



International Science and Technology Institute, Inc.

EVALUATION REPORT
CATHOLIC RELIEF SERVICES
DJIBOUTI
FOOD AND NUTRITION PROGRAM

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Djibouti
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1. OVERVIEW OF PROGRAM SETTING.

1.1. Country Description

The Republic of Djibouti, squeezed between Ethiopia and Somalia on the horn of Africa, presents a unique set of circumstances to students of developing nations. Its special characteristics include:

- Its small size: 23,000 km² spread over an arid, volcanic landscape with scant agricultural potential.
- Its extreme "hot season" climate: between May and September temperatures climb to 40°C with 70% humidity.
- Its small, predominably urban population: 75% of the total of approximately 300,000 reside in towns or cities and two-thirds of Djiboutians live in the capital port city of Djibouti-City.
- Its relative cultural homogeneity: the two ethnic groups, Issa and Afar, are culturally very similar even though they speak different languages. These two peoples do not necessarily work closely together, however.
- Its recent independence: Djibouti gained its independence from French rule in June, 1977.
- Its historical development as a French military and naval base at the edge of a barren landscape sparsely populated by nomadic herders from which all Djiboutian citizens are descended: some 80,000 nomads still traverse the interior of Djibouti, freely crossing into neighboring Ethiopia and Somalia.
- Its unusual epidemiological environment: the tropical diseases with plague the rest of Africa: Schistosomiasis, Filariasis, Onchocerciasis, Guinea-worm and even malaria, are rarely seen in Djibouti except among recent immigrants.

This physical, social and cultural environment is further shaped by a relatively low rate of adult literacy (9%), attributable largely to the paucity of educational opportunities available to Djiboutians during the colonial period, and by the high rate of unemployment or partial employment (up to 75% of the active population aged between 15 and 59 years). In Djibouti, income is derived primarily from the public sector, the military establishments and trade and services. The high cost of living resulting from the dependence of imported goods places many Djiboutian families under severe economic stress. The estimated mean monthly income of 75,000FD (\$425.00) per month is grossly inflated by the inclusion of the high salaries

of the relatively large European community of 10,000 people or so. At least 30% of Djiboutian families earn less than 40,000FD (\$225) per month of which up to 3/4 can be spent on housing and "Khat"* consumption.

1.2. Major Health Problems

Djibouti's status as an LDC (lesser developed country) is reflected in the high mortality rates. The estimated crude death rate of 20 to 25 per 1000 is among the highest in the world. Infant mortality, estimated at between 125 and 250 per thousand is equally high. The principal causes of mortality and morbidity among both adults and children are those of poverty and poor environmental hygiene: undernutrition, diarrheal disease, tuberculosis, and a variety of infectious diseases including respiratory infections, sexually transmitted diseases, eye and ear infections, hepatitis and tetanus. Diarrheal disease in children is reported to account for 30 to 40% of all dispensary consultations and 60% of all deaths in the 0 to 5 year age group. Malnutrition, thought by many experts today to be directly related to repeated episodes of acute diarrhea, can be estimated from recent CRS data to affect at least 35% of children under 5 years, (under 80% weight for age by Harvard standards). At least 13% of children in this age group are under 70% of standard weight for age. CRS data shows worst months for malnutrition rates to be June through November and best months to be January through March (see graph 1-A). Dikhil, Tadjourah and Obock Districts have highest rates and Ali-Sabieh the lowest. No

*"Khat" is an amphetamine-like drug chewed in the form of leaves by the vast majority of Djiboutian men and many women, costing about 500FD per daily session.

comprehensive study of diarrheal disease and malnutrition has been done in Djibouti; one can only speculate on the factors which contribute to this serious health problem. However, the fact that an estimated 70 to 80% of mothers start bottle feeding their infants before the age of three months, either in combination with breast feeding or exclusively, would suggest that child feeding practices play a pivotal role in the epidemiological picture.

1.3. Government of Djibouti Primary Health Care Initiatives

There is growing recognition by the Government of the Republic of Djibouti (GROD) as well as by the international organizations assisting the Ministry of Health (MOH) that an increased emphasis on preventive health programs, as opposed to the almost exclusively curative approaches favored until very recently, represents a potentially highly effective and cost-effective strategy to health care, given the morbidity patterns described above. The GROD has, since early 1984, taken several steps to institutionalize a primary health care program emphasizing preventive measures especially for women and children under five:

- A coordinator of Primary Health was named and confirmed in the MOH.
- An initial official primary health care strategy and five year plan has been outlined and is in the process of being formalized.
- A national primary health committee has been created, including representatives from various health services (Hygiene Service, Health Education Unit, Nurses Training School, Vaccination unit, etc.). This committee meets weekly to discuss ongoing projects and activities.
- A bimonthly primary health care meeting unites MOH representatives with representatives of the major donors (WHO, UNICEF, CRS, Coopération Française)
- Half of the 23 nursing students at the nurses training center have started specialized training in community health including weight monitoring, health education, data collection and analysis, vaccinations and management of diarrheal disease (oral rehydration) and malnutrition.
- In-service training for existing health personnel is planned along similar lines starting in 1985.

- The MOH has recently mandated that health center personnel establish close working relationships with the community health committees established by the Hygiene Service in collaboration with local political authorities and other community leaders including representatives of the national women's organization.
- An official child health card has been designed and prepared for printing.
- Efforts to design a basic primary health care primer for health center personnel have been initiated.

These initiatives represent the first steps to the further development and implementation of the primary areas of emphasis of the tentative strategy proposal outlined by the GROD in March of this year which can be summarized as follows:

Health Education

- Training of Health personnel including:
 - continuing education and training of existing personnel;
 - basic training (at the Nurses Training Center) of new personnel;
 - upgrading of traditional birth attendants; and
 - selection and training of community health workers.
- Community health education
 - strengthening of the "cellule" of Health Education to produce appropriate educational materials;
 - integration of health education into the dispensary program (home visits, group "animation", counselling); and
 - use of the mass media.

Mother and Child Health

- reinforcement of pre- and post-natal consultations;
- nutritional surveillance;
- EPI vaccination program; (expanded program of immunization)
- promotion of breastfeeding;
- control of diarrheal disease and promotion of Oral Rehydration Therapy; and

- strengthening of the statistical data collection system so as to be able to evaluate these programs.

Control of Transmissible Diseases

- control of tuberculosis;
- eradication of endemic malaria; and
- establishment of a national program for the control of sexually-transmitted diseases.

Water and Sanitation

- surveillance and protection of potable water sources and
- reinforcement of local sanitation through community health action.

Nutrition

- Promotion of the consumption of local produce (fish, meat, milk, vegetables, fruits).

Organization of a System of Health Care

- improvement of existing structures
 - decentralization and task definition for existing health personnel;
 - reorientation of health services toward development of integrated primary health care accessible to the community; and
 - creation of a national health council to develop, plan and coordinate health programs and activities.
- Creation of new health structures, including community health committees and
- Evaluation of resources and potential development of traditional medicine.

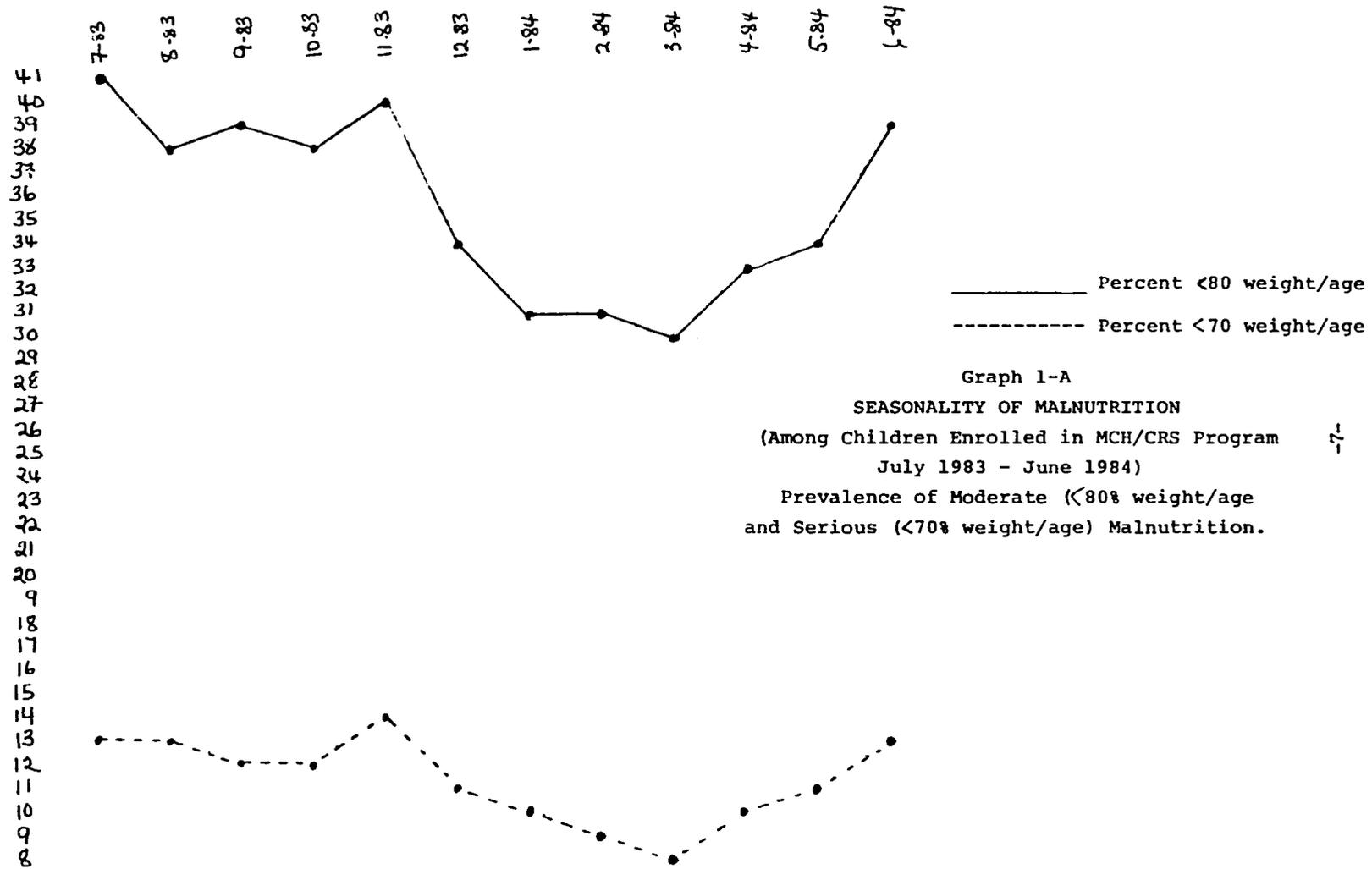
Furnishing of Essential Medicines

- creation of a national commission to establish national pharmaceutical policies;
- public education concerning proper use of medication; and
- research of traditional pharmacopia.

1.4. Donor Strategies and Programs

The other major donors in health in Djibouti support and encourage this GROD strategy in a variety of ways. WHO emphasizes program support in the areas of personnel training, mother and child health, vaccinations, infectious disease control (diarrhea, tuberculosis and sexually transmitted diseases), control of Khat and water and sanitation. Concrete contributions include medicines, ORS packets and long-term technical assistance in the areas of statistical data gathering and analysis (a study on Khat consumption is ongoing, an infant mortality and morbidity study is planned for early 1985), mother and child health and personnel training. Short-term technical assistance is being offered in the development of strategies for the control of diarrhea, sexually transmitted disease, tuberculosis and Khat. UNICEF supports the vaccination efforts by contributing all the necessary vaccines. UNICEF also supplies ORS, vitamins and certain equipment to dispensaries. Nutrition education activities are supported through a UNICEF grant to the CRS program and a communications specialist is expected to work with the media to develop health education messages. UNICEF has also provided technical assistance over the past four years to an ongoing rural water project and plans to continue this assistance. The French aid organization has contributed primarily technical assistance to support curative activities but is currently trying to reorient its inputs toward preventive health programs. USAID is currently preparing a primary health care project plan emphasizing diarrhea control, health education and personnel training.

The overall strategy of all the donors is one of intense and mutually supportive collaboration to assist the GROD in the development of an integrated national health plan especially in the area of primary health care.



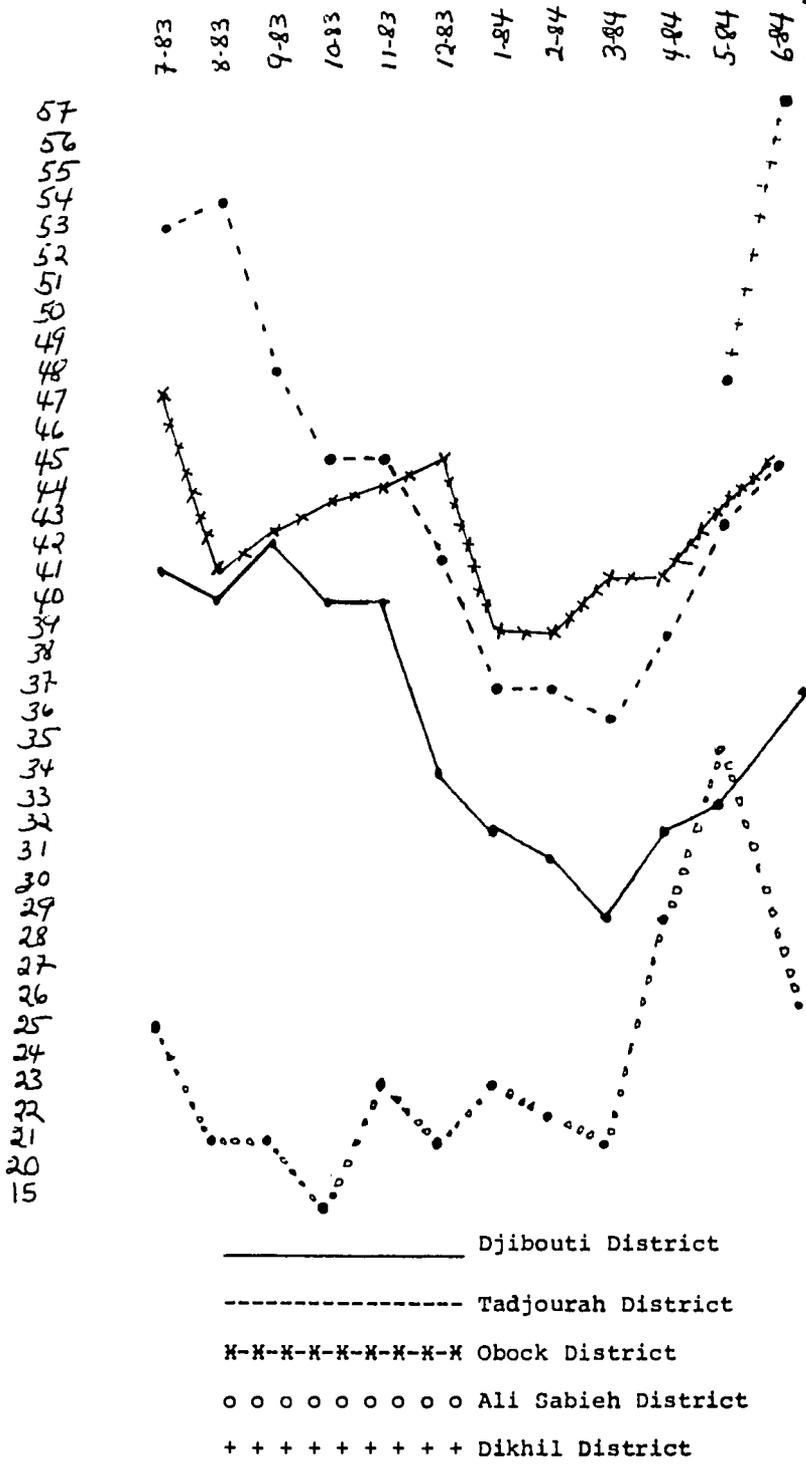
Graph 1-A
 SEASONALITY OF MALNUTRITION
 (Among Children Enrolled in MCH/CRS Program
 July 1983 - June 1984)
 Prevalence of Moderate (<80% weight/age
 and Serious (<70% weight/age) Malnutrition.

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Graph 1-B

NUTRITION RATES BY DISTRICT

(Among Children Enrolled in MCH/CRS Program, July 1983- June 1984) Prevalence of Moderate Malnutrition (<80% weight/age)



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————— Djibouti District
 - - - - - Tadjourah District
 x-x-x-x-x-x-x-x Obock District
 o o o o o o o o Ali Sabieh District
 + + + + + + + + Dikhil District

2. EVALUATION PURPOSE AND METHODOLOGY

2.1 The CRS MCH Program.

The central purpose of the evaluation is to provide guidance for the preparation of a new field support grant for CRS/Djibouti. Therefore, the evaluation attempts to synthesize existing information, especially the very substantial evaluation base provided in Cook's May 1984 KAP study and in Prins' March 1984 Health Sector Analysis, and to fill remaining gaps.

Not all remaining gaps could be filled by the present study due to time constraints. A two-week period was allotted for country orientation, consulting background materials, preparing questionnaires and making site visits, and interviewing the health and other donor community. The evaluation team considers most relevant the following remaining gaps:

- the economic status of the attending population compared with the non-attenders(1);
- mothers' knowledge of the individual health card and the value and use of CSM;
- family food habits (attempted by Cook) and;
- accurate assessment of attendance patterns to reflect dropout and re-enrollment rates.

A Scope of Work for the Evaluation was prepared by Voluntary Foreign Assistance/Food for Peace (FVA/PPE), AID/Washington, reviewed in detail by CRS/Nairobi, and approved by USAID/Djibouti. The Scope of work laid out the following objectives:

- To evaluate the CRS Food and Nutrition Project in order to identify strengths, weaknesses; extent to which project objectives were reached, its contribution to helping the MOH develop/increase its capability to provide MCH services, and how effectively it promoted other development activities.

(1)

Cook's study noted the low literacy rate of 2.5% in the total study population (PMI and non-PMI, women only) which he compared to 9% in the overall population (men and women-Ruben, 1978). The only distinguishing socio-demographic characteristic that could be compared was to show that PMI women had larger families than non-attending mothers.

