northwest has a serious shortage. Over the previous seven months, only 5,000 charts had been received in the Northwest whereas needs were estimated at 80,000 for a one-year period. The team noted this shortage during clinic visits in the Northwest where personnel in centers lacking cards were recording weights without percentiles into health notebooks or using two other cards: the Morley Road-to-Health Card and the GURC card. All mothers interviewed had either the CRS or GURC chart. A cooking demonstration was observed in one clinic.

Mothers' Knowledge. This section is not applicable to CRS/GURC education methods.

k. Conclusions: Education Effectiveness

Neither AID/W nor USAID has required an "effective" education program as part of the Title II package.

After two years in operation, in well-established centers of the Southwest and Northwest Provinces, the individual growth charts do not yet serve as effective educational tools as evidenced by mothers' responses to open-ended questions concerning the chart.

Projected advances toward more formal commitments to weight gain of their child by mothers are unlikely until the charts are in effective use.

As noted earlier, the time for counseling at the time of weighing appears to be compromised by requirements of master chart completion.

The CRS-GURC agreement at the national level contains no provisions regarding implementation of CRS educational objectives.

Wording in the CRS-MCH Center Agreement is not specific regarding the content of the educational program. There is no commitment required of centers to carry out the educational program as stated.

The teaching and understanding of the complex concept of reimbursement of local equivalents appears to be far from developed.

TABLE IV - 9

LEVEL OF IMPLEMENTATION OF MAJOR EDUCATIONAL OBJECTIVES AS STATED BY CRS

Objective	Percent Implemented			
Sample Size and Units	Agreement CRS-Center 1 agreement	As Stated by Clinic Directors 17 supervisors	As Observed by the Team 12 observation visits	As Reported by Mothers % Correct Responses 116 mothers/caretakers
Growth Chart				
Meaning of Colors	0%	65%	0%	32%
Meaning of Direction of Line	0%	57%	0%	33-36%
Advice Given	0%	100%	0%	27%
Equivalents				
Correct Local Substitutes				
• Oil	0%	100%	0%	100%
• Cornmeal	0%	100%	0%	100%
• Milk Powder	0%	100%	0%	5%
Amount to "Reimburse" Child	0%	0%	0%	NA
Preparation of Commodities				
• Oil	0%	100%	Observed one demonstration	100%
• Cornmeal	0%	100%	correct for all	100%
• Milk Powder	0%	85%	three foods	8%
Contractual Agreement	- NOT IMPLEMENTED -			

Key: NA = Not Available

The reported teaching and learning of preparation of Title II foods as stated by CRS was good for oil and cornmeal. However, directors do not always teach correct preparation of milk powder and only 8% of mothers reported adding it to the cornmeal as intended by CRS.

No set of comprehensive teaching materials with focused messages pertinent to stated objectives appears to exist.

The presently constituted educational delivery system (including clinic personnel training, teaching materials and delivery format and communication techniques) does not appear to be effective means of educating mothers according to the stated objectives. This conclusion is based mainly on the team's assessment of mothers' responses to open-ended questions and to a lesser degree on observations made during clinic visits.

4. Recommendations: The Growth Surveillance System

a. CRS/GURC should consider less frequent weighings of children over one year of age and in good nutritional status in the interest of greater efficiency and effectiveness of staff.

b. CRS/GURC/USAID should seriously re-evaluate the master chart, its cost to the program (one-person day monthly in every clinic), and the present benefits which appear to be minimal. CRS/NY and Nairobi ought to be appraised of these problems of utilization for clinic personnel, at least as they exist in Cameroon. Another possibility is to train staff in Cameroon to recognize now unexploited potential. For example, data on seasonal trends of malnutrition could be derived. These data were not being used in Yaounde nor did CRS have plans to adjust food distributions according to special area or seasonal needs.

c. CRS should provide more training and technical assistance to all levels of staff in completion of and use of both the individual and master charts. Clinics seemed to have enormous problems in correct completion of the individual chart and to have little idea of what to do with the master chart, except that its completion was mandatory and of first priority.

d. CRS/GURC should conduct a study of and monitor on an ongoing basis the errors in correct completion of the individual growth chart. The design of the chart(s) should be evaluated and revised as needed to rid the chart of defects which contribute to errors.

e. AID/W, if it desires to direct Title II programs increasingly in the direction of development, should insist on the components that will ensure mother education. This stage may be more important to emphasize (and more realistic to achieve) than the final objective of improved child nutritional status.

f. CRS should attempt to make the efforts required to educate clinic personnel sufficiently to give reality to the stated educational objectives or revise them to fit realities.

g. CRS and GURC should request via USAID technical assistance to sort out barebones of a system in support of the growth chart as part of the MCH education package and to meet other stated educational objectives. The model could subsequently adapt to the different Provinces.

h. AID may wish to consider requiring that CRS provide documentation that education about growth chart (1) can be used to accomplish stated objectives; (2) can be communicated effectively; (3) can be understood by mothers; (4) is actually provided to mothers effectively; (5) is in fact understood by mothers; and (6) is acted upon by mothers.

i. Other MCH programs in the world that are not utilizing growth charts are allowed to continue in operation so that it is unjust to recommend program curtailment until printed charts are available. However, CRS might wish to avoid future confusion caused by interim use of other cards by limiting the opening of new centers and the number of new enrollees until adequate supplies are available.

j. CRS should reconsider supplying milk powder as a commodity because it is not used by mothers according to objectives as stated and intended. To avoid mothers' making a drink with powder or adding it to tea, MCH clinics might mix milk powder with cornmeal at the time of distribution so that use of powder will be as intended. Otherwise, CRS should consider other commodities which are frankly baby foods and which will not be misused as milk powder is.

k. The education provided by the GURC MOH in the clinics where foods are distributed usually does not directly support the concept of mothers' commitment to improve child health as demonstrated by the growth chart.

Since the GURC has agreed to use of the CRS growth chart in the Northwest, Southwest and East Provinces, such support would seem to be mutually beneficial. If, however, the GURC does not believe as CRS does that the growth chart system is the best educational tool available, the two organizations should agree on the best combination of materials to utilize.

1. It is recommended that CRS and GURC request technical assistance through USAID to assist with the improvement of MCH health and nutrition education. The program particularly needs: to be suited to mothers' perceived needs and to behavior changes that she is willing and able to make; personnel who are trained in effective communication techniques and in handling content at the literacy level of the audience.

C. PREVENTIVE HEALTH SERVICES

1. Medicine Provision

The CRS Operational Plan (FY 1981) states that "each center has a program of...components...which (include): immunization and treatment of ailments." "Anti-malarial and anti-worm medicines are provided by CRS as part of the total nutrition package..."

CRS stated that lack of these medicines could be due to inadequacies of supply or the decision not to supply clinics which are not "trustworthy." CRS attempts to supply all clinics, but inventory demands must "percolate from the center to the national level and be responded to."

Clinic supervisors interviewed by the evaluation team stated that they either received no supplies of anti-malarial or anti-worm medicines or in very sporadic, limited amounts. Mother interviews confirmed this finding; 47% of the mothers stated they did not receive worm medicine for their children. For those who received medicine, 58% had to pay for it. They stated that it was received one out of three times; 73% said they received Nivaquine (malaria suppressant) with 68% indicating that it was given free. When paying in 31% of the cases, mothers most often paid under 100 CFA.

2. Vaccinations

When interviewed by the evaluation team, CRS stated that they decided four years ago not to supply vaccines because the demand for them was so high that clinics had the impression that CRS was conducting a vaccination program and nothing else. The lack of a vaccination program within the "CRS package" was confirmed during field study.

The GURC has a field team which appears to visit villages throughout Cameroon on a sporadic basis.

3. Recommendations: Preventive Health Services

a. CRS may wish to revise the Operational Plan to reflect current policies and procedures regarding medicines and immunizations. TURC ought to be informed about CRS immunization program, termination, etc., to ensure appropriate collaboration in MOH.

D. NUTRITION IMPACT

1. Introduction

The evaluation of the impact of the CRS Title II Program on the nutritional status of preschool children was of some interest to all users of the evaluation. Therefore, a major portion of the field work was devoted to collecting data on the growth of children. Two principal methods of data collection were used:

1. The team took actual measurements of height, weight and arm circumference of 375 children; and

2. The team extracted birth dates, weights and weight percentiles from 647 growth cards in health clinics.

Early on in the conduct of the evaluation, it was clear that definitive scientific data which would:

- Be generalizable to the entire CRS food distribution program in Cameroon; and

- Clearly identify whether food aid was a significant factor impacting on the status of children

could not be provided by the evaluation team. Briefly, the time and funds for generating results of this nature were simply not available to the team.

However, the team conducted three studies which provide data to identify:

1. Whether there is an impact on the nutritional status of children in program and control villages studied;

2. The impact on the nutritional status of children attending eight clinics; and

3. The feasibility of conducting future, larger studies of nutrition impact.

The team believes that these data are useful because they provide insight into the effect of the program in the villages studied. (2)

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(2) The team does not argue for the representativeness of the Growth Chart study. It does, however, represent a population of a larger geographic area, which is biased in favor of clinics where weighing, recording procedures, and the growth cards themselves appear to be properly kept.

Because sample sizes were small within age groups and statistical tests could sometimes not be applied, statistical significance is not always reached. However, trends are persistent and clear, and are similar to findings of other evaluations of feeding programs. (3) For reasons not fully known, children attending the program have better nutritional status than children who have not had access to a program recently, a difference which could be caused by better SES of the self-selected attendees. Children attending the program have better nutritional status when compared to those entering the program, a more convincing suggestion of program benefits. (4) Powerful correlates of nutritional status, such as SES, infection, and demographics, may come into play. These studies, with their strengths and limitations, are discussed in the following section

These studies are: 1. Study of children in 1 program and control village; and 2. Study of new entrants compared with participants.

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(3) Nutrition Intervention in Developing Countries, Study I Supplementary Feeding, M.A. Anderson, et al., Harvard Institute for International Development, Oelgeschlager, Gunn and Hain, Publishers, Inc., Cambridge, Mass., 1981.

(4) However, our participant group is biased in favor of better nutritional status when compared to new entrants because the new entrants are a mixture of irregulars-to-be (known to have poorer status) and regulars-to-be (known to have better status). Our participant group is by definition a group of regular attendees because the criterion for use of a participant growth chart was at least 66% attendance in a year.

2. Study of Children in a Program and Control Village

a. Introduction

The purposes of developing a study of program and control villages, with measurements of children taken by the team and interviews to assess other factors which may affect nutritional status, were to:

- Show that under certain circumstances, namely in those villages chosen by defined criteria, a nutritional impact does nor does not occur;
- Identify and, if possible rule out, other factors (besides the health/food program) known to be correlated with nutritional status; and
- Identify and describe problems in the field so that larger studies may be conducted at a later date.

The team proposed in Yaounde to study two program and control villages. No prior field assessment had been done when the team arrived, so it was not known if suitable comparable, matching control villages could be found. CRS advised that the program had saturated roads in the Southwest and Northwest Provinces and that control villages (untouched by the Program) could most readily be found in the Eastern Province. The team proposed to give priority to the Eastern Province for this reason, but agreed to change the focus to the Northwest and Southwest when USAID strongly objected. In the field, the team found that, indeed, both Southwest and Northwest programs serve numerous villages for a radius of 10-20 kilometers and that accessible roads were "saturated." This is documented in a report, "Nutrition Impact Feasibility," at the end of this section.

Considerable field time was invested in on-site investigation of recommendations from government health and agricultural officials for comparible, untouched villages. Finally, one control was identified in the Northwest. Therefore, the team reports results of only one program and control village, instead of two.

b. Brief Description of Methodology

This study was carried out in the Bafut area in the Northwest Province. The program village chosen for study was Bafut-Bawum and the control village was Manji. Team members measured program children on a regular clinic food distribution day at the Bafut Mission. Control children responded to the request of the local chief that they come for measurement at the Manji Government Health Center. Both program and control clinics provided curative health care (consultations) and in-patient maternity services. The Bafut Mission also provided in-patient care. Preventive health services consisted of a vaccination program in both clinics.

Team members took body measurements of height, weight and arm circumference. Length measurements were not taken because the team lacked the staff (an extra three people) and recumbent board necessary for children under two years. An "Impact Questionnaire" for mothers/caretakers was developed to assess if other factors known to be correlated with nutritional status in Cameroon (National Nutrition Survey) were different for the two villages. Assessment of comparability helps to determine if other factors besides the health/food is affecting nutritional status.

A detailed description of the methodology is provided in Chapter Three and the "Impact Questionnaire" is in Appendix 3.

c. Results of Study in Program and Control Village

Table IV-10 shows the prevalence of chronic undernutrition (stunting: Ht/Age $<$ 90%, Wt/Ht $\geq$ 80%) by age groups. Since the age composition of the program and control groups was different (Table IV-14), it was necessary to separate the groups by age. Sample sizes in age groups were below 30, so statistical tests were not applied. However, the trends are that the program children have better nutritional status than the control children.

Rates of chronic undernutrition for the program village were similar to, or lower than, rates for the country as a whole (Table IV-10). The reason for higher rates in children over 25 months in the control village is not known. Since sample size in these age groups were small (range 10-33), this could result from chance.

Table IV-11 shows the levels of acute undernutrition (Ht/Age $\geq$ 90%, Wt/Ht $<$ 80%). There was a greater prevalence of acute malnutrition in the program group than in the control group; however, levels were very low (4% in program, 0% in control). The levels of acute malnutrition are also low for the country as a whole (1% nationally).

The prevalence of low arm circumference (Table IV-12) was also higher in the program group (1.6%) than in the control (0%), but the level was extremely low.

Table IV-13 shows the prevalence of underweight children (Ht/Age $\leq$ 80%). The program village has higher rates in children 7-12 months and 25-36 months; the control village has higher rates in children 13-24 months and 37-48 months.

Program and Control villages were comparable on a number of demographic, socioeconomic and health services utilization indicators (Tables IV-14, IV-15, and IV-16). A significant difference between the two populations "called out" was the age distribution (Table IV-14) in the 7-12 month, 25-36 month, and 49-72 month age groups. For this reason the data were presented by age group only and were not combined.

TABLE IV - 10

PREVALENCE OF CHRONIC UNDERNUTRITION BY AGE GROUPS IN PROGRAM AND CONTROL VILLAGES COMPARED TO NATIONAL SURVEY DATA FOR CAMEROON

Age, Months	Program: Bafut-Bawum Sample Size	Program: Bafut-Bawum Percent Undernourished*	Control: Manji Sample Size	Control: Manji Percent Undernourished*	P Value or Trend**	National Survey, Range for Age Group***
25-36	44	15.9%	10	50.0%	Trend: Control Higher	22.3 - 24.5
37-48	25	16.0%	14	50.0%	Trend: Control Higher	27.4
49-72	12	16.7%	33	48.4%	Trend: Control Higher	26.8

* Chronic Undernutrition: Height-for-Age: Low: Less than 90% of reference median height-for age. (Waterlow classification) Weight-for-Height: Normal: 80% or more than reference median for weight-for-height.

Ages and percentiles calculated using the Ahlers Program.

Because of the lack of length measurements, these data do not include the data on children under two years which appear in other tables.

** Statistical test not applicable for sample sizes of 30 or less in a study group.

*** Chronic Undernutrition as reported in National Survey (page 74) includes children of normal and low weight-for-height. Data by age and by Province not reported in survey.

TABLE IV - 11

PREVALENCE OF ACUTE UNDERNUTRITION BY AGE GROUPS IN PROGRAM AND CONTROL VILLAGES COMPARED TO NATIONAL SURVEY DATA FOR CAMEROON

Age, Months	Program: Bafut-Bawum		Control: Manji		P Value or Trend**	National Survey, Range Over Age Group***
	Sample Size	Percent Undernourished*	Sample Size	Percent Undernourished*		
25-36	44	0%	10	0%	-	0.8 - 1.4%
37-48	25	4.0%	14	0%	Trend: Program Higher	0.9%
49-72	12	0%	33	0%	-	0.5%

* Acute Undernutrition: Height-for-Age: Normal: 90% or more than reference median height-for-age.
(Waterlow classification) Weight-for-Height: Low: Less than 80% of reference median weight-for-height.

Ages and percentiles calculated using the Ahlers Program.

Because of the lack of length measurements, these data do not include the data on children under two years which appear in other tables.

** Statistical test not applicable for sample sizes of 30 or less in a study group.

*** Acute Undernutrition as reported in National Survey (page 75) includes children of normal and low weight-for-height. Data by age and by Province not reported in survey.

TABLE IV - 12

PREVALENCE OF LOW ARM CIRCUMFERENCE* IN PROGRAM AND CONTROL VILLAGES IN CHILDREN AGED 13-59 MONTHS AND COMPARED TO COUNTRY-WIDE LEVEL

	Program: Bafut-Bawum		Control: Manji			
Age, Months	Sample Size	Percent Low	Sample Size	Percent Low	P Value or Trend**	Cameroon, Country-Wide
13-59	125	1.6%	64	0%	Trend: Program Higher	11.0%

* Low Arm Circumference: Less than or equal to 13.5 cm.

** Statistical analysis not possible when there are zero cases.

TABLE IV - 13

PREVALENCE OF UNDERWEIGHT BY AGE GROUPS IN PROGRAM AND CONTROL VILLAGES COMPARED TO NATIONAL SURVEY DATA FOR CAMEROON

Age, Months	Program: Bafut-Bawum		Control: Manji		P Value or Trend**	National Survey, Range for Age Group
	Sample Size	Percent ≤ 80% Wt. for Age*	Sample Size	Percent ≤ 80% Wt. for Age*		
7-12	24	8.3%	4	0%	Trend: Program Higher	16.4 - 25.7%
13-24	47	6.4%	21	9.5%	Trend: Control Higher	24.9 - 26.3%
25-36	45	8.9%	11	0%	Trend: Program Higher	18.6 - 22.9%
37-48	25	8.0%	14	28.6%	Trend: Control Higher	19.9%
49-72	12	16.7%	34	17.6%	Trend: Groups Similar	20.8%

* Underweight: 80% and under weight-for-age of reference median.

Ages and percentiles calculated using the Ahlers Program. Measurements conducted by team.

** Statistical test not applicable for sample sizes of 30 or less; therefore, trends are indicated for the reader's assistance.

TABLE IV - 14

COMPARABILITY OF PROGRAM AND CONTROL VILLAGES FOR FACTORS RELATED TO NUTRITIONAL STATUS

Factor	Program Sample Size	Program Percentage	Control Sample Size	Control Percentage	P Value*
DEMOGRAPHIC					
1. Household size more than 10 members	90	16.7%	47	12.8%	N.S.*
2. Birth Order	132		90		
1-4		56.0%		66.7%	N.S.
5-8		37.9%		33.3%	N.S.
9+		6.1%		0%	<.05 Assumed base
3. Age Distribution	163		93		
0-6		9.2%		8.6%	N.S.
7-12		16.6%		5.4%	<.01
13-24		26.9%		22.6%	N.S.
25-36		24.5%		11.8%	<.01
37-48		13.5%		15.1%	N.S.
49-72		7.4%		36.6%	<.001
		100.0%		100.0%	
4. Sex	136		103		
Male		53.7%		44.7%	N.S.
Female		46.3%		55.3%	N.S.
5. Marital Status of Mother	91		48		
Monogamous		73.6%		64.6%	N.S.
Polygamous		14.3%		25.0%	N.S.
Not Married		7.7%		8.3%	N.S.
Sep./Wid.		4.5%		2.1%	N.S.

* N.S. Difference not statistically significant.
P Value - Level of statistical significance.

TABLE IV - 15

COMPARABILITY OF PROGRAM AND CONTROL VILLAGES FOR FACTORS RELATED TO NUTRITIONAL STATUS

Factor	Program Sample Size	Program Percentage	Control Sample Size	Control Percentage	P Value*
SOCIO-ECONOMIC					
1. Occupation of Head of Household (Father)	80		43		
• Farmer Food Crop or Unemployed		7.5%		2.3%	N.S.
• Cash Crop		10.0%		4.7%	N.S.
• Laborer		41.3%		55.8%	N.S.
• Profess'l or Other		41.3%		37.2%	N.S.
2. Occupation of Mother	90		47		
• Farmer Food Crop or Unemployed		88.9%		83.0%	N.S.
• Cash Crop		0%		0%	
• Laborer		0%		0%	
• Profess'l or Other		11.1%		17.0%	N.S.
3. Household Structure	76		47		
• Tradit'l: Wall-Mud Roof-Thatch		9.3%		6.5%	N.S.
• Improved: Wall-Mud Roof-Tin		69.7%		87.2%	$<.02$
• Concrete: Wall-Bricks Roof-Tin		21.1%		6.4%	$<.02$

* N.S. Difference not statistically significant.
P Value - Level of statistical significance.

TABLE IV - 16

COMPARABILITY OF PROGRAM AND CONTROL VILLAGES FOR FACTORS RELATED TO NUTRITIONAL STATUS

Factor	Program Sample Size	Program Percentage	Control Sample Size	Control Percentage	P Value*
SOCIO-ECONOMIC					
4. Livestock Ownership	91		48		
5+ Sheep		0%		0%	
5+ Goats		14.3%		12.5%	N.S.
5+ Pigs		6.6%		4.2%	N.S.
5. Someone other than mother present at time of interview	91	6.6%	48	39.6%	<.001
6. Mother illiterate	91	50.5%	48	43.8%	N.S.
7. Mother: Little or no education	91		48		
0 Years		45.1%		39.6%	N.S.
1-5 Years		8.8%		14.6%	N.S.
HEALTH AND HEALTH SERVICE UTILIZATION					
1. Child: Recent Onset of Fever, Gastro'l Upset or Other Illness	122	28.7%	83	24.1%	N.S.
2. Child with Estimated Date of Birth (e.g., no birth certificate or clinic record of date of birth)	176	7.4%	94	13.8%	N.S.

* N.S. Difference not statistically significant.
P Value - Level of statistical significance.

The socioeconomic status of the program group was significantly better than the control group for one indicator. As an example, 21.2% in the program versus 6.4% in the control had concrete houses (Table IV-15). The importance of this result is that the finding of better nutritional status in the program group may be caused by the food aid program or by better socio-economic status.

The choice of the program village appeared to be adequate. Regular CRS program components were present (food ration, growth chart and education). However, most mothers had the Cameroon government growth chart. Only three mothers from the control village were known to the director as attendees of the program clinic. One attended the control measuring session and was removed from analysis.

The control village had formerly (15 months prior to the study) received a CRS food distribution program. This is a limitation of the study. This control village was still the best identified in the field research, despite this limitation. The Manji Government Health Center Services appeared comparable to Mission services.

The rate of known birth dates was high in both the program (92.6%) and control (86.2%) groups (Table IV-16). Thus, the age assessment was reliable.

d. Conclusions: Study of Program and Control Villages

The data provide useful information on the nutritional status of the two villages studied. In general, the program group had better nutritional status than the control group.

Lower prevalences of chronic undernutrition in the program village compared to control may be related to the food distribution program or to better socioeconomic status in the program village. It is possible that SES has been affected by the economic value of the food aid to the family.

Due to the large dilution of the ration which ultimately reaches the child, and the apparent ineffectiveness of the educational program, it is difficult to conclude that the impact may be due to the food distribution program.

Lower levels of acute malnutrition in the control group may be influenced by selection out of the sick for a call-out without food or other more valuable incentive.

These results are not conclusive regarding nutritional impact for the following reasons: inadequate documentation of receipt of program components by beneficiary family; coverage of program too small (one center of 130), sample size too small in one groups,

lack of longitudinal data; control group had a program 15 months ago; lack of house-to-house subsampling to verify that children who came to both program and control site were representative of each village population as a whole.

Overall, the findings are consistent with the National Survey in that the primary nutrition problem is one of chronic rather than acute or severe malnutrition.

