

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE <b>PD-AAN-289</b> Somalia Rural Health Delivery <i>ICM</i>			2. PROJECT NUMBER 649-0102	3. MISSION/AID/W OFFICE Somalia
5. KEY PROJECT IMPLEMENTATION DATES			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY)	
A. First PRO-AG or Equivalent FY <u>79</u>	B. Final Obligation Expected FY <u>85</u>	C. Final Input Delivery FY <u>84</u>	<input type="checkbox"/> REGULAR EVALUATION <input checked="" type="checkbox"/> SPECIAL EVALUATION	
6. ESTIMATED PROJECT FUNDING			7. PERIOD COVERED BY EVALUATION	
A. Total \$ <u>20,405</u>			From (month/yr.) <u>October 1980</u>	
B. U.S. \$ <u>15,249</u>			To (month/yr.) <u>December 1981</u>	
			Date of Evaluation Review <u>January 1982</u>	

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

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., algram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. A revised PP be prepared reflecting changes in scope of project and roles of principal parties.	C. Habis USAID/S	4/82
2. A review of all PIO/Cs be conducted, a summary prepared on status of items, and recommendations made on items required to be cancelled or located: a. Revised commodity list prepared b. Revised vehicle list prepared.	G. LaBombard USAID/S	2/82
3. An interim statement be prepared which authorizes categories of increased expenditures for logistic support for MSCI. Expenditures made in this category during the past 3 months should be reviewed and approved if found justifiable.	J. Cipolla MSCI	3/82
4. A draft revised financial plan be prepared with the recommended changes in inputs, and outputs, and a new implementation and work plan prepared for the next 18 months.	J. Kelly & Controller USAID/S	2/82
	J. Cipolla MSCI	
	J. Cipolla MSCI	2/82

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

<input checked="" type="checkbox"/> Project Paper	<input checked="" type="checkbox"/> Implementation Plan, e.g., CPI Network	<input type="checkbox"/> Other (Specify) _____
<input checked="" type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	_____
<input checked="" type="checkbox"/> Logical Framework	<input checked="" type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify) _____
<input checked="" type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

A.	<input type="checkbox"/> Continue Project Without Change
B.	<input checked="" type="checkbox"/> Change Project Design and/or
	<input checked="" type="checkbox"/> Change Implementation Plan
C.	<input type="checkbox"/> Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Name and Title)

Anita Mackie  
Health Economist  
REDSO/EA

12. Mission/AID/W Office Director Approval

Signature	<i>Jim Kelly</i>
Typed Name	Jim Kelly
Date	March 2, 1982

### 13. SUMMARY

At the end of the project's second year the two field teams located in Baidoa, Bay Region, and Burao, Togdheer Region, are substantially on target and meeting goals for training staff. Field placement for the technicians was delayed a year by the inability to erect the prefabricated houses. Temporary housing and makeshift training facilities are currently being utilised. Both staff or students are well-motivated and have developed useful curricula. Facility construction requires priority consideration, including renovation of units to which graduating students will return.

The MOH is making some progress in creation of a unit to support and supervise Primary Health Care. Much remains to be done, policy formulation has just been initiated. Logistic support systems for drugs and transport are lacking. Service components such as EPI and laboratory analysis have not been clearly defined nor implemented. The ability of the Government to provide the necessary budget support for a nationwide system of primary health care is questionable. The recommended reduction in the size of the project to the two existing Regions with construction of only 12 Primary Health Care Units will enable the MOH to appraise their future manpower needs, costs, and logistic support necessary for expanded national coverage.

### 14. EVALUATION METHODOLOGY

The reason for the evaluation was to examine the project design and measure progress against the PP and suggest modifications in view of changes which have effected Mission staffing patterns, field placement of the technicians and the MOH's ability to support Primary Health Care. The delays

occurring in the project made it premature to conduct the full evaluation planned for the end of the third year of implementation.

The evaluation was conducted by REDSO/EA, assisted by AID/S staff, January 11-20. Interviews were conducted with all MSCI project staff, MOH personnel concerned with PHC, and WHO-supported staff in the MOH. Site visits were conducted to Baidoa and Burao and included meetings with the D.G., Regional Medical Officers and Primary Health Care Coordinators, observation of training sessions, interviews with students and visits to outreach activity sites. Project files were examined.