- To recommend ways of improving health and nutrition benefits of the program. This will include identification of other program areas, i.e., ORT, immunizations, as well as strengthening program components. The team will assess both CRS and government capacity for carrying out recommendations, including manpower, management and technical requirements and recommend specific activities necessary to bring about recommended changes.
- To assess the role of food aid in reaching program objectives and determining consequences of phasing out food on achieving nutritional and health benefits.

Methods used to meet these objectives included:

- Analysis from data available at CRS/D: Master Charts; compiled data sheets on ration distribution, beneficiaries, graphed children growth percentiles;
- Questionnaires developed and applied to PMI and Medical personnel; (Annex 2)
- Informal interviews with the health and donor community (See Persons Consulted, Annex 1)
- On-site studies: attendance regularity, rate of enrollment; motivation for PMI attendance; nutritional status. All studies were analyzed except for the nutritional status data taken on 150 children weighed during the team visit in October to be compared with nutritional status at entry. A large percentage of birthdates were estimated with too little precision, often to the nearest year. Also, too many children had new weight charts following the summer dropoff in attendance and therefore no real data on nutritional status at entry were available.

Nine centers were selected for visit. Because of extreme variation in the centers and time constraints, no criteria were established for selection except to see as many in Djibouti-town as possible and to visit two additional Districts. Centers visited were:

- SMI-2 (social security health center); Arhiba (Afar community), predominantly Somali centers of Balbala, Farah-Had, Engueilla, and Ambouli.
- Three village Centers - 1 in Ali Sabieh District and two in Dikhil District - two refugee settlement towns and all of mixed Somali-Afar populations.

2.2 The CRS Total Title II Program.

The evaluation team did not assess other components of the past CRS program, notably the refugee and school feeding programs and agricultural activities, due to time constraints prohibiting carrying out further site visits, program analyses and interviews

and because these activities appeared to be of minimal importance to the continuing OPG support that is being recommended. However it is recognized by the team that the emphasis in the past OPGs has principally been providing support costs for the food aid for these programs. That the team sees more cost-effective potential for future OPG money does not make it less important to look at the MCH program in the context of the overall CRS food inputs into Djibouti.

During the period examined for MCH cost-effectiveness, July 1983-June 1984, the total tonnages distributed for the major programs were, in metric tons, and distribution percentages:

MCH	655	24%
School/Child Feeding	260	10%
Refugees	1517	56%
Food for Work	<u>265</u>	<u>10%</u>
	2697	100%

CRS has been phasing out its refugee program over the past 18 months as repatriation occurs or as phaseover to WFP takes place. During the two six-month segments in the July 31, 1983-June 30, 1984 period studied above, programmed numbers of refugees covered by CRS were reduced from 25,000 to 15,000. They have further been reduced to 5,000 and by January 1, 1985, the refugee program will be phased over completely to WFP. Thus while this program shows up as a predominant food input during the 12-month period studied--i.e. 56%, the refugee line distribution will be 0 in a few months as will Food for Work, while MCH will assume a 60:40 food input ratio with school/child feeding and overall tonnage levels will have decreased to about one-third. WFP has programmed 15 kilograms of food per month for 16,200 refugees, or nearly 3,000 metric tons of cereals, oil, milk and tinned meat or fish.

School feeding inputs were somewhat below the programmed amounts in the 12-month period studied above due to the late startup and accumulated stocks. However, deliveries have been normal in the current school year and it is expected that somewhat less than the 283 MTS programmed will be distributed. School feeding has required little administrative time according to CRS, and normally the Ministry of Education pays for transport from the warehouse to the schools although CRS had to assist this past year. CRS is negotiating with WFP to take on this program.

3. CRS PROGRAM HISTORY AND DEVELOPMENT: OVERVIEW OF PROBLEMS.

Catholic Relief Services began work in Djibouti in late 1979 in response to a request by USAID to take charge of the continuation and expansion of the PL-480 Title II food distribution for refugees which has been begun in 1978 by USAID. In June 1980, CRS/Djibouti initiated its Food and Nutrition MCH program with a group of 640 mothers and children at five maternal and child health centers (or "PMI's": Protection de la Maternelle et Infantile) in Djibouti-City, namely, Farah-Had Ambouli, Engueilla, Balbala and SMI-2. The program was modeled on similar well-established CRS programs in 15 sub-Saharan African countries and included three elements:

- The distribution of a five-kilogram ration per month to mothers and their children under five years of age as an economic assistance to needy households.
- A nutritional surveillance system based on the Harvard weight-for-age standard.
- The education of mothers about child nutrition.

In Djibouti, the initial response of the population to this program was disappointing: only 2% of the under-five population was reached. According to reports in the CRS files: CRS experienced difficulty in meeting with MOH officials; motivation on the part of PMI personnel was low; storage facilities were often inadequate; and the transportation system was unsatisfactory.

In response to the low attendance, CRS regrouped the food and nutrition program to three of original five centers (Farah-Had, Ambouli and Engueilla). Selection criteria were relaxed to allow all mothers of children under five to enroll. Radio broadcasts were used to publicize the program and encourage mothers to attend. Interest in the program began to grow until, six months later, eight centers including the refugee centers in Ali Sabieh and Dikhil were operational and

coverage had risen sharply to 8400 mothers and children. By March of 1981, 12 centers had been opened and coverage had peaked at 11,261. While overall coverage began to decline, the number of centers continued to increase: to 16 by September of 1981, 18 by June of 1982, 20 by mid-1983 and 21 today. It was only in March of this year (1984) that coverage again reached the 1981 peak. It should be noted, however, that at no time has program attendance been high enough to pose a food programming problem so that there has never been a need to develop more selective criteria for food eligibility.

Despite the low overall coverage levels, sharp fluctuations in numbers attending have made planning of food distribution and other program components difficult. The small number of attending mothers during the summer months may be attributed, in part, to the common practice in Djibouti of migration to cooler areas in the interior to escape the summer heat. However, the erratic attendance patterns which have plagued the program since its inception are aggravated by relatively high drop-out rates among short-term program participants and overall high rates of absenteeism among all participants. In 1982 the expected increase in coverage after the summer lull never occurred. Coverage levels remained low until early 1984 (a year and a half later) when a combination of factors again spurred mother's interest in the program: Radio broadcasts were again used to explain the program, a national vaccination campaign actively recruited mothers to bring their children to the centers, a national oil shortage made CRS oil more valuable to mothers, and, perhaps, the replacement of NFDM by CSM attracted more mothers. The higher coverage levels experienced during the early months of this year again dropped to previous low levels with the return of the summer hot season, although the

decrease in the level of coverage was less than that of 1982 and 1983.

Low coverage may result to some degree from other problems which have plagued the program since it started. One of these have been the acceptability of the commodities which make up the ration. Participants have complained of both the quality and the quantity of rice distributed. The NFDM was never well utilized except during severe drought conditions. The substitution of CSM for NFDM in January of 1984, while widely seen as an improvement, has not gained complete acceptance by mothers, largely because of inadequate commodity education. Most mothers do not understand the nutritional merits of CSM and many appear not yet to know how to use CSM. CRS expects the ration to be an economic and nutritional supplement to families but, in the context of the Djiboutian economy, now questions the actual value of the package to a Djiboutian household. The team shares this concern (see section 4.1 for further discussion).

Another perennial problem has been the skills and motivational level of the personnel in charge of the day-to-day operation of the centers. Early reports refer to the lack of availability of trained personnel as a limiting factor to growth, expansion and improvement of center activities. Management skills for food handling and control were lacking, resulting in stock interruptions as well as inadequate reporting and accountability of food use. The low level of skills and motivation among staff was also reflected in the frequent errors observed on the Master Charts and mothers' cards. Repeated, if restricted, efforts have been made to address these problems. In December of 1981 a three-day seminar was held for center personnel. Topics covered included: The goals of the program

administrative costs; the preparation of NFDM and the correct filling out of the child growth cards, the Master Charts, and the monthly reports and registers. The seminar included a two-hour session on health education. In 1983 a series of 4-hour workshops were organized in each district. The charts and cards were reviewed. The use of the ration components was discussed and a new food delivery system was introduced. A session on fish promotion included a demonstration on the use of a flipchart. During this time period, CRS Food and Nutrition supervisors visited the centers as often as possible, although usually in response to a crisis, to give individual training and help to the staffs at their work site.

Despite these efforts charts and growth cards continue to be filled out incorrectly, weighing errors occur frequently, and age calculation is often incorrect. Food control and accountability continue to be major problems. Partially this may be attributed to the constant turnover of center staff but many long term personnel also have problems.

It should be noted that the heavy burden placed on CRS national staff by the food monitoring requirements and by the preparation of program reports and planning documents have hampered the development of a training strategy with clear objectives and consistent follow-up. As a result, center staff training has been sporadic, catch-as-catch can, and while perhaps well-executed when done, insufficient to develop consistent working habits among the personnel at the centers. The recently established practice of monthly meetings with the center responsables is a positive step toward resolving this problem, creating an opportunity for regular mutual feedback and exchange of ideas between national staff and local implementation staff. A further positive initiative has been the training of

nurses involved in the CRS program at the National Institute of Nutrition and Technology in Tunis. In September 1982 eight nurses participated in a three month training course, six more went in 1983 and another seven went this year. These training programs appear not only to have broadened the technical knowledge of those participating but to have given motivational impetus to the returned trainees who are often praised by their supervisors as being among the more dedicated workers at the health centers.

Two further problems which existed at the beginning of the program are now of diminished importance primarily due to CRS efforts. Initially, food storage facilities were very inadequate. Some food was stored in a responsible's house causing personal difficulties and resentment. Facilities have now improved. CRS has obtained funds to build or buy storage facilities in some centers. Otherwise food is stored in a room of the dispensary, a less satisfactory arrangement as this means giving up valuable health center space for food storage.

Initially, food was transported from the port to the distribution sites by the GROD. Due to the inefficiency of the government agency handling the transportation, stock interruptions were a chronic problem in the dispensaries. In early 1983 CRS took over responsibility for the food deliveries and the situation improved.

These latter two problems point to an apparent lack of interest in the program on the part of the GROD and MOH. Not only does CRS/Djibouti pay for all transportation costs, something rarely done in other countries, but CRS/Djibouti is also required to pay port fees for the importation of the food, which at least one other major food donor to Djibouti (WFP)

is not required to do. In order to transport the food from the port to the dispensaries, CRS rents trucks which it earlier donate' to the government refugee relief organization, ONARS. Over the past two years MOH officials and representatives have repeatedly and publicly criticized the food component of the CRS program on the grounds that food distribution in the dispensaries caused mothers to perceive the MCH as a food distribution outlet rather than a health service, that it placed an undue logistical burden on health personnel and disrupted MCH activities, that it fostered dependency and reduced the possibility of developing a sense of personal responsibility for health among dispensary clients. These criticisms were published in a 1982 report on the first national primary health care workshop.

In conclusion, since the beginning, the F/N program in Djibouti has been plagued with the chronic problems of low coverage and low rates of attendance or interest by the mothers, poor motivation by center personnel, food accountability and management and government disinterest. Numerous circumstances contributed to the development of these problems:

- The rapid expansion in the number of centers, from 0 to 12 in the first nine months of the program, to nearly double that in the next two years did not allow for sufficient consolidation and development of the program in existing centers during the early years. Staff training, program planning, follow-up of activities were neglected in favor of food handling and distribution activities. Rapid expansion in the number of centers did not lead to increased overall participation of mothers, perhaps because the overall program was not attractive enough to mothers and the value of the food alone was an insufficient drawing card. The development of a better overall program in a more limited number of centers might, perhaps, have resulted in an equal or higher rate of coverage than that currently existing.
- The youth of the independent nation of Djibouti is reflected in the low skills level of center personnel as well as in the lack of government sophistication in planning for the integration of donor inputs into an overall national development strategy. Some of the early criticisms of the Djibouti program may reflect comparisons with more experienced nations as well as with "older" programs.

- The CRS program in Djibouti is just over four years old. Some of the problems it has experienced are simply those to be expected in a young program: storage, transportation and management inefficiency, for example. In the early development of any program certain activities, especially those involving major logistical inputs, always demand an unfair share of staff time and attention while other perhaps more important, but less immediately demanding aspects of the program (training, education) tend to be neglected.
- Since CRS/Djibouti began as a refugee feeding activity, clear guidelines, objectives and protocols have never been established for other program components. This omission has hampered the systematic development of the non-feeding areas of the Food and Nutrition program.

CRS/Djibouti at this time has arrived at a natural turning point in the history of its activities. Geographic expansion has nearly reached its limits. Problems have been identified and analyzed. The relationship with the GROD has deepened to a point where dialogue is possible. The personnel of the MOH have acquired an experienced base from which to judge the program and its effects and by which to respond with an independent vision of needed changes and orientation.

Some small progress can be seen in some of the problem areas. On a larger scale, the program has introduced growth surveillance of under five children into the country and captured the interest of the Ministry of Health in the collection of these statistics. Planning is now taking place within the Ministry for a national growth card and research is being done on different systems. A national five year plan has been drafted for Primary Health Care and an effort has been made to coordinate with the numerous donors who support the system. The CRS contributions have been incorporated into this planning effort and their MCH -reinforcing activities have been recognized.

CRS/Djibouti has thus reached a period of consolidation of past successes as well as of enrichment of previously neglected project components while reducing problems by progressive and systematic strengthening of existing skills and professional cooperation with the GROD.

4. ANALYSIS OF PROGRAM OPERATIONS

4.1. The Title II Food Ration

4.1.1 Appropriateness of the ration

During the first three years of its operating time in Djibouti, CRS provided a five kilo ration per mother and children under five years of age, comprised of 2 kilos each of rice and NFDM (non-fat dry milk), plus 1 kilo of oil. In 1984 NFDM was replaced by CSM (corn, soy, milk) for the following reasons:

- Lack of interest by participants in NFDM. Recipients are accustomed to a full cream milk, that can be purchased on the local market i.e., Nido, Gloria and reconstituted or sterilized products (imported). Many recipients tended to reconstitute NFDM improperly in an effort to achieve the taste of the full cream product, thus producing problems for children's digestive systems. Only during severe drought conditions was milk accepted by recipients.
- Poor "shelf life" in the hot and humid climate. Lack of interest in the product caused long storage periods (up to 18 months) and old stocks were reported to cause diarrhea.
- Availability of local milk products. Goats-, cows-, and camels-milk as well as imported powdered and liquid products, are widely available at reasonable cost.
- Requests by mothers for a "baby food". Oil, rice, and NFDM were not considered specifically for babies or small children, but rather foods used by the entire family. It was hoped that mothers would target CSM more effectively to the youngest members.

CRS acknowledges that commodity education has not been able to keep up with the high turnover rates of program participants. The result is that CSM is not yet appreciated for its nutritional value, it is equated with millet by some clinic personnel. Some mothers did not bother to take it home.

The quality of the rice distributed by CRS is universally considered poor as compared with other locally available rice. The oil is not recognized by mothers as being of superior quality or food value than locally available oil, but is perhaps the most valued of the three commodities, especially during the recent oil shortage.

4.1.2 Nutritional Value of the Ration.

The 2-Rice, 2-CSM, 1-oil ration provides 790 calories and 17.8 protein⁽¹⁾ grams daily. Assuming each mother receives 2.6 rations and attends 65% of the time,⁽²⁾ the family has access to 1335 extra calories and 30 extra protein grams, daily. Since the food is not directed to the youngest members it is highly optimistic to assume that the under five children receive their "share" of the total food. If they did, in an average family of 5-6 members, an under five year old child would receive approximately 243 calories and 4.5 protein grams extra daily. Even if food isn't targeted to the youngest, the daily caloric and protein content of the family ration is equivalent to the needs of one child so that in nutritional terms it means at least one less mouth to feed for the family. (Under five children need approximately 1300 calories a day, by FAO standards) Adding two kilos of rice would bring daily calories available to 1735, and protein grams to 37.

4.1.3 Economic Value of the Ration.

The evaluation team has estimated the economic value of the ration in the perspective of family income, and concludes that its impact on families is highly questionable. Many officials have suggested that the discontinuation of the ration would cause serious economic distress for most participating families. Some hypothetical calculations concerning family income available for food purchasing would seem to contradict this contention.

1. Per 100 grams, the calories and protein grams for each commodity are as follows:

	Calories	Protein Grams
Oil	884	0
Rice	363	6.7
Corn-Soya-Milk	380	20

(1) Source: Title II Commodity Reference Book.

(2) See section 4.4. on Attendance and Coverage for an explanation of these numbers.

While accurate income and family budget statistics are not available, a crude and conservative estimate of family food expenditures can be made from available information. A recent World Bank study for a housing and urban development project states that 30% of households in Djibouti town earn less than 40,000FD per month. The average monthly salary of 42 CRS food and nutrition employees paid by the mothers' contributions is 15,000FD per month. The nurses responsible for the CRS program in the centers earn approximately 45,000FD per month and appear to enjoy a higher standard of living than most of the attending mothers. Major family expenditures include rent, khat and food. Family rental for a shared dwelling in a poor neighborhood can be conservatively estimated at 5000FD per month (some estimates go as high as 20,000FD for a one-room dwelling). Khat expenditures have been estimated at between 15 and 75% of family income; for the sake of our example, we have used a conservative estimate of 20%. The World Bank study estimated food expenditures at between 48 and 85% of income; for our example, we have chosen a high estimate of 80% of those financial resources remaining after rent and khat have been paid. Using these bases, a family earning 15,000FD a month would spend 5,000FD on rent, 3,000FD on khat (20% of 15,000 or enough for six khat sessions) and 5,600 FD on food (80% of 15,000-8,000). The daily food allowance for such a family would average 187FD. A family earning 40,000FD per month would spend 5,000FD on rent, 8,000FD on khat (enough for 16 khat sessions) and have a monthly food budget of 21,600FD or 720FD per day.

