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**ACSI II CONCEPT PAPER/  
EVALUATION SYNTHESIS**

**September 20, 1989**

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**MANAGEMENT  
SCIENCES FOR HEALTH**

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## Introduction

The present African Child Survival Initiative/ Combatting Communicable Childhood Diseases project (ACSI-CCCD-I/CCCD) was initiated in 1984 and is scheduled to terminate in 1991. In preparation for the approaching termination, AID contracted in January, 1989 with Management Sciences for Health (MSH) of Boston, Massachusetts to develop a "concept paper" outlining suggested parameters and modalities of a follow-on effort. A team composed of the following was selected for development of the paper:

Dr. David Sencer, formerly Director of the Centers for Disease Control (CDC) and Commissioner of Health for the City of New York; presently consultant with MSH;

Mr. Glenn Patterson, formerly Deputy Assistant Administrator for Africa and AID Mission Director, now a private consultant;

Mr. Martin Mogwanja, a national of Kenya, presently serving as UNICEF Country Representative in Lesotho;

Assisting the team as a source of invaluable historical information and insight was Mr. Andrew Agle, Assistant Director, International Health Program Office, CDC.

It became clear during early discussions with AID that a general consensus already existed of the desirability, indeed the necessity, of continuation of a major U.S. Child Survival Effort in Africa. However, guidance was solicited on the following: suggested goals and purposes of the new project (or program); program components including technical interventions proposed and institution-building activities recommended; discussion of global issues and policy considerations such as sustainability, privatization, and health care financing; structure and management of AID project efforts; and issues related to donor coordination.

In carrying out the mandate, the team held discussions with appropriate officials in AID, CDC, major other donors, AID contractors involved in related activities, and a panel of outside experts. Field visits were made to Nigeria, Ivory Coast, and Zaire along with visits to WHO headquarters in Geneva and the Africa Regional Office in Brazzaville (WHO/AFRO). (A full list of individuals consulted is listed at Annex 1). Work was carried out between February and April, 1989.

Subsequently, the contract was amended to include an evaluation synthesis working from existing documentation. This report is attached as a supplement with a description of the methodology used to develop the information. The country reviews of documents for the synthesis was conducted by Judy Seltzer-Stewart and Michelle Volpe of MSH and Rita Milkki of CDC.

The patient and persistent support of Dr. James Shepard, Ms. Myra Tucker and Ms. Peggy Meites of AID was crucial to the completion of this report.

## Executive Summary

This Concept Paper presents a proposed Project Identification for the continuation of AID's program of Child Survival in Africa. The technical strategies are those based on the AID Worldwide Child Survival Strategy and the African Bureau's Child Survival Strategy. They are also in keeping with those of the World Health Organization. The policy considerations of country determination, sustainability, Africanization and involvement of non-governmental sectors are all in accordance with current AID policy.

The Project is designed to combat 1) the high levels of infant and child mortality, 2) inadequate concern for maternal health and child spacing as they influence child survival, and to improve the countries' abilities manage their own activities.

The Project has as a goal a 25% reduction in child mortality and proposes that each country participating in the Project develop quantifiable targets for the variety of interventions that can be undertaken.

The country programs are to be built upon a basis of epidemiologic surveillance, which is the key discipline for country managers to use in identifying problems and evaluating progress. This become the basis for managerial decisions since the system can also be used for finding the cause of problems that need to be solved.

A series of technical interventions will be available for countries that include not only the current three interventions, immunization, oral rehydration management and malaria, but also opens the opportunity for additional interventions as well as changing emphasis in the current. Child spacing activities directly relate to the survival of children and the project while not delivering services, should encourage the development of epidemiologically sound programs for child spacing. As additional operational research results become available case management of acute respiratory illness must be given attention. It is one of the leading causes of mortality and as case management programs for diarrheal disease and malaria are developed the add on of ARI must be kept in mind.

Institutionalization and sustainability were not mentioned in the original project. Today these concepts must play an integral role. These goals can be reinforced by by strengthening the planning, managerial, and implementation capacity at the country and district levels; changing behavior of both end-users and health care personnel through education, promotional communication, social marketing, and training; improving the management and availability of resources through cost containment, additional public, private and donor financing, and improved management of facilities, supplies, personnel, and equipment; and finally by increased operational research to improve program impact, and as importantly, to economically measure and publicize project impact to sustain demand.

In the past the main interactions have been between AID, CDC and the MOH's. While there has been some involvement of other contractors in the future the project will need to utilize the expertise not only of other contractors, but to an increasing degree the private sector and non-governmental organizations in the countries. Much closer ties with other donor agencies must be developed to conserve the resources that are available.

Changes in management are also proposed to further the opportunities for sustainability and institutionalization. It is proposed that the Missions take a stronger role in the management of country projects. It is recognized that the Missions, particularly in Africa, are inadequately staffed in experience health officers, and the proposal makes suggestions as to how this can be remedied and keep greater involvement in the projects.

## I. PROGRAM FACTORS

The economic and demographic future of the countries of sub-Saharan Africa is so bleak that they can not afford the burden of a childhood population continually threatened with death and disability.

In 1988 Smuckler and Berg wrote : "Africa generally is in crisis. For two decades, population growth has outstripped agricultural productivity. During this time, two major famines have swept across the continent. Economic growth rates have plummeted. We do not exaggerate when we say that the basic building blocks of societies - education, food, and health - are at risk in large parts of sub-Saharan Africa."

"Unless deteriorating conditions are turned around, an increasing number of African countries will suffer economic stagnation, increasing poverty, environmental degradation, and decay of their already fragile social and political institutions. Should this occur, not only will a major continent become increasingly marginal to the international economy and society, but the lives of millions of Africans will be unbearably bleak. We cannot stand by and watch African move to widespread disaster. Our sense of humanity will not permit it."

Three decades ago, George Herbert Tinley Kimble wrote in his book Tropical Africa "It is bad enough that a man should be ignorant for this cuts him off from the commerce of other men's minds. It perhaps worst that a man should be poor for this condemns him to a life of stint and scheming in which there is no time for dreams and no respite from weariness. But surely worst is that a man should be unwell for this prevents his doing any thing about either his poverty or his ignorance."

Prevention of illness should be the cornerstone on which to build an education system and a healthy economy. Fredricksen wrote that until epidemic death was conquered, child spacing for the sake of healthier children and mothers and for population planning was not to be expected.

Expenditures on prevention now will not only protect the health of the future generation and the women who bear and care for them, but can serve as the basis for the development of a health system that can recognize problems and develop solutions before the crisis stage. Preventive health services lend themselves to rational solutions. Success in this area can give governments the courage to approach the curative system in a rational manner.

### A. Conformity with Recipient Country Strategy/Programs

The countries of sub-Saharan Africa have recognized the disastrous effects of childhood mortality and morbidity upon the social and economic potential of their areas. In the countries participating in ACSI/CCCD this is evident by the adoption of National Plans for the control of diseases preventable by immunization; deaths from diarrheal disease; and malaria morbidity control (in many areas). These have been incorporated into the National Health Plans.

These countries not only have plans, but are beginning to implement programs that have national goals and targets relating to the various control strategies. In many instances these goals have been influenced by external pressures from WHO (Health for All by 2000) and UNICEF (Universal immunization by 1990), but to an increasing extent they are developing plans that meet country specific needs and capabilities, rather than accepting a template from without.

The Ministries of Health of these countries have strategies for Primary Health Care that incorporate these plans and programs. Not all countries, however, have a formally stated policy on child spacing, an essential element in promoting child survival.

The above are evidences that ACSI/CCCD has been in accordance with countries' health policies and programs, but does not speak to effectiveness of programs or to their ability to sustain themselves.

ACSI-II will not only conform, as its predecessor did, to national priorities, but will continue to provide technical assistance that will lead to better management skills, technical skills, problem solving and sustainability. These will continue to be built on the foundation of epidemiologic surveillance and planned action programs to address the problems that are defined.

## **B. Conformity with AID Strategies**

### **1. Technical Strategies**

The basic AID Worldwide Child Survival Strategy, while emphasizing the "twin engines" - immunization and ORT, is not proscriptive of other activities that are locally important and technically feasible. This same document includes family planning as a public health measure that has a positive effect on both mothers and children. AID emphasizes the need for congruity with WHO technical guidelines, which ACSI-II will continue to do. In addition the proposed program will be in conformity with the African Bureau's Child Survival Strategy (AFR/TR Feb. 25, 1987).

### **2. Policy Strategies**

Four basic policy strategies are addressed in the proposed project: country determination, sustainability, Africanization and involvement of non-governmental sectors.

As in the past, ACSI-II country plans will be originated by the recipient country, reviewed, modified if necessary and approved by the AID Mission. However, the AID Missions will be given greater responsibility for the management of the country activity, bringing a greater sense of ownership[ to the project than existed in the beginning of ACSI-I. In this second phase greater emphasis will be given to the country's own evaluation of problems and solutions than in the original ACSI-I/CCCD. At that time there was a greater need for demonstrable action by the countries for confidence building. Now the MOH's have an improving capacity for their own planning.

The issues of sustainability are already being addressed, but the original design of ACSI/CCCD emphasized technical interventions to the extent that the solid work of strengthening country capabilities, experimentation in cost-recovery and search for multiple sources of support have not been recognized. In the coming project, much more specific attention will be paid, among others, to the development of program managers who have the capability of directing, planning and managing.