#### 15. EXTERNAL FACTORS

At the national level there has been a dramatic change in the terms of trade with the increase in petroleum prices. Most of Somalia's foreign exchange is now utilised for fuel, with little remaining for necessary imports such as drugs and medical supplies. The petrol price rise alone has a major impact on the logistic support costs of supporting primary health care given the dispersed population and vast distances to the various regions.

Given the present financial condition of the country there is a major question about the ability of the country to meet recurrent costs in the health sector. Like most developing countries, the majority of the budget goes for the hospital sector, 15 Regional hospitals and 70 district hospitals half of which are staffed by nurses only. During the evaluation it was observed that district hospitals (even those with physicians) were without basic drugs and supplies necessary for minimal functioning levels. Primary

health care and preventive health always assume a lower level of importance than the hospitals and curative medicine, it is questionable whether they can be expected to receive increasing levels of recurrent cost financing.

Present salary levels in the MOH for all categories of health manpower are low, and many trained staff leave for higher paying positions in the Gulf States. The decision was made to give incentive payments to all staff involved in this project. Incentive pay is also given to health manpower involved with the Refugee Health Unit. Other bilateral and multilateral (UNICEF) donors are not paying incentives resulting in an imbalance between regions. If this situation continues, the scarce health manpower will be attracted to this project. Whether they can be retained at peripheral PHC facilities may depend on continued incentive pay and the adequacy of logistic support. No special program has been undertaken as yet to reach the nomadic populations.

## 16. INPUTS

There have been major problems in meeting the implementation schedule (PP. Annex M-5) for the building construction. None of the project housing for the US staff or their counterparts had been built during the first two years of the project, nor had the training centers been erected. Renovation of the district health centers had not been undertaken, nor the construction of the PHCU's. Since the proposed building construction schedule was three years behind schedule (even if all the proposed buildings listed were completed during the next 12 months) it is more realistic to confine the project to two Regions only, Bay and Togdheer. The plans for 16 PHCU's in each Region are unrealistic in terms of both construction feasibility and capability of logistic support. It is suggested that the number be reduced to 6 per Region.

Comments on the inputs planned under the PP will follow the Detailed Budget Breakdown (Annex H-14).

#### A. Technical Assistance

##### 1. Long Term

Both teams are complete with the exception of one PH Nurse/Educator whose nomination has been approved and is expected shortly. Her late arrival is due to the replacement of an original team member due to personality clashes. The quality and quantity of work being conducted by all members of the staff was above average. Everyone was working under difficult circumstances in temporary quarters (except for the COP), few of the necessary inputs had arrived to make teaching easy.

Recommendations: Continue the long term assistance as planned, but confine the teams to continued input in two regions. Some training programs should be lengthened, depending on the specific needs of the students, and the period of active supervision over field staff operations which together with in-service refresher courses will keep the existing field composition fully occupied. Since the present supply management specialist is currently fully occupied providing logistic support to the teams (seen as an AID/S role in the PP), an additional person should be added in this category to perform the training function for mechanics and equipment maintenance technicians to support field operations. The scope of work for the extra technician for an initial 6 months period should be prepared by the MSCI COP and submitted to AID/S for approval.

The method for construction of the PHCU's has not been chosen. A plan has been drawn up by an A and E firm from Nairobi. The REDSO engineer

should make recommendations to AID/S on whether local private construction firms should be utilised, the current parastatal firm constructing the housing for technicians or whether MSCI should hire one or two ex-PCV type of construction supervisors and undertake to do the simple construction themselves. Both costs to the project and expected timeliness of completion should be considered. If the third mode is selected, one or two long term technicians will need to be added to the MSCI budget.

## 2. Short term

To date the project has expended about 15 pm of short term assistance. About 1½ months have been on personnel and office management training, about 2½ months to assist in the design of a vital statistics information system, 5 months on epidemiology and 6 months on an anthropological study of nomads' health practices.

Recommendations: Funding under this category could be used to pay the initial 6 months for a mechanic/equipment maintenance trainer, or could be reduced somewhat and shifted elsewhere. Fifteen pm/annum for both specified and unspecified assistance should be sufficient unless a strong case is built to address a problem area.