The local market value of the CRS food ration is estimated by CRS at 510FD based on observed prices of this food being sold in local markets. Since 100FD is paid to obtain each ration, one ration can be estimated to contribute 410FD to the family

food budget. On the average, participating mothers receive 2.6 rations at each monthly visit to the center and pay 260FD. This amounts to 1066FD in food value. The average attendance rate is estimated at 65%. On the average, mothers enrolled for a 12 month period would receive 8,315FD worth of food over the year ($1066 \times 12 \times .65$) or 693FD per month (23FD/day). According to Cook, only 25% of mothers no longer in the program had been enrolled for over one year. Our own study shows that not more than 40% of mothers now in the program have been enrolled for over one year. An average mother remaining in the program for six months would receive 639FD ($1066 \times 6 \times .65$) or 347FD/month (12FD/day) and a mother remaining only three months would receive only a yearly average of 6FD per day in food value. Cook estimated that 40% of women remained in program more than six months and 60% remained more than three months. 40% remained for three months or less.

In short, a very poor mother with a daily food budget of 187FD per day (for a family of at least three people) could expect to increase her family's food budget by no more than 20% if she attended each monthly weighing session. An average mother in this category attending only 65% of all sessions would increase her daily food budget by only 12% ($=23/187$). A relatively wealthier mother (still in the bottom 30% of income groups) with 720FD available for daily food expenditures would increase her daily budget by no more than 5% by attending all monthly weighing sessions. These estimates do not include any transport fees mothers might have to pay.

The high degree of absenteeism among enrolled mothers and the large number who leave the program after only three months or less would suggest that many women do not find this relatively small increase in their food budgets worth the time and energy they must invest in order to obtain the ration.

In its Operational Plan for FY 1985, submitted on May 15, 1984, CRS, dissatisfied with the economic and/or incentive adequacy of the 5 kilo, 2-CSM, 2-Oil ration, requested 2 more kilos of rice a month for each beneficiary. This presents a daily economic supplement of only about 10FD/day for the average mother.

In the Djibouti context of wide food availability at low prices (from other CRS programs and other donor programs), perceived or resale value of the current and proposed Title II rations is exceptionally small, especially when viewed in the perspective of income and cost of living which are disproportionately high for poor people compared with many other countries.

WFP is the largest food supplier in Djibouti and has taken over the refugee feeding phased out by CRS over the past years. Refugee rations provide nearly three times the amount of food per person given under the MCH program.

On an annual basis, WFP provides for 16,000 refugees. At 15 kilo grams each per month, this results in the import of 2,880 metric tons a year. Most of the food goes to Dikhil (10,000 refugees), Ali-Sabieh (4,000) and Balbala (1-2,000).

Due to arrive about January 1, 1985 is "emergency" food requested in March 1984 and approved in September 1984 which is destined for 72,000 drought victims. An estimated 4,000 metric tons of cereals, oil and milk are to be delivered.

Red Crescent supplies modest quantities of rice from Libya, milk from West Germany, milk and oil from Switzerland through the International League of Red Cross.

When the large tonnages are considered in the context of a 300,000 population, it is easier to understand the relative insignificance of the MCH package.

Everyone agrees that much donor food is available at cheap prices in the market (\$.85 for a kilo of cereals) though no reliable estimates are available. A telling symptom, however, is that WFP reports no takers in their efforts to set up a Food for Work program.

4.1.4 Ration Delivery.

During the 12-month period studied for cost-effectiveness, 655 metric tons were used for 8312 averaged beneficiaries per month. This should provide each child and mother with 6.6 kilos per month. However, as discussed below under Attendance, our averaged mothers come only two-thirds of the time and would therefore be eligible to collect an average of 3.3 kilos monthly for herself and each child. Thus it appears that twice as much food as reported in the center distribution reports is sent out. Tables 4.1-A and 4.1-B show that mothers get slightly more than the estimated 2.6 rations per family but that the centers often do not distribute the total ration (5 kilograms). The second table shows considerable unevenness in reported ration distributions ranging from lows of 33-42% of the ration to highs of 125-200%. The overall averages for the Districts however are all below 100%, or 5 kilos: Djibouti-Town received 92% as did Tadjourah District while Ali Sabieh received 55% and Obock 73% for the period studied. It appears that half of the food is "lost" to the MCH beneficiaries but the team was unable to pursue this question further than to note the discrepancy in records studied.

4.1-A Average Number of Rations Delivered
 PER FAMILY (MOTHER PLUS CHILDREN) JULY 1984 - JUNE 1984
 ALL REPORTING CENTERS, DJIBOUTI

District Center	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Average
Djibouti	2.6	2.7	2.5	2.6	2.9	2.7	2.9	2.5		2.6	2.7	2.7	2.7
SMT	2.6	2.6	2.5	2.6	2.6	2.7	2.6	2.7		2.6	2.7	2.7	
Farah-Had	2.7	1.5	2.6	2.6	2.5	2.7	2.7	2.9		2.5	2.9	2.7	
Engueilla	2.3	2.3	2.1	2.1	1.9	2.3	?	2.9		2.4	2.4	2.5	
Balbala	2.6	2.8	2.8	2.9	3.4	2.7	3.4	2.8		2.5	2.7	2.7	
Ambouli	2.3	2.3	2.4	2.4	2.3	2.7	2.6	2.5		2.3	2.4	2.4	
Arhiba	2.4	2.4	2.5	2.9	4.1	2.4	2.5	2.5		2.5	2.5	2.5	
PMI Mobile	2.6	3.4	2.5	2.8	2.8	2.8	?	2.6		3.0	3.8	2.9	
Arta Oueah	3.4	4.5	3.0	2.9	4.2	3.4	?	2.9		2.9	2.6	3.9	
Ali Sabieh	2.4	2.2	2.9	2.4	2.7	2.7	?	2.7		2.6	2.6	2.6	2.6
Obock	2.9	3.0	2.9	2.8	2.9	2.9	3.1	3.2		3.0	2.9	2.8	2.9
Tadjourah	2.8	2.7	2.7	2.8	2.7	2.7	2.7	2.7		2.8	2.6	2.6	2.7
Tadjourah	2.9	2.7	2.8	2.9	2.8	2.8	2.8	2.6		3.0	2.6	2.7	
Sagallou	2.8	2.8	3.0	2.7	2.6	2.6	3.1	?		2.6	2.6	2.6	
Adaillou	2.7	2.7	2.6	2.7	2.7	2.7	2.6	2.9		2.9	2.8	2.7	
Dorra										2.6	2.6	2.6	
Randa										2.8	2.6	2.6	
Dikhil											2.4	2.5	2.45
Yoboki											2.4	2.3	
Dikhil												2.6	

Source: Compiled Monthly Distribution Reports, CRS/Djibouti

4.1 -B

% OF RATION DISTRIBUTED BY CENTERS BY MONTH
 JULY 1983 - JUNE 1984, IN DJIBOUTI-PAYS

District Center	1983						1984						AVERAGE
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	
Djibouti	80	98	102	91	79	78	91	119		67	104	98	92
SMI-2	110	117	105	110	88	90	106	157		87	106	109	
Farah-Had	69	64	99	100	33	91	94	99		62	88	95	
Engueilla	76	88	107	100	183	105	?	102		95	94	95	
Balbala	128	155	128	95	122	112	110	126		123	127	142	
Ambouli	85	139	116	107	20	42	63	151		87	145	?	
Arhiba	40	68	92	100	75	67	61	60		86	86	98	
PMI Mobile	60	69	81	60	51	57	?	97		63	59	31	
Arta/Oueah	58	65	77	71	70	70	?	96		93	94	201	
Ali Sabieh	58	37	38	53	48	55	?	100		42	66	?	55
Obock	70	65	59	66	68	61	89	82		73	67	100	73
Tadjourah	82	78	81	64	80	100	138	-		91	108	95	92
Tadjourah	77	75	84	60	59	82	156	91		111	98	81	
Sagallou	65	100	86	62	-	110	191	-		138	148	?	
Adaillou	95	75	75	68	125	122	103	124		54	126	103	
Dorra										93	87	?	
Randa										97	97	98	
Dikhil											89	66	77
Yoboki											89	?	
Dikhil												66	

1 Ration = 5 kg, 2 of Milk or CSM, 2 of Rice and 1 of oil
 Source: Compiled Monthly Distribution Reports, CRS Djibouti

4.2 The Role of Food Aid

The "Food and Nutrition" program in the PMIs has been dominated by Title II food operations, despite the insistence of CRS on the accompanying weighing and accurately kept growth charts.

The safe delivery of Title II food from U.S. ports to the hands of mothers at distribution points in Djibouti, in the approved amounts and in good condition, is an enormous logistical responsibility even to long-experienced food handlers. The problems inherent to new programs (correct delivery planning in light of seasonality of attendance, the introduction of foods that are unfamiliar; training a network of staff in commodity handling and reporting) were further complicated in Djibouti by the effect of severe climate on commodity shelf life and lack of a transport system that could meet CRS' delivery requirements. CRS/Djibouti reports that food crises are the norm whether in the form of missing stocks, over-distribution, or overstocking and shortages in storage sites due to plummeting or rocketing attendance. Control of accounting on beneficiary numbers and ration amounts is extremely difficult and to date, unsatisfactory. Despite cleared audits, CRS/Djibouti considers current abuses to be excessive in terms of management time needed to deal with them. The result is that food control, for which CRS is fully accountable to the U.S. Government, is the priority management problem for the entire CRS staff. Covering port fees and costs of inland transportation often paid by the host government contributes to the high program costs. Combined with the cost of the food itself and ocean freight and management by CRS and others, the cost per child or beneficiary appears excessive (See cost effectiveness, 6)

Current delivery of food to MCH centers and distribution there is the subject of much criticism. Even when the food is thought to be a useful incentive to get more mothers to attend the MCHs many MOH, other GROD and donor community staff, think it is harmful to proper MCH conceptualization. Some think it limits participation to the poor; most believe it distorts the objective of preventive health. Thus, the suggestion has been made frequently that food distributions should be quite separate from the rest of MCH activities. CRS considers it unfeasible to create new distribution site(s) because of investments they have made to date in training of food handlers and accountants in MCHs, and in construction and renovation of storage facilities at the MCHs. Neither is CRS convinced that mothers would (or should) be willing to spend even more time obtaining food rations already of questionable incentive merit. It must also be added here that CRS has tried to move away from handouts to needy families both on their own conviction, and in accordance with the strong emphasis in USG policy that food should be integrated maximally into MCH systems.

Three arguments have been put forward by those MOH and MCH staff members who favored continuation, even if in modified form, of the food distribution component of the CRS program:

- 1) The food is being distributed to the neediest families in Djibouti, who would suffer severe deprivation were this nutritional supplement to their diet removed.
- 2) Without the food distribution many women would cease to participate in other important PMI activities, such as vaccinations or the budding pre-natal program.
- 3) The mothers' contributions pay for numerous center personnel who are employed not only in CRS program activities but also in other dispensary activities: assisting in the vaccination program or pre-natal consultations or even in curative care.

Each of these three arguments will be discussed below:

1) Cook's study implied that those mothers attending the MCH program were, on the whole, drawn from the more economically deprived strata of Djiboutian society than those that did not attend. The reported literacy rate of attending mothers was only 2.5% as opposed to the official rate of 9% overall literacy. However, one would expect literacy among women to be lower than the overall rate in any except the highest social strata.⁽¹⁾ Attending mothers had larger families than non-attending mothers which suggests that they may be under greater economic stress. However non-attending mothers tended to be younger with an older last child suggesting that perhaps they had already attended the program (as 13 out of 20 said they had) when their child was younger and that they had not yet had another child to enroll in the program. It is also possible that younger mothers are more influenced by their husband's view of the MCHs than are older mothers. Such speculation is meant to suggest only that no hard and fast conclusions about the economic status of attending versus non-attending mothers can be drawn from Cook's data. There are, in fact, indications that the current food and nutrition program may not be reaching the most needy families. Some center personnel felt that there were families unable to pay the 100 FD required to obtain the ration and were therefore not coming into the program. Since mothers did not appear to have a clear idea of the economic value of the ration

(1) A 1983 study of 149 women made by UNFD showed a literacy rate of 6.7% among the urban and rural sampled population.

Source: Sommaire de l'Etude Sur La Situation des Femmes, Djiboutiennes effectuée par l'UNFD entre janvier et Septembre 1983. (Mimeo)

this perception of center personnel is credible. As argued elsewhere, the economic value of the current ration, even to poor families, of which there are many in Djibouti, is questionable in relation to the investment of time and travel which must be made to obtain it. Again, the relatively high rate of absenteeism (35% on the average) among attending mothers and the high early dropout rates (30-40%) argue against the value of the ration to most mothers. Finally the high level of food aid in Djibouti would suggest that truly needy families would have access to other sources of food than the CRS program (through CARITAS, WFP or others). This last is a view which would need to be verified by further research.

2) Based on interviews with health center personnel as well as with mothers, Cook reached the conclusion that few mothers would regularly attend the PMI without the incentive of food distributions. It should be emphasized that he made remarks with respect to regular attendance, not to expectations of dropout. (It should be mentioned here too that 12 visits a year for over one year old children is not expected anywhere in the world as surveillance intensity and therefore lesser than "regular" 12/12 visits is acceptable from a public health point of view.) Cook's opinion was also voiced by the majority of Center personnel and other agency representatives interviewed by this evaluation team. Cook's data is open to another interpretation, however. Only 22% of attending mothers interviewed by him said they enrolled in the PMI for the food while 57% cited curative treatment, vaccinations and health surveillance as the reasons for their attendance. In a study conducted by this evaluation team at Farah-Had dispensary to test actual behavior, 18% of attending mothers came only for food and weighing, while 82% came for treatment and/or vaccinations in addition to

weighing on a given day. Cook found that one of the principal complaints of the attending mothers about the MCHs was the lack of medicines, suggesting that the desire for curative care was a strong motivating factor for enrollment besides the desire to benefit from the food ration. Some of the health center personnel interviewed by this evaluation team thought that while some mothers would leave the program in the absence of food distributions, many others would continue to come because the habit of regular attendance had already been acquired, or in search of curative care or vaccinations. The growing liaison between the health centers and the community health committees would favor the development of a trend in this direction. Further the requirement of some doctors that children coming in for curative care present proof of having been weighed before being examined would encourage mothers desiring curative care to participate in weight monitoring activities.

It is interesting to note in the Cook study that non-attending mothers were more likely to view the MCH as a food-distribution center than attending mothers. In the non-attending group 33% said that the principal function of the MCH was food distribution (as compared to 22% among the attendees). While the numbers are too small to draw any statistically valid conclusions, this study outcome suggests that more intense educational activities within the community could help to change mothers' perceptions of the importance of MCH activities.

3) The effect of the mothers' contributions, which at the present time are linked exclusively to the food ration (as opposed to program participation in general), on the staffing pattern of dispensaries in Djibouti is a serious issue. At the present time 42 out of 75 persons involved in the CRS program in dispensaries are paid for by the mothers' contributions. Of these, 20

are employed almost exclusively in food distribution activities. The rest have more broadly defined roles in the PMI program. In the 5 government dispensaries in Djibouti-town where a CRS center operates (excluding the center of SMI-2 which serves only employed workers and their families) mother's fund paid employees make up 23% of the entire dispensary staff. The MCH staff as a whole constitutes 45% of dispensary staff. Elimination or reduction in the food distribution element of the MCH program would necessitate finding another source of funding for the personnel currently being paid by mothers' funds as well as a redistribution of tasks and responsibilities among the whole MCH staff. This issue will need to be addressed by the GROD and CRS when any changes in the food component of the program are discussed.

On the whole, the current CRS food distribution component of the F/N program is very expensive for food rations which are still considered to be inadequate to effect a significant economic impact on even poor families. The management staff, at current strength, has been unable to solve food handling problems. It is a program preoccupied with food delivery at the expense of other programs, though the present form of food delivery is of questionable merit to health officials and to recipients. However, any changes in the program will have to be carefully planned to avoid serious disruptions in the MCH program as a whole. Changes should be introduced slowly and effects of such changes on MCH effectiveness and coverage should be carefully documented.

4.3 Targeting

Generally the CRS/MCH program is well targeted according to economic need, geographic distribution, younger age groups and malnourished status.

4.3.1. Participating mothers have larger families and lower literacy rates and represent the lower end of the economic scale according to Cook, although this conclusion is based on insufficient data. In the absence of a good SES study, it is not clear that attending mothers are poorer than non-attending mothers.

4.3.2. The program is well distributed by urban/rural setting, with 75% of the beneficiaries living in Djibouti-Ville where two-thirds of the country's population live. Coverage of the different Districts ranges from 1 - 25% of the under-five population exposed to the program. Best coverage is achieved in Tadjourah District where 1 in 4 children is exposed to the program. Least covered is Dikhil District where the program was closed for most of this period.

4.3.3. A good percentage of the attending children are under three years of age. A study of a sampling of children from the PMIs made by the Education pour la Santé in 1981 found that 73% of enrolled children were under two years of age. The evaluation team studied a sampling of Master Charts of April 1984 which showed 69 % of the program children to be below three years of age. (see 4.3.3 table)

4.3.4. Malnutrition rates of MCH children appear to be closely parallel to national averages neither reflecting the extreme pockets of high malnutrition rates nor the best nourished segments. Among children enrolled in the MCH program from July 1983 - June 1984, an

4.3.3

4.3.3

TARGETING: PERCENTAGE OF ATTENDING
CHILDREN UNDER THREE YEARS OF AGE
IN SEVEN CENTERS, APRIL 1984

	<u>Number of Children <3</u>	<u>Number of Children Attending</u>	<u>Percent of Children under Three years age</u>
Farah Had	502	691	73%
Arhiba	524	794	66%
Balbala	862	1122	77% HIGH
Arta	207	420	49% LOW
Obock	188	272	69%
Ambouli	464	646	72%
Tadjourah	<u>191</u>	<u>304</u>	<u>63%</u>
	2938	4249	69%

average of 35% were <80% weight for age with a range from 30-41%.
An average of 11% were <70% weight for age with a range from
8.4-13%. An average of 2% were <60% weight for age, with a range
from 1.5-2.8%.

4.4. Attendance and Coverage

4.4.1. Attendance is highly irregular, mortgaging chances for impact economically from the ration, or educationally from the program.

Included in Cook's report is a study of program abandoners over 1982 and 1983 at a large urban center. 41% of those mothers had abandoned after 1-3 months; 34% left after 4-12 months; and only 25% stayed one year or longer. Among the longer-term enrolled groups--seven months or more in the program-- the majority had at least three absences a year.