Africanization in the proposed project will emphasize the use of African consultants, African training resources and African Regional resources such as WHO and UNICEF. However, the project will also recognize that for the sake of sustainability, the premature withdrawal of technical assistance is often contraindicated.

The realities of the supply of medical services in Africa demand that all sources of service be utilized, not just Ministries of Health but the private sector, the non-governmental sector, district and local health services. While the MOH bears the responsibility for assuring their citizens of equitable quality, access and appropriate health care as defined by the disease and socio-geographic environment. MOHs should not necessarily, or be expected to, assume the role of sole provider. In ACSI-II, greater reliance will be focused on a high level of collaboration and consultation to the non-MOH sectors, to guarantee the delivery of preventive services to all.

## **II. PROJECT DESCRIPTION**

### **A. Perceived Problem**

It is usual in a child survival context to perceive the problem as being one of mortality and morbidity. There is no denying the problems exist in Africa. Sub-Saharan Africa has the highest infant mortality rate of any region in the world. Up to 25% of children born never see their 5th birthday. But the more basic problem is how the excess morbidity and mortality will be abated. The technologies for major decreases in mortality and morbidity exist. The management systems to utilize these technologies exist in concept but not in practice.

It is usual to perceive of management deficiencies as a lack of infrastructure. In most countries of Africa, the problem is not just infrastructure, but a fragile superstructure. The capable manager of child survival activities is probably forced by default to manage AIDS activities, maternal and child health activities and primary health care. The manager of child survival activities must cope with the full gamut of management problems. The manager does not need to be proficient in all aspects but must have the realization of the importance of these skills. Supervision, training, financial management and logistics are the wheels upon which the programs run and all must be given attention.

For the management structure to function effectively, there must be an information system that is capable of providing both health and management information to allow the manager to make rational and cost effective decisions that will lead to more efficient delivery of preventive services.

A good information system for the planner and manager will identify problems that need to be solved on a local level, both technical and managerial. This requires the local capability to conduct operational research, a capability that now is mainly provided by external experts.

A good manager needs to communicate effectively. This communication must be to other members of the policy making hierarchy; to health providers and to consumers. Health managers who are for the most part physicians are not skilled communicators, and their talents must be improved if they are going to generate the demands for the services from the consumer, and the willingness to provide the resources from the decision makers in the large frame of government. Not only must they communicate the problems to the policy makers, but they must direct communication (education) to both the providers of service and consumers, so that demand from below is met with understanding from above.

While the perceived problems from a distance may be managerial in nature, at the local level the policy makers will see the problems in the light of disease, demography and costs. It is essential that policy makers understand that "quick

fixes," e.g., mass campaigns are not "permanent fixes." Likewise, the non-occurrence of disease is not the signal for discontinuation of activity. Policy makers must understand that markers of improvement are not always measured directly in decreased morbidity or mortality, but in provision of service. Without nationwide highly sophisticated vital statistics systems national changes in mortality from diarrheal disease, for example, will be unable to be measured. Surrogate markers, such as percent of diarrhea admissions dying, must be understood and respected.

## **B. Project Goal and Purpose**

1. The original Project Paper for ACSI/CCCD had as its goal to improve the health of the pediatric population. The goal for ACSI-II is to reduce the childhood mortality by 25%. This is a country specific goal, not a regional goal, since declines should not be expected to temporally parallel activities. The period of management strengthening, development of surveillance and information systems and problem solving are necessary before the impact of technical interventions are realized.

2. The purpose of the project is assist in improving management capabilities in the health system to apply the appropriate technologies to reduce the mortality and morbidity. The development of an appropriate epidemiological surveillance system and related health information system is a key management element in the long term sustainability of preventive health services and through these systems countries can achieve the most cost beneficial outcomes the a limited number of technical interventions and supporting activities. Intercountry cooperation and international cooperation will be sought as part of the longer term efforts at Africanization.

## **C. Expected Achievements/Accomplishments**

It is expected that the goal of 25% reduction in child mortality will be achieved. The use of child mortality, or the rate of deaths under the age of five per 1000 live births, is used rather than Infant Mortality since new and simple techniques have been developed that allow this to be monitored on a continuing basis whereas IMR's are much more difficult to accurately determine. This method was developed by the Center for Population Studies of the London School of Tropical Medicine and Hygiene by Brass and McRae and have been extensively validated in the field.

If the IMR in all the sub-Saharan countries were reduced from the current figure to 75, the saving of life in one year would be 970,000. If there was a 25% reduction in child deaths, the savings would be 1,090,000. Not only is there a 12% increase in lives saved, but the savings are more easily monitored and thereby the measurement is more useful for target setting

Country targets will be developed and used in planning, monitoring, and evaluation. As new knowledge has developed, original targets will be adjusted, up and down, to meet the criteria of epidemiologic relevance, technical feasibility, and advisability.

Regional targets for specific interventions will be achieved and/or maintained.  
Examples are:

Neonatal tetanus will be eliminated;

Poliomyelitis will be eradicated in countries where this has been adopted as a national goal. Epidemic control measures will be in place, however, since wild virus will still be circulating on the continent;

Measles immunization by age 1 will be maintained at 80%;

90% of admissions to health facilities for diarrhea and malaria will be treated in accordance with national policies;

A national policy for acute respiratory disease will have been adopted and implemented;

All national health authorities will be involved in child spacing activities in accordance with a stated national policy;

Referral systems for high risk mothers will be in place in all urban areas.

Disease interventions will be fully incorporated into the primary health care system and there will be appropriate decentralized management.

National Health Plans will reflect a national child survival plan.

National Health Plans for prevention will show a phased approach towards sustainability, recognizing that program sustainability must come before financial sustainability, and that the needs for external technical assistance must gradually decline.

The efforts to strengthen the regional international organizations will have succeeded and external support is no longer needed.

Health profession schools in Africa will have incorporated into their curricula appropriate training in primary health care technologies.

#### **D. Project Outline and How it Will Work**

The proposed project is both a continuation and an extension of the existing ACSI/CCCD project.

##### **1. Background of Present ACSI/CCCD Activity and Survival Effort**

##### **Relationship to AFR Child**

The AID Combatting Childhood Communicable Diseases project was authorized by the Administrator in September, 1981. The objective of the project was to increase the ability of African governments to:

control measles, polio, tuberculosis, diphtheria, pertussis, and tetanus under the WHO-sponsored Expanded Program on Immunization;

provide simple and effective treatment for Diarrheal Disease;

control diseases of local importance such as Yaws and Yellow Fever.

The treatment of Malaria in children under five and in pregnant women was added under strong urging from African Ministries of Health and constitutes a major component of the program. The control of Yaws and Yellow Fever, given distinctly lower priority by African Ministries, was relegated to an inactive component.

The project was intended as a multidonor program sponsored by a seven-nation bilateral Cooperation for Development in Africa (CDA) coordinating group and involving international agencies and private groups. The U.S. input was to support 15-20 country programs through technical assistance in planning and operations, training of field staffs, disease surveillance and evaluation and commodity support. The project also provided for four intercountry (regional) activities as support to the individual African country programs. These included:

- intercountry training at the senior and middle management levels;
- health information systems
- health education
- operations research.

After authorization of the project in 1981 AID signed PASA's with the Centers for Disease Control (CDC) and the Peace Corps; a grant was made to the WHO Regional Office for Africa (AFRO) for intercountry activities, and 13 bilateral country programs were phased in over four years. Ten bilateral projects continue: Burundi, Central African Republic, Cote d'Ivoire, Guinea, Lesotho, Liberia, Nigeria, Swaziland, Togo, and Zaire. Projects in Malawi and Rwanda reached their PACD's and were not renewed; the Congo project was terminated early for lack of host government financial participation.

Initial ACSI/CCCD authorization was for eight years and \$47 million; a 1986 amendment added three years, increased the funding ceiling to \$89 million, and changed the name to ACSI/CCCD in recognition of ACSI/CCCD as a full-scale Child Survival project. A 1988 amendment increased the ceiling to \$123 million, allowing the 10 bilateral activities to be extended to the 1991 PACD.

In addition to the ACSI/CCCD activity, the Africa Bureau, following AID's Child Survival Strategy, identified in 1987 eight child survival emphasis countries in which activities were begun. These were: Kenya, Malawi, Mali, Niger, Nigeria, Senegal, Sudan, and Zaire. (This represented an additional five countries to those already participating in the ACSI/CCCD program).

The targets of the Africa Child Survival Strategy (in which the ACSI/CCCD activity was a major component) were

Reduce the IMR to less than 75/1000 live births per year.

Immunize 80% of children under 5 years of age.

Assure wide access to appropriate and correct case management of diarrheal disease episodes for children under 5 years of age.

Provide widespread access to voluntary family planning.

Reduce the percentage of children under 80% weight for height to less than 10%.

Provide access to an appropriate anti-malarial treatment for at least 80% of the children under 5 years of age consulting for fever/malaria.

It will be noted that the goal for ACSI-II differs in the key indicator, using childhood death rate rather than infant mortality rate. This has been discussed above, and is in keeping with the current UNICEF feeling that the CDR is a more accurate indicator of the job to be done than the IMR.