3. Study of New Entrants and Program Participants

a. Introduction

The second type of study to determine if there is an impact on children attending the food program was a comparison of children in the program to children entering the program for the first time. This type of evaluation strategy involves using "internal controls"; that is, children who are already in the program can be used as their own control. This strategy is recommended by CRS for ethical and economic reasons. (5)

b. Methodology of New Entrants/Participants Study

The team collected data from CRS and GURC growth cards during regular clinic distribution day in six Northwest and three Southwest clinics. Data taken from growth cards were date of birth, weight measurements and the clinic assessment of the weight-for-age percentile. The team calculated age and weight percentile using the Ahlers program for 95% of the measurements used for this analysis. The data collection instrument is shown in Appendix 3 and the methodology discussed in greater detail in Chapter Three.

A participant was defined as a child who had been in the program for a year and who had attended at least 8 out of 12 possible visits for a 66% attendance rate. A new entrant was defined as a child entering the program for the first time. Data were tallied on each child at several points in time: at first entry, the day of the team's visit, and one year prior to the team's visit (when possible). Therefore, the new entrant data were historical for part of the sample. Also, 16% (12 out of 72) of new entrants later entered the participant group.

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(5) "Control Groups for Food and Nutrition Programs Impact Studies," F. Jacob, in Whither Title II, Catholic Relief Services, 1980, Appendix II.

Data regarding other factors known to affect nutritional status, such as socio-economic status, maternal factors, etc., were not available on the growth cards and therefore were not collected.

A possible bias of this design is that the participant group is "selected" for better nutritional status because high attendance rates in this evaluation and in other studies have been associated with better nutritional status. The new entrant group contains both future "irregular" attendees and "regular" attendees.

c. Results of New Entrants/Participants Study

Table IV-17 shows the prevalence of children underweight in participants compared with new entrants by age. While not statistically significant, the participant group has persistently lower rates of underweight children. The participant group had 6.9%-18.5% less underweight children than the new entrant group.

The age composition of the two groups was compared and found to be statistically the same, so the data were combined for all ages (13-60 months) in Table IV-17. The combined group of participants had 6.9% less underweight children than the new entrant group.

d. Conclusions: New Entrants/Participants Study

The children participating in the food distribution program had better nutritional status than children entering for the first time. Though not statistically significant, this trend was seen in all age groups except in 13-24 months.

Because other factors associated with nutritional status cannot be accounted for, it is not possible to definitively state that this difference is caused by the food program.

TABLE IV - 17

PREVALANCE OF UNDERWEIGHT IN PARTICIPANTS IN THE CRS FOOD DISTRIBUTION PROGRAM COMPARED WITH NEW ENTRANTS IN THE PROGRAM BY AGE

Age, Months	Participants Sample Size	Participants Percent ≤ 80% Wt. for Age	New Entrants Sample Size	New Entrants Percent ≤ 80% Wt. for Age	P Value*
13-24	77	18.0%	43	18.6%	N.S.
25-36	31	6.5%	16	25.0%	**
37-60	16	18.8%	13	30.7%	**
13-60	124	15.3%	72	22.2%	N.S.

* P Value = Level of statistical signficance.
N.S. = Not significant.
** Test not applicable for sample sizes less than 30.

Data Sources: CRS or SUKC Growth Cards. Data collected during team visit on distribution day at Oku Elak Health Center, Nso PMI, Santa Health Center, Shisong Mission, Bali Catholic Mission, Mudeka Health Center, Banga Bakundu, and Tole Tea CDC. Ages and weight-for-age for Oku Elak, Nso and Santa calculated by team.

4. Feasibility for Future Nutrition Impact Study

a. Introduction

The team prepared an assessment of feasibility for conducting a countrywide representative evaluation of nutritional impact of the CRS program. The USAID Mission requested that the team write up such a feasibility report for use in pursuing their objective of eventually undertaking a field sampling of anthropometric data from matched program and control sites that would be generalizable to the entire CRS program in Cameroon.

With the principal purpose of determining whether suitable control areas could be found for comparison to CRS program areas the team proposed to write up: the criteria employed for identifying control villages under field conditions; the types of problems encountered including ethical considerations; and the workability of the "call-out" sampling technique.

b. Methodology

Based on the criteria for comparability (see Chapter Three), the team identified prior to departure for the field, a list of potential program/control village pairs for the Southwest, Northwest and Eastern Provinces. CRS advised on this preliminary selection, and team members consulted with field workers available in Yaounde as to accessibility and validity of selection.

Further refinement of suitability of the program/control pairs was made in the field and included:

- Interviewing CRS provincial staff to learn more about the programs in villages;
- Determining any outlying villages being served by CRS program sites;
- Research on comparability of control villages through work with Provincial Chiefs of Preventive Medicine, Divisional Prefects, and Community Development Officers (Ministry of Agriculture), Community Development Corporation officials in Southwest, and Fons in Northwest;
- Solicitation of further suggestions for control villages from the above sources; and

- Site visits to potential program and control villages to make final determination of appropriateness of program and comparability of control according to criteria in Chapter Three. The site visit also included walking through villages and getting superficial information about appropriateness of control such as type of dwelling, latrines, distance from major roads, and occupation.

c. Results: Nutrition Impact Feasibility

The team rejected at least 12 pairs of program/control villages in the Southwest and 17 pairs of sites in the Northwest once on the scene. The villages and the reasons they were found unsuitable are listed on Tables IV-18 and IV-19. Principal reasons for rejections were:

- Program villages: food program had begun too recently; the GSS system had not been used in preceding six months.
- Control villages: different level of health services; distance from main road dissimilar; different HOH/mother occupation.
- Both: current measles epidemic; potential sample size too small (< 30).

The major obstacle was program saturation of the area. The control villages identified as good matches with a program village were touched by the program to some degree. This information was rarely obtainable in advance of a site visit. Both in the Southwest and the Northwest, CRS MCH distribution sites serve numerous villages within a radius of 10-20 km. The program has saturated accessible roads in the Southwest and the Northwest. The degree of saturation is indicated in Tables IV-20 and IV-21, which list neighboring villages served for selected villages.

The average time required to make a site visit assessment in the rainy season was one day per village. The villages of Etam, Nganjo, Kombone in the Southwest and Mbakon, Befang, and Misaje in the Northwest were visited by the team and rejected as potential impact sites for reasons stated above. The location of these villages in Cameroon is shown on maps, Figures III-3 and III-4 in Chapter Three.

The team tested the "call-out method" as a sampling technique in two villages, Santa and Manji, with the help of the chief and his messengers. Time did not permit carrying out a house-to-house subsample verifying representativeness. This exercise requires mapping the area, portable equipment suitable for use in homes and flexibility of schedule to find mothers at home in the evening.

TABLE IV-18

PROGRAM/CONTROL MATCHES CONSIDERED AND REASON(S)

FOUND TO BE UNSUITABLE IN SOUTHWEST PROVINCE

	Pair Considered		Reason for Rejection
1.	Program: Mudeka Control: Mondoni		Mondoni is 6 km to Mudeka; Mothers go to Mudeka
2.	Program: Banga Ba Kundu Control: Mbalangi		Mothers of Mbalangi go to Banga Bak Clinic
3.	Program: Mabeta CDC Control: Batoke		Batoke found not to be a CDC camp; also, Batoke mothers go to Victoria PMI
4.	Program: Mabeta CDC Control: Bonjongo		Bonjongo found not to be a CDC camp; Bonjongo open only since February, 1981
5.	Program: Bimbia CDC Control: Bota CDC		Bota mothers go to Victoria PMI for food
6.	Program: Kombone HC Control: Etam		Kombone - People mostly traders; - Tribe: Bakundu Etam - People work at French saw mill; - Tribe: Bakosi - Mothers go to Fiango HC for food
7.	Program: Kombone HC Control: Nganjo		Mothers from Nganjo to to LOBE PMI; some also go from Nganjo to Kombone; Tribe of Nganjo is Mbonge; occupation Nganjo: Farming
8.	Program: Kombone		As potential for study of participants vs. non-participants; not feasible because town too dispersed along road
9.	Program: Kompone Control: Buta Matoh		Buta Matoh determined to be isolated village not comparable to Kombone; level of health services was high in Kombone and low (no services) in Buta; Buta-isolated; Kombone-on main road

TABLE IV-18 (cont.)

10.	Program: Control:	Kombone Bumboko	Bumboko determined to be too isolated to compare to Kombone; Bumboko is collection of several tribal groups - not homogeneous group
11.	Program: Control:	Debundsha Bakingili	Bakingili found to be 8 km from Debundsha; mothers go to Debundsha for food
12.	Program: Control:	Bonjongo HC Batoke HC	Both villages same to be (Bukawarian) Bonjongo - has had food program -only since Feb. 1981

TABLE IV-19

PROGRAM/CONTROL MATCHES CONSIDERED AND
REASON(S) FOUND TO BE UNSUITABLE IN NORTHWEST PROVINCE

	Pair Considered	Reason for Rejection
1.	Program: Bafut Mission Control: Mbakon	Level of health services - lower in Mbakon than Bafut
2.	Program: Missaje HC Control: Dumbo	Found that 1/3 of mothers attending Missaje Clinic are from Dumbo; level of health services lower in Dumbo (outpost only); current measles epidemic in area
3.	Program: Widikum Control: Betang	Site visit attempted to Widikum; Vehicle became mired in mud and could not continue
4.	Program: Mmen Control: Essu	Essu 1/2 size of Mmen
5.	Program: Kumbo Control: Neighboring Village	Kumbo area well-covered by centers
6.	Program: Tatum Control: Mtumbolo	Tatum on main road; larger than Mtumbolo
7.	Program: Mbot Control: Mbinka	Mbot size 3 times that of Mbinka
8.	Program: Missaje Control: Berabe	Food habits different in Berabe
9.	Program: Batut Mission-Mambuh Controls suggested by Ministry of Agriculture, Divisional Delegate and reasons for rejection:	
10.	Mankanikong	Served by Mobile Clinic from Mambuh
11.	Mbebili	Served also by Mobile Clinic
12.	Mankwi	Served by Mobile Clinic from Mambuh

TABLE IV-19 (cont.)

13.	Buwe	Has only health outpost - level of services different
14.	Boukari	Outpost only
15.	Nchum	On main road; no health services at all
16.	Njibijang	On main road; no health services at all
17.	Program: Verkova Control: Jakiri	Discovered no program in Verkova

TABLE IV-20
List of Neighboring Villages Served by Programs

Province	Center	Neighboring Villages Served (When info collected)	
NW			
	BAFUT CATHOLIQUE	Akofunguba	
		Njindom	Mobile
		Mankanikong	Clinics.
		Enyah	
		Mambu	
		Bawum	Served by Main
		Nsoh-Mbebili	Center.
	ELAK OKU	Mbom	
		Jiyane	
		Lui	
		Ngashia	
		Kiyon	
	TATUM	Memfu	
		Tatum area	
		Mbaru Ndjeru, Mbaru Ngendzen, Mbaru Wooh, Mbaru Talong, Mbaru Song, Mbaru Tansam.	
		Sangfir	
		Mah	
		Kishong	
		Ngarum	
		Ntumbau	
		Nseh	
		Mbaku	
		Njong	
		Sasah	
		Konifem	
	BALI CATHOLIQUE	Exs: Pinyin, Batibo	
	SANTA	1) Njong	
		2) Mbei, Santa Mbei.	
		3) Santa Akum, Nko Mbou	
		4) Santa Mbu, Miwah	
	MISAJE	na	
	JAKIRI	na	
	SHISONG	Exs: Nkambe, Ndop.	
		Mobile clinics: Nwem, Sob; Nkar, Yocovi and Wainamah	

TABLE IV-21

List of Neighboring Villages Served by Programs

Province	Center	Neighboring Villages Served (When info collected)
NW	NSO PMI	na (Tobin)
	BAMESSING	Exs: Babakitungo Bamali
SOUTHWEST		
	MUDEKA	na
	TOLETEA	na
	VICTORIA	na
	MUKONJE	
	BANGA BAKUNDU	parameters: Ediki and Malendi
	BUEA BOKWANGO	na
	MUEA	na

In the Manji area, where the call-out was tested, clinic personnel estimated that 50-75% of children in the village came as requested for measuring. The same call-out technique in the Santa area brought out only children attending a nearby CRS food program. Reasons given by the chiefs' messengers that other mothers did not come were: more time needed for advance notice (4 days not enough); village misunderstanding of the purposes of the measurement; and villagers not used to attending a health clinic.

d. Conclusions

It is extremely unlikely that untouched control areas to match CRS program villages in the Northwest and Southwest for a representative study can be identified, assuming adherence to the criteria considered minimal for adequate comparability.

The rainy season not only dampens the enthusiasm of drivers but greatly lengthens the time needed to complete field work. The Title II program does continue to function for the most part during the rainy season and only because food has been delivered in advance over roads that become impassable for large parts of the day in the rainy season. With sufficient time to wait for opportune hours for travel, a four-wheel drive can usually get through to most villages.

Other factors affect the field time needed in or out of rainy season. Completing minimal protocol is ethically important and time consuming. The time needed to await "rest days" is important and when it is essential to see mothers at home, only a few evening hours may be used from the day.

Sufficient preliminary study and consultation should be allowed for determining the appropriate incentives acceptable in the culture and correct in the context of anthropological ethics, i.e., the concern should go beyond finding incentives that are effective in bringing people out. The team did not obtain a good reading on this and was not convinced that the material rewards considered -- tea, sugar -- were correct. They therefore relied on the persuasion of a prestige figure (the Fon) and that this did not work may have been due to a number of reasons:

- It was incorrect to assume the Fon's persuasion would work;
- The message was not delivered correctly to the people; and
- The time allowed was too short or too long.

The success of the call-out technique may be directly related to the incentive adequacy.

The team was unable to test their preferred incentives for a control area:

- Go into an area where CRS would eventually establish a program but had not yet (the East); or

- Provide a group with a regular monthly distribution which would be the equivalent "incentive" given the program group -- the cooperation of CRS would have been needed for this.

5. Recommendations on Nutrition Impact Studies Made and Feasibility for Future Studies

The recommendations for nutrition impact studies made during the course of this evaluation and the recommendations for feasibility for nutrition impact studies to be carried in future by the USAID are so closely interrelated, they have been presented together in this section.

a. If USAID continues to consider the use of control areas necessary for a definitive nutrition impact evaluation, it is recommended that USAID pursue such a study in the Eastern Province utilizing sites where CRS plans to initiate a program (ethical and incentive considerations thereby dealt with) and undertake a longitudinal study of children as they enter the program. Working in the East has the advantage of good chances for virginal control areas and the disadvantage of the CRS program being relatively new there.

   * It must be noted that the expense of longitudinal studies and the methodological problem of "lost to follow up" are likely to be significant disadvantages.

b. If USAID continues to consider it moreimportant to study only the Northwest and Southwest Provinces where the CRS program has been operating for 10 years or more, then it is recommended that the Mission compromise on a different evaluation approach, e.g. using an internal control. Actual measurements could be taken and a comparison made of participant children for varying lengths of time in the program. To be meaningful, it is recommended that regular and irregular participants be identified and treated separately.

c. It is recommended that the concerned agencies in Cameroon--CRS, USAID and GRUC/MOH--meet to determine agreed specific nutritional status objectives they consider desirable and attainable for the program and evaluate the program against those objectives. Otherwise, impact results may be controversial and not serve the consensus of purpose and expectation.

d. It is recommended that field work be scheduled during the most favorable weather to facilitate travel on dirt roads and to permit the best utilization of team time.

e. It is suggested that some of the field protocol be dispensed with by advance courtesy letters sent to all of the concerned officials. It is recommended, however, that time be allocated for carrying out some protocol visits and for fulfilling the travel check-in requirements that any accompanying Government staff have.

f. The feasibility of further impact studies should be field tested before developing a final design and work scope.

g. It is recommended that the impact results reported herein, which suggest a general positive trend that program participants are in better nutritional status than non-participants, not be utilized as conclusive evidence for decisions about terminating or expanding the program. It is recommended that the Mission could make use of the results as a basis for projecting quantitative nutritional status improvements that might be expected from the program.

h. It is recommended to USAID and AID/W that, given the complexity of determining the causes of results obtained, the adequacy of components should be documented in Title II evaluations worldwide and in future Cameroon studies. Preferably, a preliminary assessment of quantity and quality of program components should be made prior to allocating funds for widescale (expensive) representative studies.

i. It is also recommended that the question of self-selection (of a healthier population into the program) be studied to determine characteristics of the participants vs. non-participants; to measure the ability of individual mothers to manage family resources and child care, and to decide the appropriateness of institutions such as MCH centers as vehicles to the neediest.

j. It is suggested that all parties consider the practicalities of providing food against seasonal shortages rather than on a year-round basis.

k. It is further suggested that regular program attendees might be seen less and weighed less frequently than monthly in order to free time for reaching the needy and malnourished with a minimal (less than MCH) package of perhaps food plus immunization.

It is suggested that irregular attendees need not be separated or stigmatized but that expectations should be lower and the reporting should be separated for those who might be referred to as irregular chronic needy.

E. REACHING THE NEEDY

1. CRS Policy on the Needy

a. Selection of Areas to Serve

CRS' policy, at least in Africa, is to select distribution sites according to the requests that are received from centers willing to cooperate and support the program. Thus, CRS' capability to select the poorest areas and populations is limited by the willingness and ability of local (distributing) agencies to participate in the program. CRS' experience has been that food resources alone do not always elicit local agency interest in the program. (6)

In Cameroon, CRS has begun in the last two years to open centers in the Eastern Province which has more pressing needs than the Northwest and Southwest and the agency has stated its interest in working in the Northern Province (if USAID agreed to a beneficiary increase sufficient to make the move worthwhile in terms of cost-effectiveness and, presumably, if Outreach funds were to be approved in support of such a move).

CRS/Yaounde stated in its FY 1982 Program Plan that "Continued efforts will be made to reach those in isolated and peripheral areas by encouraging out-stations operated by personnel attached to hospitals or more urban centers."

b. CRS Definition of Needy

CRS does not see the need to distinguish needy within a population because in CRS' view, all are needy. "Needy" is defined as a subsistence population which must spend a high percentage of income in food and necessities to survive.

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(6) Interview with Father Carlo Capone, August 13, 1981, New York City. Father Capone emphasized that there is more food available than "legitimate requests"; a legitimate request is one from a recipient who is prepared to pay in productive services or prepared to guarantee improved nutritional status in children. Extending this point to the global level, Father Capone stated that there is no CRS world-wide strategy (in light of impending budget tightening) because CRS is not free to concentrate food aid where they would like, but rather must respond to requests from those willing to pay administrative expenses and accept program requirements.

2. Clinic Policies on Reaching the Needy

In practice, the team observed actual cutbacks, or plans to cut back work, in mobile clinics (7) or outposts because health staff were finding beneficiaries more interested in the food than in preventive care. While some clinics reported home visiting carried out by the MCH or perhaps by Community Development workers, it was clear that reaching into the community to find the needy and malnourished was neither a priority nor practical given the usual clinic overload with those who already came. Health personnel thought that the mobile clinics or outposts reached populations in more serious need and agreed that the system necessarily favors those within closest proximity since the attendees pay less for transport in money or time, and health staff make more efficient use of their time in the MCH clinic.

Populations who attend the MCH centers where CRS distributes food in Cameroon are not likely to be the poorest and most malnourished in the geographical sites selected. (8) One of the clinics visited (Banga Bakundu) had separate Swiss-donated milk which staff gave to the

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(7) Shisong Clinic in the Northwest is a case in point. Detailed notes on field observations and interviewing with regard to outpost efforts are in Appendix 7.

(8) Some food aid critics speculate that the old family feeding is the new MCH. Family feeding delivered food to the needy who came to get it without, as Dr. Capone has stated graphically, "having to sit on a scale or come dragging a plough" to be eligible. It can be argued, as CRS might, that the program reached further into deprived areas where the makings of a minimal program did not have to exist for eligibility. Design of the MCH program was not merely based on the desire to target food to the most vulnerable members of the family but on the expectation that valid MCH programs would assure the concentrated delivery and utilization of resources. It was also based on an awareness that food aid may be wasted without simultaneous attention to child health and it assumed that MCH networks would provide the essential, largely preventive, health care. The current Food and Nutrition program seems to be straddling those two concepts, the first primarily humanitarian and the second more "developmental." OFFP appears to recognize the need for a bridging period in its permitting CRS to experiment with increased rations with an intermediate goal of increasing family revenue before being expected to produce an impact on the targeted family members.

extremely needy who came from long distances sporadically. This represented an attempt to separate "program" from irregular attendees. The example was also a reminder that "good" program beneficiaries are not necessarily the neediest. For the most part, CRS meets welfare demands of those who are not able to participate in the MCH programs with food donations given by EEC.

3. Criteria for Attendance at Clinics

Believing that "Title II programs cannot be forced on beneficiary households" (Capone), CRS policy is to admit all who wish to attend and are willing to make the payment of 100 CFA or about $.28 for a ration. The attendees are mothers/caretakers who can pay the fee, who hear about the program and are able to, or wish to, spend one-half to one full day at the clinic.

In most of the interviews with clinic personnel, the team members heard the health staff express the satisfaction that the program did not distinguish between the rich and poor, that it was food for everyone. Only upon the special initiative of a clinic was preference given to malnourished children over healthy children. Clinic midwives and nurses guessed that many mothers with malnourished children do not come to the clinic as they do not understand the merits of food and are "ignorant." Some health workers estimated there were from "few to many" very poor mothers who might need the food ration but did not come to the clinic because they could not afford the $.28 fee.

CRS had no consistent policy on providing rations to the poor who say they cannot pay. Some centers made no exceptions in case of evident extreme need; others allowed five exceptions per month. It is CRS' viewpoint that paying the fee causes the parents to appreciate the program more; and if more exceptions were made they would all say they were unable to pay.

No eligibility criteria exist for graduating children who are in normal nutritional status, except in rare instances of extreme duress of too many beneficiaries to handle. Th policy is to allow children to stay in the program from six months until reaching school age.

4. Status of the Needy and Coverage

a. Geographic Areas of Need in Cameroon

The geographic areas in greatest need as measured by per capita income (CDSS, FY 1982) and prevalence of serious malnutrition (Nutrition Survey, 1978) are the Northern and Eastern Provinces, followed by the Northwest, with rural subsistence areas the most deprived.

Sixty percent (60%) of CRS beneficiaries are in rural areas of the Northwest, with another 24% in the Southwest, and the remainder for the most part in the East.

b. CRS Coverage of Malnourished

CRS food distributions reach an estimated five percent (5%) of the 3-59 month old population in Cameroon, as shown in Table IV-22. In terms of children under 80% weight-for-age, using the CRS criterion for below-normal child growth, the same Table shows that CRS beneficiaries constitute about two percent (2%) of the 273,341 infants and children in this underweight category. The potential coverage of malnourished children is 13-26%. (9)

In the Provinces where CRS distributes food, Table IV-22 shows the extent to which the programs cover the estimated underweight 3-59 month old population: 10% in the Northwest; 5% in the Southwest; and 4% in the East.

c. The Needy Among Program Participants

The team conducted several studies, each of which pointed to the fact that the participation of program attendees was characterized as regular and irregular attendance at clinics. This conclusion was arrived at by gathering of data from independent sources suggesting that overall participation actually was far greater than the "programmed participation." Further analysis of data pointed to the fact that a characteristic of the irregular attendees was significantly poorer nutritional status. Pursuit of this point was important for policy and operational reasons: some theories suggest that it is best to focus resources on those who will take advantage of them and use them appropriately (e.g., as would regular attendees); also, implementation of a "contractual agreement" with mothers for their child to grow could imply that poor users of the program (those not keeping an agreement) would simply be excluded from the program. The team wishes to clarify what the status of poor users of the program might be, because results certainly suggest that those who might need the program the most are those outside the program, or those marginally using the program. Further, it appears that a simple indicator, poor attendance rate, has identified a high risk population within the larger population of attendees, and it is based on data most readily available to the clinic: child growth cards.

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(9) CRS reports 35,000 "programmed" or "averaged" beneficiaries in the program which the evaluating team has estimated to mean approximately 70,000 real beneficiaries. (See next sections.) Were these beneficiaries all malnourished, 3-59 month old infants and children, they would represent 13-26% of the 273,341 children estimated to be in that category.

TABLE IV - 22

Numbers of Children Attending CRS-MCH Centers in Eligible Age Group and under 80% weight for age compared to the overall population in the Age Group and Estimated number in population under 80% weight for age.