## B. Training

### 1. In-country

Groups (a) and (b): The orientation for tutors has gone well, and because of the delay in reaching the field they have received additional months of training, much of it theoretical. The field teams were pleased with the tutor's performance under field conditions and felt that the

longer than planned training was beneficial. The retraining for trainers had been scheduled for three months, some were taking four months. Perhaps the period should be made more flexible to suit student's stages of development and up to 6 months allowed. Currently a delay between classes was developing with the next graduating class from the Hargeisa Nursing School not being released until about April. Some of the current class of students would benefit from additional teaching and/or more intensive field supervision.

Recommendations: There has been a problem with the present system of the MOH only being the selecting agent for the students in these two categories, tutors and trainers. It is suggested that discussions be held with the responsible MOH officials to perhaps increase the class size by one and allow the MSCI staff to drop any student during the first month without prejudice should they prove unsuitable.

Group (c): The basic training for health workers has commenced at both sites with small numbers of students. The staff are pleased with the motivation and dedication of the community health workers and TBA's currently being trained. This program will expand as the PHCU sites are selected and developed.

## 2. Participant

### (a) Long term US

One candidate for the MPH is currently at UCLA. She worked without pay for three months in the Central Office, has signed a bond to return for 5 years and appears to be a suitable candidate to assume the position of Deputy Administrator of PHC on her return. Other

candidates were expected to be physicians to be sent for MPH's.

Recommendations: Other physicians selected for this training in the US have not been returning to Somalia on the completion of their degree. With 3 changes in the persons filling the positions of Minister for Health and Director General, and 2 changes in the Director of PHC, selection of qualified persons who will fill responsible positions in PHC becomes very difficult. It is recommended that funding in this category be reduced.

(b) and (c) Short term (US) and Short Term (3rd Country)

There are currently qualified and motivated persons associated with the program who should receive short term training. The supervisor of the Central Medical Store, Osman "Harari" is one, and there will be a need for additional training for accountants.

Recommendations: The funding allocated for the short-term training be put in one category for both US and other African countries and every encouragement be given to reverse the ratios and conduct the majority of the training in African Programs, with the US only being used for training in specialties unavailable elsewhere.

(d) Workshops/Seminars

The first major workshop to discuss Primary Health Care will commence on February 3 and is expected to produce policy recommendations at its conclusion. This is clearly a workshop of great importance to the projects' future success and viability. Future workshops on specific topics will be required over the life of project.

Recommendations: The US is only one donor involved in PHC, albeit the largest financial contributor. Other donors inputs (German, Italian, UNICEF,

Belgium, and WHO) should be sought whenever possible and workshop/seminar funding should be considered if other groups wish to organize get-together to discuss topics of concern in PHC. WHO leadership in such workshops may provide a more "neutral" forum than a large US presence.

There is an urgent need for discussions on 2 topics: the place of EPI in PHC and the roles and functions of laboratory technicians and aides in PHC. These should be held soon and after general agreement is reached a short paper should be prepared by the MSCI COP detailing how these areas will be incorporated into the existing structures and what additional inputs will be required. In the case of laboratory technicians, favorable consideration should be given to inclusion of basic laboratory supplies (glassware, small equipment, reagents, etc) to the project inputs.

The third recommendation would be for the initiation of discussions on future cooperation between the Refugee Health Unit and PHC. Both units are currently training field staff, and both have developed management skills at the central MOH level. Whenever possible experiences should be shared and joint standards reached.

### C. Salaries and allowances

Salaries of all local staff, including their incentive pay are currently being paid from the TRUST FUND MONIES. There has been a problem with some of the field staff not receiving their wages though the funds have been given to the Regional Medical Officer. This is a problem which the MOH will have to address.

Recommendation: Increased accountability needs to be demonstrated on expenditures of Trust Fund Monies. On the payroll side the names of persons being paid need to be recorded as well as job titles. Salaries for unfilled positions need to be deducted.

D. Commodities

1. Vehicles (a passenger and b truck)

The original PP called for 42 passenger vehicles and 4 trucks. This is clearly in excess of requirements given the cutback in project scope. Out of the original shipment of passenger vehicles 6 were given to EPI and 1 to Family Health Initiatives. Prior to any other order being placed, agreement should be reached on the role of this project in support of these programs. Responsibility for maintenance and parts supply for the above vehicles has sometimes fallen on the logistics technician, overburdening the system until MOH mechanics are trained.