## **2. Evaluation**

The ACSI/CCCD has been one of AID's most closely monitored and heavily evaluated projects, both regionally and bilaterally, with overall findings nearly uniformly positive. Major accomplishments noted in the evaluations have related to:

its effectiveness in mobilizing widespread support and concentrating efforts in countries and among donors for immunization, CDD, and malaria activities;

its consistent observation and promotion of WHO policies and strategies (as well as active dialogue in the design of those strategies);

well-targeted operational research to improve program effectiveness; innovative improvements in information gathering, both through computerized health information systems and disease surveillance;

and the generally high quality of technical assistance and project management.

While the project has been praised for its valuable contributions to technical and management training of African health personnel and its serious effort to utilize and strengthen African institutions which are responsible for implementing Child Survival activities, even greater effort has been urged in this area if program sustainability is to be assured. There has also been a consistently expressed concern regarding the difficulty in accurately measuring impact, but recognition that an adequate impact-measurement system will require even more of the program's limited resources (in the form of surveys, technical assistance, computers, training, etc.). There is virtual unanimous agreement that the achievement and sustainability of the mortality/morbidity targets will require far more time than the original project foresaw.

The above comments on evaluation are the result of examination of all external evaluations of the regional program and of the country programs, as well as selected internal evaluations. These evaluations are not "evaluations" in the sense that they measure accomplishments in relation to goals, but rather were designed to identify management problems that could be addressed rapidly.

Measurement of program accomplishments in terms of meeting targets and goals are better expressed in the Annual Reports of the Project and in the synthesis of accomplishments that forms the separate report attached.

This dichotomy of evaluations and management monitoring could be improved. AID should discuss with WHO and UNICEF the feasibility of expanding the current EPI and CDD Program Evaluations to be Child Survival Evaluations. Periodic (every 4-5 year) intensive evaluation by external donors and country health authorities may offer a

better measure of program accomplishment. It is possible to utilize the Brass-McRae methodology on a more frequent basis, perhaps annually, to provide a rough evaluation of effectiveness, which coupled with a continuing Information System Report currently used should provide sufficient current information for agency needs.

### **3. Proposed Program Structure**

#### **a. Development of Epidemiological Surveillance and Problem-Solving Capability in Country**

The key to sustainability is the development of in-country capacity to identify priority problems, design or revise activities to address those problems, to marshal resources in the most cost-effective way, to manage implementation of the interventions efficiently, and to evaluate effectiveness and revise the strategy accordingly.

Essential to this process and the base upon which it rests is information and capability (and motivation) to use that information effectively. Information must be current, representative, easily collected, properly analyzed, and appropriately available. The organizational and individual desire to take appropriate action on the basis of information available is also necessary. These elements of an epidemiologic surveillance and related health and management information systems (ESS/HIS/MIS) are key parts of any sustainable program. No significant resources should be put into Child Survival in any country on a long-term basis unless this element (ESS/HIS/MIS) is a part of the program, either supported by the U.S. or by another donor or (rarely) already adequately developed and managed in country by health authorities themselves.

The U.S. has a model of a system which is appropriate for transfer after modification to specific country situations. Several valuable institutional resources exist in the U.S. CDC and state and local departments of public health are experienced in the development of epidemiologic surveillance systems and schools of public health have appropriate educational resources upon which AID can draw for the implementation of this essential part of the program. We believe there continues to be a strong case for a global regional contract to implement this element of the program in most country projects. Such a relationship is likely to provide greater continuity, a strong institutional base for follow-on professional relationship after AID assistance is terminated, facility of greater intercountry collaboration, and cost savings. Such a regional institutional relationship will also lead to simplified management.

#### **b. Technical Interventions**

No child ever died directly (repeat directly) from a faulty health information system. To save children also requires technical interventions to prevent or combat disease. In spite of the emphasis referred to above on the institution-building aspects of Child Survival, adequate and demonstrable progress must still be made in reducing disease and death. Otherwise, resource from the Congress and private agencies will be reduced; the credibility and "entree" of the U.S. in policy dialogue and to support institution-building will be reduced, and the value of its health programs will be called into question.

ACSI/CCCD, which predated and helped shape the Congressionally mandated Child Survival Initiative, chose to concentrate on diseases preventable by immunization

(EPI), control of diarrheal disease (CDD) through oral rehydration therapy (ORT), and, at the insistence of African health authorities, malaria treatment and prophylaxis. Although these initiatives were categorical (and often in the minds of country authorities, vertical programs), they have invariably been incorporated into more comprehensive child health programs and the primary health care system as activities became established and demand for the services became more widely based.

There is a wide degree of consensus that a principal element in the success thus far of the ACSI/CCCD project has been the limitation of the number of program interventions and the predominant position given to the priority interventions. These are still the major killers of children in Africa, and there is a large degree of agreement that they should continue to form the backbone of future efforts. (Naturally, approaches have changed and must continue to change with new knowledge and changing epidemiological circumstances). In addition to the previous three, however, Child Spacing must be considered a primary intervention and should be an identifiable part of the child survival strategy in National Health Plans. This does not mean that it must be administered through the same project, but every opportunity for program reinforcement and complementarity must be considered.

The simplicity of a small number of interventions should be preserved in each country program, but the increasing diversity among countries require that a greater degree of variation be supported.

#### **i. Diseases Preventable by Immunization**

Universal Childhood Immunization is far from a reality in Africa, and although a national vaccine delivery system now exists in most countries and relative gains have been impressive, vaccine preventable diseases remain leading causes of death in infants and children. Continued emphasis must be given over the next ten years to increasing coverage. The next 50% will be far harder to reach than the last 50% and will require new strategies. These strategies will depend upon improved surveillance, supervision and operational research.

Emphasis in ASCI-II should be made to assure that the national programs reach all parts of countries and then as country programs mature, emphasis for assistance should be placed on technical help in focusing resources on disease reduction. Early, the emphasis will be on coverage, and the later stage on epidemiologically identifying segments of the population not being reached and where disease transmission still occurs.

##### **(a) Measles**

Measles immunization should continue to receive the high priority, since such immunization has been shown to have major impact on decreasing mortality from other causes. Operational research should be continued to develop new vaccines which would permit immunization at six months, thereby further shortening the immunization schedule and thus both increasing coverage and reducing per unit costs.

##### **(b) Poliomyelitis**

The Polio Eradication initiative being launched by WHO with support from Rotary International and the African countries will be part of that initiative. To achieve eradication, surveillance and outbreak control will become keys to success, just as they were in the smallpox eradication program. Eradication efforts must be back-stopped by virus laboratories. Countries should be discouraged from developing their own, and assistance provided WHO AFRO to develop regional reference laboratories.

### **(c) Tetanus**

Neonatal tetanus is the third area of the current EPI program that must be strengthened in the Africa Region during the next decade since the countries of the region have voted for an eradication effort. In contrast to polio where the human is the host, tetanus spores are present in nature, so a continuing effort to maintain universal female immunization will be required, until the children of today's EPI programs reach child bearing age.

### **(d) Hepatitis B**

In Africa, the leading cause of cancer deaths is liver cancer, a direct result of infection with Hepatitis B virus during early childhood. Current technological developments of a recombinant vaccine are rapidly bringing the costs down to the point where it will soon be feasible and desirable to include this vaccine in the EPI efforts. The schedule of vaccination is such that the antigen can be added relatively easily to the current schedule. While mortality from liver cancer does not occur in childhood, its prevention in childhood is an example of cost-effective "piggybacking" thus increasing the demand for epidemiologically based programs.

#### **ii. Control of Diarrheal Disease**

While considerable progress has been made, it is estimated that up to 25% of all deaths of children under 5 is still related to diarrheal disease. More than half of those deaths are attributable to dehydration, for which ORT and the effective use of ORS and home fluids will continue to be the preferred intervention. Other causes of death are undernutrition, dysentery, and persistent diarrhea.

ACSI/CCCD has followed the technical recommendations of WHO in establishing training centers in teaching hospitals where providers can be trained in the appropriate treatment of dehydration; assisting in the managerial and supervisory training for providers at the field level; and assisting in the production (or procurement) and distribution of ORS packets.

There is growing recognition that these actions alone are not enough and that greater emphasis must be placed on the prevention of diarrhea. Highly targeted and carefully researched health education must be continued in nutrition, the continuation of breastfeeding, adequate weaning practices, personal and domestic hygiene (especially handwashing) and the proper care of water once retrieved from the source.

Mother education is the key to those measures that can be taken in and around the home including the continuation of feeding of the infant and the use of any appropriate fluid at hand in preventing dehydration. Mothers must also know how to get access to ORS and to use it as the signs of dehydration appear. Experience in Zaire would suggest that self-referral to the nearest health center is more effective than the use of ORS in the home, but continued operational research in this and other areas of mother education is needed.

A principal continuing challenge to the program includes incomplete acceptance of ORT as an adequate technique to manage diarrhea, especially important among health professionals in general and physicians in particular. Special attention must continue to be given to the inclusion of ORT training in the preparatory as well as in-service training of health professionals, and especially physicians. Nutritional rehabilitation, when needed, is also an essential component of the curative intervention.

Improving water supply and community sanitation are, of course, necessary to the long-term control of diarrheas and water-borne diseases. However, these are expensive and cross many sectors. The appropriate role for ASCI-II is to help identify from a health impact point of view the areas of highest priority and to encourage the allocation of resources accordingly. For example, the high incidence of guinea worm infection is an excellent indicator of bad water, and surveillance of guinea worm infection is extremely useful in guiding the government in allocating its scarce resources for water and sanitation.