Province or City	Total Population (adapted from 1976 Census)	Estimated # of Children 3-59 Months of Age (1)	# of Children Attending CRS-MCH Centers in 1981 (2)	% of Total Children of Eligible Age Attending CRS-MCH	% of Children 3-59 Months Under 80% Weight/Age	Estimated # of Children Under 80% Weight/Age (3)	Estimated # of Children Under 80% Weight/Age in CRS-MCH Program (4)	% of Total Children Under 80% Weight/Age Served by Program
Central South Excl. Yaounde	1,154,594	207,827	negl.	-	14.8	30,758	NA(6)	NA
East	366,235	65,922	9,550(5)	14	21.2	13,975	500(7)	4
North	2,233,257	401,986	-0-	-	27.3	109,742	-	-
Southwest	620,515	111,693	17,080	15	19.1	21,333	1,015	5
Littoral Excl. Douala	451,890	81,340	-0-	-	16.7	13,584	-	-
Northwest	980,531	176,496	43,370	25	15.5	27,357	2,814	10
West	1,035,597	186,407	negl.	-	21.9	40,823	NA	NA
Yaounde	344,663	62,039	-0-	-	8.3	5,149	-	-
Douala	475,964	85,674	-0-	-	12.4	10,620	-	-
TOTAL	7,663,246	1,379,384	70,000	5		273,341	4,329	2

(1) Estimated at 18% of the total population.
(2) Estimated at double the averaged beneficiary figures provided for the period April 1980 to March 1981 (Table IV-28). Extrapolated for provinces from Tables IV-26 and IV-27.
(3) Based on data in the National Nutrition Survey.
(4) Extrapolated for two provinces from master chart data compiled on 40 centers averaged over a four month period in NW and SW provinces.
(5) Estimates for approximately 20 centers, no figures given.
(6) Data not available.
(7) Data Not available. Estimated.

The team notes at this point that no causal association of any sort is being proposed between attendance rate and nutritional status or program impact. Further, it is fully recognized that attendance rate may be a surrogate for other correlates of nutritional status such as socioeconomic status. The point of the analysis is that (1) a higher risk group of children has been identified; (2) these children are characterized by irregular attendance and poorer health status; and (3) an indicator of that risk is identified which clinics may find useful for targeting purposes.

In this section of the report, data are presented which estimate actual numbers of attendees and describe the status of a particular group, irregular attendees, within this group.

- Studies to Estimate and Characterize Attendees

The CRS food program reports serving a programmed 35,000 beneficiaries in 122 centers. Provincial records of Monthly Distributions of Title II Foods report numbers of participants and numbers of new participants by month. The team compiled numbers of participants (and new enrollees) for a four month period for 40 randomly-selected centers, 20 in the Northwest and 20 in the Southwest. Single months were available for the Eastern Province. Averages of participants and new enrollees were then calculated for each center, summed, and extrapolated to the entire program. Tables IV-23 and IV-24 show these data for participants. These data illustrate that there were 21,685, 8,540 and 8,200 beneficiaries for the Northwest, Southwest, and Eastern Provinces. The same procedure was followed for the new enrollees. Table IV-25 shows the averages and extrapolates for the Northwest and Southwest. There were 22,680, 9,240 in the Northwest and Southwest. Data on the East was lacking for new enrollees.

Since Monthly Distribution Reports combine the participants with new enrollees, they must be separated to arrive at a final estimate of regulars plus new enrollees. This separation and calculation of new enrollees as a separate group assumes that the participant group is the same group throughout the year; the average new enrollees per month are multiplied by 12 to reflect the fact that there is a constant influx of entrants who become part of the regular participant group. The team also recognizes that there are probably old enrollees among these figures and that those who have dropped out for a few months may have re-entered the program as new enrollees. Calculation of regulars and new enrollees for the Northwest, Southwest and are estimates for the East are shown in Tables IV-26 and IV-27. These results are summarized in Table IV-28 which show a

grand total of 35,096 "regular" attendees and 39,792 "new enrollees."(10)

A second method based on a different set of data which estimates the numbers of attendees also illustrates that a portion of attendees are irregulars and that the total "participants" is probably 70-80,000 per year. This calculation is based on growth card studies (n=278) showing percentages of children having certain attendance rates and applied to the base estimate of 35,000 "programmed" beneficiaries. This method, which is explained in Table IV-29, shows that there are an estimated 83,628 beneficiaries per year and that 44% of these children are not the same children each month.

To summarize this section of the report, it appears likely that there is a modest corps of regular attendees and a large group of irregular attendees. The total number of beneficiaries is estimated at 70-80,000.

- The Nutritional Status of Children Who Attend Less Often

The team conducted a study of nutritional status using growth cards and records of attendance on those cards. The purpose was to find out if children who attend less often have better or worse nutritional status than regular participants.

The relation between attendance rate and nutritional status is seen in Table IV-30 and IV-31. Low weight-for-age was associated with attendance rates of less than 50% ($P < .05$, Table IV-30) in children 18-36 months. This trend was also evident from other data on this age group shown in Table IV-31. The rate of malnutrition was 8-12% higher in the groups with low attendance rates than in the groups with high attendance rates.

This study shows that the nutritional status of those attending less often is worse and that this group constitutes a needy group within the program.

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(10) This analysis suggests that there are about 50% new children present each month. More precise data by number of months in program suggest that the actual true new enrollees is in the range of 8-50%. Growth card data (n=593) show that 31% of the sample were in the program 1-6 months. Distribution reports show about 8% new each month. The remaining 20-40% are probably irregular attendees.

TABLE IV - 23

Number of Beneficiaries (Averaged for March - June incl., 1981) from Provincial Compilations Monthly Distribution Reports of Title II Food compiled on Randomly Selected Centers in the Northwest and Southwest Provinces

Northwest		Southwest	
Center	Averaged Number of Beneficiaries	Center	Averaged Number of Beneficiaries
Widikum	265	Eyang	91
Mbengwi	611	Tole Tea	777
Mbot	334	Victoria	609
Bamessing	179	Bokwango	172
Nso	471	Banga Bakundu	375
Shisong	1918	Lobe	267
Jakiri	181	Mudeka	153
Banso BBH	344	Mbak Supe	157
Mbiame	133	Mukonje	112
Misaje	304	Mokondange	89
Belo-Kom	964	Tali	257
Santa	415	Konye	126
Nkum Kov	226	Buea	354
Bali Cath.	652	Muea	282
Tatum	211	Bimbia	160
Njottin	1076	Mbonge	180
Elak Oku	129	Mbeta	198
Kmu	205	Idenau	103
Bafut	1192	Misselele	170
	9810		4632
Average = 516		Average = 244	
Extrapolated to 42 operating centers: 21,685		Extrapolated to 35 operating centers: 8,540	

TABLE IV-24

Number of Beneficiaries for Month Available (March-June 1981) from CRS Files on the Eastern Province

Center	Number of Beneficiaries	Month
Abong-Mbang	433	May
Andom Zapi	126	April
Bandongoue	130	April
Batouri Dispensaire	450	April
Batouri Hospital	n.a.	
Belobo Catholique	80	n.a.
Belabo Dispensaire	138	June
Belabo Sofibel	113	July
Bertoua Pediatrie	n.a.	
Bertoua PMI	1000	June
Bertoua Service Social	411	June
Betare-Oya	350	June
Deng-Deng	120	July
Diang Dispensaire	157	May
Dimako Dispensaire	388	June
Dimako Sfid	249	June
Doume PMI	325	March
Enamengal	n.a.	
Garoua Boulai	493	May
Mbang	n.a.	
Mbethen	78	May
Mindourou Haut Nyong	117	May
Mindouion Kader	95	April
Ndelele	n.a.	
Ngoura	179	May
Nkette	n.a.	
Nkol-Muoaln	n.a.	
Ntel SCPL	n.a.	
Sodepr Panch	n.a.	
Tongo Gandima	n.a.	
Ndokayo	123	March
Total	5555	

Average per month = 265

Extrapolated to 31 operating centers: 8,290

TABLE IV-25

Number of New Enrollments (Averaged for March - June incl., 1981) from Provincial Compilations of Monthly Distribution Reports of Title II Food compiled on Randomly Selected Centers in the Northwest and the Southwest Provinces

Northwest		Southwest	
Center	Averaged New Enrollments	Center	Averaged New Enrollments
Widikum	34	Eyang	5
Mbengwi	56	Tole Tea	46
Mbot	29	Victoria	127
Bamessing	42	Bokwango	7
Nso	22	Banga Bakundu	44
Shisong	84	Lobe	12
Jakiri	48	Mudeka	9
Banso	30	Mbak Supe	8
Mbiame	22	Mukonje	20
Misaje	23	Mokondange	4
Belo Kom	172	Tali	26
Santa	40	Konye	2
Nkum Kov	20	Buea	32
Bali Cath.	14	Muea	28
Tatum	16	Bimbia	4
Djottin	50	Mbonge	11
Elak Oku	35	Mbela	16
Nku	33	Idenau	6
Bafut	93	Misselele	13
	45 Average		22 Average
For 12 months: 540		For 12 months: 264	
Extrapolated to 42 centers in the Northwest: 22,680 new enrollees/yr.		Extrapolated to 35 centers in the Southwest: 9,240 new enrollees/yr.	

TABLE IV-26

Estimated Regular and New Enrollments
in Northwest and Southwest Province

	Northwest	Southwest
Averaged Total Enrollment per Month (Table IV-3)	516	244
Extrapolated to (77) operating Centers	21,685 (42)	8,540 (35)
Average New Enrollments per Month (Table IV-8)	45	22
Average Regular Attendees per Month (Total minus New)	471	222
Total Regular Enrollments, year Extrapolated to Total Operating Centers	19,782	7,770
Total New Enrollments, year (New per month x Number centers, x 12 months)	22,680	9,240

TABLE IV-27

Calculation of Estimated Numbers of Regular Attendees and New Enrollments per Year - Eastern Province

Regular + New Enrollments, year (Table IV-7)	8,200
Estimated 8% new per month	656
Total Regular Attendees only (31 centers)	7,544
Total New Enrollments per year (656 x 12)	7,872
Total Participants	15,416

TABLE IV - 28

Estimated "New" and "Regular" Attendees by Province and Total for Cameroon

Province	"Regular"	"New"
Northwest	19,782	22,680
Southwest	7,770	9,240
East	7,544	7,872
TOTAL	35,096	39,792

Program Total: 74,888

Source of Data: See preceding tables for calculation of these figures. Original data source: Monthly Distribution Reports of Title II Foods compiled from Provincial records.

TABLE IV-29

Estimated Numbers of Attendees Based on Attendance Rates

Percent of Beneficiaries++	Average Months of Attendance	Total Beneficiary Months for Year	Number of Attendees
29%**	11	121,800+	11,073
27%	8	113,400	14,175
27%	5	113,400	22,680
17%	2	71,400	35,700
100%		420,000*	83,628

* 35,000 x 12 = 420,000 total Beneficiary months per year

** Percent of total beneficiary months = 29% x 420,000 = Total beneficiary months for each line item.

+ Divide beneficiary months by average months of attendance to get number of attendees: 121,800 divided by 11 = 11,073

++ Source: Growth Card Studies in nine clinics, N = 278.

TABLE IV-30

Current Nutritional Status of Program Children (4 NW Clinics) by Age and by Attendance Rate in Last Nine to Twelve Months *

Age, months	Attendance Rate Last 9-12 months	Weight-for-Age, %of Ref. Med		Percent Below 80%	P** Value
		Below 80%	80 % or More		
18-36	< 50%	6	25	19.3	<.05
	≥50%	10	131	7.1	
37-60	< 50%	4	26	13.3	N.S.
	≥50%	6	38	13.6	

* Ages, weight-for-age percentiles, and attendance rates calculated by evaluation team from data on CRS or GUBC Growth cards using the Ahlers Program. Data collected during team visit on distribution day at Oku Elak Health Center, NSO PMI, Santa Health Center and Bafut Catholic Mission Center at Mambuh in Northwest Province.

** Chi-square test. N.S. = Results not statistically different. P Value = Level of statistical significance.

TABLE IV - 41

Current Nutritional Status of Program Children (2 NW & 3 SW Clinics)

by Age and by Attendance Rate in Last Nine to Twelve Months*

Age, Months	Attendance Rate Last 9-12 Months	Weight-for-Age, % of Ref. Med. Below 80%	80% or more	Percent Below 80%	P Value
18-36	< 50%	3	14	17.6	N.S.
	≥ 50%	2	19	9.5	
37-60	< 50%	3	4	42.8	Trend: Rate higher in Low Attendance Group. Sample size too small for test.
	≥ 50%	2	5	28.5	

* Based on weight-for-age percentiles determined by clinics; ages and attendance rates calculated by team from dates on GURC or CRS growth cards using the Ahlers program. Data from Shissong Mission and Bali Health Center in NW and Banga Bakundu Mission, Mudeka Health Center and Tole Tea CDC Center in SW.

• Chi-square test. N.S. = Results not statistically different. P Value = Level of statistical significance.

c. Children Who Are Needy By Age Group

The Cameroon National Nutrition Survey illustrates that all types of malnutrition, chronic, acute and underweight, peak between 6 and 24 months of age (11), the peak prevalence rates being 28.5%, 3/6% and 28.8% respectively. There is a decline of chronic undernutrition and underweight from 24 to 30 months. Then chronic undernutrition rises to 27.4% from 36-47 months. Underweight ranges from 18.6% to 20.8% after 30 months of age. The most vulnerable age group is 6-24 months of age.

d. The Status of Non-Participants

The team attempted to study participants and non-participants in a community because there is little known about the population entirely outside the program. The team wished to learn something about this group to determine if its needs were greater and if, indeed, the MCH health clinic distribution system was the most likely channel to reach this group. The team measured children at a village school with the assistance of the local chief in "calling out" all villagers. Later it was learned that non-participants had not attended. The team's recommendations regarding this group are found at the end of this section.

5. Conclusions: Reaching the Needy

AID and CRS have different policies regarding who the poor and needy are and the practicalities of reaching them. The regulations themselves are conflicting stating a goal of reaching the most malnourished and needy but suggesting elsewhere that resources may be used better in preventive programs.

The CRS program in Cameroon does not reach the neediest population as defined by socioeconomic or nutritional status.

Potential coverage of the malnourished population is 13-26%. However, these speculations of 13-26% coverage of malnourished are unrealistic in light of: CRS policy; lack of effective delivery routes; undiagnosed social problems that inhibit participation.

There appear to be two large groups of recipients: regular attendees and irregular attendees. The irregular attendees have significantly poorer nutritional status.

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(11) Cameroon National Nutrition Survey, pages 74-77.

Poor attendance rate is an indicator of higher risk for malnutrition and may be useful to clinics in identifying a needy group from among program participants.

The Title II food program in Cameroon appears to be a "nutrition" program for one group of attendees and a kind of stop-gap assistance for another group. "Averaging" them disguises what impact might be made on the core program group.

The actual number of program recipients is conservately estimated at 70,000. Approximately 44% of children in centers are not the same children each month. About 24,000 children receive the program for 7-12 months in a year. About 46,000 receive much less than the intended amount of ration, education and health services.

MCH clinic channels may not be the most effective route to the poorest and most malnourished.

The principle of mother fees in support of the administrative costs of the program seems valid to the evaluators if exceptions can be made for malnourished families.

6. Recommendations: Reaching the Needy

AID and CRS should agree on and provide guidance with regard to priority populations to be reached with Title II; the related question of what should be done about needy who may be poor participants and "irregular" should be answered.

A fair system for assessing validity of needy families without the fees should be established by CRS provincial offices. A stated percentage of fees collected might be set aside for "subsidizing" these families with each clinic/community supporting its own beneficiaries.

The CRS contractual agreement theory implies that the mother attending less often is not keeping her commitment to child growth and therefore should not be allowed to participate in the program. Team data suggested that, in fact, mothers who attend less often have more malnourished children. Dropping irregular attendees from clinic rolls is not a recommended policy.

Too little is known worldwide about the non-participants in Title II program sites. Such a study is recommended to be made in a village where food distributions now occur in order to determine: why non-participants do not come, what their socioeconomic status is versus the rest of the community, what are the likely effective channels to them, the social problems that inhibit participation in service programs, and the desirability of serving these groups in terms of available resources and cost-effectiveness.

CRS initiatives in serving the Eastern Province are to be lauded. This represents an expansion into an area of need and support for this effort is recommended.

F. COST-EFFECTIVENESS

1. Calculation of Costs

The team, due to time constraints and understanding of its work purview in the widest sense, did not audit program costs, as requested by the MOH, to determine whether or not they were actually incurred as stated. The team rather had to be content with an analysis of reports made available by the CRS/Yaounde Office (there were no detailed files readily available in the USAID).

Costs of the Title II food and ocean transportation are those incurred between the period October 1, 1979 and September 30, 1980, utilizing the prevailing Commodity Credit Corporation (CCC) prices and estimated ocean freight for the period.

Other program costs are taken from CRS' Annual Public Summary of Activities and are those incurred during the period January 1, 1980 to December 31, 1980, a slight variation of the 12-month period used above for computing the food and ocean transport prices but representing inland transportation which accommodated approximately the same rate of commodity flow.

The tables that follow, Table IV-32 and IV-33, show the sources and itemized inputs provided by the Government of Cameroon, the United States Government, CRS and the participating mothers, and they show the costs by metric ton and ration and by beneficiary. The cost per metric ton of delivered food to beneficiaries was $786 or $.79 a kilogram and $3.50 for a ration of five kilograms of cereal, NFDM and oil in a 2:2:1 ratio. The cost of delivering a ration to the targeted child, however, must be multiplied by six due to family sharing and comes to $21 a ration.

Actual beneficiaries are estimated conservatively at 60,000. The annual cost is $23.91 per recipient.

Averaged beneficiaries in the CRS program during the period were 30,000, giving an averaged beneficiary cost of $47.82 annually.

These one-year costs compare similarly with those found in recent evaluations. However, to arrive at the costs for treating malnourished children (not necessarily the objective of preventive programs), it is necessary to multiply $23.91 by five (approximately 20% are malnourished or below 80% weight for age), giving a total of $119.60 annually.

CRS Title II - MCH Program, Cameroon

ANNUAL COST OF THE PROGRAM

October 1, 1979 to September 30, 1980 (Rate: 220 CFA = $1.00)

		CFA	$ U.S.
CRS	Inland transport	29,512,120	134,146
	Salaries for three provincial supervisors	6,076,840	27,622
	Personnel, PMIs, 100 centers, 20% time	5,280,000	24,000
	Warehouses and offices for CRS	(in kind)	
USG	Title II foods per attached list (FY 1980)	167 239,380	760,179
	Ocean Transportation	71,890,060	326,773
CRS	Salary, National Supervisor	1,980,000	9,000
	One-time contribution for program upgrading: $80,000 (used for seminars, purchase of scales, etc.) prorated over 10 years	1,760,000	8,000
Participating Mothers	Fees collected in centers for participation and purchase of growth cards. Salaries of all project personnel except national supervisor; (warehouse men, night watchmen, port officials, casual labor, accounting, and tee checkers); per diem of supervisors on tour; rent; CRS provincial office expenses; warehousing; medicine; vehicle maintenance. Container sales' proceeds; Pallets, medicine (Nivaquine), cups and funnels.	31,882,180	144,919
	TOTALS	315,620,580	1,434,639
	Cost per metric ton	172,943	786.10
	Cost per kilogram[1]	173	.79
		135,760,020	617,091
		120,195,240	546,342
		59,665,320	271,206
		315,620,580	1,434,639
Maternal	Beneficiaries in program: 30,000.	Cost per beneficiary per year:	10,520 47.82
Children	Beneficiaries in program: 60,000.	Cost per beneficiary per year:	5,260 23.91

TABLE IV-33

Title II Commodities Shipped to Cameroon, CCC Value and Ocean Freight
FY 1980 and FY 1981

	000 Lbs.	Metric Tons	CCC Value	Ocean Freight	Total Value
FY 1980					
Bulgur	1,730.5	784.9	$ 200,497	$ 118,846	$ 319,343
NFDM	1,533.7	695.7	245,388	133,799	379,187
Oil	760.0	344.7	314,294	74,128	388,422
Total	4,024.2	1,825.3	$ 760,179	$ 326,773	$ 1,086,952
FY 1981					
Cornmeal	1,450.0	657.7	$ 179,320	$ 107,672	$ 286,992
NFDM	1,633.6	741.0	300,523	154,180	454,703
Oil	919.0	416.8	353,411	97,700	451,111
Total	4,002.6	1,815.5	$ 833,254	$ 359,552	$ 1,192,806

Often neglected in calculations is the cost for the total program life -- in this case, approximately five years, since the child is expected to enter at six months of age and, has been determined in the study, normally does not leave until school age. Therefore, the cost per child would be $119.60 for the lifetime program. For the malnourished child, it would mean a cost of $598 for the five-year program.

2. Conclusions

The annual cost for actual beneficiaries as estimated by the team is $23.91. The cost per averaged or programmed beneficiary is similar to costs incurred in other Title II programs in Africa, close to $50 annually. This annual estimate masks: the lessened costs in terms of real beneficiaries; the greatly increased costs in terms of targeted child, in terms of malnourished targeted children, and finally in terms of the total costs for the five-year period during which the child is eligible to be in the program.

If the concerned organizations consider that the CRS/MCH program must produce cost-effective care of malnourished children, the impact does not justify use of the selected vehicle.

3. Recommendations

It seems useless to speculate whether replacement costs for food aid might be better spent on other preventive activities until there is a commitment for doing so on the part of AID. The Government of Cameroon should decide whether the amount it spends in cash and personnel offers an adequate return and if not, what alternative programs it might undertake to achieve similar or, more likely, different objectives.

G. EFFECT ON AGRICULTURE

1. Consultation

The relatively small quantities of Title II commodities are probably neither a critical element in the nutritional status of the Cameroonian population nor do they, given the structural rigidities of local markets, represent a disincentive to Cameroonian producers (Dr. John Schamper, USDA, personal communication).

2. Conclusions

While Cameroon is likely to be closer to agricultural self-sufficiency than many other African countries, there will continue to be pockets of need due to faulty distribution and storage networks and seasonal shortages and the chronic needs of those families in all societies that seem to keep falling between the cracks.

It is important for the GURC to decide whether it can afford to assist these families in the future, and whether it wishes to do so, and where the responsibility should lie.

3. Recommendation

The relevant Ministries who have cooperated with the Nutrition Planning Committee should help decide what the GURC responsibility is with regard to (a) the families that CRS has been assisting, and (b) the families in even greater need than those CRS is and has been assisting, and (c) who should take responsibility for this role.

H. OTHER IMPACTS AND BENEFITS

1. Effect on Clinic Attendance

All interviewed clinic personnel said that Title II food distributions vitally affected the number of mothers who attended clinics, but most thought that some would continue to come without food. Enrollments in clinics which had previously distributed food and had stopped at the time of the evaluating team visit showed significant to drastic reduction in numbers. (12)

In clinics where foods were distributed in Cameroon, the value of the rations most mothers received monthly was $18.20 in exchange for her time plus costs of the ration, transport, purchase of growth chart and containers, which might come to $2 or $3.

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(12) From an enrollment of 400 beneficiaries with Title II distribution, Akum Clinic had dropped to an enrollment of 50-80 at the time of the team visit. Bafut Presbyterian Clinic had an enrollment of 200 with Title II food and that had dropped less drastically to 150 after 15 months without the food.

Nevertheless, attendance rates are often quite low and averaged below 60% suggesting that the Title II food may not always represent a good exchange for her time. Clinic personnel stated that mothers were most often absent during planting and harvesting times and that they favored going to work in the fields. This could mean that they went to the fields when the economic return there was, or seemed to be, higher. This might be a pattern to encourage rather than discourage so as not to interfere with production at the family level.