Our own attendance study of 134 children in five centers over the period beginning June 1983 through October 1984 showed that out of the total children enrolled at that time, 30-40% had been there for one year or more. This rate for participants compares with Cook's 25% for dropouts. See Table 4.4-A.

Average attendance for the period is 65% (number of months attended out of total months enrolled). This means that more than a third of enrolled children (from the groups still enrolled in October) on the average were absent in any given month. Months of lowest attendance were: in 1983, July, 36%; August, 46%, September, 51% and December, 45.5%; in 1984, January (55%), but these figures are skewed by the fact that only those children still enrolled in October 1984 were included and not all children enrolled at the time.

Cook found that the summer months constituted the focus of attendance irregularity. He found that in 1982 and 1983, attendance during the month of July was 50% less than average attendance during the best attended months (October-May). This time period corresponds to the months of traditional summer migrations to the cooler regions of Djibouti, Ethiopia and Somalia, as well as to school vacations and, during these

years, to the fasting month of Ramadan. PMI staff vacations also tend to fall during this hot summer season. The low attendance months coincided with months of highest malnutrition in the centers--July, August and September. Cook and others speculate that the reason is either that poor families remain behind and with their lower weight children, influence the higher rates; or the eating patterns in the hot months bring about a drop in weight growth. Statistically the lower numbers may also give larger impact to lower weight preschoolers. Following up on the projection of women interviewed by Cook et al. that 21% of the women expected to be away in July 1984 (compared with 50% in previous years), we found that, compared with best-attended months, October-May, attendance in July 1984 was in fact 25% less. This variation between years suggests that movement out of the hotter areas during the summer are perhaps only half responsible for the low attendance. In the months of lowest attendance rates - June and August - our study showed a correlation with a low new enrollment level compared with other months. The numbers are too small to note other than a trend. However, this trend to low rates of enrollment in the summer combined with the high rate of summer dropouts (Cook study) ought to be considered together when looking at the causes of overall attendance decrease in the summer, and suggest that seasonal fluctuations in coverage figures reflect variable enrollment and dropout rates among short-term program attendees rather than among the "hard-core" of longer term program participants.

A more complete understanding of attendance patterns and the rates and reasons for dropouts is essential to program planning. No adequate study has been made to date.

4.4.2 Program growth in terms of total coverage has been disappointing to CRS who expected a doubling of the current size of their program on a sustained basis. Instead the program fluctuates, predictably dropping during the summer months but also in unpredictable ways. For example, over the last 21 months of operation (beginning in January 1983, ending in September 1984, the program has reached as many as 8203 children and as few as 2445). Graph 4.4.-A shows coverage over this period; it can be seen that numbers grew rapidly from a low in October 1983 until March 1984 then began a descent, initially without the effect of summer migration. It must be recalled that the March 1984 peak was reached three years earlier in January of 1981, right after the program started. Nevertheless, overall numbers in 1984 have nearly doubled those for 1983 including the slow months. Part of the March-June spurt in numbers attending is thought to have been result of an oil shortage in the country making the food package more interesting at least briefly. Between the two years, different patterns are apparent for some months: In 1983 coverage went up by 11% in September; in 1984 it went down by 13%. In February 1983, coverage dropped significantly, by 31%, whereas in the same month in 1984, it rose perceptibly, by 9%.

As Cook pointed out, the pattern of increased malnutrition rates during the slow, summer months continued, with highest rates showing up June through September (See graph 1-A).

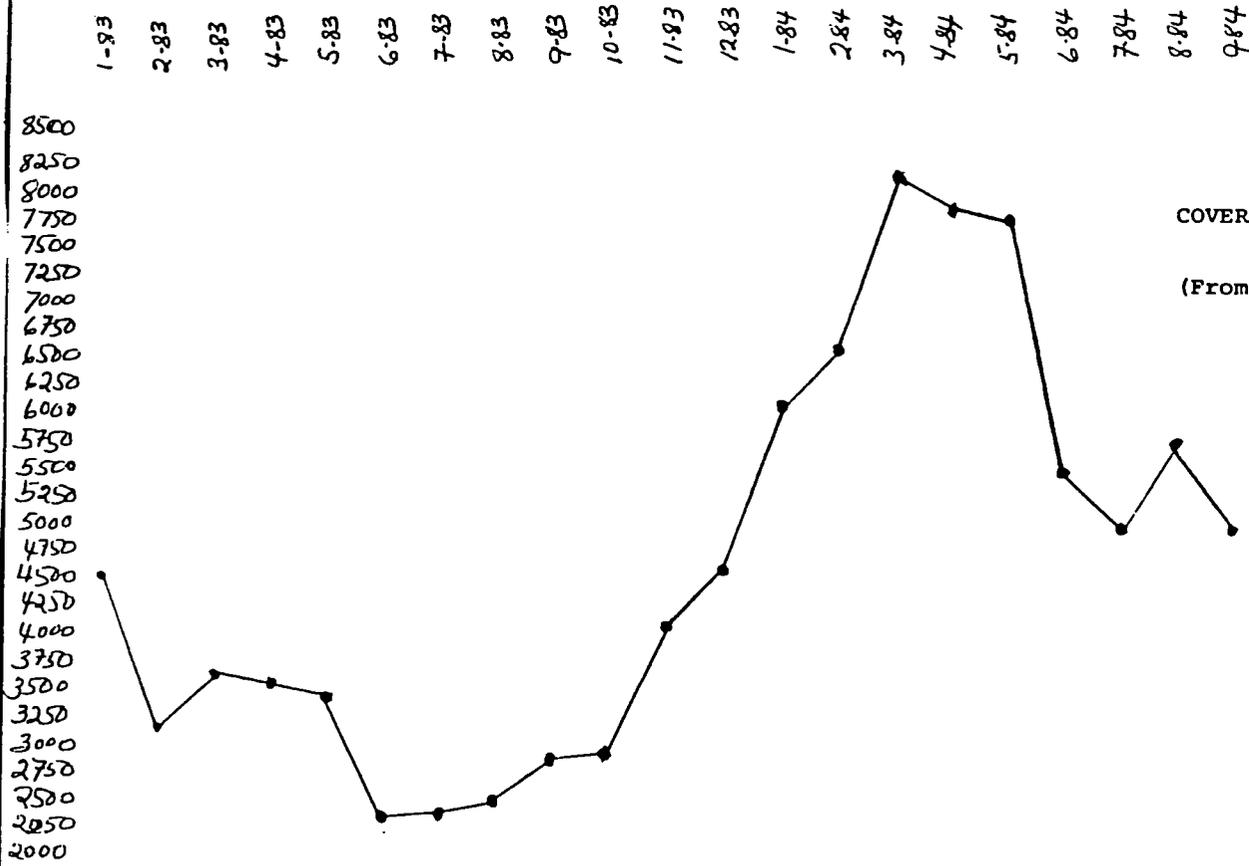
In terms of average numbers covered each month--i.e., not always the same children--the coverage is small, a little more than 5,000 from July 1983 to June 1984. (See table 4.4-B) This averaged figure, however, masks the number of families reached by the program over the 12 month period. The pattern of attendance interval cited above in the Farah-Had dropout study offers

some guidance for estimating total numbers reached in a given year but should be perhaps modified to reflect: a) lower percentages of dropouts for the population currently in the program than for those already out; and b) a re-entry rate for which no statistics are available. If we modify the Farah-Had dropout figures rather arbitrarily by raising the attendance rate up 10% the following calculation of total attendees is reached.

ESTIMATED TOTAL ATTENDANCE
 JULY 1983 - JUNE 1984
 FROM AVERAGE 5138 CHILDREN MONTHLY

INTERVAL COHORT	FARAH- HAD % IN INTERVAL	ADJUSTED -10% IN INTERVAL	NUMBER IN ATTENDING COHORT	MULTIPLE FACTOR X/12 MOS.	ESTIMATED ATTENDEES
12 MONTHS+	25%	35%	1798	1.0	1798
9 MONTHS	16%	25%	1336	1.3	1737
5 MONTHS	18%	28%	1439	2.4	3454
2 MONTHS	<u>41%</u>	11%	<u>565</u>	6.0	<u>3390</u>
	100%		5138		10,379

This estimate of total children reached, 10,379 may be on the conservative side. It appears safe to estimate that double the averaged number is in fact reached by the program in varying degrees of intensity. In the perspective of a total under five population estimated at 54,500, the MCH./CRS program may be touching one out of five children. Most program mothers have 1.6 children so it can be estimated that more than six thousand families are touched by the program. (See table 4.4-C)



GRAPH 4-A
 COVERAGE OF UNDER FIVE CHILDREN
 OVER 21 MONTHS
 (From January 1983 through
 September 1984)

4.4-A Attendance Regularity of
PMI Children enrolled as of October
1984 in 5 Centers from July 1983
to October 1984 and Rate
of New Enrollments

A.

ATTENDANCE	1983						1984									
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE	JUL	AUG	SEPT	TOTAL
NUMBER OF CHILDREN ENROLLED	44	48	49	55	59	61	69	80	92	104	111	117	123	128	138	1278
% PRESENCE OF ENROLLED CHILDREN	36	46	51	64	64	48	55	76	78	70	77	62	67	63	65	64.2
B.																
ENROLLMENT																
% OF NEW ENROLLMENTS N = 91		.2%	1%	7%	5%	3%	12%	9%	14%	13%	7%	7%	3%	5%	11%	100%
% ENROLLED IN LAST THREE MONTHS				16%	20%	23%	28%	28%	35%	32%	28%	20%	14%	11%	13%	
% ENROLLED IN LAST SIX MONTHS							41%	43%	50%	50%	48%	48%	39%	35%	30%	

Source: Individual growth cards, from groups weighed between Oct.16-25,1984, at Farah Had, Ambouli, Balbala and SMI-2 PMIs.

4.4 -B

COVERAGE GROWTH AND SEASONALITY OF LEVELS OF MALNUTRITION
FOR CHILDREN WEIGHED IN PMI CENTERS FOR TWELVE MONTHS BEGINNING
JULY 1983 AND ENDING JUNE 1984 BY DISTRICT AND BY CENTER

District	JULY 83	AUG 83	SEPT 83	OCT 83	NOV 83	DEC 83	JAN 84	FEB 84	MAR 84	APR 84	MAY 84	JUNE 84	AVERAGE
Ali Sabieh	274	448	519	367	469	562	590	657	668	374	462	326	476
Ali Sabieh	274	448	519	367	469	562	232	337	252	242	329	-?	
Holl-Holl	-	-	-	-	-	-	225	253	238	rej?	-	190	
Ali-Adde	-	-	-	-	-	-	56	-	56	57	57	54	
Mouloud	-	-	-	-	-	-	27	32	79	29	39	45	
Dasbyo	-	-	-	-	-	-	50	35	43	46	37	37	
District Djibouti	1768	1724	1946	2069	2940	3433	4630	5039	6363	6047	6203	4210	3864
Arta/Wea	271	285	213	265	321	350	413	382	441	420	411	315	
Arhiba	361	258	299	309	408	368	607	699	920	795	803	520	
Ambouli	173	89	84	196	242	427	365	422	626	647	373	194	
Engueilla	206	248	228	200	326	332	435	487	636	584	550	448	
Farah-Had	178	217	?	198	220	385	475	623	623	682	807	517	
PMI-Mobile	54	79	?	279	481	496	709	621	685	886	763	292	
Balabala	363	346	930	385	671	753	1254	1305	1789	1239	1584	1148	
SMI-2	162	202	192	237	271	322	372	500	644	794	912	776	
District Tadjourah	258	223	238	322	488	448	596	680	918	1175	743	493	548
Adailou	134	120	124	130	113	110	124	97	118	112	142	137	
Sagallou	37	30	30	55	39	44	28	30	45	51	65	-	
Banda	-	-	-	-	-	89	224	269	124	271	158	208	
Dorra	-	-	-	-	175	-	33	106	379	437	96	-	
Tadjourah	87	73	84	137	161	205	186	178	252	304	282	148	
District of Obock	158	177	151	192	211	217	229	249	261	272	269	227	218
District of Dikhil											117	258	32
Dikhil											-	167	
Xoboki											117	91	
Total Graphed Children	2458	2572	2854	2950	4108	4660	6045	6625	8210	7868	7794	5514	5138
Nutrition Status													
<80	41	38	39	38	40	34	31	31	30	33	34	39	35
<70	13	13	12	12	14	11	9.6	9.1	8.4	10.2	10.6	12.9	11
<60	2	2	2.5	2.4	2.8	2.4	1.8	1.9	1.6	1.7	1.5	2.0	2.0

4.4-C

CRS COVERAGE OF VULNERABLE
CHILD POPULATION, BY GEOGRAPHIC AREA OF DJIBOUTI
JULY 1983 - JUNE 1984

NAME OF DISTRICT (% OF POPULATION DISTRIBUTION) 1)	TOTAL POPULATION 2)	ESTIMATED # 5 YR. OLD POPULATION (16.5%)	AVERAGE MONTHLY COVERAGE OF 5YR. OLD POPULATION IN PMIs		PERCENT OF <5YR OLD POPULATION COVERED AS % OF TOTAL <5 POPULATION IN THE DISTRICT	ESTIMATED ACTUAL COVERAGE OF <5YR OLD IN PMIs		PERCENT OF 5YR OLD POPULATION COVERED AS % OF <5 IN THE DISTRICT
			NUMBER	% OF TOTAL		NUMBER	% OF TOTAL	
DJIBOUTI (59)%	194,700	32,175	3864	(75%)	12%	7805	(75%)	24%
ALI-SABIEH (16.5)%	54,450	8,984	476	(9%)	5.3%	962	(9%)	10.7%
DIKHIL (12.0)%	39,600	6,534	32	(.6%)	.5%	65	(.6%)	1%
TADJOURAH (8.0)%	26,400	4,356	548	(11%)	12.6%	1107	(11%)	25.4%
OBOCK (4.5)%	14,850	2,450	218	(4.2%)	8.9%	440	(4.2%)	18.0%
TOTAL	330,000	54,450	5138	(100%)	9.4%	10,379	(100%)	19.1%

Notes: Because of highly irregular attendance in the PMIs, averaged numbers of children do not give a picture of population reached, however erratically. Thus, in addition to the averaged child coverage, an estimate has been made of the estimated actual child population reached.

Sources: 1) Unpublished information on population distribution, Bureau of Census.

2) Estimated Population, "Planification: Perspectives de la Population Djiboutienne D'ici à la Fin du Siecle (An 2000)"

4.5. Growth Surveillance System as Monitoring Mechanism.

CRS' Growth Surveillance System (GSS) consists of the individual card showing one child's progress (see 4.7.) and the Master Chart from which the weight/age percentile is found to be recorded on the individual card, and which constitutes a permanent record of nutritional status of attending children, by month and by center. The results of weighing sessions are recorded on one or several Master Charts in each Center and then forwarded to CRS/Djibouti where a compilation is made for all children for each month, showing numbers in each centile of weight according to the standard for age. Quarterly reports then summarize the percent of children under 80% weight/age, the cutoff indicator used to delineate malnourished children. Ideally the Master Chart is a monitoring tool; it is not a data source for measuring nutritional impact.

The CRS Master Chart is not the only method for surveilling growth progress but it is a tested method and has been put into place in Djibouti at considerable cost. CRS must provide the necessary training, equipment (scales), material (charts, report forms) and supervision to introduce this system into a PMI. To be an effective surveillance mechanism, the Master Chart must be filled out correctly following the correct weighing, reading and recording of consecutive children's weights.

At conception in 1979, the F & N program consisted mainly of food distributions. Weighing and utilization of the GSS were gradually introduced. Nearly two years after the program began, a little over 40% of the centers were sending monthly reports, not always very accurate, based on Master Chart data compilations. Greater attention was applied to this program element in late 1982 and by December, 72% of the centers were reporting. A series of in-house workshops on the GSS and cor-

rect weighing procedures were held in 1983 and by July of last year, 93% of the centers were reporting with increasing accuracy. Today after five years of operation, the system can be said to be established, but CRS recognizes that maintaining adequate reporting standards requires continuous supervision, training of new staff and retraining of old staff. Since the beginning of Calendar Year 1983, quarterly reports with a summary of growth surveillance data have been sent to the Ministry of Health.

The evaluation team observed that center staffs were more adept with the Master Chart than the individual health cards, perhaps with the knowledge that errors were quite quickly detected and referred back to them, whereas the multitude of errors on child cards suggested too rare checking by supervisors. Too often, the team noted, the person who completes the Master Chart, who is necessarily giving primary attention to both finding the correct percentile, reading it to the person filling out the individual card, and placing the dot in the appropriate place, is also the person who counsels the mother about her individual chart. Individual counseling gets short shrift in this arrangement.

The team observed that some centers had copies of the data for feedback purposes, presumably, but the systematic analysis of different MCH nutrition status profiles is still in the future. Beginning steps have been made by discussing results in different centers at the monthly meeting of MCH personnel.

The GROD has demonstrated its interest in the CRS master chart and surveillance system. Health center physicians repeatedly expressed their appreciation to the evaluation team for the data it provided. The card is being taught at the Centre de Formation (the Nurses' Training School) and its continued and in-

creased effectiveness will depend on CRS resources for this purpose. The Ministry of Health (with printing costs covered by UNICEF) has plans to print a new health card which incorporates the Master Chart. The MOH, however, has not decided to use CRS' individual card, but rather to record weights on the individual "Master Chart". One cannot argue persuasively for maintenance of the CRS mothers' card since it has not been fully understood by mothers nor used widely as an educational tool. Nor are they a reliable source of child growth history since too many are lost. The surveillance system has not yet been used as a motivational tool to stimulate community understanding and participation in the whole weighing procedure and thereby bring more mothers to the MCH.