Recommendations: The MSCI staff has listed 15 vehicles for future orders. The type of vehicles ordered should be decided on by the specifications given and according to the Procurement Specialist's judgement. The requests by location are listed as:

Mogadishu: 2 CJ-5 types (Dr. Ismail, Cipolla)  
2 Pick-ups (Azocar & garage)  
1 Truck (warehouse)  
2 Tanktrucks (this should be evaluated in the light of decisions on petrol and diesel availability.

Baidoa and Burao: 2 Busses (combis) for training centers  
2 Pick-ups (training center, food and supplies)  
2 CJ-5 types for the PHC coordinator  
2 Pick-ups (for logistic support to the PHCU's)

Not considered in this request are 2 new vehicles for field visits by the long term technicians. The present Chevy Internationals have been unreliable in the bush. Admittedly, maintenance has been poor and petrol scarce. Every consideration should be given to supply of one satisfactory vehicle for field visits to each site. The new truck should be one which has a smaller capacity and has 2 wheel drive. The original order for 4 wheel drive for all paved road supply was not justified.

#### 1. Vehicles (c fuel and d maintenance)

Fuel supply allocations from the MOH has not been sufficient to support field operations. Daily rations are small and much valuable time is spent arranging to get signed papers for it and then waiting or searching for it. The estimate of 5% maintenance costs under prevailing conditions is too low.

Recommendations: At Central Warehouse (MOH for PHC) storage tanks be installed and prior agreement reached with the MOH on reasonable monthly budgets for POL. Distribution should be under the control of the logistic support unit. In the field a separate allowance for the POL for the technical staff should go directly to them either as cash or credit from the Petroleum Agency. Maintenance costs should be raised to the prevailing level, 20 or 25%.

#### 2. Drugs

The PP calls for an initial supply of drugs to each health facility only.

Recommendations: The PP be amended to include drug supplies for all health facilities included in the project areas for life of project. The present lists of drugs by level should be refined with experience and with inputs from other PHC projects. Consumption rates are unknown. The initial drug order should estimate needs for 1 year, and then a more refined PIO/C prepared for restocking.

Discussions should be held with MOH on the recurrent cost implications of drug supplies given free at all levels. Some communities are willing to pay for drugs at the lowest level. The MOH needs to discuss this and at least permit local trials of payment by patients for drugs. The MOH appears unable to supply hospitals with basic drugs, and donated drugs from multilaterals have been observed in local pharmacies. The PHC system cannot function without an adequate drug supply system, and the project should at least be able to provide the MOH with good figures on usage and costs of specific drugs.

### 3. Equipment and Supplies

These are primarily for equipping and supplying the different levels of health units including the offices, warehouses, and transport maintenance unit at the central level. These have not been reviewed in detail.

Recommendations: The Dejarnes report on the PIO/C's be located and an update version prepared. Errors of the following types have been reported during the course of the evaluation:

- (a) Lack of inventory control on arrival.
- (b) Diversion of items to other projects.
- (c) Lost items at the port and in warehouses.

- (d) Poor decision-making on place of purchase, lack of utilisation of local resources.
- (e) PIO/C orders placed but items outstanding for long periods.  
With the arrival of a full-time procurement specialist on the Mission Staff these problem areas will doubtless be addressed. He should be given considerable responsibility for control of orders. If additional input on technical details is desired, this could always be requested by cable from REDSO/EA.
- (f) Orders for vehicle parts for vehicles built 1 year after those delivered.
- (g) Inapplicable supplies; battery acid for sealed batteries. Order was cancelled but battery acid still arrived.

## E. Construction (GSDR)

### 1. Health post

This item has not been needed yet, but requires further elaboration by the MOH. The reduction in size of the project will reduce the budget necessary. Agreement needs to be reached on the size and type of health post. Usually materials only are supplied and the local community donates the labour.

### 2. Other GSDR Construction

The MOH has supplied land and a basic structure for the transport warehouse for logistic support and training mechanics. Due to the high

cost of the estimates given by commercial contractors for renovation, MSCI's technician is supervising the remodeling. The MOH needs to agree to a budget for this purpose, or to cover all necessary costs. At the moment reimbursement seems to be on an ad hoc basis.