That mothers come principally for food (they stated that food was the most important component in the clinic package in interviews) is deplored by some health staff while CRS/Yaounde (Kelleher) suggested that increasing clinic going habits was a step toward acceptance by the population of preventive medicine. The MOH (Joe) reinforced the interest of the Ministry in expanding preventive health care in the rural areas of the country. CRS/New York/Nairobi (Dr. Capone) has suggested that improved clinic attendance is not a valid objective of food aid, arguing that this objective could be more cost-effectively achieved through other means. The team questioned whether in fact there would be other resources available for such an incentive, should it be deemed desirable, and speculates that non-food aid might lead to even less nutritional input into the household.

2. Conclusions

a. Beneficiaries value the food component of the MCH package above other services. Clinic personnel and others consider food to be a highly effective incentive for increased enrollment but are not always pleased that mothers/caretakers come principally for the food.

b. Despite the value of the rations received by attendees worth about $18 in exchange for $2 or $3, attendance rates of 60% and less allow us to speculate that this is not always a good trade-off for agricultural returns. Health staff further ventured the opinion that mothers preferred to be in the fields (when economic balance tipped that activity in favor of the food provided in the clinic).

c. The program is too young to demonstrate that preventive health habits have been affected. Mothers do not yet attend primarily for health care, but the reason may be that the available health services and quality of education are not always compelling reasons for her to attend.

3. Recommendations

a. If the Ministry of Health considers introduction of preventive health to be sufficiently important, they should improve the services offered so that they are as attractive and beneficial as traditional medicine.

b. The MOH and USAID should decide whether it is effective to use food as an incentive toward better utilization of rural health services.

c. If food is to be considered an incentive for clinic attendance, it should be used to ensure an attendance perhaps more in line with the needs of children -- i.e., less frequent weighings than now effected, especially after the first year of life, and the food should be distributed to meet seasonal needs so that the mothers' values and satisfactory health surveillance begin to coincide.

I. RECOMMENDATIONS ON EXPANSION/CONTINUATION/PHASEOUT

a. In the nutrition impact recommendations above, the team noted that the results obtained in the present study are sufficient evidence of nutritional improvement in program children though the trend in that direction is clear. The team wishes to add its judgment that whatever the results that had been obtained, it would recommend that anthropometric studies in isolation are an inappropriate source for making decisions on Title II expansion, continuation or phaseout. This opinion is taken because of:

- the imperfections of existing data;
- the large expense of collecting new data on a representative country sampling and the obstacles for carrying out this exercise definitively;
- the lack of a sound comparative framework for judging the most deserving countries for food aid; and
- the lack of accepted upon tested methodologies to indicate, for the satisfaction of all effected, that a program is attaining a minimum goal.

b. It is recommended within Cameroon, and for other Title II programs, a first step to more effective program evaluation is to obtain a consensus among concerned and cooperating parties on goals and objectives and whether food aid is seen as an interim or long range program. Phaseout plans, however, for the immediate or eventual future should be a part of this planning. It is particularly important to decide whether food aid is intended to be a/an:

- preventive health program;
- curative program for the malnourished;
- income transfer in neediest communities/families;
- developmental program for educating mothers and using food either as an incentive for attendance or an economic tradeoff for her time.

In Cameroon the central governing contract (GURC-CRS) should state the agreed objectives of the program - and change them when necessary - noting the resources to be supplied by both parties.

With assistance from the MINEP Planning Advisory Service perhaps, the GURC and CRS should set out quantitative targets. It is suggested that for the program as presently constituded, there should be a distinction made between regular program enrollees and irregular occasional needy. In setting targets, there might be

- expected nutritional improvement in regular enrollees or a maintenance of good health (if preventive goals are agreed);
- provision for an expected number of chronic needy who are provided with occasional supplements but for which attendance or improvement is not a condition of continuation.

c. USAID should indicate to the GURC what replacement, if any, it would make in technical assistance if food aid is terminated abruptly; likewise long range input to replace food aid should be indicated so that available resources for similar or modified programs can be assessed.

d. If the program is to continue, CRS with USAID assistance, should make plans for basic improvements in the education component, particularly, and in all key components noted above so that the program can have a chance of producing nutritional improvement or other designated objective.

APPENDIX 1

SYSTEMATICS GENERAL CORPORATION
SCOPE OF WORK FOR EVALUATION
OF P.L. 480 TITLE II
FOOD AID PROGRAM IN CAMEROON

SYSTEMATICS GENERAL CORPORATION SCOPE OF WORK

SCHEDULE

I. Title

Evaluation of P.L. 480 Title II Food Aid Program in Cameroon.

II. Objectives

Evaluations are intended to serve as a management report for (1) clarifying program objectives, and for (2) identifying ways of improving the food delivery system so as to increase benefits to the target groups being served.

The study is expected:

1. To clarify current objectives of the voluntary agency programs.
2. To review and evaluate the program in terms of its contribution to planned accomplishments and objectives.
3. To confirm the validity of program objectives at both the impact and implementation level.
4. To recommend any changes in program directions or implementation -- including the food delivery system -- which would increase its benefits.

Although a review and evaluation of past performance is an objective, emphasis should be given to the analytical and planning aspects pertaining to the future of the program.

III. Statement of Work

The contractor will provide a General Evaluation Specialist and Nutritionist who will carry out the following work. (This scope may be altered following the first week overseas and accomplishment of tasks 1 through 3 below:)

1. Contractor will spend 3 days at FFP/W for initial briefing and to review desired areas of concentration to be taken up during this contract.

2. Travel to Cameroon to confer with USAID/Cameroon, West Africa Regional Food for Peace Office, and CRS Program principals to refine scope of work and methodology.

3. Based on data gathered, contractor will prepare a modified scope of work, specifically suited to Cameroon. Contractor will also determine availability of program data analysis.

4. Review with the cooperating sponsors, AID/W, relevant host government agencies, and USAID/Cameroon the planned outputs and project purposes as defined in available project documentation and as perceived by the principals.

5. Examine the background and current structure of the CRS Title II program in Cameroon analyzing the roles of the voluntary agency and the host government agencies, the range of inputs and outputs, and the target groups benefiting from the program.

6. Assess the policies and practices of the host government, cooperating sponsor and AID to determine congruence and harmony of program and project purposes, strategies and other policy-related matters, and implementation approaches. Also determine the extent to which the CRS/Cameroon program objectives are consistent with overall FFP policy and practices.

7. From secondary sources assess the extent, degree and basic characteristics of malnutrition in the various regions of Cameroon; describe the specific impact (purpose to goal linkage) that achievement of current program objectives is expected to have on the malnutrition problem. (If a problem of varying objectives has been identified, this should be considered in the analysis).

8. Appraise the relation between program inputs and outputs, focusing on how efficiently key functions are performed by the relevant organizations.

9. Assess the contribution to date, and the projected contribution, of Title II inputs/outputs to the improved nutritional, economic or educational status of the various target recipient groups. (Actual measurement of these impacts depends on the availability of data. If data are not available, some inferences can be made, and recommendations should be offered for undertaking surveys or studies or for establishing an information system.)

10. Ascertain the linkages between CRS and host government feeding programs with the nutrition activities and determine to what extent these linkages contribute to the efficacy of the feeding programs.

11. Assess the impact of P.L. 480 Title II commodity importation to Cameroon to determine if it is a disincentive to agriculture production.

12. Based on the above review, prepare a set of recommendations for short-term and long-term actions by USAID/Cameroon, host government, and CRS for improved program effectiveness and operations. Describe the rationale and projected impact of any changes recommended. Areas for recommendations include possible re-direction as to focus of objectives, target groups or geographical areas; structural modifications in the organization and implementation of the program by USAID/Cameroon, host government, and CRS. Recommendations should also be made as to any steps which might be taken to improve host government capacity to meet near-term and future management responsibilities associated with the food delivery system and its objectives.

IV. Relationships and Responsibilities

While in Cameroon, contractor will report to USAID Mission director or his designee.

While in AID/W, contractor will report to Carolyn Weiskirch, PDC/FFP/POD, Room 541, Rosslyn Plaza, telephone number (703) 235-9210.

V. Reports

After completion of field work, contractor will prepare a first draft report in the host country to be discussed with the USAID/Cameroon and CRS prior to departure from the country. Within ten working days after departure, a second draft report (ten copies) will be provided to FFP/W. Following receipt of USAID and CRS/Cameroon comments on the second draft report, a final report (ten copies) will be provided.

APPENDIX 2

CABLE SUMMARIZING WORK SCOPE AGREED UPON
BY SGC CONSULTANTS AND USAID/YAOUNDE IN CAMEROON

Department of State

INCOMING TELEGRAM

PAGE 01 YAOUND 06627 041324Z 2062 068347 AID3875
ACTION AID-25

ACTION OFFICE FFP-02
INFO AAAF-01 AFDR-06 AFCA-03 FVA-02 PPCE-01 PDPR-01 PPPB-03
GC-01 GCAF-01 GCFL-01 OFP-01 PVC-02 AFDA-01 AGR-01
RELO-01 MAST-01 /038 A4 88

INFO OCT-01 AF-10 EB-08 L-03 SP-02 /059 W
346285 051345Z /41

R 040805Z SEP 81
FM AMEMBASSY YAOUNDE
TO SECSTATE WASHDC 0814

UNCLAS YAOUNDE 6627

AIDAC

E.O. 12065: N/A
TAGS:
SUBJECT: PL 480 TITLE II - CRS CAMEROON EVALUATION

REFS: A) YAOUNDE 4937 B) YAOUNDE 2499

1. PRIOR DEPARTURE FROM U.S. KING AND SEATON WERE MADE AWARE MISSION POSITION REGARDING USE OF CONTROL GROUPS, MEASUREMENTS OF HEIGHT AND WEIGHT RANDOM SAMPLING OF PROGRAM AND CONTPOL VILLAGES, AND SAMPLE SIZE OF 200 OR MORE. PER TEAMS CONSULTATIONS WITH MISSION DIRECTOR LEVIN, R. BROWN AND M. GOLDMAN , MISSION RATIONALE WAS STATED TO BE UNRELIABILITY CRS WEIGHTING AND AGE ASCERTAINMENT PROCEDURES. TEAM SERIOUSLY CONSIDERED EVALUATION OBJECTIVES AND METPODOLOGIES OF AID/W CURC, CRS AND USAID/YAOUNDE. HOWEVER TEAM IS CONSTRAINED BY LIMITED RESOURCES TIME LIMITED CRS PARTICIPATION, SHORT RAINY SEASON. THEREFORE TEAM PROPOSED TO STUDY THE NUTRITIONAL IMPACT OF THE MCH PROGRAM IN 2 PROGRAM VILLAGES AND 2 CONTROL VILLAGES ONE PROGRAM/ CONTROL IN NORTHWEST AND ONE OTHER IN 2 SOUTHERN PROVINCE AS THE MAXIMUM IMPACT EVALUATION EFFORT POSSIBLE TO MEET OBJECTIVES OF ALL PARTIES CONCERNED. THIS PLAN WAS STRETCH OF AVAILABLE RESOURCES, BUT TEAM CONVINCED STUDY IS STATISFICALLY VALID AND WORTHWHILE EFFORT FOC THE VILLAGES STUDIED. THIS STUDY IS INTENDED TO ANSWER THE QUESTION CAN THE MCH PROGRAM HAVE A NUTRITIONAL IMPACT ON THE EVALUATED VILLAGES? TWO PROGRAM VILLAGES WILL BE CHOSEN USING OBJECTIVE CRITERIA IN CONULTATION WITH CRS IN ORDER TO DOCUMENT THAT PROGRAM INPUTS ARE FUNCTIONING AS EXPECTED AND THEREFORE THAT OUTCOME IS POTENTIALLY RELATABLE TO DOCUMENTED PROGRAM COMPONENTS.

2. TEAM WILL DO OWN MEASUREMENT OF HEIGHT AND WEIGHT OF APPROXIMATELY 400 CHILDREN ASSESSINGSCE WITH GOVERNMENT BITH CERTIFICATES IF FOUND TO BE ACCURATE. PLAN TO WEIGH AND MEASURE PROGRAM AND CONTOL CHILDREN IS IN LIEU OF COMPILATION AND ANALYSIS OF CRS GROWTH CHART DATA. RISKS INHERENT IN OBTAINING CONTROL DATA ALSO RECOGNIZED. CONTROL VILLAGES WILL BE AS COMPARABLE AS POSSIBLE: TEAM WILL COLLECT CERTAIN DATA ITEMS TO ESTABLISH THIS. DATA BASE CAN BE EXPANDED AT LATER DATE IF DESIRED. CONCULTANTS WILL PROVIDE REPORT OF FIELD EXPERIENCES AND FEASIBILITY CONSIDERATIONS FOR FUTURE STUDIES. TEAM AIMS TO VISIT 15 PERCENT OF ALL PROGRAM VILLAGES FOR EVALUATION OF PROGRAM PROCESS. TEAM CONSIDERS THIS THE MAXIMAL COVERAGE POSSIBLE WITHIN TIME AND RESOURCE CONSTRAINTS. TEAM WILL MAKE EFFORT TO ACCOMPLISHTHIS DESPITE PREDICATABLE ROAD PROBLEMS AND OTHER TIME DELAYS.

3. MISSION COMMENT: MISSION DISAPPOINTED THAT EVALUATION DESIGN PROPOSED BY CONSULTANTS, BECAUSE OF TIME AND RESOURCE LIMITATIONS, WILL NOT PROVIDE CONCLUSION ABOUT THE PROGRAMS NUTRITIONAL IMPACT WHICH COULD BE GENERALIZED TO THE ENTIRE CRS PRROGRAM IN CAMEROON. THE MINISTER OF HEALTH ALSO REQUESTED AN EXAMINATION OF THE PROGRAM'S IMPACT REF A. WE ARE CONCERNED THAT EVALUATION MAY NOT SATISFY HIS INFORMATION REQUIREMENTS EITHER. NEITHER

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MISSION NOR CONSULTANTS CONSIDER TWO CONTROL AND TWO PROGRAM VILLAGES ADEQUATE SAMPLE SIZE TO PRODUCE STATISTICALLY RELIABLE CONCLUSIONS REGARDING NUTRITIONAL IMPACT OF PROGRAM OPERATING IN 3 VERY DIFFERENT PROVINCES.

4. CONSIDERING CUTBACK IN TIME AND RESOURCES REQUESTED FOR EVALUATION; INABILITY OF MISSION TO RECEIVE TDY ASSISTANCE AS REQUESTED TO PREPARE SCOPE OF WORK AND WORKPLAN PRIOR TO ARRIVAL OF EVALUATION TEAM; AND LOGISTICAL COMPLICATIONS CREATED BY UNEXPECTED FAILURE OF CONSULTANTS CONTRACT TO INCLUDE FUNDS AND AUTHORITY TO HIRE IN-COUNTRY PERSONNEL, MISSION CONCURS WITH TEAM PROPOSALS PARA 1 AND 2 ABOVE. IN ADDITION TO ANSWER IMPACT CONCERNS EXPRESSED BY BOTH THE CURC AND MISSION WE HAVE REQUESTED THAT TEAM ALSO INCLUDE IN THEIR FINAL REPORT A SCOPE OF WORK AND STUDY DESIGN FOR CONDUCTING AN IMPACT EVALUATION WITH A STATISTICALLY VALID NUMBER OF PROGRAM AND CONTROL VILLAGES, AS WELL AS RECOMMENDATIONS FOR IMPLEMENTING SUCH AN EVALUATION UNDER THE CONDITIONS ENCOUNTERED IN CAMEROON FIELD WORK. THIS WAS DISCUSSED WITH AA /FVA DURING HER RECENT CAMEROON VISIT.

5. CONSULTANTS HAVE AGREED TO PREPARE SOW AND FEASIBILITY ANALYSIS FOR VALID IMPACT EVALUATION AND REQUEST AMENDMENT OF CONTRACT TO PROVIDE EIGHT ADDITIONAL DAYS EACH FOR TASKS NOT COVERED IN CURRENT CONTRACT. CONSULTANTS ALSO PLAN TO USE FUUNDS PROGRAMMED FOR ECONOMIST FOR BIOSTATISTICAL CONSULTATION UNLESS OTHERWISE ADVISED. NEW TASKS WILL ALSO REQUIRE EXTENSION OF DEADLINES FOR BOTH PRELIMINARY DRAFT AND FINAL REPORTS...

6. DURING LAST WEEKNIH YAOUNDE CONSULTANTS WILL PROVIDE FEASIBILITY REPORT FOR IMPACT EVLUATION AND SUMMARY OF OTHER FINDING S WHICH HAVE BEEN ANALYZED TO DATE. DUE TO OTHER COMMITMENTS DRAFT REPORT WILL HAVE TO BE WRITTEN COMPLETELY IN U.S. AFTER DEADLINE PREVIOUSLY ESTIMATED. CONSULTANTS STATE IT WILL REQUIRE ONE TRIP MARYLAND/WYOMING TO CONFER ON FINDINGS, CONCLUSIONS AND RECOMMENDATIONS. SUGGEST COMPLETION DATE FOR DRAFT REPORT BE SET AT NOVEMBER 10.

7. REQUEST CONFIRMATION THAT CONTRACT AMENDMENT PER PARAS 5 AND 6 WILL BE PROCESSED ASAP.

8. CONSULTANTS HAVE CLEARED TPIS CABLE IN SUBSTANCE. SUGGEST AID/W DISCUSS CURRENT EVALUATION WITH DR. HEATHER GOLDMAN WHO EXPECTS TO BE IN AID/W SECOND WEEK SEPTEMBER FOR CONSULTATION.
HORAN

APPENDIX 3

DATA COLLECTION INSTRUMENTS

APPENDIX 3

DATA COLLECTION INSTRUMENTS

Title II Evaluation - Cameroon CRS Food Distribution Program

Checklist - FFP/AID

1. Title II Evaluation Process

   1.1 FFP/AID evaluation objectives are spelled out on page I-9 of the generic work scope. Could you comment on these points?

   1.2 Among the reasons for undertaking the ongoing Title II evaluations is that of being better prepared for decision making required by expected budget constraints. Pending completion of the series, does an unevaluated program that is not well-run stand a better chance of approval than a program that has been evaluated and found to be wanting in major respects?

   1.3 Place of Cameroon in the evaluation series. How was it selected? How many African countries have been evaluated to date? How many will have been by August 1981? How many in the world? What effect does accumulated knowledge have on subsequent evaluations, in your opinion?

2. Role of CRS

   2.1 What are the advantages and disadvantages of utilizing voluntary agencies for carrying out Title II programs compared with direct bilateral food grants?

   2.2 Why is CRS frequently the sole voluntary agency in African countries? Why in Cameroon?

   2.3 What is the special nature of the CRS Food Distribution Program in Africa, and specifically Cameroon? Is this an experimental program between AID/FFP and CRS permitting CRS/Africa to show results within a given time frame? What are the expected results? Progress to date? May all sponsoring agencies order similar rations? and promote home equivalencies in lieu of efforts to ensure delivery to targeted beneficiaries? Are the evaluations expected to provide answers?

   2.4 What is your reaction to the ideas presented by Dr. Capone and others with regard to:

   - The developmental potential of food aid, and its role as income transfer.

- The apparent wisdom of dealing at the family level in Africa and other cultures (why did family feeding lose its appeal in FFP/AID/ Congress?).

- The suggestion that FFP should spell out conditions to be met in MCH programs in order to assure attainment of nutritional objectives. Are operational grants widely available to make such conditions feasible?

3. Administrative and Policy Structure

3.1 Describe the line of authority FFP-REDSO-Cameroon FFP Representative. Does it cross at the regional level with CRS authority?

3.2 Are AERs approved at the regional CRS and AID level? Lacking evaluations, how are conflicts about maintaining, reducing, increasing or terminating sponsoring agency programs resolved?

4. Use of Title II Food

4.1 FFP's view and/or policy with regard to the use of food with other resources within FFP, or using food with other resources within AID, or with resources from different donors.

4.2 FFP's view of the merits of direct interventions with food versus monetization and use of proceeds for regular development projects.

5. Agreements and Criteria

5.1 How much control or influence does FFP have or wish to have over the type of distributing agencies employed by the sponsoring agencies? On the agreements or contracts made which concern the use of food?

5.2 Since CRS does not appear to spell out criteria of its own in the crucial area of selecting sites and beneficiaries, how does FFP see their requirements being met effectively?

Does FFP believe, from the experience gained to date through knowledge of program operations and evaluations, that reaching the poorest and neediest is a realistic objective for food aid programs? Has Section 202 (b) (3) of PL 480 giving priority within preschool programs to "malnourished children and poorest regions of countries" been tempered in the AID interpretation provided on page 10-3 of Handbook 9.. "as a practical matter, commodities should be directed generally towards systematic preventative work (not second and third degree malnutrition) among the vulnerable groups..."

Does FFP believe that improving nutritional status of targeted groups is a realistic objective for food distribution programs? Are there other more important goals? Can such goals as increasing clinic attendance be more economically achieved with other means than food aid?

Title II Evaluation - Cameroon CRS Food Distribution Program

Checklist - CRS/New York

1. Title II Evaluations

1.1 What do you understand to be the purpose of the projected evaluations? Are they likely to be useful to CRS/NY in worldwide planning?

1.2 Did you advise on the design of the generic scope of work for the evaluations? What would you have done differently? Which parts are most appropriate in your opinion?

1.3 For convenience, the table included in the generic scope which cites AID/FFP objectives for these evaluations is attached. Would you state the preferred objectives of CRS/NY and comment on them.

2. Cameroon Evaluation - CRS Food Distribution Program

2.1 Do you agree with the selection of Cameroon for evaluation at this time?

2.2 What do you see as similarities in likely problems and findings in the Cameroon evaluation compared with other CRS/Africa evaluations?

2.3 What overall guidance would you provide the evaluating team? From your vantage point, what are the distinguishing characteristics of the CRS/Cameroon program?

2.4 What do you consider the major objectives and benefits of the CRS/Food Distribution Program in Cameroon to be? Would you also comment on the groupings suggested in the attached second table.

2.5 Would you give your views on attempted evaluation in Cameroon of nutritional impact, based on "before and after" within CRS program?

What are your views on comparing program children with a control group of the same community, assuming that ethical questions can be answered by offering services and counsel while obtaining data?

If time permitted, do you think it would be useful to ascertain nutritional benefits for the entire family of the beneficiary(ies)?

2.6 Growth Surveillance

2.6.1 Dr. Capone has pointed out that donated food does not translate into nutritional improvement without other inputs. Is it not risky for CRS to stake all on results evident on the growth surveillance chart? i.e. Other factors beyond CRS control might make improvment impossible. Do you think such factors are present in Cameroon? Do you see other benefits of the program in Cameroon?

2.6.2. Does the Government of Cameroon accept the format and content of the growth surveillance charts used by CRS? Does the Government use the CRS charts in clinics where CRS does not operate? If not, what system does it prefer and use?

2.6.3 Have master chart data been analyzed for Cameroon? Is it available to the team?

2.7 Nutrition Education

2.7.1 In additon to the growth chart, what nutrition education does CRS (as opposed to clinic) consider minimal in its Africa programs? Is Cameroon an exception?

2.7.2 Is there available the "expected nutrition knowledge" list or summary for mothers in the program for an indicated period of time? What nutrition basics are they expected to know after three months? six months? one year? What are mothers expected to know about the growth chart? If child doesn't gain weight?

2.7.3 Does CRS consider that it has sufficient "negotiating power" with its own resources combined with food to require minimal nutrition education from distributors?

2.7.4 Is CRS generally satisfied with the education content in its MCH programs? How could it be improved?

Please comment on the usefulness and shortcomings of operational grants.

What would be the ideal AID or FFP complement to CRS resources?

2.8 Economic Impact of Ration

2.8.1 Can you describe CRS views on the ration as a form of economic assistance to the family? What is the basis of this philosophy?

2.8.2 Is the ration size in Cameroun of economic importance to the family?

2.8.3 Can you suggest a methodology for measuring the economic value to the family?

3. Policy Questions

3.1 In what ways, if any, do AID Title II policies and regulations constrain CRS work, particularly in the MCH area?

3.2 Does CRS agree on AID's prioritizing of MCH and FFW? What would be CRS' priorities?

Dr. Capone insists on the family sharing concept. Is his opinion shared by CRS headquarters? Is it based on the philosophy of working at the family, rather individual, level or (and/or) on expected greater effectiveness of food use?