4.6 STAFF CAPABILITY AND TRAINING; MANAGEMENT AND SUPERVISION

4.6.1 CRS/Djibouti Program Staff: National Office

Currently 14 people are employed at the CRS/Djibouti national office. Of these, all but one, the country representative, are paid for by the funds of the current OPG. All but 3 of the 14 staff members are local-hire, host-country nationals. The three Americans include the representative, a food and nutrition supervisor/coordinator and an assistant director in charge of food and program management. Both of these latter have Masters' degrees in public health and several years experience in Africa prior to their arrival in Djibouti. However, Djibouti is their first post with CRS. The host country staff includes a Food and Nutrition Supervisor assistant with an MPH from UCLA, two bookkeepers,^a/commodity manager, a secretary, 3 drivers, 2 guards, one janitor and a warehouseman. Salaries for this staff totals \$93,437 per year (not including those of the expatriate staff). Table 4.6.1 details the job responsibilities, training and salaries for each of these persons. Of this personnel, only the warehouseman and the Commodity manager have been exclusively occupied with food distribution activities. An average of 70% of the time of all the others has been directed at the support of MCH activities including food distribution.

In addition to the OPG-supported personnel, CRS employs another Health Education Coordinator with a Master's Degree in Sociology and a driver through the UNICEF grant to support the nutrition and health education program for girls in the Foyers Sociaux (women's union), and promotional activities for fresh fish.

The evaluation team did not study in-house personnel management or staff utilizations patterns. CRS/Djibouti has

TABLE 4.6.1

OPG-PAID HOST-COUNTRY CRS OFFICE EMPLOYEES

TITLE	JOB RESPONSIBILITIES	YEARLY SALARIES	TRAINING
1) F/N Supervisor/ Asst	MCH Center Supervisor Growth Surveillance System training	\$17,914	MPH (UCLA)
2) Bookkeeper	Outreach Grant UNICEF financial Reports Agricultural advisor	\$12,893	Argricultural Training in Tanzania
3) Bookkeeper/ Office Manager	F/N grant financial reports	\$11,332	2 year Accountant Course
4) Commodity Manager	Title II and warehouse bookkeeping	\$12,214	Partial Masters in Mathematics
5) Secretary	all typing and filing receptionist	\$5888	Secretarial School in Djibouti
6) Head Driver	office errands	\$7939	
7) Driver	up-country trips	\$5021	
8) Driver	in Djibouti-town trips	\$5021	
9) Day Guard	guard office	\$5021	
10) Night Guard	guard office	\$2714	
11) Janitor	cleans office	\$2714	
12) Warehouseman	check stocks truck loading	\$5904	

recently revised its contracting procedures, establishing fixed term contracts rather than open-ended contracts thus allowing greater control of staffing needs. At present, all host country contracts terminate in April, 1985 with the present OPG.*

Salary levels appear high as compared to similar programs in other countries and as compared to host country salary levels. However, CRS/Djibouti has recently conducted a comparative salary study which revealed that, while GROD salaries are generally lower than those paid by CRS/Djibouti, government employees receive numerous additional benefits such as free housing and utilities, pensions, bonuses, and medical benefits which make the higher CRS salaries equitable in the Djiboutian context.

4.6.2 Other Staff Supported by the CRS F/N Programs

Forty-nine additional personnel contribute to the CRS Food and Nutrition program in Djibouti through their work in the dispensaries, schools, and women's groups of the UNFD. Seven are supported by the UNICEF grant and work as "fish cookers" in the fish promotion program. The remaining 42 are "volunteers" supported by the participant contributions collected from mothers attending the program. These personnel are selected by the dispensaries and under the direct supervision of the medecin- chef who oversees the program in each dispensary or PMI. In the various centers these personnel include two center responsables, 2 health educators, 10 weighers, 18 food distributors and cleaners, and 10 program aids. These are distributed geographically as follows:

* With the introduction of a new OPG and new thrust, staff will need to be evaluated for skills appropriate within the new context. This is most important for those persons holding food handling positions in the event of food phase-out, but all current staff positions will have to be carefully assessed.

District	responsables	health educators	weighers	food distrib./ cleaners	aids	Total
Djibouti-city (including Arta)	2	2	4	10	5	23
Tadjourah			2	1	1	4
Dikhil			1	4	1	6
Ock			1	2		3
Ali Sabieh			2	1	3	6
Total	2	2	10	18	10	42

An additional 15-20 food distributors receive a monthly food-for-work ration especially in Ali-Sabieh district. These are local women who act as mères responsables in charge of organizing the women to participate in the program, act as a liaison to carry messages to the women, and who receive health education information for dissemination, as well as keeping order during food distributions.

The majority of these personnel are occupied with food distribution, although many fill other roles in the health services which include cleaning the dispensaries and PMI centers, participating in health education activities, assisting with vaccination and pre-natal activities, weighing, and recording of statistics for the growth surveillance system. In evaluating the input of these program-supported dispensary personnel, a look at the five major government clinics in Djibouti-city (excluding the central hospital, the social security clinics of SMI and Ibrahim Balbala and Bal-ala adult clinic, but including Farah-Had, Arhiba, Engueilla, Ambouli and Balbala I) reveals that these employees make up 27% of the entire dispensary staff and 62% of MCH staff in these clinics, a major contribution to the health services of Djibouti (See Table 4.6.2 next page)

TABLE 4.6.2
STAFFING PATTERN IN 5 DJIBOUTI-CITY DISPENSARIES
(From CRS/Djibouti records)

Name of Center	Total # Dispensary Personnel	PMI Personnel				
		Total #	MOH Paid	Mothers Fund	UNICEF	OTHER
arah-Had	23	10	3	4	2	1 (FR.Vol.)
Arhiba	12	4	1	3		
Engueilla	9	8	4	1	2	1 (FR.Vol.)
Ambouli	12	5	1	4		
Balbala	20	7	-	5		Croissant 2 rouge
Total #	76	34	9	17	4	4
Total %	100%	45%	12%	22%	5%	5%

Two of the heads of dispensaries interviewed by the evaluation team felt that their PMIs would suffer a severe blow if this staff were no longer available. On the other hand, food distribution activities also take up a considerable amount of the time of the MOH and "other" employees, as do the weight monitoring activities of the CRS program. From interviews of center responsables conducted by the evaluation team it appears that a very few of the more highly trained personnel shoulder the lion's share of PMI responsibilities while lower-level personnel are often underutilized. For example, at Arhiba dispensary, the responsible reports that his job responsibilities include: supervision of weighing, filling out the CRS Master Chart and dispensary weight register, writing monthly reports to CRS, counselling mothers, conducting health education, overseeing food distributions, supervision and administration of vaccinations, keeping vaccination records and controlling the vaccine stock, assisting in curative care and training MCH staff. Other responsables have similar responsibilities.

Lower-level staff are often restricted to weighing children or distributing food or giving cooking demonstrations. Among the reasons for this imbalance in task division are the following:

- Lower-level personnel have often had limited formal schooling and are, therefore, perceived by both CRS and dispensary staff as being incapable of carrying out more complicated tasks.
- Little effort has been made to train these lower level people except in a very limited way for a very few responsibilities. CRS has focussed its training activities on center responsables and has left the training of lower level weighers, distributors and aids essentially up to the PMI staffs (who have received no skills training in the area of personnel training).
- Mastery of skills and knowledge is perceived as a basis for power which some responsables are reluctant to share with their assistants. Increased job responsibilities could also be used to argue for wage increases for which only limited funds are available (on the other hand multiplication of personnel can be equally as or more expensive than employing fewer more polyvalent people at a higher salary).
- CRS/Djibouti's attempts to define job responsibilities or influence hiring practices for mothers' fund paid personnel have been unsuccessful and resented. Decisions to hire personnel, assign jobs and define qualification standards for job candidates has been left entirely to the discretion of the PMI or dispensary directors.

Since the majority of the mothers' fund paid personnel fall into the lower skills category, their contributions to the smooth functioning of the PMIs needs to be more carefully assessed than the evaluation team was able to do. An analysis of the tasks and job responsibilities of all the PMI employees could lead to a more careful definition of roles and a more efficient attribution of responsibilities. Such a task analysis would permit the training of both lower and more highly qualified staff in appropriate skills and upgrade the general quality and organization of the whole PMI system.

4.6.3 Training

To date, CRS has contributed, in a limited way, to the training of PMI personnel through organizing a few in-country workshops, through sponsoring 24 persons for a three-month training course at the Food and Nutrition Institute in Tunisia and through regular supervisory visits to PMI centers. Recently a monthly meeting has been held with all staff responsables to provide a forum for exchange of ideas and continued training. While these activities have undoubtedly helped to upgrade the skills of some PMI personnel, all the training efforts have suffered from a lack of clear objectives and well defined follow-up. On the whole training efforts appear to have been sporadic, extremely limited in scope and of very short duration. All in-country training activities have focussed primarily on the logistics of growth surveillance and food distribution. During the first training seminar held in December, 1981, over 52% of the scheduled course time of 11 hours over a three day period was devoted to the filling in of Master's Charts and mothers' cards, to writing reports and to control of food stocks. Only 22% of the time was scheduled for health educational techniques, while 12% of the time was devoted to a discussion of the use of NFDM. The next formal training seminars were not held until 1983 when a series of 4 hour workshops were held in each district of Djibouti. Again content of the seminar emphasized the logistics of the weight monitoring and food distribution activities and the use of ration commodities. Only one out of six sessions dealt specifically with health education techniques (how to use a flipchart to promote fish consumption). Apart from these two seminars, all other training has occurred during site visits to the centers, or occasionally at the CRS office on a one to one basis. No formal protocol exists for the site visits and no

easily accessible records are kept of these visits (site reports are filled out for visits to rural centers, but are then filed and rarely referred to prior to subsequent visits). CRS reports that visits are supposed to consist of the following activities:

- Examination of equipment, scales and furnishings to see if they are properly cared for.
- Observation of weighing, Master Charting, and mothers' cards to check for errors.
- Observation of health education sessions when these occur.
- Discussion of the caisse and monthly reports and assistance with organization of activities.

Again the emphasis is on program logistics, however this is the ideal. According to one CRS staff member: "visits were often in response, to a staff quarrel, lack of reports, overuse of food, theft, changes of personnel or other problems", thus most visits were a sort of crisis intervention and offered little real occasion for training.

Center responsables interviewed describe their pre-service training for the CRS program as consisting of between 1/2 hour to 2 hours daily on-the-job training for a period of from 3 days to 2 months. When asked what they learned, they consistently said: to fill in the mothers' cards, the Master Charts and to write reports.

The three-month training at the Tunis Food and Nutrition Institute of 24 health workers over the last three year has been a valuable contribution to raising the level of PMI staff when the MOH allows them to remain in the system. The emphasis of this program has been on technical knowledge concerning nutrition, hygiene, vaccinations, breastfeeding and weaning, and diarrheal disease. Some health education was also taught, but the program appeared to be highly theoretical and not very practical. The graduates interviewed all highly valued the knowledge they

had obtained in Tunisia as did their supervising physicians, but they did not know how or failed to transmit this knowledge to program participants.

On the whole, training of CRS center staff has been less than satisfactory. It has emphasized the mechanical skills of growth surveillance and reporting and the acquisition of technical knowledge, but has not, in any consistent way, helped center staff acquire the skills necessary to help mothers improve the nutritional status of their children. The many errors observed by the evaluation team on the mothers' cards attest to the fact that even these skills have not been learned as well as necessary for effective nutritional monitoring.

4.6.4 Overall Program Management and Supervision

Management of the MCH program suffers from lack of operative guidelines, uniformity of objective and approach in the MCHs. While the "CRS unit" is within the MOH structure and immediate management in the hands of health personnel, CRS is very much identified as the benefactor of their training and hiring and as such has leverage to suggest how the staff could best be utilized. No staff descriptions have been attempted, nor has MCH scheduling and traffic flow been reviewed for improvement. CRS has been able to provide little direction on how centers should be run more efficiently due to resistance within the centers, thus restricting their domain to the technical aspects. In the past relations were not collaborative with the MOH and food aid was under constant criticism in the MCH. Fortunately the situation is rapidly changing.

CRS has not defined its supervisory function in terms of a protocol nor does the agency have a schedule for center visits. In fact centers in Djibouti are visited as often as

twice a week but overall task checks are a rarity; attention is more often given on a squeaking-wheel basis. Given the demands of putting a growth surveillance system in place and the constant training of new personnel, it would appear that CRS has not devoted sufficient personnel resources to the MCH program. Over the last 4 years, two long absences of the Food and Nutrition supervision and assistant F&N went unfilled with resulting in the availability much of the time of a single person to supervise the 20 centers.

4.7. Health Education of Mothers

On the whole CRS/Djibouti has engaged in only very limited educational activities at the Food/Nutrition centers. Of the nine centers visited by the evaluation team only two were currently carrying out regular educational activities with attending mothers. In a third center, which until recently had a regular program of health education sessions, all activities of this nature had been stopped as of June of this year. Several centers did include food preparation demonstrations as part of their regular activities but the educational value of these was unclear as mothers did not appear to be much involved in the food preparation nor in the choice of foods to be prepared. Other than regular educational sessions at centers, CRS has engaged in two nationwide "campaigns". The first, to promote fish consumption, started in early 1981 and continues to the present time under a UNICEF grant. The second campaign, designed to introduce mothers to CSM, the commodity replacing NFDM, was a four month effort. UNICEF and CRS have reported on an impact in retail sales of fish near MCHs. The impact of the second campaign is questionable especially in light of the high rate of new mothers every month and the intensity of the campaign itself which touched some centers only once.

4.7.1 Regular Health Education at Centers

Several reasons for the lack of educational activities in most centers were cited by both center personnel and others interviewed. Center personnel repeatedly referred to the lack of time and the unavailability of appropriate locales to do health education. Lack of educational materials was also a frequently cited reason for not engaging in educational sessions with mothers. A less frequently mentioned reason, but one of

great significance to center staff as became clear when they were questioned about their own training needs, was the fact that center personnel felt they had received almost no training in educational techniques and methods: They felt that they did not know how to do education. A final reason for the failure to engage in educational activities with mothers was mentioned only once by the personnel at the centers, but was repeatedly mentioned by their supervisors, both at CRS and in the dispensaries. This was the lack of motivation on the part of center personnel to engage in any activities for which they were not specifically reimbursed or otherwise rewarded.

Of all these reasons, the lack of time and space are probably the least valid. From our observations at the dispensaries it became clear that, while it is true that weighing and food distribution could be hectic, time-consuming and stressful, it was equally true that these activities were often poorly organized and inefficiently conceived from the perspective of personnel use. In one center, for example, of six people occupied in the weighing session, (for a total of 35 children), four were engaged exclusively in locating and/or filling out of mothers' cards and a separate set of dispensary records. In another center, the two staff members employed to weigh children and fill out cards took long breaks between each group of five or six children. In two other centers there were long waits for arriving mothers, who trickled in throughout the morning. In all these cases a more efficient organization and better use of time would have allowed ample opportunity for a 20-to30-minute educational activity with the mothers. The "lack of space" argument appeared equally specious. Most centers had at least some outdoor area which could have been used for education sessions.

Lack of educational materials appeared to be a more valid reason. A survey of available resources showed that, in all but one center, available visual aids were limited to the two CRS posters; one of "3 food groups" and one of a "typical" MCH session, an enlarged CRS mothers' card, some CRS "fish promotion" posters and numerous rather inappropriate posters provided by drug and baby food companies showing Europeans or cartoon characters engaged in child care and feeding. There were also Djibouti tourist posters, a few anti-smallpox posters and one French anti-smoking poster which looked remarkably like an advertisement for a new brand of cigarettes. The narrow range of topics covered by the usable materials would be extremely limiting to any educational activities and the fact that most of these posters were firmly attached to the wall rendered them unavailable for use in group discussions in any case.

Lack of training in educational methods is probably the overriding cause of the near absence of educational activities, in the CRS centers. As noted above (Section 4.6), pre-service training of CRS center personnel seems to have consisted exclusively of instruction in how to weigh children, how to fill in the mothers' cards and the master charts and how to write the monthly reports to CRS. The Tunisia graduates interviewed never listed health education techniques as among the things they had learned in Tunisia and when pressed said only that they had "discussed how to teach mothers "but had not practiced any methods. That center personnel felt the need for training in educational methods is evident from the fact that four out of six center directors questioned mentioned this as one of their most important desires for additional training. In the

two centers where health education sessions are currently being conducted on a regular basis, one is benefitting from the assistance of a French nurse who offers training sessions in educational methods to the center personnel once a week, and who assists personnel in conducting daily educational sessions with the mothers. Center staff at this dispensary repeatedly praised the French volunteer for this on-the-job training. The other center is being run by a young Djiboutian medical student who has been involved in the program for less than two months. When asked how he had designed his educational activities he said that he had heard that he should do them during a monthly CRS meeting and then just "made them up based on my medical training". His topics, while appropriate were very limited and from his description of their content, highly technical in presentation: "the importance of proteins, vitamins and carbohydrates", breast feeding (women should breast-feed for three to four months), corporal hygiene of mother and child ("do not feed child when your breast is diseased"). When asked how he verified the mothers' comprehension of his lessons he said he did not; he just "told them what they needed to know". Recognizing his limitations, this dedicated young doctor urgently requested training and materials to help him improve his educational activities with the mothers.

While lack of motivation did appear to be a problem in relation to health educational activities, there would seem to be reasons for this other than the inherent laziness or greed of center personnel. The nurse who had recently stopped organizing educational activities at the center for which he was responsible explained that he had been expected to conduct

these sessions on his own time after the regular workday. The only educational materials he possessed were some WHO booklets and he claimed to have received no response of any kind to his repeated oral and written requests of the representatives of WHO, UNICEF and CRS over the past two years for health education materials. Failure to provide direction and guidance for health education initiatives combined with the lack of training would appear to be sufficient explanations for the lack of motivation so often mentioned by the supervisory staff. In one instance CRS supplied the money for an inspired Health worker "to buy whatever he needed".

4.7.2 Individual Growth Charts.

Traditionally CRS has viewed the individual child card as the primary educational tool with mothers and indeed it has been effectively used in many programs. In visits to nine programs in Djibouti, the team did not observe effective application of the chart as a teaching tool; many responsables said they did not think the mothers understood; others, that they did, though responsables could not answer how they know that was true. The team had no opportunity to check a valid sampling of mothers or their knowledge but asked a group to explain the purpose and meaning of the chart in one center and this was handled well; it was one of the two centers with an educational program. Most of the cards are given free (a few pay 25FD); many are lost after the summer lull with the accompanying loss of continuity of child growth monitoring; and many are mutilated, smudged, in several separate pieces, making it difficult to record current weights and keep the graphing visible. The low value given the health card by the mothers suggests that personnel have not demonstrated its importance and worth.