#### F. Construction (USAID)

Buildings for the houses for the technicians, their counterparts and the student trainees as well as the training centers at Baidoa and Burao are prefabricated units. As of January, 1982, the slabs for these buildings were built at Baidoa and were under construction in Burao. The erection of the first units was proceeding under the supervision of two technicians from Panalfab at Baidoa. Details of the reasons for the delays can be found in the engineering reports, much of the delay can be attributed to the contractor selected, the Custodial Corp., a Government entity.

The District Health Centers require renovation or new construction, the REDSO/EA engineer should prepare a recommendation on the costs of the alternative courses of action and give estimates of the time involved. With both renovation and new construction the choice of contracting method for the buildings will assume great importance if the prior delays are to be avoided.

The MOH should establish a priority ordering of the district health centers to be renovated and the PHCU's to be constructed. The criteria used should include placement of returning trainees in suitable buildings, selection of catchment areas giving access to the largest populations and

logistic access. All health facilities should be within reasonable distance of the training site and access should be on a road or track passable by vehicle on a year round basis.

17. OUTPUTS

A Personnel Trained

Good progress has been made with training of the counterparts and trainers. There are individual problems and these need to be addressed in a more timely fashion by both the MOH and MSCI. One example is the frequent absence of the PHN counterpart in Baidoa.

Recommendations: New targets for numbers of staff trained should be developed. These should be broken down by field staff and central administrative staff. Both the category of staff and average length of training should be indicated. A suggested format would be:

Field Staff	Av.No.of Months Trained	Number Trained by Project Year			
		1	2	3	4

Counterparts:

Sanitarians

PHN's

Nurse Midwives

Lab. Technicians

District Supervisors:

Sanitarians

PHN's

Nurse Midwives

Lab. Technicians

PHU-Based Staff:

Sanitarians

Nurses

Community-Based Staff

CHW's

TBA's

Administrative Staff  
and Support Staff

Av.No.of Months  
Trained

Number of Trained by Project Year  
1 2 3 4

Personnel trainees

Vital Statistic Staff

Accountants

Drivers

Mechanics/car

Mechanics/equipment

etc.

**B Creation of Central Management and Support Unit for PHC at MOH**

Satisfactory progress is being made on the development of policy guidelines and curricula creation at the Central Ministry. However, much remains to be done.

Recommendations: Much more attention needs to be paid to the views of the personnel working on other PHC projects and the WHO advisor on PHC should receive more support to coordinate viewpoints and reach joint policy decisions. The American presence seems heavy-handed and only one approach is put forward. In reality there are alternative methods of reaching most

targets in PHC, and any selected approach may have to be modified after field experience. The February workshop will provide a good forum for developments in this area. None of the MSCI field staff had been invited to attend the workshop. They need to attend to provide vital feedback on how the initial systems created are working under field conditions.

Vertical programs such as EPI, MCH, TB, and malaria control are all related and a part of PHC. Working groups with the individuals concerned with these programs should be meeting to develop clear program guides for their integration in PHC. Out of these meetings should come revised statements for the PP, and any additional inputs required to support these activities should be itemized.

The laboratory technicians program needs to become a part of the PHC approach and as above needs more specification. At the moment it is unclear whether they will receive the same housing, furniture as the other trainers and students.

New criteria need to be developed for the creation of the logistic support functions. The transport unit should have sufficient functional strength to support all PHC vehicles. A similar unit should provide all equipment maintenance. The drug support system should be installed and functioning in such a manner as to supply all the PHC needs on a regular schedule.

18. PURPOSE

The approved project purpose states:

1. PHC services delivered to 4 population groups with rural settlement and nomadic populations.
  2. Establishment of a training program capable of providing PHC workers and supervisory staff for the entire country.
  3. Development of PHCP model that is replicable for the entire country.
- 
1. Change 4 to 2.
  2. ... providing trainers for PHC workers and administrative management staff to handle a national system for PHC.
  3. ... that is potentially replicable.

Progress towards attaining all three of the above purpose is reasonable for a project having one year of field operations.

The end of project status statements need to be amended to conform with the above.

The statement on water should be changed to "improved practices in the handling of wastes and improved quality of water available for human consumption."