3.3 Is it true that CRS is the principal, and often sole, agency working in African countries? Why is this the case? From 1979 to 1981 in Africa, MCH beneficiaries appear to have nearly doubled in number from 1.3 million to 2.2 million. Can you comment on future projections?

3.4 Criteria

3.4.1 How does CRS decide where it will distribute food and other resources worldwide?

3.4.2 How are distributing agents and sites selected in each country? How are commodities selected - type/size?

3.4.3 Does CRS agree formally to AID/FFP criteria of distributing food aid to the neediest and malnourished in the poorest regions? What happens when it does not, or cannot, meet these criteria? Is the policy realistic? Do outreach grants help? Other?

3.4.4 Does CRS see a long-term need for Title II in Cameroon? Is there a phase-out plan?

TABLE 1.3 AID/FFP Evaluation Objectives

(from Generic Scope of Work)

	FOOD FOR PEACE/TITLE II EVALUATION OBJECTIVES	CRS/NY EVALUATION OBJECTIVES
GOAL PROGRAM OBJECTIVES MET	1. Nutritional 2. Sustained availability & access to food 3. Other related objectives	
PURPOSE PROGRAM DECISIONS MADE BASED ON QUATE OBJECTIVE INFORMATION	1. Establishing priorities among Title II program areas worldwide 2. Establishing priorities among country Title II programs 3. Preparing & defending budget submissions 4. Changing policies & guidelines to expediate effective operations	
OUTPUTS 1. INFORMATION GAPS FILLED	1.1 Effectiveness • Reaching the most vulnerable & needy or target group • Efficacy of rations as incentives for participation & nutritional supplement • Meeting specific program objectives 1.2 Capacity to Use Title II Resources Well • Host government provisions ($) & support • Volag & distributing agencies provisions ($, personnel) & support • Efficiency of food management 1.3 Congruence of Program with Legislation • Program objectives & methods with U.S. legislated policy • Program results with mandated (host/ sponsoring government) benefits & equity 1.4 Title II Program Relationship to Other Development Programs • Positive effect (i.e., synergy) • Negative effects 1.5 Affect of Policies & Guidelines (i.e., Operating Procedures) on Title II Operations & Results	
2. ALL PARTICIPATING ORGANIZATIONS ACCEPT EVALUATION FINDINGS AS CREDIBLE	2.1 Findings are Quoted in Response to Inquiries made of FFP/Title II 2.2 Managers Judge that the Validity, Reliability, Representativeness & Precision of Data Analyzed & Methodologies Used for Data Collection do not Impair their Ability to Use Study Findings	
3. ONGOING INFORMATION & REPORTING/ EXCHANGE METHODS & EFFORTS MADE EFFECTIVE	3. Requests for Special Reports from Evaluated Country Programs Equal to Half of the Requests from Other Country Programs within One Year of Studies	
ACTIVITIES (Refer to Figure III-1, ASB		

TABLE 2.4 Perceived Program Objectives or Benefits

(from Generic Scope of Work)

CRS MCH Program

Groupings of Objectives	INSTITUTION	CRS NY	Distributing Agencies	Sponsoring Agency (Volags)	USAID	FFP/ Title II	Beneficiaries & Other
	1. Benefits received by most vulnerable & needy target groups						
	2. Nutritional impact						
	3. Sustained availability of & access to food (self-help, community development)						
	4. Other developmental effects & relationship to interventions of other sectors						
	5. Behavioral & attitudinal changes (e.g., effectiveness of nutrition education)						
	6. Cost-effectiveness of specific interventions						
	7. Fit between policy & program objectives						
	8. Other						

Title II Evaluation - Cameroon CRS Food Distribution Program

Checklist - USAID/Yaounde

1. Title II Evaluation

1.1 How could this Title II evaluation most effectively serve the interests of USAID/Yaounde?

1.2 What do you understand FFP objectives to be in the worldwide evaluations?

Would you comment on the content of the generic work scope? Which sections are most appropriate in your opinion? What should have been included? Omitted?

Please complete the right side of the attached table (from the generic work scope) stating the "preferred objectives" of USAID along side the stated AID/FFP objectives. Remarks?

1.3 Have you read any of the Title II evaluations on CRS programs in Africa? What is your opinion of their strengths and weaknesses?

2. Food and Nutrition Problems in Cameroon & Effect of Policies on them.

2.1 What does the USAID consider the major nutrition or nutrition-related problems to be? Who is most affected, where, and how?

Compare notes on key documents for the team to see in this respect. USAID's opinion of the National Nutrition Survey. Availability and date of the most recent food balance sheet. Agricultural production and projections; opinion on self-sufficiency.

2.2 How does USAID view the GURC development policies related to this area (of nutrition, food aid, agriculture, health and education): Have official statements been followed by budgetary commitments?

2.3 What is the relationship between GURC priorities and USAID priorities (general development)? (nutrition-related)?

What ongoing or project programs are being undertaken in nutrition-related activities by USAID, with GURC and with/without other donor collaboration? What is their priority within USAID priorities?

3. The CRS Food Distribution Program in Cameroon.

3.1 How does the food distribution program fit into the country development strategy as defined in the CDSS? As defined by t[illegible] GURC?

3.2 What do you think should be the major objectives and benefits of the CRS food distribution program in Cameroon?*

In you opinion, do USAID and CRS agree on objectives? Do the USAID and GURC agree on objectives for the CRS food distribution program?

3.3 Could you describe the strengths and weaknesses of the CRS program, including the following areas:

Whether the food program contributes to, or inhibits, development and self-reliance of the Cameroon officials and beneficiaries;

Capability for sound management; assurance that proper use of food is made;

USAID guidance to date on the size and scope of the MCH program and guiding criteria that it utilizes or would utilize;

Capability for demonstrating effectiveness; how has USAID judged effectiveness to date in terms of nutritional benefits and per capita costs? (Have comparisons been hypothesized with alternative programs?)

Effect of the program on agricultural self-sufficiency of beneficiary families?

3.4 Would you comment on CRS food aid philosophy as it is applied in the program in Cameroon? (Appropriateness in your opinion, and effectiveness)

4. Criteria

4.1 How much control or influence does USAID have or wish to have over the operations of the distributing agencies used by CRS? On the agreements or contracts made which concern the use of Title II food? (Since CRS apparently does not dictate criteria in the crucial area of selecting sites and beneficiaries, how does USAID see these FFP requirements - for neediest and most malnourished - being met effectively?)

4.2 Does USAID believe that reaching the poorest and neediest is a realistic objective for food aid programs? Is USAID satisfied if the MCH programs reach vulnerable groups without further focus?

4.3 Does USAID believe that improving nutritional status of targeted groups is a realistic objective for food distribution programs? Are other more attainable goals being neglected?

*If convenient, please group these according to the categories shown in the second attached table.

Does USAID think the evaluation team can spend its time in a worthwhile manner undertaking a nutrition impact evaluation?

Other comments and guidance the Mission considers useful for the team.

Title II Evaluation - Cameroon CRS Food Distribution Program

Checklist - CRS/Yaounde

1. Title II Evaluations

   1.1 How could this evaluation most effectively serve the interests of CRS/Yaounde?

   1.2 What do you understand FFP objectives to be in the worldwide evaluations?

   Would you comment on the content of the generic work scope.

   Please see the table of AID/FFP objectives of these evaluations. Kindly state the "preferred objectives" of CRS/Yaounde.

   1.3 Have you read any of the evaluations made on CRS programs worldwide? in Africa? What is your opinion of their strengths and weaknesses?

2. Food and Nutrition Problems and Development Policies in Cameroon

   2.1 What do you consider to be the most important nutrition or nutrition-related problems in the country? Who is most affected, where? Describe the severity of problems in areas of CRS activity.

   2.2 Does the CRS program respond to the groups most affected in the areas most affected? If not, why not? And if not, is it desirable to make the program more responsive? How?

   2.3 What do you understand the Government's policy and priorities to be in nutrition-related areas such as food aid, agriculture, health nutrition and education?

   2.4 What are USAID's policy and priorities in these areas? Are they consistent with those of the Government?

   2.5 Are CRS' policy and priorities compatible with those of the Government and/or those of USAID? How do they differ? Are there compelling reasons to conform them? Or good justifications not to?

3. The CRS Food Distribution Program

   3.1 What are the objectives or benefits of the program (quantitative and qualitative)?

   3.2 To what extent is the program achieving its objectives?

3.3 In what ways, if any, are the programs constrained by AID policies, regulations, or enabling legislation? By GURC policies or regulations? Other?

3.4 Do you have an agreement with GURC? May we see it?

3.5 Do contributions from other donors relate to or affect your program?

3.6 What is CRS/Yaounde policy and expectation regarding the potential takeover of the food distribution program by Cameroonians?

3.7 Does CRS see a long-term need for Title II in Cameroon? Is there a phase-out plan?

3.8 How does CRS decide where it will distribute food and other resources in Cameroon? i.e., how are the distributing agents and sites selected?

3.9 How was the ration composition determined? What is its economic value? What percentage of nutritional requirements is it intended to meet or is this not a direct objective? Is CRS/Yaounde satisfied that it has selected the best ration level? Explain.

3.10 Services Offered

3.10.1 Please describe the services offered in the majority of health centers in which CRS provides food. Are the services different in centers that are not given food? Does CRS have an agreement with centers? May we see it?

3.10.2 Is the progress of recipients monitored (growth and development--anthropometric measures & charting, health protection)? Does each child have a growth chart? Is it kept by the mother or mother substitute? Does the clinic maintain individual records on children? on families? Are master charts prepared? Are they available to the evaluation team?

Does the Government of Cameroon accept the format and content of the growth surveillance charts used by CRS? Does the Government use the charts in clinics where CRS does not provide food? If not, what system does it prefer and use? Can data from the latter system be compared with CRS data?

3.10.3 In addition to the growth chart, what nutrition education does CRS (as opposed to any education given in the clinic whether CRS is there or not) "sponsor" or encourage? What do the clinics normally provide?

Does CRS have criteria for minimal nutrition knowledge? What nutrition basics are mothers (substitutes) expected to know after three months, six months, one year? Principal subjects?

What are mothers taught about the growth chart? What is the concept of "equivalents"? What are mothers expected to understand about equivalents?

Is there a budget for materials, training, or other for the education program? Does CRS provide training or materials for education?

Is CRS generally satisfied with the education content in its programs? How could it be improved? What are potential means? What would the ideal AID or FFP complement to CRS resources be?

3.11 Motivation of Participants

3.11.1 How do participants see the benefits provided by the program?

3.11.2 Do mothers (substitutes) have responsibility for demonstrating children's maintained or improved health? Are these responsibilities spelled out in the form of an agreement or contract with the beneficiary from the outset? Is compliance monitored, and if so, how?

3.11.3 Does CRS know the effects of the food ration on the household budget? How is it determined? What are effects? Are the effects on subsistence agriculture or production of cash crops known? How determined? and what are the effects? If unknown, is CRS interested in monitoring? How might that be done?

4. Details on Design and Organization

4.1 Geographical Scope: How many clinics offer CRS/Title II-supported services? Please provide a list of these centers (with a map if available) and the names of the distributing agencies. Please indicate the date when CRS food was first provided and the date when growth surveillance charts were first utilized.

4.2 Beneficiary Scope: How many children are enrolled in each center? Total in the program? How many mothers (substitutes) are enrolled?

4.3 Attendance: How many children attend each center per month on the average? High and lows at specified seasonal points? How many mothers, or mother substitutes, attend on the average? How many families are involved? Can you estimate the duration that beneficiaries remain in the program? How long may they receive food assuming they comply with the rules in effect?

4.4 Personnel and management: What personnel time is spent providing or supporting Title II program services on the average? In your opinion what is the quality of the service? (especially attitude). What supervision do these persons receive from higher levels? the frequency? Is it adequate in your opinion? What is the usual level of training? Has CRS undertaken any training programs? With what resources?

4.5 Catchment area: How far do beneficiaries travel on the average to get to a center; longest, shortest distances?

Are services provided only at health centers? If not, what other delivery mechanisms are employed?

5. Overview questions of program operations.

5.1 Which elements (components of the food program or combination of elements) are responsible for positive and negative results that are being attained (included, but not limited to, composition of food ration, attitude of staff in clinics, competency and motivation of staff in clinics or elsewhere, content of nutrition talks in one-to-one or group sessions, medical care, home visits, other outreach methods, mothers' (substitutes') responsiveness to children's progress on growth charts).

5.2 Are there factors outside the control of the program supervisors that add to or reduce the success of the programs? What are they? How might they be enhanced or overcome?

5.3 What reasons may be cited for reducing, expanding or maintaining levels of food aid in the future?

Title II Evaluation - Cameroon CRS Food Distribution Program

Checklist - Government Representatives

1. The Problem of Malnutrition in Cameroon as seen by the Government

   1.1 What are the principal sources of information on which the Government officials base their knowledge of the problem? Are these sources adequate for an understanding of the problem?

   Are malnutrition rates high in your opinion? Are rates more pronounced in certain population groups and in special geographical areas of Cameroon? in particular settings (urban, rural)?

   1.2 What do you consider the principal causes of malnutrition to be? (lack of distribution network to population in need, inadequate agricultural production, scarce medical services, poor food habits and lack of education, unavailability of sufficient means).

2. Policy, Strategy and Programs of the Cameroonian Government Intended to Reduce Malnutrition

   2.1 What are the policy and strategy of the Government to combat malnutrition as described above?

   2.2 Are there quantitative objectives? and defined target populations? Priorities?

   2.3 Please describe functions and responsibilities of the coordinating body that is to link up the different programs and policies having to do with nutrition.

   2.4 Noting that nutrition is a vast subject and that many programs and activities indirectly affect the nutritional status of Cameroonians, could you separate the government programs that directly affect the target populations of the country?

3. Food Aid in General (Omitting Catholic Relief Services Program until below)

   3.1 Is food aid considered a component in a policy to improve the nutritional status for Cameroon? Does a strategy exist to get the most effective use out of it, currently and for the future?

   3.2 What food aid programs are in operation today? What are their objectives? Their advantages and disadvantages? What lessons have been learned through their past operations?

4. The Catholic Relief Services (CRS) Program in Cameroon

4.1 What do you consider the principal objectives of the CRS food distribution program to be? Are you aware of benefits that come from the distribution of foodstuffs? Who are the beneficiaries? Are there problems or negative effects stemming from the operation of the program?

4.2 How do the relevant Ministries participate in the Catholic Relief Services program (financially, administratively)?

4.3 Are the objectives of the concerned Ministries consistent with those of CRS? Is the operational system of the program the best in your opinion? What changes would you consider desirable?

4.4 Do you have an agreement with CRS? Is it consistent with those objectives?

4.5 What are your expectations as to the future of the CRS program? Does the continuation of the food distribution program affect the operation of the MCH centers? How?

4.6 Please give your summary of the CRS program operations and the relationship between the program and the policy and programs of your Ministry (your Government).

Questionnaire for Clinic Personnel

1. General Information

1.1 Name of Center _____

1.2 Type of Center _____ _____ _____
Government Private Other, specify

1.3 Nearest Town _____ Kilometers _____

1.4 How long has the Center been in existence? _____

1.5 How long has the Center distributed Title II foods? _____

1.6 How long has the Center used the new CRS growth chart? _____

1.7 How long has the person in charge been in the Center? _____

2. Participating Beneficiaries

2.1 How far do beneficiaries come from? _____

2.2 Villages from which they come _____

_____

2.3 How many are there in each session? _____

2.4 How many sessions a month? _____

2.5 Opinion of why beneficiaries come, by priority _____

food vaccinations child illness weighing/preventative care

2.6 Will beneficiaries come without food? _____ Have you been without food? _____ What percentage came? _____

2.7 Are the beneficiaries who come _____ _____ _____
poorest best off medium

_____
of all classes

2.8 How much do mothers pay for each ration?_____

2.9 Do you think there are mothers who do not come because they do not have this payment?_____

2.10 How important are the food rations to the families_____

to the children under five?_____

2.11 Do you think the mothers give the child's share to the child?_____

2.12 Do you hear about malnourished children whose mothers do not come?

_____Do you or others make home visits?_____

3. Provision of Services

3.1 Do you know of an agreement between the Center and CRS?_____

Do you have a copy?_____What are principal provisions?_____

_____

3.2 In addition to food, what does CRS provide?_____

_____

3.3 What does the Government give to the clinic in the way of medicines, vaccines, etc.?_____

3.4 How many clinic personnel assist on distribution day?_____

_____

3.5 How long does the weighing and distribution take?_____

3.6 Do you think there is a better procedure for assuring the good health of infants/children?_____

4. Criteria for Participation

4.1 What are the criteria for accepting beneficiaries?_____

_____

4.2 What are the criteria for graduating children?_____

_____How many were graduated in the past year?_____

4.3 If mothers do not attend regularly, what disciplinary action do you take?_____

4.4 How many rations are allowed per family?_____

4.5 Do you dilute rations when supplies are low?_____

Do you charge the same fee in this case?_____

5. Personnel

5.1 List of personnel who work with the nutrition program and their responsibilities, salaries, training.

5.2 Are they from the community?

6. Supervision

6.1 How often does the CRS supervisor visit the Center?_____

_____

6.2 Principal concerns of the CRS supervisor when she visits the center

_____

6.3 Do you remember the date of her last visit?_____When?_____

7. Foods and Storage

7.1 How many months supply do you store in the Center?_____

7.2 Do you often run out?_____When last?_____For how long?_____

7.3 Are there other foods in storage here that come from other sources?

_____

7.4 Are deliveries prompt from warehouse?_____

What do you do if deliveries do not arrive?_____

8. Education and Demonstration

8.1 This month's education topic(s)_____

8.2 How did you choose the topic(s)?_____

8.3 What is the basis of your information _____ _____
CRS Manual Missionary Materials

_____ _____
Government Materials Other

8.4 Do others assist with the teaching?_____

_____

8.5 What material do you have for demonstrating Title II food preparation?

_____

How much time and how often a month do you spend on this?_____

_____

8.6 What do you teach about replacing cornmeal_____

soybean oil_____and milk powder_____

when these foods are not available?

Do mothers practice these messages?_____

8.7 What do you teach mothers about the growth chart (assess capability)?

_____

8.8 Do you think most mothers are able to comprehend the growth chart?

_____

Title II Evaluation - Cameroon CRS Food Distribution Program

Observation Check List

Center_____Province_____Distribution Day?_____

1 Food Distribution

Register, Master list, other appropriate procedure for identifying beneficiaries_____

Benficiaries payments for rations, containers, growth charts

_____

Uniform measuring, use of containers_____

2. Food Storage

Adequate stocks and storage space_____

Ventilated, screened area_____

On pallets, away from wall_____

No apparent rodent/insect infestation_____

No special clutter, e.g. used containers_____

Other_____

3. Weighing Overall Satisfactory_____or Unsatisfactory_____

Adequate scales_____Balanced at zero_____

Returned to zero after weighing_____child undressed_____

Accurate weighing (without child hanging on, etc.)_____

Accurate reading_____Accurate recording_____

Method of ascertaining age: Satisfactory_____Unsatisfactory_____

Birth Certificate_____Midwives Register_____

Combination Birth Certificate and Midwives Register_____

Guessing_____Combination Certificates/Register and Guessing_____

4. Growth Chart

Accurate plotting on individual chart_____

Plotting on chart at time of weighing_ _____

Plotting on chart in presence of individual mother_____

Mother counselling based on plotting_____

Mother counselling based on apparent health of child_____

Adequacy of counselling_ _____

5. Educational Sessions

Style of session (lecture, demonstration, other)_____

Length: 1 hour or less_____1 - 2 hours_____

Breadth: 1 - 2 subjects_____several subjects_____

Many subjects_____

Quality_____(good, average, poor)

Use of educational materials?_____Type_____

Focused on food for health?_____

Demonstration of how to use Title II foods?_____

Explanation of equivalent of Title II food to local food?_____

Explanation of amount of commodity or local equivalent which must be reimbursed to child?_____

Growth chart education?_____

Level of participation by mothers in session_____

6. Posters

Address nutrition, child care?_____

At mother level?_____Clinic personnel level?_____

Pictorial?_____Language?_____

Title II Evaluation - Cameroon CRS Food Distribution Program

Questionnaire for Mothers
Process Evaluation

Process - 1
Number _____
Date _____

Interviewer _____

Center Name _____

1. Mother's Name _____ If not mother, caretaker's name _____	☐ Mother ☐ Caretaker
2. Relation Other _____	☐ Sister/Brother ☐ Grandmother/Aunt/Uncle ☐ Other
3. Number of children usually brought to center	☐ 1 ☐ 2 ☐ 3
4. Frequency of participation	☐ Every month ☐ Every other month ☐ Less than 6 times a year
5. If not every month, why not? Other _____	☐ No time ☐ Distance ☐ No money ☐ Sick ☐ Absent ☐ Other

Center Name _____ Process - 2
Number _____

6. What food do you get at the center?	☐ Corn meal ☐ Powdered milk ☐ Oil
7. How much do you usually get? Corn Meal _____ Powdered Milk _____ Oil _____	☐ 2 Kilos ☐ Less ☐ 2 Kilos ☐ Less ☐ 1 Kilos ☐ Less
8. Have you ever come and not gotten this amount?	☐ Yes ☐ No
9. How much do you pay?	☐ 50 Francs ☐ More _____
Use of Commodities - Oil 10. Show her oil	☐ Can identify ☐ Has seen ☐ Doesn't recognize ☐ Recognized after explanation ☐ Didn't recognize after explanation
11. What do you do with this Oil? Other _____	☐ Cooking ☐ Sells/trades ☐ Give away/throw away ☐ Animals ☐ Rubbing ☐ Other

Center Name _____ Process - 3
Number _____

12. If used for cooking, who eats it?	☐ Whole family ☐ Children only ☐ Adults only
13. If not used for cooking, why not?	Child Adult ☐ ☐ Doesn't know how to use ☐ ☐ Makes them sick ☐ ☐ Doesn't like taste ☐ ☐ Doesn't need more oil ☐ ☐ Needs money more than more oil ☐ ☐ Other
14. If sold or traded, what do you get in return?	☐ Food ☐ Not food
15. If you don't have this oil from the Center, what do you substitute? Other _____	☐ Palm oil ☐ Other oil ☐ Nothing ☐ Other
16. Does child receive (answer to 15) when you don't give him the oil you get from the center?	☐ Yes ☐ No ☐ Sometimes

Center Name _____ Process - 4

Number _____

Use of Commodities - Corn meal

17. Show her corn meal	☐ Can identify ☐ Has seen ☐ Doesn't recognize ☐ Recognized after explanation ☐ Didn't recognize after explanation
18. What do you do with this Corn Meal? Other _____	Eaten ☐ Gruel/Pap ☐ Foo-Foo ☐ Drinks - Beer, Aki Not eaten ☐ Sell/trades ☐ Gives away/throws away ☐ Animals ☐ Other
19. If eaten, who eats it?	☐ Whole family ☐ Children ☐ Adults only
20. If not eaten, why not Other _____	Child / Adult ☐ ☐ Doesn't know how to use ☐ ☐ Makes them sick ☐ ☐ Doesn't like taste ☐ ☐ Doesn't need more corn meal ☐ ☐ Needs money more than corn meal ☐ ☐ Other

Center Name _____ Process - 5
Number _____

21. If sold or traded, what do you get in return?	☐ Food ☐ Not Food
22. If you don't have this corn meal from the center, what do you substitute? Other _____	☐ Local corn meal ☐ Rice/other grain ☐ Cassava/Cocoyama/Plantaine/ Potatoes ☐ Nothing ☐ Other
23. Does your child receive (answer to 22) when you don't give him the corn meal you get at center?	☐ Yes ☐ No ☐ Sometimes
Use of Commodities - Powdered Milk 24. Show her powdered milk.	☐ Can identify ☐ Has seen ☐ Doesn't recognize ☐ Recognized after explanation ☐ Didn't recognize after explanation
25. What do you do with this powdered milk?	Eaten ☐ Mixes with water to make liquid ☐ Mixes with water to make paste ☐ Adds to pap/gruel ☐ Adds to tea ☐ Adds to foo-foo ☐ Eats it dry