### **iii. Malaria**

Malaria remains one of the most important causes of death among children in Africa with estimates of mortality ranging around a million per year, and chloroquine resistance continues to spread. The continuation of malaria treatment as a major component of any child survival effort is essential, not only to further reduce child mortality, but even to maintain present levels of reduced mortality/morbidity already achieved.

Under ACSI/CCCD (and related Child Survival programs) malaria activities were begun in 14 countries based on chemoprophylaxis of children and where possible pregnant women; presumptive treatment of fever; drug sensitivity surveillance; and operations research. In the most successful programs, Malaria Advisory Committees were established, and a control policy and related procedures were developed. This has led several countries to adopt a National Malaria Policy or to revise outdated Malaria Eradication Plans. It has also contributed enormously to the development of a set of WHO-approved recommendations for use by African countries. Continued assistance is essential in the development or refinement of National Malaria Plans, in training of technical and administrative personnel in malaria treatment, in quality control of antimalarial drugs, in refinement of recommendations on dosages based on continuing surveillance and operational research, and in development of procedures and criteria for evaluation of progress.

### **iv. Child Spacing**

Child Spacing has been recognized as an important factor in child survival. Data from demographic surveys invariably indicate that children born with brief intervals following prior births suffer mortality in excess of those children born with longer intervals. Most survey methods differentiate between less than 24 month interbirth intervals and more than 24 months interbirth intervals. The association of brief birth intervals with excess infant mortality is a significant one with differences in extreme cases in excess of 50/1000 live births and which is independent of the associated characteristics of poverty and poor education levels in those families in which short birth intervals are most prevalent.

Child spacing in itself and apart from its impact on infant and child mortality is an important health, environmental, economic, and social goal. The health of women is positively affected by avoidance of excessive numbers of pregnancies. When population rapidly increases and outstrips economic growth, it places enormous burdens on government's ability to provide basic services including health and jeopardizes food production sufficiency. Overly rapid rates of population growth also place stress on fragile environments resulting in desertification and increasing tolls from natural disasters. They hamper progress in extending basic sanitation services to increasing proportions of the population. Many of these other effects of overly rapid population growth also exert negative effects on child survival.

The technologies for child spacing, means for, and problems associated with their application have been well developed over the past 3 decades. The body of knowledge and experience is adequate for program policy development, program planning, program implementation, and program evaluation.

Despite clear evidence of the impact of brief birth intervals on infant and childhood mortality and the availability of reasonably effective technology to address the problem, little has been accomplished in Africa in terms of reducing the problem, and very little advocacy and leadership has been evidenced by the group of partners who so effectively lead and influence all other health-related aspects of child survival in Africa. There is, to be sure, considerable support provided to family planning programs most notably by the U.S. Government; the component of strategy which is lacking is the coalescence of child survival and child spacing activities into a complementary whole.

The reasons for this failure to exercise leadership and effective advocacy and to ignore the impact of a significant impediment to child survival are several. This paper does not propose to address all of them. One of the more important reasons that donors and child survival advocates do not address the issue is their lack of confidence in their African colleagues' abilities and willingness to address difficult and socially sensitive issues successfully. Experience of the past few years in the CCCD project does not support that contention. African child survival technicians and executives have, with only modest encouragement and support, engaged a series of thorny issues relating to public health policy and management. They also have developed their skills and knowledge regarding family planning issues and contraceptive programs through their association with PVO's engaging child spacing issues independently from but with the knowledge of governments.

The capacity of African national executives, program managers, and technicians to successfully grapple with policy development and program management issues, their knowledge and skills gained with regard to family planning and the growing importance of this aspect of child survival as progress is made in other areas all imply that the time has arrived that child spacing technologies should become an integral part of child survival programs in Africa.

At the present time, USAID is vigorously supporting family planning activities in Africa, and some success is being achieved, but impact on both child survival and the lowering of fertility rates could be achieved by greater integration into the Child Survival program. This is not to say that AID activities in family planning need be or should be administered as part of child survival projects, but Missions should assure close collaboration and mutual reinforcement at the country level.

Specifically mutual reinforcement of family planning and other child survival efforts can be increased in the following ways:

- policy dialogue with national colleagues: increasing awareness of the negative effects on child health of short birth intervals as well as other effects of high population growth (e.g. food sufficiency, pressure on fragile environments, etc.)

- collaborative and coordinated training of program managers and service delivery personnel (e.g. adding modules on child spacing to training programs for EPI and CDD training activities);

mutual reinforcement in health education programs directed at mothers including the development of effective educational materials and communications messages for encouraging child spacing and emphasizing breastfeeding;

collaborative gathering and distribution of information through the epidemiological surveillance system and health information systems;

sharing where appropriate facilities, equipment, supplies, and experience in logistics management and operational research.

#### **v. Other Disease Interventions**

To justify major resources and long-term U.S. involvement, country programs must either include or show that provision is otherwise covered of ESS/HIS/MIS and the four primary technical interventions discussed above. Country projects could selectively include one or more of the interventions discussed below insofar as such inclusion still preserved project focus and concentration.

##### **(a) Acute Respiratory Infection (ARI)**

Acute respiratory infections (ARI) cause between 25 and 35% of mortality among children less than 5 years old in the developing world. Despite the role of these infections in childhood mortality, child survival programs have only recently focused efforts on reducing the toll of ARI. The health burden imposed by ARI extends beyond mortality; these infections are also responsible for the majority of outpatient medical examinations and a large portion of antimicrobial use.

ARI has been ignored not because it was unrecognized. Confusion regarding the definition of ARI, uncertainty of the etiology of ARI, and the lack of a practical approach to ARI hindered progress and delayed efforts to reduce the burden of ARI. ARI is now defined as any infectious process involving the respiratory tract from the middle ear to the lung alveolus. Upper respiratory tract infection is defined as infection occurring above the epiglottis, and lower respiratory tract infection as infection below the epiglottis. These definitions have allowed researchers to focus on lower respiratory tract infections, predominantly pneumonia, as the major cause of death due to ARI.

Studies show that 1) bacteria are the leading cause of pneumonia in children and 2) a respiratory rate of greater than 50 per minute is now considered virtually pathognomonic of moderate or severe respiratory tract infection and indicates the need for antimicrobial therapy. Current control programs are based on these 2 findings.

Two years ago there was great enthusiasm for the development of aggressive programs to treat ARI which, with malaria, continues to be a major killer of children. The use of case management techniques for training health workers was to be adopted much as the case management technique for ORT was used. However, careful evaluation of experiences and of training materials has depended to a certain extent the global enthusiasm for an all-out attack on ARI's. Selected field studies such as the one in Lesotho are necessary in many different ecological situations, and the ACSI-II program should be in the forefront of these through the Regional Support element of the program as well as of country projects. The mechanism for stimulating and supporting local operational research that has been developed in Nigeria may be useful as a model in other countries. If local investigators conduct problem-solving

research, they become the best promoters of the results as part of successful programs. This research in ARI's is necessary to provide a firmer scientific foundation upon which to build a successful training program which in turn will lead to effective service.

Another impediment to the successful execution of ARI programs will be the inadequate drug supply system of the country. A successful ARI program requires that the right drug of the right quality be available at the right time and place. If countries choose to include an ARI component in their projects, expertise in this area should be assured.

### **(b) Maternal Health**

Maternal and perinatal mortality and morbidity are severe problems throughout Africa, and low birth weights, the result of either prematurity, poor intrauterine growth or a combination of the two, is the best single indicator of unhealthy mothers. Interventions to improve both maternal and perinatal mortality and morbidity are known, but are difficult to administer in a developing country context.

Attention has been focused on the antenatal period with an emphasis on motivating mothers to come for care early in pregnancy, and attempting to identify women with risk factors. Providing quality care even after identification has been exceedingly difficult. Neonatal tetanus coverage is disappointingly low, and there is little screening and treatment of mothers with syphilis.

Still, immediate opportunities exist for effective action. Resistance to training programs for TBAs seems to be declining. The introduction of birthweight scales and reporting systems will help produce epidemiologic surveillance information on areas where prenatal health is most greatly compromised. Childhood as discussed above is one of the most important interventions in both maternal and child health and should receive renewed emphasis under ACSI-II. In short, maternal health is best addressed through vigorous action in the areas of neonatal tetanus, training of TBAs and health care providers, child spacing and operational research incorporated with a maternal health dimension into the primary technical interventions of the program.

### **(c) Nutrition**

Malnutrition is widespread throughout Sub-Saharan Africa and is not simply (some would say not even primarily) a health problem. Rather, it is very greatly affected by civil unrest, agricultural productivity, environmental degradation, inflation and lack of purchasing power as well as by health education. Nevertheless, it is a fundamental cause of susceptibility to infant and child disease and death. The extent, location, nature, and magnitude of nutritional deficiency should therefore be analyzed as part of an adequate National Child Survival Strategy, and interventions considered which are susceptible to application in tandem with the four primary interventions outlined above.

Measles immunization, promotion of breastfeeding both as a food source and as a preventive measure in diarrheal disease control, and feeding practices during rehydration and in the clinical treatment of persistent diarrhea all offer opportunities for major nutritional impact. Obviously training, educational, communications, and information system elements in the Child Survival should be designed to have as beneficial impact as possible on the improvement of nutritional status of children.