4.7.3 Education Campaigns

The evaluation team did not investigate the impact of the fish promotion campaign. Government and donor officials interviewed seemed to feel these had been a "good thing" which should perhaps be expanded.

The impact of the CSM promotion campaign was questionable. According to center staff, the CSM promotion team had usually passed in each center once to demonstrate the preparation of CSM to attending mothers. Demonstrated preparation included primarily a porridge mixed with bananas and sugar and CSM as an ingredient in the staple pancakes. While most did feel that mothers preferred CSM to milk, center personnel reported that many mothers did not know how to use CSM. In one center the center director stated that he thought at least 50% of the distributed CSM was "fed to the goats". In another center some mothers were observed to refuse CSM at the distribution site. Mothers who did use CSM were reported to use it primarily as an ingredient for the pancakes which were eaten by the whole family or sold. One center director said mothers did not use it to make porridge because they could not afford to buy the fruit needed "to make it taste good". CSM was reportedly considered a "heavy " food (see Cook classification) and some mothers reportedly believed that CSM given alone (as a porridge) would give the child diarrhea, but that it was alright mixed with couscous.

On the whole, it appeared that the CSM promotion activities to date have been inadequate both in terms of repetition adequacy and the appropriateness of the messages conveyed. With the large turnover of attending mothers and the lack of ongoing educational activities, periodic CSM demonstrations in each center are necessary to reach more than a small percentage

of mothers who attend over a year. If CSM is viewed as a "heavy" food, its preparation as a porridge mixed with fruit may not be culturally acceptable for young children. In one center the staff reported that a preparation of CSM mixed with vegetables and meat or fish had been well received by mothers.

4.7.4 Summary of CRS Education Activities

While CRS staff has instructed F/N center personnel to integrate educational activities with the weighing and food distribution components of the program, actual education of mothers in most centers is limited to sporadic "individual counselling" of mothers when their child's percentile weight for age drops according to the graph on the mother's card. Given the numerous mistakes observed by the evaluation team in filling out of the mother's cards (in recorded ages and percentiles), the value of this "education" must be questioned. Due to the heavy burden placed on CRS personnel by the constant monitoring and reporting requirements of the food distribution program, the health education component of the overall food and nutrition program has suffered from lack of personnel training, follow-up, materials development, organizational support and time spent on conceptualization, research and regular implementation of educational activities in the centers. The evaluation team believes that the lack of motivation of center personnel for educational activities can be attributed largely to the low priority CRS and GROD has given to the development of a cohesive, well thought out, and integrated health education program component. On the other hand, the importance of food control has been reinforced by regularly voiced concern and checking by CRS, thus encouraging center personnel to focus the major portion of their time and energy on the food distribution component of the program.

Finally, there is a difference of perception between health center personnel and CRS national staff concerning training and health education inputs. CRS reports that on-going training of center personnel occurs during regular visits to the centers by CRS/Djibouti staff. These visits have occurred as regularly as twice a week at the centers in Djibouti-City during 1983. Further training has occurred during the monthly meetings. The health center personnel do not perceive these activities as "training". Whether this is due to a perception of "training" on the part of health center staff as something engaged in only a formalized classroom setting or to the fact that less training is occurring during these center visits and meetings than CRS believes, is unclear. Nevertheless, the fact that many health center workers reported that they lacked skills in the area of health education suggests that greater efforts in this area need to be made by CRS. Similarly CRS reports that it has made educational materials available to center staff but that these latter have not used them. Again this may be due to a difference in perception as to what sort of materials are needed (many center staff mentioned the need for slides or films, which may or may not be justifiable as educational tools in Djibouti) or it may be due to a lack of confidence on the part of center personnel in their ability to use materials provided.

4.8 Coordination and Integration in Health Structure.

From the outset, the CRS F & N program has been "integrated" in the health structure in that distribution sites were never developed outside the MCH network. The CRS element was not always well received and that was very much the case when food alone was introduced in some clinics. At best it was begrudgingly thought to be attracting more mothers to come to the clinics whether for treatment, vaccination or other care. It was not until CRS was able to institute a viable weighing and monitoring system and a personnel contingent to carry it out (paid from outside the MCH--the mothers' fees)--that it gained real acceptance in the MCH and strong supporters among medical staff. Along with health leaders who pressed to obtain higher vaccination coverage and to improve the very poor maternal health of clients with a pre- and post-natal service, CRS shares honors for helping to develop a meaningful MCH program in Djibouti. To those concerned with the establishment of a primary prevention program in which mothers understand and carry out responsibilities for their children's and their own health, CRS' major contribution is the implementation of a growth monitoring system. The food component muddies the waters. It is not happily integrated and one may lament the early food-alone image as damaging to the acceptance of the F & N package. In fact, as in most other countries, health staff are rarely content with a food distribution site on the MCH grounds. At best it is a necessary evil that goes with the other good health work being done by CRS. Even those who are totally convinced that mothers need food to go along with the medical advice or treatment given her malnourished children would prefer that it be provided elsewhere.

Integration is an overarching and complex issue and it is discussed throughout this report. The more focused study here

is of the working relations at the MCH level as observed by the team.

Direction of the MCH activities is carried out by responsables, often nurses or nurses' aides paid by the Ministry of Health. One was paid by the Ministry of Labor, one by ONARS and two by Red Crescent and others by religious missions. Within the MCH is the strictly defined "CRS unit" of staff paid by mother fees; these are the weighing aides, assistants who fill out cards and counsel, food distributors and helpers, as well as responsables.

In many instances, the medical staff provide guidance and supervision to the MCH staff. On the whole, the team found the MCH staff to be well-integrated and the MCH (and "CRS unit" within it to be well integrated with the medical staff). Some Doctors-in-charge were particularly capable in their overall supervision and management to ensure a sense of teammanship among staff. In these cases, the helpers and aides from the MCH side might clean all the premises e.g. or as observed, within the MCH unit, a nurse might have to forsake weighing for vaccination.

The evaluation team was often told by Dispensary medical staff that it was very helpful to have the extra money and personnel performing multi-purpose functions, which often made the difference between a smoothly operating clinic and one that fails to function due to small needs or lack of manpower. This leads to the related issue of mother fees. CRS asks mothers to pay 100 FD as a monthly program fee, but mothers are not turned away from either food supply or health services if they are unable to pay; it is left to the discretion of each MCH to decide who is unable to pay. Numbers of mothers who do not pay have been very small in any case.

This paying system has been approved by the MOH but goes against their current philosophy of free medical service for everybody. This attitude may be changing and if so, CRS will have made a major contribution toward instituting such a system.

5. IMPACT ON HEALTH SERVICES AND POPULATION.

5.1 Health Services.

Health services in Djibouti were entirely curative before Independence (1977) and in the first and second years thereafter. An unusually high percentage, 50-70%, are reported to have access to these services which are provided free of charge*. The only MCH activity was a center at Pierre Pascal in operation for several years but serving civil servant families exclusively. It was not until 1979 that the first public MCH center opened at Engueilla, followed over the next year or two by the opening of other MCH centers such as those at Farah-Had, Ambouli and Balbala. CRS also entered the Djibouti scene in 1979 just as the country was making its first steps toward the development of a preventive health system. In 1980 as child vaccination campaigns were progressively integrated into the MCH activities, CRS was also introducing the weight surveillance component and training staff to carry out the weighing and recording along with the food distributions. Pre-natal consultations have only recently begun to be incorporated in the MCHs. Thus, CRS with its food, child weighing charts, and training was a principal party to the initiation of primary health activities in Djibouti.

* In the absence of reliable statistics on dispensary attendance, it is difficult to define "access" with any precision. Since medical care is provided free of charge to any Djiboutian resident who presents him or herself at a government dispensary, one would expect many people to make frequent use of curative care facilities although the team was unable to investigate records which would either confirm or deny this assumption. The MOH reports, however, that as many as 80% of the children born in Djibouti-town are born in a health facility, suggesting that same services are widely used. A study done in 1983 by the Union Nationale des Femmes Djiboutiennes showed that less than 20% of the 149 rural and urban women interviewed had never visited a dispensary. Of the rural women 80% live within a 2 hour walk from the nearest dispensary as compared to 100% of the urban women.

The major positive change effected by CRS in MCH management is the addition of staff to the clinic, extra staff considered by several medical officers to be much more highly motivated than others (one thought this was because it was in their interest to work to encourage more mothers who pay fees to support the staff, to come regularly), and staff who are deeply appreciated extra hands in dispensaries/hospitals with limited cleanup and maintenance help. Many of the Tunisia graduates are able to be more multi-functional in the MCH work, having learned to give vaccinations, for example.

Successful use of the weighing chart is bringing an increasingly reliable referral system into play. Doctors and nurses are insisting that children be weighed before they give treatment or medicine, and the weighing staff are becoming more adept at referral to renutrition centers in the case of severe undernutrition and to doctors for acute diarrhea, etc.

Discussed elsewhere in detail (see 4.2., The Role of Food Aid) is the mixed positive and negative opinions on how food aid has affected the health system. Among those interviewed by the evaluation team, opinions were mixed on the usefulness of food aid as an incentive, the majority of center staff considering it to be of great importance to mother attendance. Some thought it should be targeted on the basis of greatest vulnerability to malnutrition--therefore to the youngest, under two children, and to pregnant and lactating mothers; others thought it should be targeted to the economically neediest among the attending population. Except for the food distributors themselves and a rare exception, health personnel at the center and national level think that the CRS food distribution at the MCH site has actually set back efforts to instill a sense

of responsibility for one's own health in the population, obscuring that concept with a highly visible food assistance program. The evaluation team considers this perception, whether correct or not, to be very significant; it diminishes an otherwise positive image of CRS in the MCH.

A practice of vital concern to MCH, (and CRS) objectives, namely the distribution and advertising of infant formula in the MCH, has not yet been corrected by policy change but is under active consideration. CRS has not attempted to make demands for policy changes in exchange for its contribution, but had to content itself by counteracting the formula propaganda, i.e., by encouraging mothers to breastfeed instead.

5.2 Impact on Population

The most optimistic role that food aid can play is to effect a measurable improvement in infant/child growth and survival. From the available, comparative data it appears that there is less severe malnutrition in Djiboutian children in 1984 than existed prior to the development of the PMI network and the introduction of Title II-CRS food. Program attribution, though, is obscured by external affecting factors favorable to improved health, such as a higher standard of living today, diminution of drought ravages, and simultaneous growth of new health services, notable widespread vaccinations and the beginnings of pre- and post-natal care. Normally, to expect a nutritional impact on children in a family, food aid providers attempt to encourage mothers to give all or part of the food to the youngest members. These efforts have not been made in the Djiboutian program due to the limited enthusiasm of new enrollees to date and the highly irregular attendance

rendering unfeasible attempts to extract a commitment from mothers to feed the child enough for normal growth in return for being kept in the program.

The evaluation team did not attempt to study nutritional impact (see Methodology) because of serious limitations of the data. A small study has been made recently at Farah-Had⁽¹⁾ suggesting a significant improvement at 12 months of age after six months in the program. 541 children were followed from entrance in January 1984 through June 1984. The same children were used as control and program groups. The percent under 70% weight for age for entering children at the different age intervals was compared with the same children OF THE SAME AGE GROUP after six months in the program. The results indicate that a significant improvement is shown in the 6-12 months interval: 6-month program children show 8% under 70% while new entrants show 14%.

These results do not represent the overall program; they pertain only to the children who remained in the program. A further limitation is that the January-June period is not representative of the total year.

Impact on economic status (see 4.1 and 4.2) was found to be limited. It is estimated that the monthly food budget for a poor family is about \$32. The value of the food that an average program mother receives for the family is \$3.92 and may not be perceived by mothers to be worth that much, particularly the CSM portion which probably has no resale value. The time given to obtain this amount of food is 2-4 hours in the center and perhaps another hour to walk to and from the center. As pointed out elsewhere the economic importance of

(1) Unpublished study made at Farah-Had PMI by Dr. Filippi and Marie-Pierre Calderon, January-June 1984.

the Title II package is lessened by the availability at controlled prices of staples such as bread, wheat, sorghum, vegetables and fruits.

The unquestioned impact of the Title II food aid package on coverage and attendance has been challenged by the evaluation team. The rate of increase in population coverage attained in CRS' four years of recruiting effort (with few penalties or conditions) is not convincing evidence of its popularity or incentive value. And once enrollment has occurred, the ensuing low rates of attendance regularity and high rate of dropouts do not argue for success of the food package. Though most health officials have seen food aid as a necessary evil because it has attracted more mothers than would come otherwise, they are not of one voice as to which components are the most attracting to the mothers who do come. The available surveys, beginning with that of Baudouy in 1980, confirmed by a study made by Education pour la Santé in 1981 and reconfirmed by Cook in 1984, note consistently that the overriding incentive for coming to the health center is treatment/medicine, with food a secondary force in drawing power.

6. COST-EFFECTIVENESS

The evaluation team first calculated costs for each source, e.g., U.S. Government, whether Outreach, OPG, or Commodity Costs, and estimated contributions (of personnel, equipment, space). In most instances, the Food and Nutrition (MCH) program was estimated to have taken 70% of staff time and vehicles out of the total time devoted to all feeding programs (school, refugees, Food for Work) and other CRS activities. The 12-month period selected for study began on July 1, 1983 and ended June 30, 1984; this interval seemed to represent well the highs and lows of program coverage and an average year of program costs.

Annex C shows costs according to source and budget heads. A second cost breakdown estimates the separate costs for food handling as distinct from other Food and Nutrition program costs. This was done because of the special concern for the role of food aid as a key program component.

A summary of total costs is shown below, with the percentage input by each contributor:

U.S. Government	\$850,687*	77%
Catholic Relief Services	35,250	3%
Djiboutian Government	71,300	6%
Community	44,900	4%
Other donors	<u>108,407</u>	<u>10%</u>
Total	1,110,544	100%

*Includes \$389,997 for food and ocean transportation.

By selected budget heads, separating commodity costs from program costs, the breakdown is as follows:

<u>Budget Head</u>	<u>Total</u>	<u>%</u>	<u>Food Costs</u>	<u>Program Costs</u>
Labor	\$357,299	32	\$148,634	\$198,665
Consultation, Technical Assistance	46,314	4	-	46,314
Training	29,000	3	-	29,000
Education, Equipment, Food purchase (Fish)	38,168	3		38,168
Food	284,698	26	284,698	-
Rent, Construction (Rental Value)	97,462	9	47,906	49,556
Storage	47,500	4	47,500	-
Transportation	210,103	19	198,523	11,580
	<u>\$1,110,544</u>	100	<u>\$737,261*</u>	<u>373,283</u>

*66% of program budget is for food costs.

In the 12-month period, there were 5195 children on the average receiving rations each month, plus an estimated 3,117 mothers, with total beneficiaries averaging 8,312 monthly.

As noted elsewhere in this report, the CRS/Djibouti program is highly diluted and reaches about double of these "averaged" figures. Because an unwritten goal is to bring mothers into the MCH we have included those exposed to the program in our calculations. It is misleading, however, to see the lower cost per beneficiary for these larger numbers of irregular attendees as a program advantage. Rather, it should be kept in mind that costs are down because a larger number gets less each, which is counter to the goal of improving child health by regular surveillance and food supplement.

- The annual cost per program child is \$214.
- The annual cost per program mother is \$360.
- The annual cost per beneficiary (children and mothers) is \$134.
- The annual cost for each malnourished child (<80% weight for age) is \$618.
- The cost for "exposed-to-the-program" mothers is \$171.

These per capita costs are extraordinarily high. The more normal range of annual costs per program child⁽¹⁾ e.g., in take-home programs like the CRS/Djibouti one, range from \$10 to \$50.

Even if we estimated the food costs at local market value, approximately \$2.32 a five-kilo ration, rather than at CCC value plus ocean freight, about \$3.00, this would bring annual costs down by no more than \$7.00 a year.

Omitting all administrative costs, the food handling costs before the foods ever arrive at the PMI, amount to \$756 a metric ton and together constitute nearly half of the total cost of the program. Further, these are all recurring costs for the U.S. Government. Neither port fees nor inland transport is paid by host country sources as often is done in other countries. Omitting the donated food and ocean freight, but including CRS management (labor costs), the total handling or food support costs paid by the USG are approximately \$325,000. (Included: clearing agent expenses; port dues; transportation and labor, port to central warehouse and warehouse to site; storage in central warehouse and at site ; CRS management: labor, vehicles, office rental for PMI food share). CRS is understandably considering cost-effective options for follow-on grant money being requested for the next two years. Continuing the current program would require \$650,000 to keep food aid at current levels and prices.

This calculation covers Food and Nutrition food costs only. If CRS continued school feeding, this would add 1724 metric tons and cost an additional \$105,000.

(1) Austin, J.E. et al.: Nutrition Intervention in Developing Countries, AID, 1981.

Timmons, Miller, and Drake, Community Systems Foundation: Targeting: A Means to Better Intervention, AID, 1983.

Outreach funds have covered most of the food handling costs in the past years as can be readily seen in the breakout of total costs. For the period studied, \$123,526 in Outreach funds were used for this purpose. A potential source for filling the gap that will be left by depleted Outreach funds was the monetization of Title II of foods in Djibouti. Earlier this year, from February-May, 1984, with the initial collaboration of REDSO (Regional Development Office/AID in Nairobi) CRS explored with ONAC and local merchants, such a possibility.

6.1. Monetization Exploration (Report made by CRS)

Preliminary contacts with ONAC, the GROD parastatal in charge of commercialization of imported foodstuffs, were positive. However, no guarantees concerning price could be agreed upon nor could any payments be made until the goods were delivered to port and inspected for quality. Mr. Bouh, ONAC Director, stressed that this was a wide-open market and economy and prices fluctuated by 10-15% from month to month based on stocks, expected arrivals, and the quality of goods.