Center Name _____ Process - 6
Number _____

25. What do you do with powdered milk? (Cont'd) Other _____	Not Eaten ☐ Sells/Trades ☐ Gives away/throws away ☐ Animals ☐ Other
26. If eaten, who eats it?	☐ Whole family ☐ Children only ☐ Adults only
27. If not eaten, why not? Other _____	Child Adult ☐ ☐ Doesn't know how to use ☐ ☐ Makes them sick ☐ ☐ Doesn't like taste ☐ ☐ Doesn't need more milk ☐ ☐ Needs money more than powdered milk ☐ ☐ Other
28. If sold or traded, what do you get in return?	☐ Food ☐ Not Food
29. If you don't have this powdered milk from the center, what do you substitute? Other _____	☐ Other powdered milk ☐ Other milk ☐ Beans/Nuts/Fish/Meat/Eggs ☐ Nothing ☐ Other

Center Name _____ Process - 7
Number _____

30. Does your child receive (answer to 29) when you don't give him the powdered milk you get at the Center?	☐ Yes ☐ No ☐ Sometimes
31. Are you able to give your child more food because of the food you receive at the Center?	☐ Yes ☐ No
Growth Chart 32. Do you have a chart like this? May I please see it?	☐ Yes ☐ No
Following Questions Refer to Chart in Mother's Possession 33. If/when your child is here (green), what does it mean? Other _____	☐ Healthy/Not Sick/Normal ☐ Healthy/Eating Well/ Gaining Weight ☐ Other ☐ Doesn't know
34. If/when your child is here (yellow), what does it mean? Other _____	☐ Not Healthy/Sick/Not Normal ☐ Not Healthy/Not Eating Right/Losing Weight ☐ Other ☐ Doesn't know
35. What could make a child go from green to yellow?	☐ Gets Sick ☐ Doesn't Eat Enough ☐ Loses Weight ☐ Other ☐ Doesn't Know

Center Name _____

Process - 8
Number _____

36. What could make a child go from yellow to green? Other _____	☐ Gets Well/Healthy ☐ Eating Right ☐ Gains Weight ☐ Other ☐ Doesn't know
37. After your child is weighed, when they put a mark here (yellow), what do they tell you to do? Other _____	☐ Bad mother/child is sick ☐ Give more food to child ☐ Take child to clinic because he is sick ☐ Nothing ☐ Other ☐ Doesn't know
38. When they put a mark here (green), what do they tell you to do?	☐ Good mother/child is healthy ☐ Give more food to child ☐ Nothing ☐ Other ☐ Doesn't know

Center Name _____ Process - 9
Number _____

39. What else do they tell you about at the Center? Other - 1 _____ Other - 2 _____	Mention Recognize No ☐ ☐ ☐ Water Hygiene ☐ ☐ ☐ Gen. Hygiene ☐ ☐ ☐ Local Food Rqmts. ☐ ☐ ☐ 3 Food Groups ☐ ☐ ☐ Medicines/Clinic ☐ ☐ ☐ How to Cook ☐ ☐ ☐ Other - 1 ☐ ☐ ☐ Other - 2
40. When you come to the center, do they give you medicine for your child?	Worm Medicine ☐ Give ☐ Sell ☐ None Nivaquine ☐ Give ☐ Sell ☐ None
41. How often do they give you this medicine?	Worm Medicine ☐ Every time ☐ Less freq. Nivaquine ☐ Every time ☐ Less freq.
42. How much do you pay for this medicine?	☐ Nothing ☐ 100 frs or less ☐ More than 100 francs

Center Name _____ Process - 10 Number _____

43. What do you like about the center?	☐ Food ☐ Medicine ☐ Weighing child/growth chart ☐ Education/lessons
Other - 1 _____	☐ Other - 1
Other - 2 _____	☐ Other - 2
44. What do you not like about the center?	☐ Food ☐ Too little ☐ Too much ☐ Don't like milk ☐ Don't like corn meal ☐ Don't like oil ☐ Medicine ☐ Weighing child ☐ Education/lesions ☐ Nurse is not kind/not treated well ☐ Have to pay for food ☐ Have to pay for medicine ☐ Schedule/location
Other - 1 _____	☐ Other - 1
Other - 2 _____	☐ Other - 2

COMMENTS

UNITED REPUBLIC OF CAMEROON
CRS EVALUATION SURVEY

QUESTIONNAIRE FOR MOTHERS
NUTRITION IMPACT EVALUATION

Impact - 1
Number _____
Date _____

Interviewer _____

Center/Village Name _____

☐ Santa Clinic ☐ Bafut Catholic
☐ Catholic Mission ☐ Presbyterian Center

1. Mother's Name _____ If not mother, caretaker's name _____	☐ Mother ☐ Caretaker
2. Relation Other _____	☐ Sister/Brother ☐ Grandmother/Aunt/Uncle ☐ Other
3. Number of children usually brought to Center	☐ 1 ☐ 2 ☐ 3

Questions about Children	Name	Name	Name
4. What is your child's name			
	Number 1	Number 2	Number 3
5. Is it a boy or girl?	☐ Boy ☐ Girl	☐ Boy ☐ Girl	☐ Boy ☐ Girl
6. Has he/she been sick since the market before last?	☐ Fever ☐ Diarrhea ☐ Other	☐ Fever ☐ Diarrhea ☐ Other	☐ Fever ☐ Diarrhea ☐ Other

Center/Village Name_____ Impact - 2
Number _____

Questions about Mother	
7. Marital Status	☐ Married - only wife ☐ Married - husband has other wives ☐ Never married ☐ Separated/widowed
8. Literacy	☐ Can read ☐ Cannot read
9. Years of Schooling	☐ Primary ☐ Secondary ☐ Higher School ☐ University
10. Occupation of Mother and Husband	Mother / Husband ☐ ☐ Unemployed ☐ ☐ Food Crop ☐ ☐ Cash Crop ☐ ☐ Livestock/Herder ☐ ☐ Laborer ☐ ☐ Professional ☐ ☐ Other
11. Type of House	Walls: ☐ Wood, ☐ Sun-Dried Blocks, ☐ Cement Blocks, ☐ Painted, ☐ Not Painted Roof: ☐ Thatch, ☐ Tin, ☐ Other
Other	

Center/Village Name _____ Impact - 3 Number _____

12. Do you ever sell any food crops in the Market?	☐ Yes ☐ No
13. Number of People in Household	
14. Livestock	☐ Poultry ☐ Sheep ☐ Goats ☐ Cattle

ANTHROPOMETRIC MEASURES

CHILD'S NAME _____ NUMBER _____ ☐ P

MEASURE: WEIGHT _____ HEIGHT _____ AGE _____ ☐ E

CALCULATE: WT/AGE _____ WT/AGE _____ WT/AGE _____

CRS CARD: WEIGHT _____ AGE _____ WT/AGE _____

CRS: RECENT ILLNESS _____ SKINFOLD _____ ARM _____

CHILD'S NAME _____ NUMBER _____ ☐ P

MEASURE: WEIGHT _____ HEIGHT _____ AGE _____ ☐ E

CALCULATE: WT/AGE _____ WT/AGE _____ WT/AGE _____

CRS CARD: WEIGHT _____ AGE _____ WT/AGE _____

CRS: RECENT ILLNESS _____ SKINFOLD _____ ARM _____

CHILD'S NAME _____ NUMBER _____ ☐ P

MEASURE: WEIGHT _____ HEIGHT _____ AGE _____ ☐ E

CALCULATE: WT/AGE _____ WT/AGE _____ WT/AGE _____

CRS CARD: WEIGHT _____ AGE _____ WT/AGE _____

CRS: RECENT ILLNESS _____ SKINFOLD _____ ARM _____

Title II Evaluation - Cameroon CRS [redacted]od Distribution Program

Data Collection Instrument

Child No.	Date of Birth	Date First Visit to Clinic	Age First Visit o Clinic (calculated)	Weight, Kg First Visit Clinic	Weight %ile First Visit to Clinic (calculated)	Weight %ile First Visit to Clinic
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

Title II Evaluation - Cameroon CRS Food Distribution Program

Data Collection Instrument

Child No.	Date of Approx. visit 12 mos. ago	Age at Visit 12 mos. ago (calculated)	Weight, kg. at Visit 12 mos. ago	Weight tile at Visit 12 mos. ago (calculated)	Number of Visits last 12 mos.	Attendance Rate last 12 mos. (calculated)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						

d	Date Today	Age Today, (calculated) Mos.	Wt, Kg. Today as determined by Clinic	Weight %ile Today (calculated)	Weight %ile Today Determined by Clinic	Total Time in Program (calculate: age now minus age at entry)	Total Number Visits	Attendance Rate since Entry (calculate)	No Visits last 5 mos.	Attendance Rate last 5 mos. (calculate)

Form for Calculation of Monthly Ration Per Recipient and Range

of Beneficiary Attendance Over Four-Month Period

Village Name	Month	Number of Participants (New)	Oil			Cornmeal or Bulgur			Milk		
			Gals.	Liters	Liters per Beneficiary	Bags	Kgs.	Kgs. per Recipient	Bags or Packets	Kgs. Delivered	Kgs. per Recipient
	March										
	April										
	May										
	June										
	July										
	March										
	April										
	May										
	June										
	July										
	March										
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	March										
	April										
	May										
	June										
	July										
	March										
	April										
	May										
	June										
	July										

APPENDIX 4

INDIVIDUALS CONSULTED IN CONDUCT OF THE EVALUATION PROJECT

APPENDIX 4

INDIVIDUALS CONSULTED IN

CONDUCT OF THE EVALUATION PROJECT

AGENCY FOR INTERNATIONAL DEVELOPMENT

AID/Washington

Ms. Peggy Sheehan, OFFP, Chief, Title II Division
Ms. Carolyn Weiskirch, OFFP, Evaluation
Ms. Nancy Fox, FFP, OFFP, Title II Africa Region Program Officer
Ms. Hope Sukin, DS/N
Dr. Stewart Blumenfeld, DS/N
Mr. Kurt Schafer, Cameroon Desk
Ms. Judith Gilmore, FVA/PMS

AID/Yaounde

Mr. Ronald D. Levin, Director
Mr. Bernard Wilder, Asst. Director
Mr. Ray Martin, HNPO
Mr. Ray Riffenberg, Evaluation Officer
Dr. Heather Goldman, Nutrition Advisor
Dr. Richard C. Brown, HNPO

AID/Abidjan

Ms. Sam LaFoy, FFP

OFFICE OF MANAGEMENT AND BUDGET

Mr. Mike Usnick

DEPARTMENT OF AGRICULTURE

Mr. Gary Smith, Agricultural Economist
Ms. Charlotte Miller, Anthropologist

OTHERS CONSULTED BY THE SGC EVALUATION TEAM

Dr. Marcelo Selowsky, World Bank
Dr. Phillip Foster, University of Maryland, College Park
Dr. Ray Hepner, University of Maryland at Baltimore
Dr. Frederick R. Trowbridge, Johns Hopkins School of Public Health
Dr. Helen R. Abbey, Johns Hopkins School of Hygiene and Public Health
Dr. Nkwi, University of Yaounde, Cameroon
Ms. Marcia Griffiths, Manoff International, Inc.
Dr. Tom Cook, Manoff International, Inc.
Ms. Betsy Stephens, International Science and Technology Institute
Ms. Joanne Leslie, International Science and Technology Institute

CATHOLIC RELIEF SERVICE

CRS/New York & Nairobi

Dr. Carlo Capone, RMO, CRS Nairobi
Mr. Michael Wiest

CRS/Yaounde

Ms. Kathleen E. Kelleher, Program Director
Mrs. Veronique Ada, National Coordinator
Mrs. Sabina A. Tothy, Preschool Supervisor - Southwest
Mr. Ronald Sampson, Program Assistant
Mr. Mathias, Warehouse Clerk (Functioning as Regional Supervisor for Northwest)

GOVERNMENT OF THE UNITED REPUBLIC OF CAMEROON

GURC

Dr. Kessing, Asst. Director, Preventive Medicine and Hygiene
Mr. Elias Joe, Chief, Health Education Service, Preventive Medicine and Hygiene
Mrs. Tessa Epale, Chief of Education and Research, Nutrition Service, Preventive Medicine and Hygiene
Mr. Baboulak Emile, Counterpart Dr. C. Schuftan
Dr. Claudio Shuftan
Dr. John Schamper, Ministry of Agriculture
Dr. Theodore Ahlers, Ministry of Agriculture

Southwest Province

Governor Dr. Njiinjch Aloysius Niowana
Bishop Pius Awa
Mr. Ake Donatus, Prefect of Meme Division, Kumba
Mrs. Lazi Ngah Shadzeka, Divisional Officer, Meme Division, Kumba Central Sub-Division

Northwest Province

Secretary General David N. Posah
Mr. Lawrence Ekinde, Director Adm., World Food Program
Dr. Emmanuel Wansi, Divisional Chief Preventive Medicine
Mr. Samuel Tingem, Preventive Medicine Section
Monseigneur Paul Verdzekov
Prefect Akotoh Ndang, Prefect Donga Mantung Division at Nkambe
Mr. Tam Johnson, Office of Prefect, Donga Mantung Division
His Highness Fon Michael Fuma of Misaje Clan
Mr. Mbonchom Samuel Neba, Divisional Delegate for Agriculture, Mezam Division, Bamenda
His Highness Fon Abumbi II, Fon of Bafut
Mr. Akoso Peter, Assistant, Palace of Fon
Fon of Santa

CLINIC DIRECTORS/SUPERVISORS

Southwest Province

Mrs. Bimony, Mudeka Health Center
Mr. John Kubuh, Tole Tea CDC
Miss Rose Monono, Tole Tea CDC
Mrs. Odendakwah, Victoria PMI
Miss Margaret, Mukonje
Sister Anne Kratzer, Banga Bakundu Mission
Mrs. Carolyn Teke, Buea Bokwango Health Center
Mrs. Grace Azomo, Buea Bokwango Health Center

Northwest Province

Mrs. Elizabeth Fube, Director, Manji Government Health Center
Sister Gisela, Bafut Catholic
Mrs. Mary Chin, Elak Oku
Sister Clara, Tatum Mission
Sister Angelica, Bali Catholic
Mrs. Ndah Sirni Helen, Santa Health Center, Midwife in charge
Mrs. Togha Modest, Midwife, Santa
Mr. Maluh Mbetuh Daniel, 3rd year Diplome d'Etat, Student Nurse, Santa
Miss Mokom
Helen Malifon, 3rd year Diplome d'Etat, Student Nurse, Santa
Mrs. Francisca Ngah, Misaje Health Center
Mrs. Lawan, Jakiri Center
Sister Electa Kong, Shisong Mission
Dr. Dawson, Shisong Mission
Mrs. Wirdzenyuy, NSO PMI
Mrs. Lole, Bamessig

APPENDIX 5

CRS - MCH CENTER AGREEMENT

CATHOLIC RELIEF SERVICES

United States Catholic Conference

The Cameroon Program

Post Office Box 55
VICTORIA
U. R. of Cameroon

Tel: VICTORIA 33.82.17
Cable: CATHWEL VICTORIA

CENTRE_____ DATE_____ 19_____

The following conditions are agreed to by this centre as requirements for participation in the pre-school sponsored by Catholic Relief Services.

1. Full monthly rations will be distributed to the programme participants in accordance with the guidance provided by C.R.S. For the current year the correct rations are:

2. Punctual and complete monthly reporting and transmission of mothers fees will be effected in accordance with the guidance provided by C.R.S. regional pre-school Supervisor with the original posted to C.R.S. Yaounde. The contribution of 100 frs. CFA per participant will be sent directly to C.R.S. Yaounde unless other arrangements are made with the C.R.S. Regional Supervisor.

3. A clean, dry, well-ventilated store will be used for the storage of food supplies. These will be placed on elevated wooden pallets to protect the food from moisture etc. Stock cards will be kept and they along with the store will be available for inspection by the C.R.S. representative at any time. Every effort to control rodents, insects will be made.

4. No food will ever be sold under any circumstances.

5. No food will be distributed to anyone not enrolled in the Pre-school Programme.

6. The only persons eligible for food rations are children who have been registered at the centre and who are at least six months and not yet six years old.

7. A nutrition or general health/household care lesson will be included in every session of the pre-school programme.

8. The centre will be responsible for the weighing scale loaned to it by C.R.S. for the duration of the programme as well as any other cups or incidental equipment.

9. During each food demonstration, emphasis will be placed on the local equivalent of the imported foods so that the children will not suffer if the imported food supply is ever interrupted or discontinued.

10. Mother must accompany children and assist at all programme activities including weighing, food distribution and nutrition lesson.

11. Each child must be physically present for the pre-school session. A mother with more than one registered child must bring each child to the centre regularly to qualify for food ration.

12. To sell empty containers at the price fixed by C.R.S. and proceeds sent to C.R.S.

13. To appoint at least one person to supervise the distribution, record keeping, storage and use of the food for all consumption, record keeping, storage and use of the food for all consumption centres receiving it.

14. To notify C.R.S. of any deterioration of food and to request handling instructions from C.R.S. before taking any action.

15. To reimburse C.R.S. for any food lost or damaged through negligence or mis-use in the event such lost is assessed against C.R.S. by the donating U.S. Government Agency.

_____ _____

CENTRE REPRESENTATIVE C.R.S. REPRESENTATIVE

DATE:_____19___ DATE:_____19___

APPENDIX 6

EVOLUTION OF USES OF P.L. 480
EXCERPTED FROM CHRISTOPHER STEVENS,
FOOD AID AND THE DEVELOPING WORLD,
ST. MARTINS PRESS, Pg. 26-32.

USA

The USA created food aid as we know it today, has supplied the overwhelming bulk of the aid that has been given, and has a major voice in world food aid policies and practices. Although US food aid can be traced back to before World War 2, it is generally accepted that its present form dates from June 1954 when the US Government approved Public Law 480: the Agricultural Trade Development and Assistance Act, better known by its now ubiquitous initials – PL 480. Like many permanent features of society, this was intended as a temporary measure which would run for three years only and thereby exhaust the American agricultural surplus. However, within little more than a year of its enactment, its initial authorisation was increased from $1 billion* to $1.8 billion, and the following year to $3.5 billion as the surpluses grew larger not smaller.[5] By 1975, a total $24.251 billion-worth of agricultural commodities had been supplied under PL 480, equivalent to 16 per cent of total US agricultural exports during the period.[6] The gross cost of financing this programme including transport and other expenses, was $33 billion.[7] Over two-thirds of the cost of commodities was for cereals, and almost one-half was for wheat and wheat products. Soyabean oil accounted for 6 per cent of the cost, and dried skim milk for 5 per cent. Various 'blended foods' which have been introduced in recent years, mainly to overcome a shortage of dried skim milk, account for only 1.5 per cent of total costs.

The PL 480 programme is split into a number of 'titles' each of which governs the terms under which food aid is given. The number and the content of the titles has changed over time, which can be confusing since 'Title III' today is quite different from the 'Title III' of, say, 1967. When initially enacted, PL 480 had three titles. Title I provided for the sale on concessional terms of surplus agricultural commodities for payment in the local currency of the recipient, which could then be used either for US purposes or for mutually agreed economic development projects in the recipient country. Title II covered grants for emergency relief, community development, school feeding and other economic development purposes. However, Title II

* The term 'billion' is used throughout the book to represent thousand million.

assistance could not replace Title I or other sales. Title III authorised domestic donations of surplus commodities as well as overseas donations via US voluntary agencies and multilateral organisations, and it also covered food exports to finance barter trade.

Title I was the most important of the three, and indeed accumulated counterpart funds of local currencies faster than they could be spent. Partly as a result of this, sale for foreign currencies has been replaced by dollar sales. This change was authorised initially by a new Title IV enacted in 1961, but since 1966 long-term dollar credits have been subsumed under Title I and no new local currency sale agreements have been concluded under this title since the end of 1971.[8] Nonetheless, substantial amounts of foreign currency continue to be made available through repayments of earlier loans. There are currently five countries in which the supply of US-owned currencies arising from PL 480 is in excess of requirements, and until recently Tunisia fell into this category.

In 1966, PL 480 was revised substantially. The requirement that a commodity must be in 'surplus supply' to be used as food aid was modified to being 'available', and although the new term was hedged with restrictions, the change resulted in greater flexibility.[9] Furthermore, the USA gave notice that it would produce agricultural commodities specifically for food aid. Under the revised law, Title III was confined to barter deals and lost its responsibilities for providing food to multilateral organisations, which now fall under Title II.

Yet further changes were introduced by the International Development and Food Assistance Act of 1977. Title I has been amended so that 75 per cent of sales must go to countries which meet the poverty criteria established by the International Development Association (IDA),* and also so that it is now possible for the US Government to cut off food aid to states that violate human rights. A further amendment to Title I allows high protein and blended or fortified foods to be sold to the recipient country at prices which discount the cost of processing; this is the first time that sale at anything other than prevailing world market levels has been permitted. The act has created a 'Food for Development' programme as part of an extended Title III under which funds derived from the local sale of commodities supplied under Title I need not be repaid if these are used in agricultural and rural development projects. Thus, whereas American food aid used to be in grant

* The International Development Association is an affiliate of the World Bank (IBRD) which promotes economic development by providing finance on more flexible terms than conventional loans.

Table 2.3: Gross Cost of Financing Programmes Carried out under the Agricultural Trade Development and Assistance Act of 1954, Public Law 480, 83d Cong., as amended, 1 July 1954, through 30 June 1975 (in millions $)

Fiscal year ending 30 June	Title I		Title II, donations abroad		Title III	Total
	Sales for foreign currency	Long-term dollar and convertible foreign currency credit sales	Famine and other emergency relief	Voluntary agency programmes	Bartered material for supplemental stockpile	
1955	129.5	–	86.9	214.5		430.9
1956	624.2	–	93.6	271.2	–	989.0
1957	1,396.4	–	124.9	234.1	217.3	1,972.7
1958	1,144.7	–	121.4	254.3	83.9	1,604.3
1959	1,113.3	–	97.9	178.7	314.7	1,704.6
1960	1,308.0	–	95.5	130.8	192.4	1,726.7
1961	1,557.3	–	198.6	169.3	200.5	2,125.7
1962	1,608.1	29.0	241.9	191.7	193.3	2,262.0
1963	1,739.4	80.3	215.6	238.8	99.7	2,373.8
1964	1,636.2	65.1	228.2	341.6	37.7	2,308.8
1965	1,505.8	211.0	147.2	174.6	40.6	2,079.2
1966	1,287.8	274.8	222.5	148.3	25.8	1,959.0
1967	1,067.8	221.7	335.9	34.2	32.5	1,692.1
1968	784.8	350.0	344.6	–	25.9	1,505.3

Table 2.3 continued

1969	373.0	495.4	364.2	–	1.7	1,234.3
1970	336.3	560.0	351.0	–	0.2	1,248.6
1971	225.2	625.9	395.7	–	0.1	1,246.9
1972	156.0	614.9	524.4	–	–	1,294.3
1973	8.2	736.3	396.1	–	–	1,140.6
1974	0.3	577.8	384.8	–	–	962.9
1975	4.6	767.9	460.4	–	–	1,227.7
Total	17,997.7[a]	5,609.9[b]	5,431.3[c]	2,582.1[d]	1,466.3[e]	33,087.3

a Represents the gross cost to CCC of financing sales of US agricultural commodities for foreign currency. Includes commodity and other costs, ocean transportation costs, and interest costs.

b Represents the gross cost to CCC of financing long-term dollar credit sales of US agricultural commodities. Includes commodity and other costs, ocean transportation costs, and interest costs. The export value of commodities financed and ocean transportation costs (except ocean freight differential) are repayable by the importing country or private trade entity.

c Represents CCC's investment value in commodities made available for donation abroad under Title II of Public Law 480, ocean transportation costs for such donations and for foreign currency for use in self-help activities. Also includes gross cost of foreign donations through non-profit voluntary agencies beginning 1 Jan. 1967.

d Represents CCC's acquisition cost value, plus the cost of any processing and packaging performed after acquisition, for commodities donated through non-profit voluntary agencies under authority in sec. 416, Agricultural Act of 1949. This authority was repealed by the Food for Peace Act of 1966, Public Law 89-808, and such donations consolidated into new Title II of such act, effective 1 Jan. 1967.

e Represents the value at which barter materials were transferred to the supplemental stockpile.