19. GOAL

The program goal can remain as stated:

"Improvements of health among Somalia's rural and nomadic population through a health delivery system reaching the village level."

The measures of goal achievement need only slight changes:

#3 could be improved to "decrease of 20% in infant mortality in catchment areas of PHCU's."

20. BENEFICIARIES

No reason to expect a change from the PP.

21. UNPLANNED EFFECTS

Not applicable at this stage in project development.

22. LESSONS LEARNED

The contracting experience to date has suggested methods to be avoided if timely completion is considered.

23. SPECIAL COMMENTS

Program Management

The lack of progress on this project in the early phases has been mainly due to AID/S paying insufficient attention to monitoring. This has been rectified during the past five months. The contractor problems with the prefab housing erection which are now being tackled with vigor could have been addressed earlier. The tardy manner in which PIO/C's have been submitted reflects on the Project Manager and the lack of prompt utilization of the procurement expertise which has always been available in REDSO/EA. Now that the Mission has its own procurement officer this should not reoccur. The files have been poorly maintained and it is often impossible to find important documents. The lack of a secretary should not be used as an excuse since AID professional staff can file themselves.

In order to rectify the above problems various individuals in the Mission have been assigned specific tasks to perform. This may be expeditious in the short run, but can result in overlapping functional responsibilities and lack of knowledge of all relevant facts by individual decision-makers. A Project Committee was formed in November 1981, regular weekly meetings are now being held to share information and coordinate the skills brought by the concerned individuals. These meetings should include the MSC1 COP. It would be helpful, if at the close of each meeting a list could be made of actions to be performed, by whom and when so that written documentation of progress exists.

Program management by MSC1 has focussed excessively on the administrative tasks of keeping an office functioning, perhaps because the project does not include an administrative officer and the COP has been playing this role. The administrative burden is large since individuals employed by the MOH but

assigned to PHC are being supervised and trained in addition to the direct project staff. This has resulted in neglect of the needs of the field staff on both a technical and personal level.

The field staff have been functioning well since their assignment to Baidoa and Burao. However, they are cut off from a communications viewpoint, this problem being acute in Burao where the telegraphic service has been down for a month. Use of the police radio was refused except in extreme emergency and then only with a letter of authorization from headquarters. MSCI and AID/S should examine the purchase of a radio system for regular contact with remote field staff. No regular pouches are sent on the internal flights, yet this system is possible to arrange and is currently being used by UNDP. The field staff are ignorant and thus feel neglected of up-to-date developments at the headquarters. Even a carbon copy of a single handwritten page giving the high and low points of the work at the MOH offices would serve to keep the team united and involved.

The problem of supply of food and regular shopping is easier to address at Baidoa with more available locally and the shorter distance to Mogadishu. There is little available in Burao and the few fruits and vegetables on the market are about 4 times the cost in Mogadishu. Goat meat is the only meat available most of the time. Central staff should be sufficiently sensitive to this to always take a case of food on any visit since few personal items are necessary for short stays. The AID/S Director suggested that a monthly trip be arranged for shopping at Hargeisa at project expense. The shortage of fuel at both locations has further added to the feeling of isolation.

Since all field members are technically competent and motivated individuals it will be a tremendous loss to the project if all decide to terminate at the end of their 2 year contracts. Indeed the number renewing can be regarded as an index of the quality of backstopping by MSCI and AID/S.

For a training project little attention has been paid to support of the teams by supplying reference materials on primary health care either for the staffs' use or by students. Lists have been prepared but like many other PIO/C's may not have been submitted. MSCI should have authorized purchase of sufficient books for the small numbers involved in current training programs as well as for their own staff.

The lack of strong leadership dedicated to development of a strong PHC program at the MOH has also made the tasks more difficult. There have been good individuals involved at many different levels, but effective management needs continuity of senior decision-makers. This has not occurred during the life of the project.

	<u>AID</u>	<u>GOSL</u>	<u>TOTAL</u>
Technical Assistance	47,600	-	47,600
Facilities	62,000	-	62,000
Training	6,700	1,500	8,200
Commodities	50,800	-	50,800
Personnel	-	70,000	70,000
Operations	-	19,000	19,000
Contingencies	<u>25,800</u>	<u>-</u>	<u>25,800</u>
	192,900	90,500	283,400