CRS then began to investigate the market through private sources. The information compiled led to the following conclusions:

- Local merchants did not appreciate these subsidized transfers of commodities due to the potential to take some of their market share and undercut prices.
- The U.S. Embassy had previously monetized some commodities to the chargin of local merchants.
- The type of sorgho (SFSG) CRS uses in programming is different from the popular sorgho consumed.
- The rice that CRS imports (10-15% broken) is of a poor quality and unacceptable to most of the population and would not be purchased by local merchants.
- Wheat flour is already subsidized by the government for bakeries pushing the price below CCC prices.

- Oil is undoubtedly the most desirable commodity to monetize. However soybean oil is not desirable to the majority of the population. The people prefer the cheaper palm oil which is imported in large quantities. Even if the price of soybean oil could parallel local prices to even attempt to match sales is difficult as the desire for soybean oil is not developed. Even riskier is the fact that CRS could conceivably be forced to bring the goods into country and sell by the ton from a warehouse. This scenario is unacceptable to CRS for obvious reasons. (Bypassing ONAC can save 7%-10% from sale price.)

In general Djibouti, as a port, has tremendous quantities of foodstuffs passing through to Somalia and Ethiopia. The country's basic grains are therefore inexpensive and readily available due to the prices of stocks from which they are taken. The private nature of the economy makes entry by an American NGO for profit (this would be people's perception) purposes an extremely risky, unfavorable operation.

N.B. 19,000 sacks of wheat are sitting in the ONARS warehouse rotting due to a failed monetization scheme. ONARS unsuccessfully attempted to sell or exchange the wheat (German donation) for rice.

6.2 Analysis of High Costs

Monetization is no longer a reality since CRS' plan is to phase out of Title II food programs in Djibouti before support funds run out. Thus any monies to support the food program during the phaseout period will have to come out of the new OPG or from additional funds made available under the Outreach grant. CRS has estimated that it has sufficient funds to support the program at current levels to June 1985.

Some reasons for the high food costs per beneficiary and the high recurrent USG costs are the following:

- Only half of the food sent to the centers is taken home by the beneficiaries according to Center Monthly Reports on number of beneficiaries and foods distributed, and by estimated attendance regularity. Providing twice the amount of

food intended for the beneficiaries costs \$270,520⁽¹⁾ more than it would have otherwise.

- The Government of Djibouti has been unable to pay port charges or inland transport which are often host country contributions in other country programs.
- Because of the high cost of living in Djibouti (per diem for expatriates is \$182, and was \$152 a year ago), labor costs for expatriates are exceptionally high. Housing and utilities cost \$30,000 a year. Labor costs for local employees are at least double those paid elsewhere, and housing and other costs are unusual budget burdens.
- Program coverage is small; doubling which CRS hoped to achieve and could have done with the same amount of money had mother participation been greater, would reduce the per beneficiary cost by one half.
- Mothers' fees do not make the impact on program expenses often felt in other countries because numbers are small and attendance, so irregular. The 3,117 mothers in the program from July 1983 - June 1984 collecting 2.6 rations-if fully paying (100 FD/ration)- could contribute a maximum of \$55,000 to program costs.

(1)

Half of food value and handling costs, computed as follows:

CCC Value	\$142,349
Ocean freight	52,649
Port, Clearing, Warehouse rental, transport	51,762
Storage	23,750

7. SUMMARY OF EVALUATION FINDINGS

7.1 Objectives/Indicators for Food and Nutrition Program.

CRS' stated objectives in the OPG were: to improve nutritional status (as assessed from the Growth Surveillance System (GSS); to attain higher coverage and better attendance on the part of mothers; to establish growth surveillance in the MCH system (through training and supervision); and to facilitate Center operations by establishing separate storage capacity for Title II foods. No health education objectives or indicators were developed. In fact no indicators or quantified targets were stated, except:

- To increase beneficiary coverage from 12,000 (in March 1983) to 17,500 by "FY 1984" presumably the beginning, October 1983.; and
- To train six additional health educators/nurses in Tunisia.

The UNICEF fish promotion activity's stated goal was "to introduce fish into the diet of the Djiboutian family", without specifying the number of families targeted or an evaluation mechanism.

The Evaluation team thought that the lack of clear analysis pertaining to goals, indicators and quantified targets for the Food and Nutrition program, and especially the lack of a plan of operations for how objectives were to be achieved, has contributed to a lopsided emphasis on the food delivery component at the expense of the rest of the program as well as the uneven quality of the other program components-growth surveillance and health education.

7.2 The Overall CRS Title II Program in Djibouti.

Only the MCH program is examined in detail by the evaluation team because of its relationship to the continuing OPG. However the MCH food aid has been examined in the context of

the overall CRS Title II program in Djibouti. Over the period studied for MCH cost-effectiveness, July 1983-June 1984, the MCH portion of food distributed in Djibouti was only 24 percent of the food distributed, 655 metric tons distributed to an average of a little more than 8,000 mothers and children. The other 2042 metric tons were distributed to 3,500 school children, to 20,000 refugees, and to workers, dependents, and needy families. The refugee program will have been phased out or over to World Food Program by January 1, 1985.* The school/other child feeding is also expected to be taken on by WFP.

7.3 The Special Context of CRS' Contribution in Djibouti.

Djibouti is a very young country located in the drought zone of Africa. Donated foods have come from everywhere, and food is relatively cheap due to controlled prices of staples and to the availability of donor foods in the market. Other programs (refugee and emergency) notably, offer 13.5-15 kilo monthly food rations per person compared with the 5 kilo MCH ration. Thus, the traditional CRS/MCH Food and Nutrition package fails in the Djiboutian setting; it does not carry the value it normally has for participating families. Further, not unlike the situation in many other developing countries, food distributions are not welcomed within the MCH system.

Djibouti as a new nation in the process of establishing its health system has provided CRS a unique opportunity to participate in the implementation of a primary health care program. CRS began operations with food distributions to refugee camps, and has in four years emerged with a health-oriented program and as a fully accepted partner in the preventive health

* FFW will be phased out by January 1, 1985.

field along with the government and other donors who have shared tasks in developing the MCH program. CRS' particular contribution has been the establishment of a weighing and growth surveillance component and in the provision and training of MCH personnel. However, health colleagues lack enthusiasm for the CRS food distributions being carried out in the health network.

Many of the management problems for which CRS must be partially responsible are attributable in large degree to the youth of Djibouti, especially as reflected in the low skills level of center personnel and the need to teach, train and supervise for the most basic tasks.

7.4 Predominance of Food Management in MCH Program Priorities and Budget.

Food handling and management take 70% of CRS MCH management time and due to the crisis nature of food problems, takes priority over other activities. Costs for food handling and administration amount to two-thirds of the annual Food and Nutrition budget of a little over \$1 million. 655 metric tons of rice, oil and CSM (corn-soya-milk) are brought in and reach a maximum of 6,000 families on an irregular basis. By the time a ration estimated at 3.3 kilograms (reduced from 5 kilograms because of an attendance rate of 65%) a month reaches a beneficiary it costs \$134. For mothers (families) receiving a monthly ration of 8.5 kilograms (5 kilos for mothers plus 1.6 children under five X 65% attendance) the cost per mother/family for the food and minimal education is \$360. For the targeted program child, meaning under five years old, the cost is \$214 a year, several times the cost of similar take-home programs in other countries.

Management of food plus the food value constitutes two-thirds of the MCH budget and staff time. These costs are almost totally the burden of the U.S.G. which not only provides the food and ocean freight but pays port fees and all inland transport which host governments and mothers' fees cover or help to cover in other countries.

Omitting the donated food and ocean freight but including CRS management (labor costs), the total cost of food support and handling paid by the U.S.G. from Outreach and OPG monies over a 12-month period, amounts to \$325,000.

Given that the CRS program and OPG are to be a self-contained two year program, even were the current MCH food component considered priority to the program, the team would have been hard put to find a rationale in support of this continued level of food support cost.

Despite these high costs and priority treatment, control of the foods continues to be unsatisfactory to CRS. The team found that only about one half of the food sent out for MCH beneficiaries is accounted for in the Monthly Distribution Reports received from the Centers. It is suspected that the "lost" foods are handed out to non-MCH families. Yet, just this lack of program control costs the program some \$270,000 more than it would otherwise.

In the MCHs, food distributions are an annoying presence and even those health staff who are fully convinced of the incentive and economic value of the food, think the food should be distributed in a separate location away from the MCH. There is a strong belief in the health and donor community that food aid in the MCH setting undermines their efforts to establish a sense of responsibility among the people with regard to health care.

7.5 Value of the ration.

- The nutritional value of the ration theoretically provides enough calories and proteins to feed one family member, but there is no assurance that all of the CSM is accepted and consumed.
- Many health personnel perceive the food to have important incentive value in drawing mothers to the MCH services. Because so many things occurred simultaneously in the development of the MCH system -- recognition by the Government that MCHs should be established, the weighing and growth surveillance introduced by CRS, the vaccination campaigns, radio appeals on the importance of the MCH attendance and the beginnings of pre-natal consultations, it is difficult to separate the influence of the food and decide what role it played in drawing women to the centers. Undoubtedly, it was of significance, at least on a tryout basis. However, when we looked at the indicators of sustained interest, we found a very irregular attendance of about two out of three times and a high dropout rate, 30-40%, after very short periods of participation, which do not argue for successful incentive value.
- The value of the food that an average program mother receives for the family is \$3.92 (based on 2.6 rations per family and a 65% attendance rate) and her estimated monthly food budget (that of a poor family) is \$32. The relatively low economic value of the ration may explain the apparent indifference to regular pickup of the food or giving it up altogether.
- The value is diminished further by the availability of foods at reasonable prices in the market (or in other food distribution programs) making it appear that mothers probably would not come for the food without the drawing power of treatment and use of PMI services.
- Though most agree that food has important incentive value, whether true or not it is perceived that way, and some think it is inhumane to withdraw food that has been received by a truly needy population, all do feel that the food should be distributed in a separate location.
- Since it is generally accepted that there are needy families among the MCH participating mothers, this problem is under discussion between CRS and the Ministry of Health to decide the criteria needed for economic targeting and if deemed desirable by MOH, finding eventual donors to provide food supplements in a continuing basis following CRS phaseout of food activities. CRS will carry out distributions as agreed with the MOH on a phaseover basis.

7.6 CRS' Contribution in the Primary Health Care (MCH) System.

Along with health leaders who pressed to obtain higher vaccination coverage and to improve the very poor maternal health of clients with a pre-natal service, CRS shares honors for helping to develop a meaningful MCH program in Djibouti. Almost everyone agrees that CRS has made a major contribution in introducing weighing and growth surveillance in Djibouti and that it has raised the level of personnel available to the dispensaries, both in numbers and in quality, through the institution of a development fund (mothers' fees) which in part pays for the extra staff, and through the training provided nurses and other health workers, which enable them to be multi-functional in the health centers.

On the other hand, education in the MCHs is sorely missing for the most part. Even one-on-one mother counselling in connection with the growth chart is lacking, inadequate or done in the wrong way. There is not yet enough understanding of the individual card either on the part of the staff or the mothers. When it is understood, the MCH staff do not know how to use the chart well as a teaching tool.* While it is true that there are no operating guidelines for health education of mothers in the MCHs, one would expect to find some experimental activities with created aids, but any effort observed is the rare exception. There have been no sustained efforts to get an education program launched. What is done is ineffective.

These education inadequacies are directly related to a lack of training at all levels both in content and techniques. The Tunisia training has greatly improved the level of those

* The Master Chart is in fact too complicated to be an appropriate data gathering mechanism.

practical, how-to-teach aspects seem to have been neglected and/or were not applied in their jobs soon enough after return.

Plans for diminishing and eventually phasing out food aid at the MCHs will entail personnel adjustments affecting a cadre of 42 workers in 20 MCHs --responsables, assistant child weighers, counsellors and food distributors --who have been trained to support the growth surveillance and food distribution activities as well as to assist with other clinic activities. If and how mother fees are to be continued with less or no food in the centers must be agreed between CRS and MOH as quickly as possible. Many of these people will be needed to continue growth surveillance and the new activities planned by CRS. Finding the means for their remuneration, which must be self-sustaining, is a primary issue to be resolved before the new OPG can be completed. In the case of food handlers who may not be well equipped for the new MCH activities, CRS will attempt to find job alternatives as food distributions lessen and end.

7.7 CRS Management Capability

In studying CRS' resources in Djibouti, the MCH program strengths and weaknesses, fit of CRS strategy with that of the government and international health community, current and potential management capability, the team concluded that the current emphasis on food aid as distributed in the MCHs is inappropriate and not the ^{most effective use} of human and financial resources. The Ministry of Health is increasingly vocal in its opposition to donor foods playing any part in the nutrition and health activities; it therefore behooves CRS to negotiate Title II withdrawal from MCHs without waiting to be asked to do so. By so doing, the inevitable need to accommodate food handling with the lion's share of management resources, leaving

very little for the other MCH components, is progressively diminished.

While MCH as a type of Title II program is very demanding in administrative time both for food and the other components (growth surveillance, education, and training), taking 70% of CRS' human and financial resources, CRS' role in the preventive health program has the potential for far wider-reaching and lasting objectives on a larger target population.

CRS has the opportunity now to take advantage of the bases established in the MCHs and with health staff, to phase out the food aid in a responsive, ethical manner and to establish the health education and training element for the Government's diarrheal control program which is being elaborated.

In numbers and salary levels, CRS' present staff appears excessive. However, it must be noted that the salary of a professional Djiboutian is likely to be higher than that of a CRS professional; CRS has had in the past to accept personnel judged appropriate by the the Labor Office. All salaries and allowances are relatively high because of the high cost of living in Djibouti. As for the number of personnel, a large percentage of whom now are occupied with food handling activities, the design team will have to analyze current tasks and projected future tasks before deciding on appropriate labor costs in the OPG.

8. RECOMMENDATIONS

8.1. CRS/Djibouti should seek to increase program impact on the health of children and their mothers in a more cost-effective manner ("do more for less"), with more lasting benefits. CRS should build on the base of its past activities in the MCHs, reinforcing and broadening the educational and training aspects of its program while reducing the emphasis on food distribution, aiming at a phaseout of its involvement in food distributions in dispensaries. To do so, CRS will need strong and regular technical assistance inputs from PRITECH in the areas of baseline studies and evaluation, operational research, training curricula and techniques, message and materials development, interpersonal and mass media education.

8.2. Any change in orientation should be firmly rooted in on-going activities and future related developments in the Mother and Child Health programs supported by the GROD within the dispensaries. While the GROD does not support food distributions in the MCHs, they do want to develop weaning foods from locally available foods. Since CRS is perceived as a prime mover in the area of nutrition in Djibouti and has in fact concentrated on nutrition-related activities in the past, the development of a stronger educational and demonstrational program should grow out of this area of expertise. Initial expansion of educational activities should concentrate on a limited number of themes related to the nutritional status of children, namely:

- Consolidation, improvement and standardization of a growth surveillance system in the dispensaries with appropriate data analysis for use by the GROD as well as dispensary personnel and mothers. This need not include the Master Chart nor the CRS individual child card.

- Promotion of breastfeeding and discouragement of bottle feeding.
- Control and prevention of childhood diarrhea including the use of oral rehydration and appropriate feeding during and after bouts of diarrhea.
- Operational research in the area of nutrition including development of appropriate dietary messages to mothers for the feeding of infants and children using local foods.
- Operational research on the effects of various systems of interventions by dispensaries on the nutritional status of mothers and children as well as attendance and user satisfaction among the target population.

8.3 Present and future financial resources should be targetted increasingly toward the attainment of the objectives of this new orientation. An initial step in this direction is to develop a plan for phaseout and/or phaseover of food distributions with the MOH, following up on a recent meeting between CRS and the Director of Primary Health Care where basic principles were agreed upon. The team recommends that phasedown start no later than May 1985 when the summer slowdown begins, and earlier should the criteria have been established for determining which families should receive continuing food aid. It is envisaged that the distributions would be out of the MCH system by September 1985. However, the details of this plan should be left to CRS and MOH decision. The evaluation team are concerned that staff and task changes be effected to accomodate the new program as early as possible without causing undue hardship to families grown dependent on CRS food. It should be noted that the phaseover period coincides with large planned food inputs by WFP.

In the interest of focussing the maximum number of resources on the inputs necessary to assure the success of this new orientation, the evaluation team recommends that CRS/Djibouti limit its involvement in either presently ongoing or future small scale peripheral activities not directly related to the new

strategy. Concerned activities would include school feeding, refugee relief, gardens and educational activities in schools,

8.4. CRS should continue to work with the national PHC Coordinator in determining the appropriate role for MCHs in responding to needy families--i.e., their referral responsibility and criteria for carrying it out. With a larger goal of helping the Government to enunciate a policy on free food distributions, CRS and MOH should continue to address questions relevant to the role of the health services in food distributions:

- Should the dispensary system be the referral point for a target population to receive food aid?
- Who constitutes the targeted population: what are the characteristics of this population; and what are the criteria for selection of mothers into a food distribution program (economic, social, health indicators)?
- What quantity and quality of food ration should be distributed in order to have a significant impact on the nutritional and economic status of targeted families within the context of Djibouti economic realities?
- Which donors would be the most appropriate and cost-effective source for the food rations? WFP, Caritas and other donors should be considered.
- What can the government do to reduce the cost of food distribution: assist with port fees, inland transport?

8.5 CRS should assist the GROD in the initial phases of implementation of any eventual program of nutritional supplementation for needy families referred from the dispensary network. This assistance could be in the following areas: the establishment of a distribution system; training of personnel; and the establishment of a system of control and management of food supplies.

8.6 CRS and the Government must plan for the effects that a reduction in mothers' contributions, due to a reduction in food

aid at dispensaries, will have on those dispensary personnel now paid for by these mothers' funds. Of 42 such people, approximately 20 are employed solely to distribute food. These people should be assisted to the extent possible to find other employment in the case that their services are no longer needed in the dispensaries. Among the rest of the personnel paid by mothers' fees, many assist in MCH activities other than growth monitoring, such as vaccinations, pre-natal consultations and health education. Ideally provisions should be made to maintain these partially-trained and fully MCH-oriented people within the new program. CRS should continue to work with the PHC coordinator to develop a source of salaries for these people, preferably from a self-sustaining paying system and preferably before the CRS paying system vanishes from the MCH.