Source: USDA, *Food for Peace, Fiscal Year 1975* (Washington, 1977), Table 8.

form only if supplied under Title II, it is now possible for shipments under Title I to be grants as well. However, to qualify for a Food for Development programme, a country must undertake steps 'to improve its food production, marketing, distribution, and storage systems'. The act specifies that a minimum of 5 per cent of Title I funds are to be allocated to Food for Development in 1978, and that this proportion will rise to 10 per cent in 1979 and 15 per cent in 1980 and following years.

The Title I sales programme is the responsibility of the US Department of Agriculture (USDA). Thus, liaison in the recipient country is maintained by an officer in the US Embassy. Title II is a joint responsibility of USDA and the US Agency for International Development (USAID), and liaison in the recipient country is through the USAID office (although, of course, this office is formally attached to the Embassy). The USDA determines the types, quantities and values of the commodities available, while USAID manages the programme design and monitors implementation of the projects. With both titles the mechanics of purchasing and overseeing the logistics of the food is the responsibility of the Commodity Credit Corporation (CCC), which is part of the Foreign Agriculture Service of USDA.

Title II activities are carried out by a variety of 'co-operating sponsors' who propose programmes for USAID consideration and have responsibility for their implementation. There are three types of co-operating sponsor: (a) non-profit voluntary agencies, both private such as CRS, CARE and CWS,* and intergovernmental like UNICEF; (b) friendly governments operating under bilateral agreements with the USA; and (c) the World Food Programme (WFP). The four recipient countries studied in this book have experience of all three types of co-operating sponsor, all have received WFP aid, and all except Botswana have CRS missions, while in addition Tunisia has experienced Title II food channelled through CARE and on a bilateral government to government basis. Although CRS and CARE obtain most of their food aid under PL 480, the USA is not their sole supplier. Both voluntary agencies have their eyes on the EEC milk supplies.

The changing size of the various titles over the years is shown in Table 2.3, pages 28/9, while the cumulative size and geographical distribution of the Title I programme is conveyed by Table 2.4, page 31, which gives the quantities supplied between fiscal years 1955 and 1975. The largest recipient has been India which has obtained 25 per cent by value [illegible] of the commodities supplied over this period, while

* Catholic Relief Services, Cooperative for American Relief Everywhere, Church World Service.

Table 2.4: US Public Law 480 Title I – Cumulative Quantities Programmod under Agreements signed between Fiscal Years 1955 and 1975* (by region of destination, in thousands)

Region	Wheat and wheat products (bushels)	Feedgrains (bushels)	Rice (cwt)	Cotton (bales)	Tobacco (lb)	Fats and oils (lb)	Dairy products (lb)	Other (lb)
Europe	532,354	152,474	498	3628.3	177,818	3,493,866	46,297	380 813
Africa	157,986	23,900	11,505	458.6	33,559	1,210,305	41,529	49 804
Near East – South Asia	3,485,064	596,436	68,040	3520	138,306	6,947,406	329,187	99 46[illegible]
Far East – Pacific	522,109	117,288	194,088	8565.6	303,306	638,326	580,400	254 654
Latin America	541,872	47,662	4,006	276.2	34,382	916,353	37,104	59 240

* Quantities shown reflect a combination of quantities shipped under agreements for which all activity is complete, plus quantities programmed in signed agreements for which activity is not complete.

Source: USDA, *Food for Peace: Fiscal Year 1975*, (Washington, 1977), Table 9.

Pakistan, Vietnam and Korea have each received 7-9 per cent.[10] Africa has received only 3.6 per cent by value overall, but it has received more than this proportion of fats and oils and of dairy products (8 per cent and 6 per cent respectively). The geographic distribution of Title II food aid during this period is given in Table 2.5, below. Again, India has received the largest share, with 12.5 per cent by value, but generally Title II is less concentrated than Title I. Tunisia has received 3 per cent of shipments by value, the same proportion a Egypt, the Philippines and Vietnam.

Table 2.5: US Public Law 480 Title II – Total Commodities shipped from 1 July 1954 to 30 June 1975 (by region of destination, weight and Commodity Credit Corporation dollar value)

Region	Quantity (thousand lb)	Value (thousand $)	Value as % of total value
Europe	9,458,366	1,097,395	16
Asia	31,378,095	2,503,200	36
Near East	24,886,741	1,733,546	25
Africa	6,284,397	458,250	7
Latin America	10,159,610	1,110,817	16

Source: USDA, *Food for Peace: Fiscal Year 1975* (Washington, 1977), Table 18.

These cumulative figures do not indicate changes in emphasis over time. Figures for the value of Title II food aid shipped in fiscal year 1975 show that while Africa still receives less than some other regions, its current importance is greater than the aggregate data would suggest. It accounts for 21 per cent of total shipments, compared with 44 per cent for Asia, 16 per cent for the Near East and 18 per cent for Latin America.[11] However, figures on Title I programmed under agreements signed in fiscal year 1975 suggest that Africa is even less important than hitherto, since it accounts for only 1.75 per cent by value of the total.[12]

APPENDIX 7

FIELD NOTES ON PHASING OUT
MOBILE OUTSTATION ACTIVITIES,
SHISONG CATHOLIC MCH,
BY RANDALL THOMPSON, USAID

Shisong Catholic
Thursday

There are nine food distributions per month. Distribution takes place on each Thursday at Shisong (four per month).

Distribution also takes place at five outstations per month. The distributions take place on each Tuesday, plus the first Wednesday of the month (total of five per month). The five outstations are Wvem, Sob, Nkar, Vecovi, and Wainamah.

The Mission is currently considering a phase-out of the outstation distributions. There are apparently several reasons for this. Evidently the Mission used to have a clinic outreach program to these villages prior to food distribution. In about 1978, the outstation villages vociferously (!) requested that food be distributed because they were aware of Shisong distribution. The sister in charge became disturbed that recipients were becoming "dependent" on food and were not getting the message of how to better use local food to nourish their children. This argument, of course, can be applied to Shisong as well, but the situation at the outstations was worse in that it took away more time from the patient care at the hospital. This time factor seems to be the overriding concern, plus the fact that the attitude of the people in the outstations does not seem to please the sisters. Dr. Dawson claimed that since the "food was not serving its purpose to educate the people," then the child welfare clinics should be turned over to the primary health care system. Another sister said that they had lectured the participants on how to prepare local food at Wvem and Vecovi. She said that this lecture had been a prelude to informing the participants that food would be withdrawn because it had served its purpose. Note the contradiction here. On the one hand, Dr. Dawson claimed that food was being withdrawn because it was not serving its purpose. On the other hand, program participants were informed that the food had served its purpose. The sister told us that the people in Wvem had been informed of the withdrawal of the food and had accepted it, but I

overheard her telling the Doctor that in fact they had not taken it well. As a matter of fact, the sisters were planning to close all the other outstations because they knew that the participants in Wvem would go to other centers to get food, thus creating a burden on the sisters. From all I heard, it appears that the sisters are fed up with all the work they are doing and are trying to justify withdrawal on more "acceptable" grounds. The program clearly creates a lot of hassles and the sisters feel that the benefits do not justify the efforts. An actual plan of withdrawal had not yet been implemented, and the doctor and sisters were not yet clear how and when they would proceed. It did seem, though, that the first step before actual withdrawal would be to present the lecture on how to use local farm foods to improve babies health.

The Mission uses the hospital ambulance to transport the food to the outstations, clearly another burden, and up to seven staff people to manage the outstation program.

APPENDIX 8

FIELD STUDY OF PROBLEMS CLINICS HAVE IN CORRECT USE OF THE GROWTH CHART: NOTES AND OBSERVATIONS,

BY RANDALL THOMPSON, USAID

Bafut Catholic
September 8, 1981

The following is a study of errors noted in recording weights and percentiles on growth cards and master charts.

In writing weights on growth charts, I noted an enormous number of errors, most of which resulted in underestimation of a child's age and subsequent overestimation of his percent of standard growth. I observed these errors in three separate charts in use in MCH centers:

(1) child's weight record over first five years (yellow graph),
(2) consultation infantile (pink card/graph), and
(3) growth surveillance chart (yellow card).

Errors which I observed were as follows:

(1) The recorder does not always understand that the bottom axis of the chart indicates the child's age, so that the recorder often places a weight right after the previous weight on the chart irregardless of the date, and they number the new weight with the next highest number. They do this even if several months have lapsed between visits; hence, the age is underestimated. I noted this error most on the yellow CRS growth surveillance card, because the months are not printed on the bottom line.

(2) The recorder understands that the bottom axis (or line) indicates age, but they do not ask the mother the child's age. They assume that the previous recorder has entered the child's correct age, and they simply count the number of months (and spaces) since the last entry and write the child's age as such. Hence, if an error was made before, it is perpetuated throughout. I noted an <u>enormous</u> number of errors such as this and all resulted in underestimation of a child's age, evidently because another error of underestimation had occurred earlier.

I observed this error several times in a gross form on the pink card (consultation infantile). Often the date was written on the graph without a year attached. If the child had missed more than a year, which was observed a few times, then the new entry was often placed after a month in a previous year, thus grossly underestimating a child's age. (I saw this a lot at Bali Catholic. It's a common error resulting from too much to do in too little time.)

(3) The recorder understands that the bottom axis (or line) of the card indicates the child's age and they ask the mother the age. She indicates year and number of months, or year and fraction. The recorder erroneously translates the age into months, which can create error in both directions. But for some reason, recorders often translate years into ten months each, and then add months to multiples of ten. Hence, two years is often written as 20 months, etc., again causing a bias to underestimate the child's age.

(4) The recorder understands that the bottom axis indicates the child's age and they ask the mother the age and correctly translate the age into months. However, the mother uses fractions. Hence, a child two years one to five months is called two years old, and a child two years six to eleven months is called two and a half years old. Again, there is a slight underestimation of age. However, this error was not observed very often.

If there are different recorders over a number of weeks, then all of these errors can be committed and over time the cumulative effect is underestimation of a child's age.

Card Designs which Aid and Abet Errors

Pink Card - Consultation Infantile

At Bafut Catholic, I noted that recorders either plotted directly onto the graph, without listing weight and date on the reverse side; or else listed date and weight on reverse side, and did not plot on the graph.

Evidently, when the recorder plots directly on the graph, the weight must have been written on a slip of paper. If the date was not written on the graph, the recorder often places the dot in the next space on the graph, The major problem with this chart is that there is no place for the date to be written on the graph.

CRS Yellow - Growth Surveillance Chart

This card is easier to read in that it has vital statistics on the same side as the graph, but it has serious drawbacks and requires extra work.

When weight is entered, then the recorder has to go to the master chart to find the percentile, then come back to the yellow chart to plot the percentile. When time if valuable, this is very likely not to be done, or to be done with a high rate of error.

The fact that age is not specified in the bottom line makes more room for error.

Yellow Graph - Child's Weight Record

The child's weight record over the first five years seems to be the best chart. However, if it would have percentiles listed on the chart, error could be greatly reduced by the following method.

When the child has a new card, the recorder should clearly write in the date of birth, and then fill out all months and years on the entire card. This way there is less chance of error when the recorder is under pressure. The recorder simply finds the current month and plots weight. If percentiles were indicated, it would help.

Also, the yellow chart should have an extra line which translates age into months, like the master chart.

APPENDIX 9

GROWTH CARDS IN USE IN CLINICS AND THE CRS MASTER CHART

APPENDIX 9

GROWTH CARDS IN USE IN CLINICS AND THE CRS MASTER CHART

GROWTH SURVEILLANCE CHART®
FICHE DE SURVEILLANCE DE CROISSANCE®

REFERENCE No
No D'INSCRIPTION

CENTRE
NAME
NOM
DATE OF BIRTH KNOWN
DATE DE NAISSANCE PRECISE
ESTIMATED
ESTIMEE

FATHER'S NAME
NOM DU PERE
PLACE OF RESIDENCE
LIEU DE RESIDENCE
DATE OF ENROLMENT
DATE D'INSCRIPTION

MOTHER'S NAME
NOM DE LA MERE
GROUP
GROUPE
SEX
SEXE

PERCENT OF STANDARD GROWTH
POURCENTAGE DE LA CROISSANCE STANDARD

100
95
90
85
80
75
70
65
60
Below
En dessous de 60

DATE

WEIGHT
(lbs or kg)
POIDS

ILLNESS
MALADIE

AGE IN MONTHS
AGE EN MOIS

TO ENTER THE PERCENT CALCULATE FROM THE MASTER CHART FILL THE CORRECT SQUARE AND CONNECT THE DOTS AS SHOWN
POUR ENREGISTRER LE POURCENTAGE CALCULER DU MASTER CHART BIEN REMPLIR LE CASIER CORRESPONDANT ET RELIER LES POINT COMME SUIT

NOTES

ASSOCIATED HEALTH ACTIVITIES
ACTIVITES DE SANTE

MALARIA SUPPRESSION
SUPPRESSION DU PALUDISME

YEAR
ANNEE

JAN	F	M	A	M	JUNE	
JULY	A	S	O	N	DEC	
JUIL						

JAN	F	M	A	M	JUNE	
JULY	A	S	O	N	DEC	
JUIL						

JAN	F	M	A	M	JUNE	
JULY	A	S	O	N	DEC	
JUIL						

IMMUNIZATIONS
VACCINATIONS

SMALLPOX
VARIOLE

VACCINATION DATE

REVACCINATION DATE

DIPHTHERIA PERTUSSIS TETANUS (D P T)
DIPHTERIE TETANOS COQUELUCHE (DTC)

INJECTION DATE 1
2
3

TUBERCULOSIS (B C G)
TUBERCULOSE (B C G)

VACCINATION DATE

POLIO

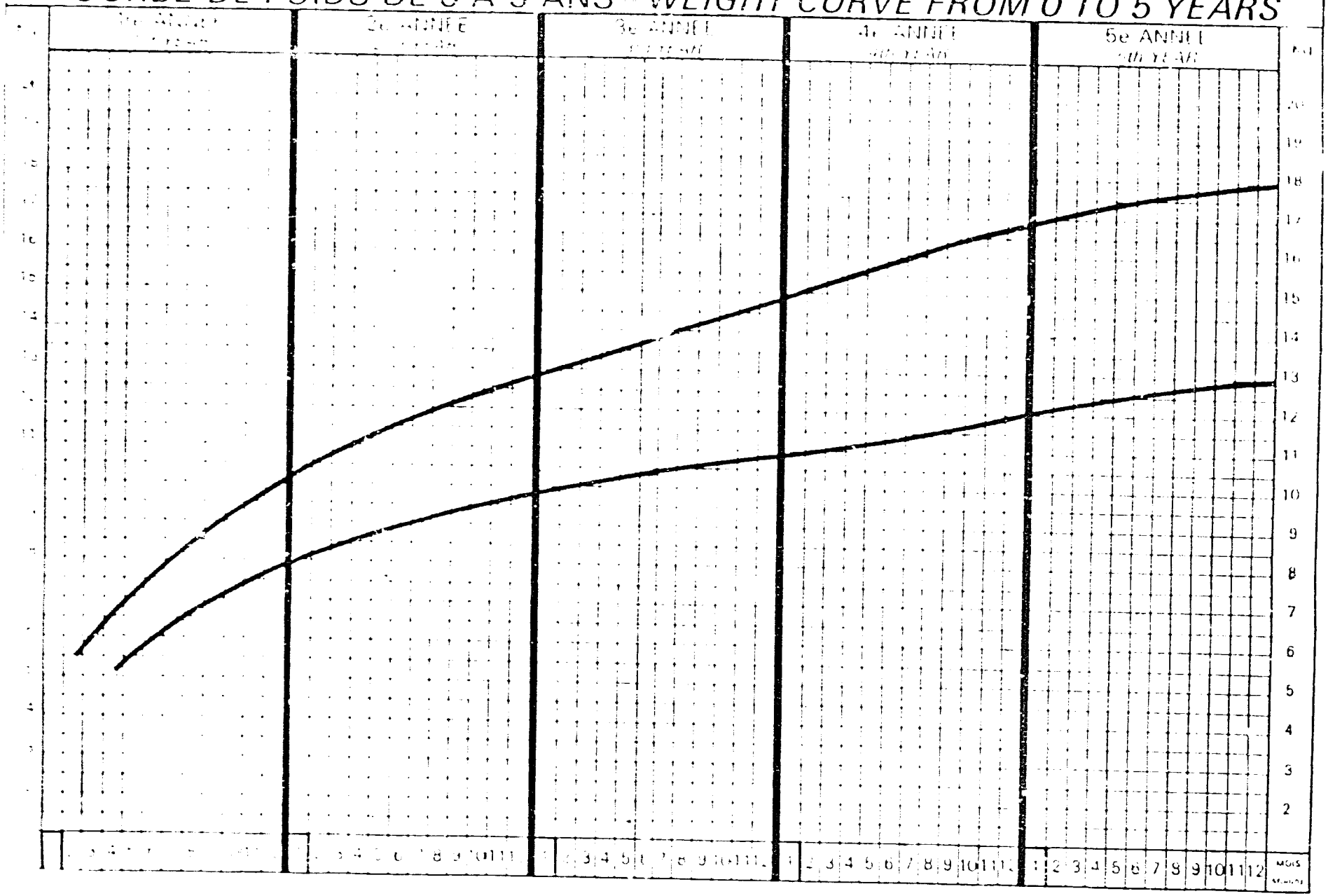
VACCINATION DATE 1
2
3

MEASLES
ROUGEOLE

VACCINATION DATE

NOTES

COURBE DE POIDS DE 0 A 5 ANS *WEIGHT CURVE FROM 0 TO 5 YEARS*



DATE	POIDS WEIGHT	TAILLE HEIGHT	OBSERVATIONS REMARKS	TRAITEMENT TREATMENT

REPUBLIQUE UNIE DU CAMEROUN

UNITED REPUBLIC OF CAMEROON

PROTECTION MATERNELLE ET INFANTILE
MATERNAL AND CHILD WELFARE

CONSULTATION INFANTILE - CHILD WELFARE CONSULTATION

N° - No. ..... Année - Year 19 ..

Département de ..... Centre de P.M.I de .....
Division — Child Welfare Centre

Nom ..... Département d'origine .....
Name — Home Division

Né le ..... Village d'origine .....
Born on — Home Village

à ..... Sexe M/F ..... Ethnie .....
at — Sex M/F — Tribe

Adresse .....
Address

Nom du père ..... Profession .....
Father's name — Occupation

Nom de la mère ..... Profession .....
Mother's name — Occupation

Frères/sœurs ..... Vivants .....
Brothers/Sisters — Living

SERVICE SOCIAL - SOCIAL SERVICE .....

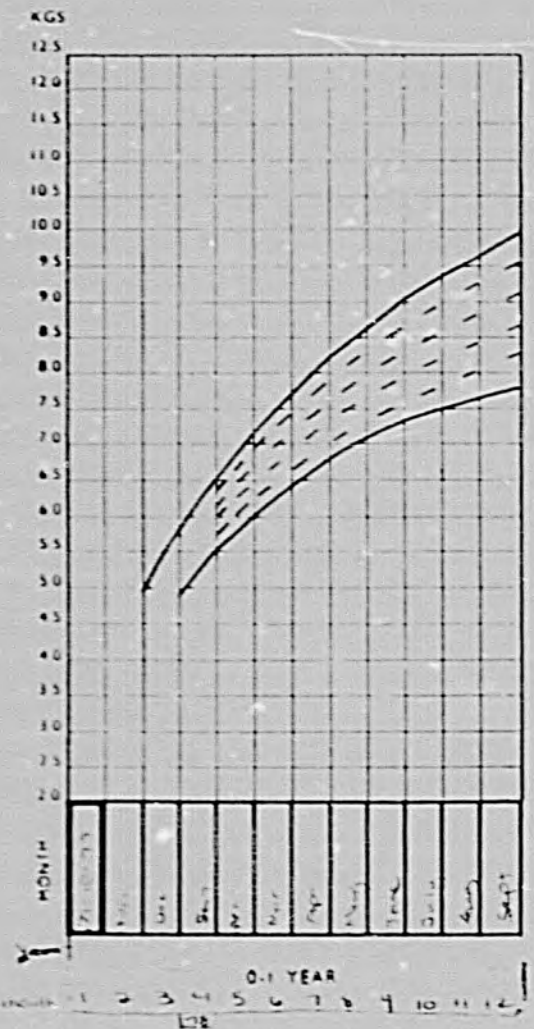
VACCINATIONS — VACCINATIONS

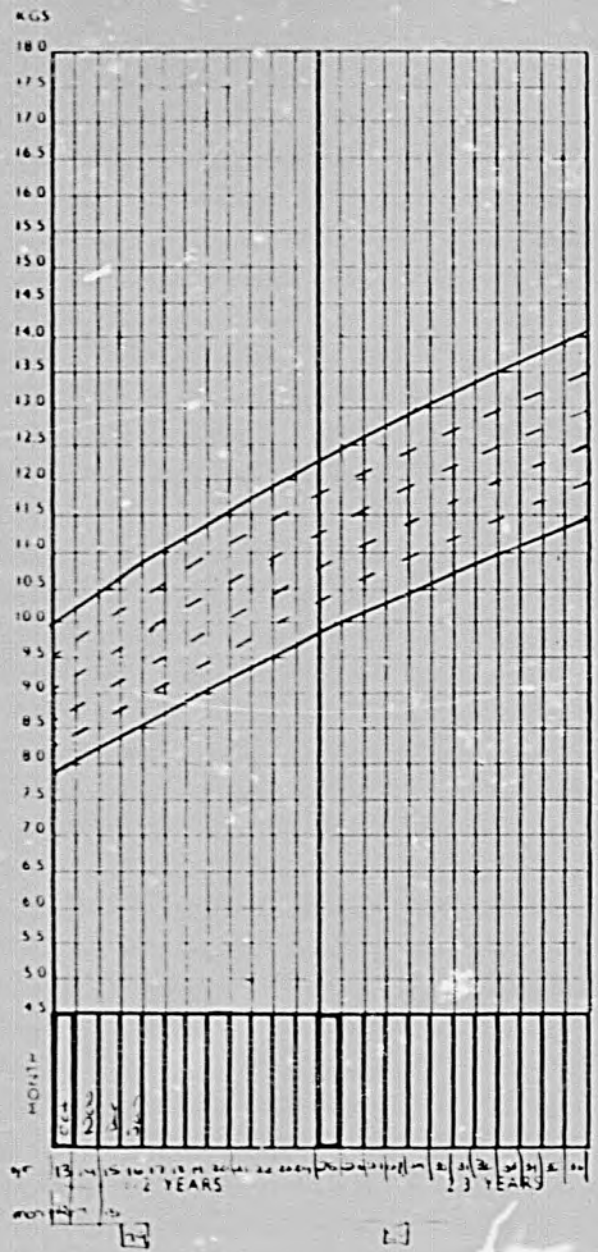
DATE	SORTE - TYPE	DOSE	CACHET ET SIGNATURE - STAMP AND SIGNATURE
	B C G Résultat - Result		
	Variole - Small pox Résultat - Result		
	D T		
	Coq Coq (Whooping cough)		
	Rougeole - Measles		
	Polio		
	A T Tetanus anti toxin		
	Autres vaccinations Other vaccinations		

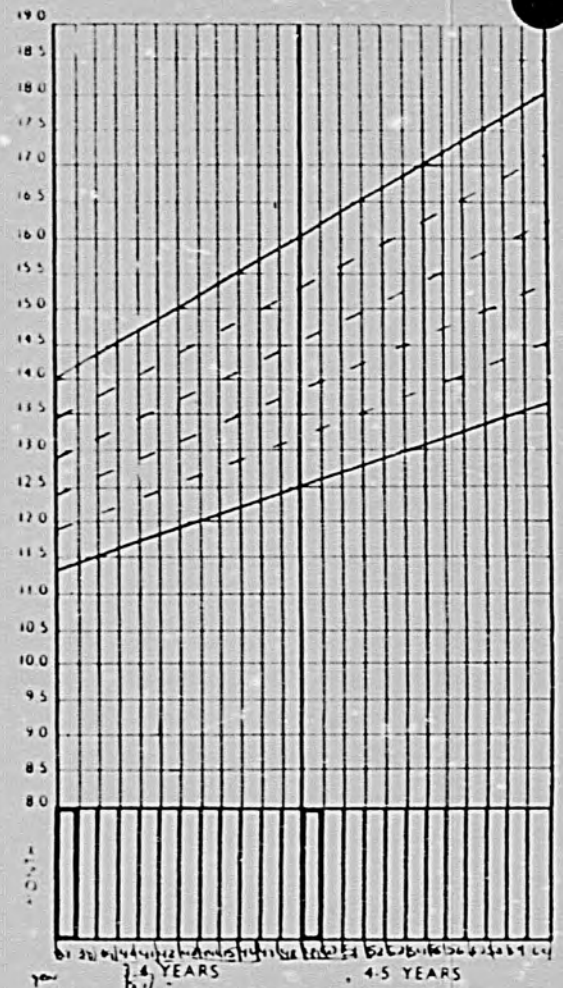
PRESENTEZ VOTRE ENFANT CHAQUE MOIS AVEC CETTE CARTE
BRING YOUR CHILD EVERY MONTH WITH THIS CARD

CHILD'S WEIGHT RECORD OVER FIRST FIVE YEARS

MAJOR ILLNESS TO BE ENTERED ON CHART







Instructions to Nurse or Clerk completing Chart. Find out month of birth of the child and fill this into all the black-edged spaces, then fill in the other months, also mark off the years as shown.