Existing delivery mechanisms also allow for the selective addition of nutritional interventions where warranted. In goitrous areas, injections of iodized oil can be incorporated into EPI programs. As field studies on the efficacy of Vitamin A produce definitive results, this might also be an additive delivered through the EP .

#### **(d) Acquired Immunodeficiency Syndrome (AIDS)**

The tragedy of AIDS hangs over Africa as the number of cases reported to WHO continues to increase rapidly. It not only threatens the lives of thousands of children, but also threatens to overwhelm already weak public health services. Large sums of external money pour into the well-intentioned fight against AIDS, but if not properly managed risk diverting scarce resources, human, logistical, and financial from other equally essential preventive and curative services.

The presence of AIDS impinges on the Child Survival effort in several other ways:

the epidemiological surveillance system and related health information and management information systems developed through assistance under the Child Survival Program (and related training and equipment) should also serve the goal of AID control wherever possible and appropriate;

in particular, sentinel systems of surveillance as they are set up can include information about the occurrence of AIDS;

vigorously pursuing correct treatment for malaria, e.g., non-injection, non-transfusion, will help limit the transmission of AIDS;

health information systems should be adaptable so that additional information can be added without overburdening the system;

the training of personnel must emphasize precautions to be taken in handling injection and surgical supplies;

add on training modules could be developed to be included in EPI and CDD training courses;

any health education programs, including social marketing, should be evaluated to determine if AIDS education is an appropriate addition;

the decentralized approach to diarrheal disease control including logistical arrangements, educational activities and public awareness efforts offer useful for similar efforts with AIDS and vice versa. Maximum use should be made of such possible collaboration.

obviously the availability of supply and distribution of contraceptives as well as related promotional and educational efforts serves both the child spacing component of the Child Survival Program as well as preventing the sexual transmission of AIDS;

#### **vi. Other Components Related to Institutionalization and Sustainability**

In addition to the technical interventions, the project must continue to give priority to functional components aimed at the following:

improving the policy environment, both nationally and regionally, for Child Survival;

strengthening the planning, managerial, and implementation capacity at the country and district levels;

changing behavior of both end-users and health care personnel through education, promotional communication, social marketing, and training;

improving the management and availability of resources through cost containment, additional public, private and donor financing, and improved management of facilities, supplies, personnel, and equipment; and finally

increased operational research to improve program impact, and as importantly, to economically measure and publicize project impact to sustain demand.

#### **4. Strengthening Country Health Planning in Child Survival**

The emphasis placed in the next decade on country-level planning and control of Child Survival activities and the central function of the Child Survival element of the national health plan will require greater attention to the planning of health strategy. Ideally, WHO leadership would be much more visible and effective in this area, and bilateral donors could provide resources and personnel under WHO auspices for assisting countries in the planning process. More leadership, skill, and resources may likely come from the World Bank in this area, but in either event the U.S. should encourage such involvement and make provision in the ASCI-II program to support on regional efforts. USAID might wish to consider supporting a short follow on session to the Regional meeting of the WHO Regional Office which could be devoted to consideration of child survival strategies. This would have the value of involving higher level planners than attend the technical meetings at present. In addition, support to country programs where appropriate should include short-term and specialized assistance in formulating the policy elements of child survival in existing health plans and information, as well as help in developing Periodic Plans of Action for the Country.

#### **5. Changing Behavior**

In both developing and industrialized countries alike, it is increasingly clear that changing imprudent behavior, whether it be smoking in the U.S. or withholding fluids from children with diarrhea in Zaire, is essential to major improvements in health status. It is also essential to the continued economic viability of the health system, since the greatest cost containment measure is increasing the part of the population that does not require services of the health system in the first place. This was recognized from the beginning, and the ACSI/CCCD project gave a prominent place to health education of users and training of health providers.

## **6. Health Education and Communications**

### **a. Health Care User**

In the context of ACSI/CCCD the purpose of health education was two-fold:

to promote utilization of EPI, CDD, and malaria control services offered at health facilities by mothers or caretakers of children 0-4 years; and

to promote adoption of specific practices in the home/community relative to episodes of diarrhea and fever in children 0-4 years.

The point was not to introduce ambitious new efforts but to take countries where they were with great diversity in experience, personnel, infrastructure, etc. and gradually strengthen and improve ongoing programs focussing specifically on the ACSI/CCCD interventions. Health education, unfortunately, was not usually included in initial country assessments, and this component was often seen as the production of posters and leaflets with messages often determined by EPI, CDD, and malaria technicians. Most were intervention specific, geographically limited, limited in time (e.g. one-time campaigns).

As health education generates demand, supply must be increasingly available in the form of trained health workers, facilities, supplies, etc. The stimulation of community demand before there is recognition and existence of the appropriate response by the "authority" whether it be a village health worker or physician can lead unwittingly to sabotage and disillusionment in the community.

The ASCI-II effort should build on the mixed experience of the past in several ways:

written detailed health education plans should be part of the original project paper and the child survival strategy.

the role of the health worker as health educator (not now perceived by health workers for the most part) should be a major focus of efforts with implications for training, supervision, evaluation of personnel, etc. This would include clinic-based patient education and training and supervision in health education for (a) regional/district supervisors; (b) health facility personnel; (c) central MOH staff as appropriate; (3) operational research as needed in these two areas.

training in health education planning/implementation for central, regional, district personnel; also, training of trainers in HE;

continued concentration on limited key child survival interventions, but selective assistance to systems development for formative research, materials development and distribution, incentives for promotion through collaboration with private producers; to be effective this assistance must be coupled with intervention activities so that the demand creation is in synchrony with program responsiveness;

continued specialized assistance to country programs and relevant operational research through S&T's Healthcom project or other specialized resource;

specific development of child survival and related materials for incorporation in the primary and secondary school curricula;

continued intercountry training efforts and materials development with help for local adaptation not only at the country level but also at the district and local levels.

#### **b. Health Care Providers**

Education and training of the health worker is a career-long process and can usefully be divided into pre-service education or training and continuing education or in-service training.

##### **i. Pre-service Education and Training**

A marked change in curricula is needed in the case of pre-service education and training of both health professionals and other health care providers. New technical information needs to be regularly incorporated into the curricula of schools of health technology and medical schools. As stated above, the role of the health care provider as health educator needs to be greatly expanded. Related to this is appreciation of the importance of the physician as role model to others in the health sector. This may suggest greater attention to the content of medical school curricula than would otherwise be warranted in the child survival effort. In each case, the active collaboration of professional groups and associations is essential for success.

Professional education must concentrate on leadership for health management based on epidemiologic surveillance since these skills are the basic essentials for planning and problem-solving which in turn are essential for sustainability. Training should take place in an African environment, and there is no substitute over time from building capacity at African Schools of Public Health. The new effort should consider, either as an integral part of ASCI-II, or perhaps more appropriately as a separate Africa Regional Project, the long-term institution building of and Anglophone and Francophone Schools of Public Health, in collaboration with other donors. Care must be taken that these schools do not attempt to emulate existing schools in the developed world, for most of these are not appropriate for basic public health education.

##### **ii. Continuing Education and Training**

In service training and continuing education should be comprehensive (available to all health workers at all levels); based on accurate and timely survey of needs; continuous (throughout the career of the health worker); coordinated to permit sharing of resources and minimize overlap; include the health worker in the planning and evaluation process; and, very importantly, be accompanied by an examination of the incentives (and penalties) related to putting the training into practice. This can only satisfactorily be accomplished by building the effort into the total child survival program, and not operated as a separate entity.

In addition, continued intercountry effort in the design of training materials and the exchange of experience should continue to be supported by the new program in collaboration with WHO.

### **7. Managing Resources**

#### **a. Health Care Financing**

The ACSI/CCCD project identified the issue of financial sustainability from the

beginning, but the focus was largely limited to government budgetary allocation and fee-for-services. With the increasing attention to sustainability during the life of the project and with the advent of the REACH project additional work was done in almost all countries on cost analysis. What is needed over the next decade is a more comprehensive view of country-specific financial strategy as part of each major program.

In general, there is the assumption, which is corroborated by several research findings, that preventive and primary health care strategies represent cost-effective technologies as compared to in-patient hospital care. There is little reason to believe that this is not indeed the case. On the other hand, even the expansion of activities which are highly cost-effective is financially difficult in the policy, and managerial context makes it very difficult to diminish funding of some health activities in order to more adequately fund others. It is almost impossible in the deteriorating economic conditions of many African countries in which ministries have recently experienced decreased funding levels.

This harsh reality has similarly affected the ability of public health facilities to provide services. Serious shortages of fuel, vehicles, equipment, and supplies frequently arise as upwards of 80-90% of budgets must be expended for payment of salaries.

Until recently, it was commonly held that only two sources of funding were ideologically acceptable to African governments--direct government appropriations for health services and donor support--while two other sources were tolerated: in-kind health services provided by charitable agencies and fees for service by private practitioners. It had been considered that public funding comprised the great majority of expenditures for health. Within the past decade, two factors have become clear. The first is that non-governmental expenditures for health comprise a greater portion of total funds than previously thought and the second, deriving from the first, is that an astonishing variety of health financing patterns exists already in African countries.