8.7 With PRITECH technical expertise, CRS should work closely with the MOH to develop a health education strategy and approach.

This should include:

- Content: definition of messages to be promoted in the dispensaries.
- A program plan for health education to be incorporated in regular MCH routines including timing and duration of sessions, range of topics to be covered, frequency of transmittal of messages, weekly or monthly schedule, supervision and training of personnel, and motivational strategies for personnel and mothers.
- Development of educational materials and methodology appropriate to the MCH setting as well as to other settings such as UNFD groups, health committees, etc. dialogue, interaction with mothers, use of visual aids and other materials.
- Supervisory strategy (feedback).
- Assisting the MOH to redefine the roles and tasks of PMI personnel so as to make the implementation of health education activities in the PMI's a realistic possibility.

8.8 CRS with technical assistance should assist the MOH to define the objectives of growth surveillance and nutritional data collection in Djibouti and reevaluate the current system in light of these objectives. A more appropriate system should be designed if necessary. If the Government agrees, a fee should be charged for new health cards to cut down losses and ensure better care in the interest of effective growth monitoring. But more important than such vaguely punitive actions as paying for lost cards is the strong promotion of health card merit and a personnel reinforcing its importance. Training and education can make such a change possible.

8.9 CRS should set up the necessary staffing to reflect the qualification needed for this new orientation. As the role of food handling dwindles, staff or tasks should be converted to or replaced by demands of the new program.

To be most cost-effective, the Project Manager (PM) would also be the CRS country representative. It is essential that the PM be a senior person, fluent in French, knowledgeable about Africa and most important, technically capable in Third World health training, evaluation and data collection. Since an important qualification will be experience in directing TA activities, it is recommended that CRS recruit outside its own network if necessary.

The evaluation team recommends that two additional expatriates should be: a health technician whose main task would be on-site training and supervision assistance with health education materials development, growth surveillance and data analysis; a records and statistics person to manage the different funds--UNICEF, OPG, PRITECH, and to assist the Government in setting up a mothers' fees system and a growth surveillance statistics compilation system.

It is recommended that PRITECH technical assistance be available on a nearly continuous basis, though in short terms, throughout the first 12 months of project activity and be regularly available thereafter.

810 CRS and the Government should negotiate an official agreement clearly defining mutual responsibilities within the context of a future CRS program proposal. This agreement should spell out any sanctions resulting from a neglect of the agreed upon responsibilities on the part of either party.

Further the GROD should demonstrate its interest in the program by making available core personnel on a regular basis to assist in overall design, training and supervisory activities; by assuring appropriate planning of MCH activities through clear task definition and assignment of responsibilities to appropriate personnel as well as development of a standardized MCH program; and by contributing to a reduction of program costs as possible (e.g. limiting the payment of fees and reimbursements to participating GROD personnel, facilitating importation of any necessary supplies or materials, partially covering housing and maintenance expenses of technical assistance as possible).

ANNEX A

PERSONS CONSULTED

AID/Washington

Ms. Hope Sukin, Nutrition Advisor, Program Operations and Evaluation Staff, PPE/FVA.

Ms. Katherine Gordon, Program Officer/Africa, Title II, FFP/FVA.

Ms. Erna Kerst, HPN/Africa Bureau.

Mr. David Eckerson, Africa Bureau.

CRS/New York

Ms. Pauline Wilson (by telephone).

REDSO/Nairobi

Mr. Robert Kidd, Food for Peace Officer.

CRS/Nairobi

Mrs. Paula Bertolin, Program Development Specialist, Africa Regional Office, CRS.

Mrs. Karlyn Eckman, Associate Director of Agriculture, CRS.

USAID/Djibouti

Mr. John Lundgren, USAID Representative

Mr. Ernie Popp, Program Officer

CRS/Djibouti

Mr. Michael Wiest (of Nairobi, on temporary mission)

Mr. Bob Roche, Country Representative.

Mr. William Canny, Program Assistant.

Mrs. Ethleen Smith Lloyd, Food and Nutrition Supervisor (on team)

Mrs. Zahra Hassan Habaneh, Food and Nutrition Supervisor Aide.

WFP/Djibouti

Mr. Jean-Jacques Van Damme, Country Representative

Croissant Rouge/Djibouti

M. Abdi Kevieh, Director

Health Community

Dr. Butera, WHO Representative

Dr. Michelle Ohms, Acting director of Engueilla Dispensary

Dr. Roberto Cooper, Technical Adviser writing DDC plan, advisor to team.

Mr. Abdulhamid Idriss, Resident Programme Officer, UNICEF

Mr. Edward Martin, Master Driller

Mr. Dominoni, Cooperation française representative.

Dr. Renaudet, Director of Hygiene Service

The Staff of the Cellule of Education pour la Sante

Radio and Television Station

Miss Samira, Director of Nurses' Training School, Peltier Hospital and her staff.

The Staff of UNFD.

The Minister of Health

Dr. J. Claude Gilles, Technical Advisor to the Minister of Health.

Dr. Abate, Coordinator of Primary Health Care

Dr. Jean-Paul Ryst, Chief Medical Officer, Ambouli and Arhiba Dispensaries.

Dr. Henri Filippi, Chief Medical Officer, Farah-Had Dispensary and Djibouti Mobile clinic.

Dr. Georges, Assistant Chief Medical Officer, Dikhil Dispensary/Hospital

Dr. Bruno Scandella, Chief Medical Officer Ali Sabieh Dispensary.

Dr. Pierre Zannotti, Chief Medical Officer Pediatric Service at Hospital Peltier

Nurses, Assistant Nurses, MCH personnel at SMI-2, Ambouli, Arhiba, Balbala, Engueilla and Farah-Had clinics in Djibouti town; Ali Sabieh Dikhil and Yoboki centers

Ms. Marie Peirre Calderon, Volunteer, Farah-Had Dispensary.

ANNEX B

RAISONS POUR LESQUELLES LES MÈRES ASSISTENT AUX PESÉES

RESUME (4 - 7 Novembre, Farah-Had)

RAISONS POUR ASSISTANCE	ANCIENS INSCRITS		
	NOUVEAUX INSCRITS	RAISONS POUR ASSISTANCE AUJOURD'HUI	
MÈRE VENUE POUR PESÉE UNIQUEMENT (POUR RATIONS)	2	10	12
MÈRE VENUE POUR TRAITEMENT/MÉDICAMENTS POUR ENFANT MALADE ET PARTICIPE A LA PESÉE POUR CETTE RAISON (RÉFÉRÉ PAR MÉDECIN OU INFIRMIER)	2		2
MALADIE CONSTATÉE LORS DE LA PESÉE MÈRE RÉFÉRÉ POUR SOINS MÉDICAUX		4	4
MÈRE VENUE POUR PESÉE ET VACCINATION	18	30	48
TOTAL	22	44	66

45
1

ANNEX B

CRS CENTER STAFF DESCRIPTION (CENTER:)

DATE:

NAME	TITLE	JOB DESCRIPTION (ACTIVITIES, TASKS, RESPONSIBILITIES (STAR * MOST IMPORTANT ACCORDING TO INTERVIEWEE))	PAID BY	LENGTH OF SERVICE W/ CRS	LENGTH OF SERVICE IN HEALTH CENTRES	EMPLOYMENT PRE - CRS	

2/10

PRE-SERVICE TRAINING CRS CENTER STAFF (CENTER:)

DATE:

NAME + TITLE	LEVEL OF EDUCATION	PRE-SERVICE TRAINING			CONTENT (← MOST "USEFUL" →)	METHODOLOGY	WHAT WAS LACKING?	COMMENTS
		TRAINERS	DURATION	PLACE				

EDUCATION (CONT.)

MATERIALS AND TECHNIQUES USED	WHO/HOW MATERIALS WERE DEVELOPED	HOW IS COMPREHENSION/USAGE VERIFIED

100

CENTER:

#	BIRTH DATE	INSCR DATE	WT BY INSCR NO	WT IN OCT	OVERALL ATTENDANCE			ATTENDANCE 7/83-10/84 (PRESENT + ABSENT)												CALCULATIONS									
					# MOS ATTENDED	# MOS ENROLLED	% WITH ATTENDANCE	JUL 83	AUG 83	SEP 83	OCT 83	NOV 83	DEC 83	JAN 84	FEB 84	MAR 84	APR 84	MAY 84	JUN 84	% OF MOS	JUL 84	AUG 84	SEP 84	ALL AT INSCR	ALL IN OCT 84	% WT AT INSCR	% WT IN OCT 84		
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TOTAL							25% WITH ATTENDANCE															25% WITH ATTENDANCE							

Amly

10/1

ADDITIONAL COMMENTS, OBSERVATIONS, INFORMAL INTERVIEW
RESULTS AT CENTER

ANNEX B

CHANGES IN HEALTH CENTER OPERATIONS AND IN TARGET POPULATION AS
A RESULT OF INTRODUCING THE CRS PROGRAM INTO DISPENSARIES

CENTER: _____

NAME + TITLE OF INTERVIEWEE: _____

INTERVIEWEE YEARS OF EXPERIENCE: 1) IN DISPENSARIES: _____

2) WITH CRS PROGRAM: _____

CHANGES IN HEALTH CENTER SYSTEM, OPERATIONS, FUNCTIONING

# OF PERSONNEL	POSITIVE	NEGATIVE
GRADE/SALARIES		
SCHEDULE/ WORK LOAD		
SUPERVISION		
"POLITIQUE SANITAIRE		
OTHER		

CHANGES PERCEIVED IN TARGET POPULATION		
	POSITIVE	NEGATIVE
# OF BENEFICIARIES		
ATTENDANCE REGULARITY		
CHILD HEALTH		
HEALTH OF MOTHERS FAMILIES		

ANNEX B

GENERAL INFORMATION SHEET

DATE: _____

CENTER: _____ AGE PMI/CAS (DATE) _____ AGE DISPENSARY (DATE) _____

PROGRAM PARTICIPANTS:

TIME	CHILDREN	MOTHERS	TOTAL	COMMENTS
AVERAGE MONTHLY				
SEPTEMBER '84				
AVERAGE DAILY				
TODAY				

(NUTRITIONAL STATUS: % < 80 _____ % < 70 _____ DATE: _____)

DAILY ACTIVITIES SCHEDULE (NUMBER ACTIVITIES IN ORDER OF OCCURENCE ON THE DAY THE CENTER IS VISITED.)

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	SATURDAY

PROGRAM DESCRIPTION:

GENERAL COMMENTS: _____

DESCRIPTION OF OUTREACH PROGRAM (IF ANY)

RELATIONSHIP TO DISPENSARY / MEDICIN-CHEF

COMMUNITY DESCRIPTION: ETHNIC COMPOSITION _____ ECONOMICS: _____

SPECIAL CHARACTERISTICS: _____

OTHER INFORMATION:

SUPERVISION:

WHO SUPERVISES	FREQUENCY PER MONTH	WHAT DOES SUPERVISOR DO?	WHAT MORE CAN BE DONE

COMMENTS (QUALITY, SUFFICIENCY):

PERSONNEL:

	MD'S	NURSES	MID-WIVES	AIDES	VOLUNTEERS	OTHERS
TOTAL DISPENSARY PERSONNEL						
CURATIVE ONLY						
PMI (SPM IF ALSO CAS)						
CRS ONLY						
OTHER ()						

COMMENTS:

GRADUATION: 0 to 5 only? _____ (yes, no) If no: Explain exceptions:

RATION:

CSM ACCEPTABILITY (IN ALLIATION TO MILK, USAGE?)

IMPORTANCE OF FOOD RATION TO MOTHERS:

MASTERCHART + INDIVIDUAL CHART COMPREHENSION + TEACHING?

TOTAL COSTS FOR CRS F&N (PMI)
PROGRAM FOR A 12-MONTH
PERIOD ENDING JUNE 30, 1984
BY SOURCE OF FUNDS
AND BY SELECTED BUDGET HEADS

(\$1.00 = 176.84 DJIBOUTIAN FRANCS)

SOURCE

A. USG

1. OUTREACH

a.	Clearing agent fees (1)	\$ 4,743
b.	Port dues (2)	8,786
c.	Inland Transport	
	<u>Port to Warehouse or ONARS</u>	
	i. Transportation (3) \$5553	
	ii. Labor (3) <u>4952</u>	10,505
	<u>Warehouse - Clinics</u>	
	Transportation and Labor	42,170
d.	Warehousing @ \$3110/Month	37,322
e.	Storage	<u>20,000</u>
	Renovation, Maintenance	
		Total Outreach: \$123,526

2. OPG

a.	Labor Costs	
	<u>2 Expatriates, 1 at 100%; 1 at 70%</u>	\$116,450
	Salary and Allowances: \$70,000	
	Home Leave: 7,000	
	Housing and Utilities: 60,000	
	<u>Local (Salary & Allowances)</u>	
	1 F/N Assistant, 100%: \$17,914	
	2 Bookkeepers, 40%: 5,157	
	70%: 7,932	
	Commodity	
	Manager 70%: 8,550	

(1) Oil, \$9.56/MIT; other commodities, \$6.60/MT.

(2) Per Metric ton, Rice, \$3.26; CSM and oil, \$24.43; SFSG, \$1.63; and NFDM, \$12.21

(3) Transport, 1500FD/MT; Labor, 30FD/Unit

108

Local (Salary & Allowances

1 Secretary,	70%	\$ 7,220
1 Driver,	70%	5,558
1 Driver,	70%	3,515
1 End- Use Checker Port Coordinator,	70%	5,938
1 Accountant,	70%	11,875
1 Guard,	70%	3,515
1 Guard,	70%	1,900
1 Janitor,	70%	1,900
7 Fish Cookers	100%	19,000
		Local Salaries \$99,974

b. Storage

Construction & Renovation \$10,000

c. Equipment & Material for PMI
(Scales, Posters)

5,500

d. Training

24,000

• in Tunisia 6 students \$17,000

• In-Country Seminars, 7,000
monthly meetings,
paper, per diem

e. Purchase of Fish and
Demonstration Material

10,000

f. Management

Office Rental (70%)

Utilities, Supplies 17,640

2 Vehicles, Purchase 12,900

Maintenance & Operation
of 6 vehicles 15,700

g. Consultation

1 Annual Visit Nairobi/Djibouti 5,000

2 Annual Visits Djibouti/Nairobi 5,000

105,740

Total OPG:

\$322,164

A. USG

3. Title II Foods & Ocean Freight
for 12-Month Period

	<u>MTS</u>	<u>CCC/MT</u>	(1) <u>Per MT(1)</u> <u>Ocean Freight</u>	<u>Total</u>
Rice	277	\$293	\$135	\$118,556
Oil	143	\$795	198.70	142,099
SFSG	29.3	\$227	175.81	11,803
CSM	149.8	\$365	152.58	77,534
Milk	<u>55.8</u>	\$555	161.93	<u>40,005</u>
	655			

\$389,997

4. Ambassador's Fund

Storage, Construction
Renovation

\$ 15,000

Total USG Costs: \$850,687

B. CRS - NY

Labor Costs

Expatriate	50%	\$ 34,250
Salary and Allowances:		\$35,000
Home Leave:		3,500
Housing and Utilities:		30,000
Representation		<u>1,000</u>

35,250

Total CRS Costs: \$ 35,250

(1) Averaged Unit Costs for CCC prices and Ocean Freight: Rice, 100# units, 6101 @ 13.3CCC + 6.15 Ocean Freight (OF); - Oil, 46.2# units, 6847 @ 16.6CCC + 4.15 OF; NFDL, 50# units, 2276 @ 13.6CCC + 3.97 OF; CSM, 50# units, 6606, @ 8.28CCC + 3.46 OF; SFSG, 50# units, 1291 @ 5.15CCC + 3.99 OF,
Source: CRS/Djibouti

2. Mother Fees (continued)

Storage - renovation	\$3,000	
Demonstration equipment, tables, chairs, grinders	<u>500</u>	
		\$3,500

Total Community Costs: \$44,900

D. OTHER DONORS

1. UNICEF

Labor Costs

Health Education Promoter 80% (consultation) (Oct-May)	\$10,314	
Driver 70%	3,325	
Vehicle, Maintenance, Fuel (1)	7,500	
Training & Materials	5,000	
Fish Purchase (50-100gram rations, 5 centers, 5 days/wk)	10,000	

PMI growth cards & charts 3,268

39,407

2. Religious Missions

5 nurses (value est. at \$5,000 ea)	\$25,000	
1 vehicle (Randa) - 25%	2,500	

3. Red Crescent

2 Nurses (Balbala)	5,000	
Rental Value, Building & whse (Balbala)	7,000	
Rental Value, Building (Yoboki)	3,000	

4. WHO

1 Health Educator (part time) consultation	15,000	
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5. ONARS (Dikhil)

1 <u>responsible</u>	1,500	
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6. FAC Medical Staff Consultation

Value est at 5000 ea.	<u>\$10,000</u>	69,000
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Total Other Donors: \$108,407

(1) \$18,000 for three years, \$1000/yr maintenance, \$500 fuel

111

C. DJIBOUTIAN GOVERNMENT

1. Ministry of Health

Labor Costs - Service Providers

Salaries MOH Personnel:

8 Responsables⁽¹⁾ @ \$2500 \$20,000

9 Assistant
Nurses/
Vaccinators⁽²⁾ 50% Time
@ \$1200 5,400

Provision of Buildings

(Rental value of 16
buildings) 32,000

Supplies (adult scales, furniture) 8,900

Ministry of Labor

2 Responsables

(Nurses) @ \$2500
SMI-2 5,000

Total GROD Costs: \$71,300

2. Community Mother Fees

Labor Costs - Service Providers

2 "Responsables" \$4071

2 Health Educators
@ \$1221 and
@ \$1289 2510

2 Distributors-
Cleaners 2443

9 Weighing Help 11,061

18 Distributors 14,258

9 Aids/Assts 7,057

42 \$41,400

(1) Arhiba, Farah Had, Engueilla, Ambouli,
Tadjourah, Dorra, Yoboki and Ali Sabieh.

(2) 2-Farah Had; 2-Engueilla; 1- Ambouli;
2-Tadjourah; 2 Ali Sabieh.