October	November	December	January	February

When the child comes for weighing make a large dot in that month's column against the weight. Connect this with the last dot.

NOTES

MALARIAL SUPPRESSION

Year

JAN	FEB	MAR	APR	MAY	JUNE
JULY	AUG	SEPT	OCT	NOV	DEC
JAN	FEB	MAR	APR	MAY	JUNE
JULY	AUG	SEPT	OCT	NOV	DEC
JAN	FEB	MAR	APR	MAY	JUNE
JULY	AUG	SEPT	OCT	NOV	DEC
JAN	FEB	MAR	APR	MAY	JUNE
JULY	AUG	SEPT	OCT	NOV	DEC
JAN	FEB	MAR	APR	MAY	JUNE
JULY	AUG	SEPT	OCT	NOV	DEC

SMALLPOX VACCINATION

DATE VACCINATION
(as soon after 3 months as possible)

DATE OF SCAR INSPECTION

DATE OF RE-VACCINATION
(between 4 and 5 years of age)

WHOOPING COUGH, TETANUS & DIPHTHERIA INOCULATION

DATE OF FIRST INJECTION
(at the age of one month or later)

DATE OF SECOND INJECTION
(one month after first injection)

DATE OF THIRD INJECTION

ANTI TUBERCULOSIS VACCINATION (BCG)

DATE OF PRE-BCG TUBERCULIN TEST

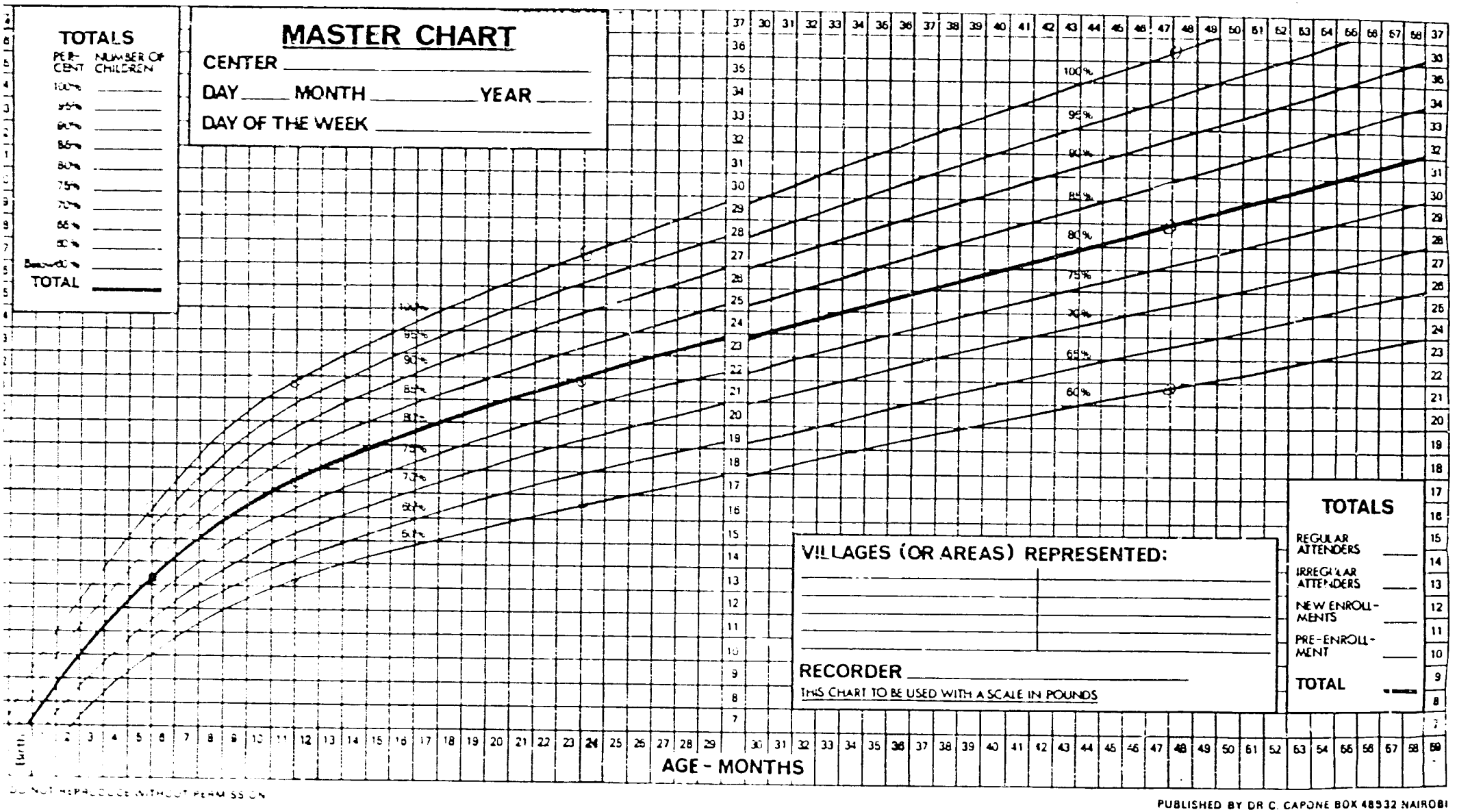
DATE OF BCG VACCINATION

WELFARE CENTRE	CHILD'S No.
CHILD'S NAME	M or F
FATHER'S NAME	
MOTHER'S NAME	

DATE OF BIRTH	DATE FIRST SEEN
NAME OF COMPOUND: No and NAME of STREET	

BROTHERS AND SISTERS

YEAR OF BIRTH	SEX	REMARKS



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APPENDIX 10

FOOD PRICES IN NORTHWEST PROVINCE

APPENDIX 10

Food Prices in Northwest Province

Food	Market Price			
	Kumbo		Bamenda	
	CFA	$*	CFA	$
Oils				
Groundnut oil, liter	592	2.69	-	-
	444	2.01	-	-
Cameroonian Cottonseed Oil, liter	500	2.27	390	1.77
Benedita (French) soy oil, liter	525	2.39	-	-
Palm oil (Red oil), liter	259	1.18	222	1.01
Staple				
Cornmeal, rough grind, Kg	146	0.66	132	0.60
Protein				
Peanut paste, Kg	-	-	303	1.38
Peanuts with hulls, Kg	263	1.20	-	-
Powdered milk, Kg				
Nido (400 gm can)	1,250	5.68	1,250	5.68
Peak (400 gm can)	1,375	6.25	1,375	6.25
Eggs, each	45	0.20	35	0.16

* Exchange Rate 1980, $1 = 220 CFA

APPENDIX 11

THE FOOD FOR PEACE PROGRAM IN CAMEROON
BY SAM La FOY,
REGIONAL FOOD FOR PEACE OFFICER

Background Description of Program

The CRS Title II program is not country-wide. It has worked longest in the South-West Province, then the North West and less than two years in the Eastern Province.

About 75-85% of the centers are GURC-administered. Of these, approximately 95% are run by the Ministry of Health, most of the rest being Ministry of Social Affairs. Some CRS Title II activities are carried out by Catholic missions, or, in the Eastern Province, ZAPI's.

CRS has traditionally considered the Cameroonian Catholic organization as its counterpart agency, although they get GURC budget support according to the country agreement. Generally, they have worked with the Ministry of Health most closely. CRS is currently negotiating with the GURC to determine which Ministry should be designated their "Ministre tutelle". Besides the Ministry of Health they also work with Social Affairs, and receives funding from them.

CRS uses centers which are already established, and their food and nutrition program is only one component of the clinic's or center's activities. MOH centers might have a prenatal clinic, vaccination services, a dispensary, or perhaps a maternity. With attendant services available, the food and nutrition program can be useful in a referral role. CRS also supports some nutrition rehabilitation centers. The CRS national nutrition supervisor finds, however, that the smaller and more distant the center, the less qualified the staff, and the fewer the supplies, equipment and consequent services, so that the food and nutrition program can become a much more important activity to the center.

Social Affairs centers, on the other hand, are less homogenous. They are woman-oriented and can involve such diverse programs as a credit union, small community projects, cooking demonstrations, health and hygiene education.

The Eastern Province, where CRS is just beginning to work, has had very scarce social services. The GURC has some scattered centers, but ZAPI, an IBRD-supported organization is also starting to work in the province - in economic, agricultural and community development. Although CRS has established feeding programs in only a few ZAPI health centers, ZAPI cooperates closely with CRS and has provided warehousing and transportation. Because of the neglect on establishing infrastructure, CRS finds the quality of center staff much poorer in the East.

So far, the CRS program in Cameroon feeds only pre-school aged children, no mothers. They do provice some "welfare" feeding (Mr. Joe's "truly needy"), but with EEC-donated food, not Title II. Such welfare programs are discouraged by Food for Peace.

B. Resources

CRS/Cameroon receives financial and material support from a variety of resources (see 1980 annual report, attached).

The GURC fiscal year is July 1 - June 30. About December CRS submits its budget request to the government, addressed to MOH, with copies to all other Ministries with whom they deal. The Programming Division of the Ministry of Economy and Plan, in discussion with the others, decides what amounts will be provided from which Ministry. Sometimes the decision is made promptly, sometimes the decision, and release of funds, are later. In the latter case, CRS/NY has had to lend funds, or the beneficiary contributions are used. When the GURC cannot cover the total budget request, the beneficiary contributions must again be used.

Besides budgetary support, the GURC has seconded three nurses to CRS as nutrition supervisors, paying their salaries. MOH provincial délégués also appear to support the program, offering provincial warehousing, office space within their own offices, etc. In the three provinces where CRS is working the MOH has endorsed the CRS weight charts.

In 1978-1979 at the same time that CRS introduced an increased, standard ration, it also raised the beneficiary contributions to 100 CFA per recipient per month. Twenty-five percent of this remains at the center to pay for such things as local center expenses in support of the feeding program - cooking utensils, storeroom maintenance. The remaining 75% is forwarded to CRS. This is used for a variety of expenses in the program: salaries, administrative costs, office rental, casual labor, fuel, per diem. Accounting for these contributions is separate. The Ministry of Finance has occasionally asked for information on its uses, but there is no official agreement of the GURC role and responsibility towards these funds.

Food and Nutrition Program

The food and nutrition started implementation in late 1978 and early 1979. Rations were increased (2kgs. commeal, 2 kgs. non-fat dry milk (NFDM), 1kg. vegetable oil), a national nutrition supervisor was hired and was sent to CRS Ghana for training in the program. CRS held seminars to teach the theory and mechanics of the program. All the elements were instituted at the same time: the standard ration, the weighing and weight/master charts, the nutrition education and demonstrations. Installation of the new system in the East had fewer problems of acceptance than in the other two provinces where there was a disruption of an established way of doing things.

This first phase of the program has concentrated on the mechanics - training of staff in using the charts, proper weighing, management and accountability for the food from receipt through distribution, giving health talks. Although many centers were very enthusiastic about the food and nutrition at first, since it attracts mothers and keeps the centers busy, the amount of work involved can cool their interest so that the nutrition supervisors must work with them until they are committed to carrying out the program.

The centers send the master charts, the beneficiary contributions and a report (copy attached) to the regional nutrition supervisors. She checks for obvious errors or deterioration in nutritional health. From these monthly master charts, she fills out a form giving a regional report on the number of rations distributed per center, number of children at what percentage of the standard of weight for age, the number of children attending and number of new registrations. These provincial reports are sent to the national nutrition supervisor in Yaoundé. There are often delays experienced in forwarding of charts and reports from the centers. Causes include poor road conditions, lack of money or a trustworthy person to carry the contributions, or in some cases because the staff has used more than their allotment of the money, which the reports would uncover.

The national nutrition supervisor does some review and analysis of her own, and sends a summary national monthly report to Dr. Capone's office in Nairobi where more expert analysis is done and comments and recommendations are sent back to CRS/Cameroon for action. For example, for the month of April, she found that out of a total of 23,738 children, 2,859 were under 70% of standard; for May, of 21,537 children, 2,833 were under 70% (5) of standard. (Because of rate charts still not being received, the total number does not reflect actual recipient levels). In this furst start-up stage, most of the emphasis has been on making sure that the data is filled out properly and pinpointing centers which need more training in the use of the master charts.

Along with checking the charts, CRS monitors activities by periodic visits from the provincial nutrition supervisors. If there are no problems, they try to visit each center every two months, but some centers get fewer visits because of remoteness or seasonal inaccesibility.

Problems are also pinpointed during quarterly meetings of provincial supervisors, the national nutrition supervisor and CRS's shipping and food manager. Such problems as delinquency in reporting, poor nutritional status or irregular attendance are reviewed. Smaller departmental meetings are also called, involving staff from a few neighboring centers for additional training or to confront identified problems.

One of the main problems so far is one of irregular attendance. One important reason for this is the lack of continuing food supply. During the planting season, the mothers find it hard to spend a day away from her fields. In some cases, the value of the ration is not considered important enough for regular attendance.

In the second phase of program implementation, CRS will focus on the "contractual" element of the food and nutrition program. They are planning on having local workshops to introduce the contractual concept to center personnel and to discuss the best means of assuring regular attendance as a part of that contract. They are also encouraging centers to follow up their activities by home visits. The results of training and monitoring are varied so far. Center personnel have a wide difference in education, from diplomaed nurses to midwives, to aides or even a local village woman, with least qualified staff ususally in the more remote areas. This affects their degree of commitment to the program or their understanding of the objectives of the program.

III. Administration/Management

A. Program Management

As detailed previously, the provincial supervisors monitor the program activities through regular visits to the centers, local and provincial meetings and review of the monthly master charts and reports. Centers with irregularities (larger or smaller than standard rations, attendance variations, poor reporting capability, delinquency in reporting) can be focussed on.

CRS also employs an end-use checker who makes regular visits to the centers and reviews the receipt, storage and use of the food (See monthly end-use check form, attached). At the moment, centers are visited about every two months, but CRS is hoping tp be able to hire another, trustworthy, end-use checker so that visits can be more frequent.

B. Food

1. NFDM

The wisdom of using NFDM in the ration has been questioned. From the point of view of its high economic value to the family, this is debatable in some pasts of West Africa where powdered milk is not wellknown or desired. However, it appears that in Cameroon this is not the case. The national nutrition supervisor has found that even in remote areas, mothers know about powdered milk and, if they have adequate means, would buy it for their child. Presumably this knowledge and preference is attributable to modern communications and marketing. In fact, she says that for the affluent families, the mothers will have a tendency to substitute powdered milk for breastfeeding. In the CRS program, CRS emphasizes that breastfeeding is to be continued, that the NFDM should only be used as a supplement and that the NFDM should not be made into milk but be mixed with the baby's "bouillie", or pap.

CRS reports that they have had no acceptability problems with the cornmeal and soy oil, the other two ingredients to the Title II ration. At one time CRS ordered bulgur, but they had problems both with acceptability and with high rates of insect infestation and spoilage.

2. Food Management

CRS employs the shipping and food manager in CRS/Yaoundé, the end-use checker and a port officer based in Douala. CRS has a warehouse in Victoria, for the South-West, with approximately a 400 MT capacity; in Bamenda, for the Northwest, of about 200 MT and one in the Eastern Province of about 130 MT; for a total estimated storage capacity of 730 MT.

The Douala port does not permit the consignee to receive shipments ex-ship's tackle. The food is unloaded and stored in Customs warehouses under management of the ship's agents. In the case of Delta, CAMATRANS acts as their agent. Because of this system, CRS must arrange for two surveys: one for discharge ex-ship's tackle for use against marine losses, and one at the time the shipment leaves the CAMATRANS custody. Both surveys are sent to CRS/NY who handles any claims for losses against either the shipping line or CAMATRANS.

CRS had had unsat sfactory service from the Lloyd's agent in providing timely and adequate survey reports. They are now using another surveyor, Mr. N'Guemo who, while not perfect, is better. Since CRS has started using him, CARE and WFP are also employing him.

The port officer prepares a breakdown plan for each shipment with the quantities to go to each provincial warehouse. Most food is transported using private truckers. Food to the Eastern Province can be moved by railroad, which gives them a special rate of only 75% cost, but the railroad is not centrally located, so that truckers are not readily available, and there are more losses from pilferage by train. CRS is hoping to rent a different, more central warehouse and uses truckers to transport much of their food to the East.

The forwarding order, receipt and control form is filled out by CRS/Douala and signed by the trucker. One copy stays with the port officer and the others go with the truck. The provincial warehouseman checks to see that the right quantity was received in good condition and signs the form. One copy stays at the warehouse, one is sent directly to CRS/Yaoundé, one goes to the CRS accountant and the last copy the trucker presents to receive payment. For the North-West and South West the Assistant Director in Victoria pays, for the East, the Yaoundé office pays the freight.

The provincial warehouseman arranges transport of the food to the individual centers, using the same system as before. The schedule of deliveries is prepared by the provincial supervisor's, based on such factors as the center's storage capacity, the rate of distribution, distance from central warehouse and the condition of the roads. All these factors result in one of the largest problems with the Title II feeding program: irregular commodity deliveries. This in turn is one major reason for irregular attendance on the part of the mothers.

CRS would like to deliver monthly to centers. They fear that if deliveries for longer periods are made, the rations at the beginning will be too large and that the center will run out of food before the next delivery. However, except for centers close to the central warehouses, this is rarely possible. For centers which are remote, have poor roads or which are inaccessible during the rainy season, CRS tries to supply food for a longer period where feasible. Unfortunately, most centers have very limited storage space and repeated deliveries of small quanitites are necessary. Truckers are reluctant to carry small loads over poor roads and also be held so strictly accountable. Some centers are forced to suspend operations during the rainy season, others have their programs suffer from periodic unavailability of rations.

Another reason why centers will have delayed food deliveries is if a ship (or ships) is delayed. Last year, one quarter's order was delayed so long, the next quarter arrived almost on top of it. In that case, there were insufficient stocks to send to centers, followed by the problem of finding enough storage for so much food at one time. CRS used a Catholic procureur's warehouse in Douala for the overflow.

Damages to food are higher before it is received at the Douala port warehouses. The handling is poor in the port and there is also pilferage. Damages at the centers is largely due to rats and then insect infestation once holes are made in the bag. When food is considered spoiled at the centers, since about two years ago, it is separated. When the provincial supervisor visits, she inspects it, certifies it as unfit and she takes it back with her. She reports the loss to CRS/Yaounde, who informs USAID and who must concur in its disposal. Once this approval is received, the food is usually given to government or private livestock or poultry projects as animal feed, where they can be sure that it won't be sold for human consumption.

IV. Observations and Recommendations

A. GURC Commitment

At the working level, GURC Ministries seem to support and work closely with CRS. They get together to discuss the CRS budget and allot amounts from individual Ministries. MOH has seconded three nurses to CRS, as provincial supervisors. Some provincial health délégués provide office and/or warehouseing. They are currently negotiating to settle on which Ministry should be the "Ministère tutelle", or counterpart. However, on a policy level, there might be less of a commitment to the CRS program, and this a case where the policy end and the executive end are not communicating. Every effort should be made on the part of CRS, and USAID, to clear up any such dual thinking.

B. Reliable Food Supply Chain

The major problem currently affecting any potential program success is the disruptions in food deliveries at the centers. Several reasons exist for this:

1. Inadequate storage at centers. This is less of a problem in the East where CRS was able to consider the storage available when accepting new centers. However, in the other areas the centers started out before this criterion was taken into account. CRS has obtained brick presses for lending to communities to build additional storage but so far has not had much demand for them. A few communities on their own initiative have built larger storehouses.

> Recommend: That CRS continue offering brick-presses to communities and otherwise try to persuade communities to provide adequate storage.
>
> Also recommend that CRS investigate the possibility of finding support to assist communities financially in building storage, including the use of Outreach funds through USAID and Food for Peace.

2. Unwillingness of truckers to transport CRS foods. It is realized that CRS feels it has more control over rate of distributions if it supplies only one month's food at a time. This concern can be addressed through continuing constant attention to compliance with established ration levels, through the reporting system, seminars and visits by the end-use checker and provincial nutrition supervisor. It would appear to be more cost-effective to send a truck once a quarter to a center instead of three times. Truckers would also probably be more willing to handle larger loads at one time. Of course, this is only possible where the center has adequate storage for three months.

Recommend: That, where local storage facilities permit, CRS aim at quarterly deliveries to the centers.

3. Shipping Delays/Bunching. The problem of getting well-spaced shipments from the US is not a unique problem to smaller CRS programs in the area. Shipping companies prefer to put the relatively small quarterly quantities on ships already scheduled for that port and consequently will sometimes delay shipments or change to a later ship. There is little to be done by CRS/Yaoundé except to place calls forward in time, specifying desired delivery dates. CRS/NY and its agent, D.F. Young are then responsible for arranging shipment.

Recommend: That CRS/Yaoundé submit calls forward promptly and give exact desired arrival dates.

Recommend: That CRS/NY use its best efforts with shippers to insure well spaced shipments.

C. Regular Attendance As stated above, one major constraint to regular monthly attendance is the periodic unavailability of food. Other reasons can be seasonal - during the rainy season because of poor roads, the planting season because of needed labor. Another reason is probably that generally the mothers have had nothing to lose from missing a month or two; unless the staff of a center has more than it can handle, no disciplinary action is taken, such as cutting a recipient out of the program. It is also unfortunate that the second phase of the food and nutrition program is still being designed, so that neither the centers nor the mothers are committed to the "contract" where the mother agrees to attend regularly in exchange for the food and services.

Recommend: That with the initiation of the "contractual" phase of the program, a system be devised to insure regular attendance. Such a system will have to be appropriate to the Cameroon scene but might be suspension from the program if the mother does not bring the child for three consecutive months, and there are no other reasons for absense such as illness, visiting in other regions, or washed out roads.

D. Use of NFDM. If for nutritional or other reasons (acceptability) it is recommended retain NFDM in the program, a very real danger of its substitution for breastfeeding exists in the Cameroonians context. Every effort should be made to insure that center personnel and mothers know that breastfeeding is better than powdered milk.

Recommend: That CRS insure that NFDM be accepted only as a supplement to breastfeeding and that the NFDM is mixed with the child's regular "bouillie" instead of as a plain milk beverage.

E. Integration with Other Development Activities. The Social Affairs centers, with their focus on women and small community activities, have potential for WID projects, or other community-level activities such as potable water, school construction, credit unions, non-formal education, cooperatives, etc. While such initiatives would per force be on a small scale, the opportunities should not be ignored by CRS or other entities such as Peace Corps and USAID.

Recommend: That CRS and other donors study the possibility of integrating Title II resources, the food and nutrition program, with other resources and development activities.