The elements of a financial strategy would cover the following:

- analysis of foreign exchange requirements specifically within the program, how they can be increasingly met by countries in light of assumed macroeconomic performance and realistic residual role likely for foreign donors; also review of foreign exchange saving technologies and adaptation where appropriate;

- focus analysis of financial sustainability not just on ASCI-II interventions but on primary health care delivery system of which they are an integrated part;

- continuing careful analysis of cost and structure of costs and experimentation with lower-cost alternatives; periodic transfer of experiences among countries;

- fee-for-service is reality in most countries, but study greater differentiation between percentage of costs paid for ORT and malaria (higher because of curative element involved) and immunization and child spacing (lower because of dimension of social benefit); review of price elasticity of specific services and impact of fees on indigent;

- experimentation and review of experience with forms of prepayment and health insurance schemes;

encourage greater effort by other donors, especially the World Bank in the whole area of rational health care financing.

Another major concern influencing child survival projects in Africa is that of efficiency in the use of resources made available for these purposes. There is general agreement that preventive and primary health care services are relatively cost-effective in comparison to other ways that health resources may be expended. There are wide variations in the efficiency of various alternative program configurations available for the delivery of such services.

ACSI/CCCD has conducted studies, some with REACH, that document the wide range in values which exist between alternative delivery systems and sites within a given system in the cost to immunize a child, treat a dehydrated child or treat a fever case. Such studies are simple and inexpensive to perform; and although these findings take some economic sophistication to understand, the project has experienced little success in influencing policy or modifying delivery systems on the basis of "more bang for the buck." It appears that while African policy makers can consider alternative revenue sources, they do not yet equally appreciate the value of structuring the way resources are expended in order to maximize output. This is perhaps due to their appreciation of the difficulty in accomplishing change within their management constraints. Further progress is essential if resources are to be adequate to reach the most impoverished target groups.

A major policy issue that needs to be addressed in ACSI-II is that of foreign exchange. National governments annually expend foreign exchange for health sector equipment and supplies far in excess of those required for child survival services. The major concern with respect to sustainability is that of program managers competing effectively for a sufficient share of foreign exchange. That task is no different than any other management task in which managers must compete for budget, personnel, etc.

As stated above, ACSI-II should continue to address the area of alternative financing systems and reexamine efforts designed to improve program efficiency, e.g., consider ways to better turn attention of national colleagues to the relative costs and effects of alternative program mixes. This will best be accomplished as program directors gain management skills and experience and confidence in planning, implementing, and evaluating programs. ACSI-II offers an excellent opportunity to blend the techniques of epidemiology and health care economics, since both disciplines are based on quantification.

#### **b. Logistics**

The poor management of equipment, supplies and facilities adds greatly to the cost of health programs in Africa. In addition to continuation of important training programs in this area, operational research and experimentation might usefully be made of greater use of management contracts, greater emphasis of management and the maintenance of equipment and supplies in training of health personnel, greater use of contracting mechanism for the provision of supplies and services to MOH's, etc.

The demands on the drug supply of malaria treatment programs now and ARI programs in the future will be major problems. The Bomako Initiative of UNICEF, while described as a primary health care initiative, is perceived by most as a payment scheme for drugs, will further intensify the attention given to drug logistics. Malaria and ARI management is totally dependant upon adequate supplies of quality drugs. ACSI-II must develop assistance to countries in this area.

## 8. Health Information Systems

Health Information Systems in the ACSI/CCCD area has four major functions that should be emulated in future child survival projects. They are

- morbidity surveillance;
- mortality surveillance;
- health service monitoring;
- dissemination of information.

These have been implemented to a large extent in the countries where it is active along with computerization at the central level, standardization of reporting, and an overall assessment of the national HIS. This approach should be continued in ACSI-II along with efforts to

- improve the quality and quantity of morbidity reporting;
- further develop sentinel surveillance;
- adopt of the Brass-McRae technique as a routine mortality surveillance system and major tool for monitoring success;
- simplify KAP protocols and extend them to health facilities and health workers, as well as mothers.

## 9. Operational Research

The Commission on Health Research for Development, headed by Dr. John Evans and composed of leading authorities on development from both donor and developing countries, convened to comment on this subject. The Commission, in a draft report, concludes that operational research (which it calls Essential National Research) should be a prominent part of all national health sector development efforts and that international support is needed for: a) promotion and facilitation of national programs; b) overcoming resource constraints; c) information exchange and sharing of experiences; d) strengthening research capacity; e) tackling "transnational" problems; f) strengthening regional networks. ACSI/CCCD has been following these precepts and much of the success of the project has been as a result of the operations research conducted in Africa in conjunction with African investigators.

The continuation of a strong operational research component is essential to the continuing success of the project, but two aspects of this component should be emphasized:

expand the use of African institutions as collaborators in operational research.

separation of operational research of purely local interest from that of more general applicability and finance the former through the country program with regional support focussing on broader issues of intercountry priority.

Operational research has rightly been responsive to individual country issues. In the future ACSI-II should have a more structured ten year approach to operations

research. This will entail strengthening key African institutions, not only to conduct research, but also to manage research, so that there is greater involvement of non-academic institutions in identifying and solving problems. The model that has been developed in Nigeria of involving local expertise to identify problems, soliciting proposals and formal review is a demonstration of how this can be done. To date most of the operations research has involved the three interventions, malaria, EPI and CDD. It should be used for the other elements of child survival, including child spacing, maternal health, and increased emphasis on behavioral and social sciences as well as systems problems whose solutions can lead to improved management and sustainability. ACSI/CCCD has begun looking at the cost implications of individual interventions, and at the program as a whole. In addition, cost-benefit and cost-efficacy data will be important in determining whether or not new interventions, e.g. hepatitis B vaccination, will be introduced. Further research in this area must be stimulated and should be heavily supported by donors.

#### **10. Involvement of the Private Sector**

After years of difficult economic experience African governments today are more conscious of the limitations of government capabilities to provide goods and services for the population, and of the absolute necessity to encourage vibrant private sector activity. In the area of primary health care generally and child Survival specifically, this may take the following forms:

expanded role of private voluntary organization (PVO's) and non-governmental organizations (NGO's). Many of these will be church-related or community-based already involved in health; others (women's groups, employee groups, etc.) may not have health care as their primary function, but are in a position to influence behavior of members and may serve as a conduit for education and communications activities. PVO personnel should be included in project training activities.

careful exploration of social marketing potential in each project. Much can be learned from the experience in family planning programs. ORT and immunization must be seen from a demand-stimulation point of view with market research, incentives for key participants in the process, and carefully analyzed promotion and subsidy strategy. As with health education, social marketing must be done in conjunction with the child survival managers in order to assure that services are available in the market place; local production of key inputs, especially ORS when economically feasible and adequate quality control is available.

taking advantage of private enterprise especially through the encouragement of health clinics of private companies to offer certain services and through the dissemination of information and educational activities for employees.

more imaginative involvement of private practitioners through, for example, incentives for TBA's to be trained and to use the training received, reform of curriculum for physicians training, fuller involvement of medical associations, nursing groups, etc.

## 11. Ministry of Health Role

The role of African Ministries of Health must change over the next decade. On the one hand, they must play an expanded role. In the early stages of ACSI/CCCD, the MOH was frequently a passive partner in the development of child survival programs, both those financed by the U.S. and by other donors including the international organizations. The next decade must see a greater leadership role for the MOH, not only with the donor organizations, but as a force to marshal efforts of existing and potential child survival providers in the country.

This leads to the second change: MOH's not viewing themselves as the only providers of services, but rather as leaders and orchestrators of country-wide efforts involving many institutions and individuals. Government MOH's are the appropriate foci for leadership, but they are by no means the only entity involved in problem-solving or sustainability. They should be responsible for assuring their citizens of equitable quality, access, and appropriate health care as defined by the disease and socio-geographic environment. MOH's should not assume the role of sole provider. It must develop its capacity to maintain surveillance, not just of the disease, but also of the services provided so that it may take action when needed interventions are not being provided. In point of fact, the bulk of the delivery of child survival services are often by non-central government organizations - the private sector of NGO's, private practitioners, missionary groups, or district and local government units. The MOH must have the capacity to analyze incentives and impediments to other service organizations in child survival and act appropriately to change them. The MOH also cannot relinquish its responsibility for monitoring the quality of services (and drugs) provided in the non-governmental sector. Finally, the MOH must vigorously participate in discussion of non-health issues (agricultural policy, food subsidies, public works related to water supply, health education in schools, etc.) which directly affect health status of the country.

This multi-faceted leadership role of the MOH can be crystallized in the national child survival plan which brings all sectors together to delineate responsibilities and identify resources. The plan must be built around a strong problem-solving capability and a functioning epidemiologic surveillance system.

## 12. Country Selection

The need for assistance in Child Survival exists in virtually all sub-Saharan African countries, and the tragedy of needless infant and child mortality is no less in one than another. Still, limitations on AID's resources and management capabilities must necessarily limit its long-term involvement to a certain number of countries. Furthermore, selection of these countries will be based on factors in addition to need and country willingness and commitment to help itself. Several elements in approaching the country selection process are suggested by the foregoing:

there is a continuing rationale for selecting a number of countries for emphasis, but the distinction between so-called CCCD and other Child Survival programs has lost its usefulness;

in selecting countries for continuation, past historical investment should be an important criteria; past investment abandoned prematurely will have been wasted to some extent because sustainability will not have been built in;

AID in its role of policy dialogue and the U.S. as an influential member of the international donor organizations should encourage other donor leadership and coverage of Child Survival efforts in non-emphasis countries; it should also reserve some funds from both the Regional Support and S&T activities in the program to supplement on a short-term basis other donor efforts in some of the non-emphasis countries; it should also insure to the extent possible that even non-emphasis countries (even those with which there is no U.S. program) has access to information and experience generated from AID country and regional efforts.

### **13. Dialogue in Improving the Policy Environment**

As stated above, the U.S. must continue to play an active role in policy dialogue at both the country, regional, and world levels on Child Survival, and the project must make provision for drawing on the resources periodically of U.S. schools of Public Health, government agencies, private contractors, local and state agencies, and PVO resources for engaging in meaningful discussion of key issues. At the present time there are biennial meetings of the countries of Africa involved in the ACSI/CCCD project. It is currently attended by government agencies, contractors, and the international organizations. With little extra effort these meetings could serve both the technical function as now, and to act as a forum for policy dialogues with a broad range of experts.

### **14. AID Management and Administration of the Program**

As stated above the AID Africa Child Survival Program would be composed of the following elements:

#### **Country Projects in Child Survival**

An Africa Regional Child Survival Support Project which finances both an array of services available to country projects and other intercountry elements discussed below, and

S&T Bureau contracted services available to African countries and Missions in specific areas.

The AID role in the administration of the Child Survival Program includes the following:

providing Agency and Africa Regional guidelines for the design and development of country Child Survival projects and reviewing such programs for continuing conformity to the guidelines;

designing and implementing such projects at the country level in accordance with an national strategy;  
conducting policy dialogue at the country level and with other donors and international organizations (especially WHO, UNICEF and the World Bank) and with private foundations and voluntary agencies;

providing continuing dialogue and technical interchange with the U.S. academic community and others related to technical and institutional issues of Child Survival and periodically making such information available for use in country programs;

carrying out training, information interchange, and operations research of a regional and intercountry nature;

providing contractual services in key areas for use by country Missions.

evaluating overall program progress.

#### **a. Management at the Mission Level**

The implications of the country focus on Child Survival over the next ten years confront AID with a difficult managerial dilemma: institutionalization and sustainability require that program management of AID-financed inputs be almost totally at the country level, yet AID's cadre of Health Officers do not have resources necessary for the management required at the country level.

Perhaps the greatest single criticism of the present ACSI/CCCD project and of related Child Survival activities sponsored by the S&T Bureau (Pritech, REACH, Healthcom, etc.) is that Missions do not have a sense of "ownership" of the projects because so much of the initiative and decision-making is taken by the contractors in Washington. On the other hand, one can imagine that when virtually all managerial responsibility for implementation is assigned to the country Mission (as is being proposed in this paper) Missions will rightly argue that personnel resources are not adequate for the task.

Partial solutions to this problem may lie in one or a combination of the following:

greater use of a "lead institution" at the country level. This "lead agency" could be a U.S. school of public health, CDC or other public health agency or a private contractor. This "lead agency" would be responsible to the Mission for administering the project on behalf of AID including all buy-ins to regional and centrally funded contracts.

experimental use of TACS (Technical Assistance for Child Survival) authority under which personnel of the U.S. Public Health Service are authorized to fill USAID posts in the health field on the same basis as AID officers. Such officers must have the capability not only to oversee management of a complex assistance program but be able to carry out policy dialogue on behalf of the U.S. Government in the area of Child Survival.

#### **b. Management at the Africa Bureau Regional Level**

The AFR Bureau would have responsibility for issuing guidelines to the Missions on the design, initiation, and termination of Child Survival projects and to monitor and periodically evaluate such projects.

It would also have responsibility for a) providing through PASA or contract an array of services (particularly those related to the epidemiological surveillance system but not limited to that) upon which Missions could draw for support through buy-ins and which could be used on an occasional or start-up basis in countries where the Mission opts not to have a bilateral Child Survival project; b) supporting operational research, studies, evaluations, etc. related to improving methodology and technical quality of the program; c) supporting intercountry and regional training and development efforts where warranted (e.g. in developing health education materials, intercountry training programs, conferences, etc.); and d) supporting the development of regional or subregional centers of specialization in Africa, e.g. institutional development of an Anglophone and Francophone School of Public Health in Africa.

WHO, both at the Geneva headquarters and at the AFRO Regional level have an indispensable role to play in the fostering of Child Survival activities within the context of other primary health care activities in Africa. A commendable attribute of the ACSI/CCCD project has been its consistent support of WHO policies and guidelines (as well as the active scientific participation in the development of such guidelines) related to child survival. In spite of its glaring managerial weakness in the past, WHO/AFRO is likewise in a unique position to foster and promote intercountry exchange through training programs, intercountry conferences and the exchange of information. These intercountry elements should continue to be a prominent part of AID's continuing Child Survival effort, financed and administered from the Regional Support component of the program. A full-time U.S. health specialist should be assigned to WHO/AFRO to facilitate program coordination and implementation of intercountry activities.

A senior project Manager should continue to manage the program under the supervision of the Director of the Office of Health, Nutrition, and Population in AFR/TR.

#### **c. Bureau of Science and Technology Programs**

The contract activities of the S&T Bureau related to Child Survival have been of invaluable help in Africa as well as in other regions, and it is certain that without them Child Survival activities would be at a far more rudimentary stage in many African countries. In the early years of the effort, there were few initiatives originating at the country level, and without Washington leadership through the S&T Bureau (and through the Africa Bureau in the form of ACSI/CCCD), programs would not have been developed. Furthermore, the S&T-sponsored activities have provided and continue to provide an extremely useful mechanism to conduct strategic research and to improve the technical products being delivered.

That having been said, the very success of the S&T and AFR activities has resulted in ongoing country programs, some under ACSI/CCCD and some independent of ACSI/CCCD, which now have a momentum of their own that should be fully integrated into their individual country plans. Still, the similarity of contractual services needed makes it convenient to continue to provide some of these services through Mission buy-ins to centrally funded activities. Thus there will still be need for various Child Survival support projects (e.g. in CDD, EPI, Health care financing, Family Planning, etc.) into which Missions could buy, but the services provided would be almost totally to carry out country activities within the context of the country child survival strategy.

S&T, of course, would continue to provide contractual funding through world-wide projects for intercountry support and for technology development.

#### **d. Participating Institutions and Contractors**

##### **i. Peace Corps**

In those countries where Peace Corps is involved in Child Survival activities there has been widespread agreement of the usefulness of the collaboration between the two agencies.

Trained and dedicated Volunteers working with host country counterparts in several components of the program (especially health education, communications, training, and management) can have a major beneficial impact on the project. It is clearly

advantageous from AID's point of view, and likewise the resources available to the Volunteers to increase the impact and sustainability of their efforts make it desirable from the point of view of the Peace Corps. It is strongly urged that the new program contain an even expanded role for the Peace Corps including the preparatory training of Volunteers, orientation, periodic attendance at national and intercountry conferences, etc. In appropriate countries the Peace should be seen as a full partner with AID in the U.S. effort.

## **ii. WHO/AFRO**

In spite of weak management of WHO/AFRO in the early stages of the ACSI/CCCD effort, there is a high degree of consensus among African health officials, other donors, and professionals related to the AID Child Survival effort that WHO's role will be increasingly important in Africa, and that there is no realistic alternative to developing the capacity (and will) of WHO/AFRO to play a more effective leadership and coordinating role in the years ahead. The U.S. should support that in the following ways:

encourage AFRO to sponsor overall health planning advice to those countries needing such advice; such help could be used in the development of national child survival strategies;

help in expanding its health information function so that regional interchange of information can be speeded;

continued support in its intercountry training activities.

## **iii. Centers for Disease Control (CDC)**

The success and accomplishments of the ACSI/CCCD project thus far have been due in large part to the technical quality of services and the competence and dedication of personnel at the Centers for Disease Control and their close collaboration with AID, African health authorities and international agencies. The worldwide reputation of CDC has been an important "entree" for AID in its Child Survival programs to get the attention and priority of African governments as well as to allow the U.S. to play a serious role in policy dialogue related to technical interventions. A large and multidisciplinary backstopping staff in Atlanta combined with institutional continuity over the life of the project have facilitated responses to individual country priorities. The institution has provided a major resource for cross-country transfer of information, experience and training. With few exceptions, the quality of personnel fielded has been evaluated as highly effective. The CDC contribution has been particularly important in the development of epidemiological capabilities in country.

This is not to say that other institutions, given as prominent a role, would or could not be equally effective, but the institutional capabilities of CDC will likely be one of the most beneficial U.S. resources that AID can make available in Africa for Child Survival.

## **iv. Other Contractors and Participating Institutions**

As stated above, the centrally funded contractors (Pritech, Healthcom, Reach, etc.) have had a major beneficial impact on African Child Survival activities. The continuation of their role is important, albeit in a way which is more integrated

into country programs and under the clear leadership of the Project Manager for Child Survival in country. U.S. Schools of Public Health, state and local health authorities, and other private health contractors offer a wealth of resources upon which Missions can and should draw in carrying out their Child Survival activities over the next ten years. In each country, it is essential that every contractor work under the clear supervision of a single Project Manager.

#### **e. Technical Review and Quality Control**

Technical review and quality control is considered separately from evaluation. It is the process by which technical quality of interventions is kept under constant review. Child Survival as a global concept is too general for meaningful continuous technical review. That review is best provided as at present by the Technical Advisory Groups (TAG) related to the individual technical components (CDD, EPI, etc.). At the present time there are TAGs for both the AID supported centrally funded programs and for WHO specific programs. Frequently there is overlap in membership. AID should take leadership to determine if the WHO TAGs could not function for ASCI-II. This would be in keeping with the recommendation that evaluations be joint AID,WHO, and UNICEF. The WHO findings and recommendations are now regularly communicated to the country programs and the actual meetings rotate through the Regions.

#### **f. Implications for Contracting and Personnel Procedures**

Missions state that the buy-in mechanism, while theoretically of great use, is becoming as burdensome as signing separate contracts for each implementation activity. A large part of the rationale for the administration of a regional PASA or contract (as presently exists with CDC) and for the signing of global contracts by S&T is the administrative convenience these offer in contrast with each Mission's signing its own separate contracts. The buy-in mechanism should be thoroughly evaluated (perhaps to incorporate some of the advantages of the IQC mechanism) to try to preserve its theoretical virtues of simplicity and convenience. Greater management of country programs at the country level suggests as stated above exploring the imaginative use by AID of Public Health Service personnel to perform some of the project and program management functions now reserved to AID officers and for which AID is short of direct-hire personnel.

### **15. Program Coordination**

As stated above, AID's role in Child Survival is in two general forms: as a financer and implementer of specific projects and programs and as a major institution on the world stage affecting the policy environment and the role and activities of other institutions, particularly the international agencies like WHO, UNICEF, and the World Bank in which the U.S. is a member. Its influence in the latter forums is derived in large part from the wealth of technical talent at U.S. universities, CDC, and other U.S. institutions which enable AID to speak with a high degree of technical credibility. It must continue to play an active role in the coordination of Child Survival efforts in Africa.

#### **a. Country Level Coordination**

The principal operational unit for ASCI-II will be the country project, and it is here that principal coordination must take place. Effective coordination will be facilitated to the extent that a comprehensive national child survival strategy exists. This should be an identifiable section of the National Health Plan. Such a

plan should address the goal, targets, and objectives for Child Survival in that country, and should define the strategies which the country will carry out to reach those goals. The plan should show how the principal tasks are divided among donors as well as among principal groups, both public and private, within the country.

Periodic review of progress and problems in country and donor activities is greatly facilitated by the existence of such a plan. Such reviews should ideally be chaired by the country Ministry of Health or other appropriate official, with assistance provided as necessary by WHO. In some cases, this is not practical, and donors themselves will periodically coordinate their efforts under the leadership of a "lead agency". In fact, a fairly effective mechanism now exists in most countries, even if informal, and thus there is already a solid foundation upon which to build.

#### **b. Coordination Within AID**

A recurring complaint of existing activities relates to the independent action of some centrally-funded contractors in the Child Survival field financed by AID and beginning activities within a country outside of the control of the Mission and uncoordinated with another contractor working in the same country. To illustrate, it is possible to imagine S&T contractor X designing a training program for a particular group of health workers at the same time as contractor Y is designing training for the same audience. Operating independently, there is confusion, excessive costs, and obstacles to sustainability. Fortunately, Missions and contractors themselves coordinate now, but the Mission and the Project Manager in country will have the clear and unequivocal authority and responsibility to direct and orchestrate all U.S. activities taking place in the country.

The Africa Bureau and S&T should also design a mechanism for periodic coordination among contractors at the Washington level.

#### **c. Coordination by Intervention**

In many respects, there is good informal coordination among international agency specialists in specific technical areas: immunization, diarrheal disease, malaria, child spacing, etc. AID has performed an invaluable service through, for example, such mechanisms as its ICORT Conferences through which the exchange of information and experiences around a single technical area could be shared. As African countries and institutions gain more experience, this aspect of the program will become more important and more valuable. Provision should be made for continued AID support.

The existing mechanisms of ACSI/CCCD, including the biennial consultations and support to the WHO/AFRO regional technical consulting groups, should continue with an even greater emphasis on responding to country-specific needs for relevant information. This could be done by: including planning and management of child survival activities as a distinct component of the technical consultations and reviews process; elaborating with WHO/AFRO a specific timetable for the development of new or revised guidelines and policies covering specific child survival issues; developing an active linkage between the "knowledge gaps" identified in technical or policy reviews and the operations research activities supported in country.

The current WHO/AFRO epidemiological bulletin offers promise, but is too new to evaluate. Experience may show that it needs to be supplemented by a more practical newsletter in English and French which can inspire and prod national ACSI-II project counterparts in developing and sharing relevant information.

#### **d. Coordination on a Global Scale**

Under ACSI/CCCD, AID and CDC have done a good job of coordination both formally and informally with WHO, UNICEF, and other principal donors. This is in spite of the difficult experience with the CDA mechanism. There is a good foundation of institutional relationships upon which to build over the next ten years, including a more prominent role likely for the World Bank and increasing activity by UNDP. There is also increasing interest in Child Survival issues from the African Development Bank and UNFPA as well.

As stated above, it is essential to coordinate first of all at the country level, hopefully on the basis of an national strategy which guides all major donor programs in this field. Coordination and resolution of institutional friction at the agency level can usually best be effected at the regional director level. Consideration should be given to the establishment at the regional level of a mechanism to bring together WHO, UNICEF, USAID, and IBRD on the issues of Child Survival. While there are global level consultations among these agencies through the Task Force for Child Survival, there needs to be a linkage mechanism at the regional level. Such a mechanism would identify strengths and weaknesses of practical collaboration in individual countries as well as program-wide issues for resolution.

#### **16. Next Steps**

Following review of the parameters set forth in this paper, the next step would be the preparation of a PID for the Africa Regional Child Survival Program or possibly proceeding directly to a Project Paper which would describe in a general sense the individual country Project Papers, in detail the African Regional Support component to the Program (including regional contracts, intercountry components, and administration), and the general support to be expected from the S&T program elements.

### **III. FACTORS AFFECTING PROJECT SELECTION AND FURTHER DEVELOPMENT**

#### **A. Social Considerations**

The socio-cultural context of sub-Saharan Africa has been discussed and defined in many documents, books and projects. For the purpose of ACSI-II some of the pertinent changing contexts will be briefly described.

Many projects in the area have been targeted to the rural areas. Urbanization and the many health problems associated with it, will have become a major factor for the health systems of the area. Since major capital investments have been made in urban areas and qualified health personnel tend to remain in the cities, it is assumed that preventive programs will "happen" and program design has favored the rural area. Because of the paucity of all government services in rural areas, rural health programs have been one method of demonstrating governmental concern for this traditionally underserved population. Future efforts will have to focus more on assuring that preventive activities actually take place in the cities, and in particular the periurban slums that develop.

The project as described above will strengthen other development activities that improve the status of women. The health education efforts are primarily mother-education. Preserving the health of children in its self allows the mother to be a more total part of the community, since she is not tied to sick children. The child spacing efforts not only will result in healthier children, but healthier mothers.

The delivery of the preventive services proposed in ACSI-II will take advantage of indigenous practitioners and local distribution channels. For example, recognizing that the village market is the source of much of the medication, emphasis would be placed on assuring that that outlet have not only supplies but quality product; pharmacists will be trained in the case management approach to dehydration management; TBA's will become an important part of the neonatal tetanus eradication program.

### **1. Beneficiaries**

The total universe of beneficiaries are the 22 million babies born each year in sub-Saharan Africa. AID policy and country determination would determine the actual numbers involved.

### **2. Participation**

A primary aim of the project is to remove barriers to access to preventive services. A strong EIC component will serve to motivate both recipients and providers.

### **3. Socio-Cultural Participation**

Since this project is designed to follow on an existing and successful project involving the same populations, there is no reason to believe that any new barriers to participation will develop.

### **B. Economic Considerations**

As stated in the first page of this document, health is a necessary prerequisite to education and productivity. Childhood morbidity influences both the physical and mental development of the child, and the relatively minor costs of community based preventive services far outweigh the costs of treatment in hospital of dehydration or the complications of acute respiratory illness.

As part of the project economic studies will be conducted to lead to more cost efficient methods of operation. Central to the activities will be information systems that collect not only health information, but sufficient management information to do the above analyses.

### **C. Relevant Experience with Similar Projects**

ACSI/CCCD is a similar project and, as stated above, is the basis for the development of this project. The original project has shown the need for greater emphasis on developing sustainability, better involvement of Missions and more rational use of other AID funded projects. The design of this project has taken these and other considerations into account.

### **D. Recipient Country Agency**

It is anticipated that the Ministry of Health will be the recipient agency in all countries. This does not mean that the MOH will be the sole participant, but will function in the manner described in II D 5 above.

The role of African Ministries of Health must change over the next decade. On the one hand, they must play an expanded role. In the early stages of

ACSI/CCCD, the MOH was frequently a passive partner in the development of child survival programs, both those financed by the U.S. and by other donors including the international organizations. The next decade must see a greater leadership role for the MOH, not only with the donor organizations, but as a force to marshal efforts of existing and potential child survival providers in the country.

This leads to the second change: MOH's not viewing themselves as the only providers of services, but rather as leaders and orchestrators of country-wide efforts involving many institutions and individuals. Government MOH's are the appropriate foci for leadership, but they are by no means the only entity involved in problem-solving or sustainability. They should be responsible for assuring their citizens of equitable quality, access, and appropriate health care as defined by the disease and socio-geographic environment. MOH's should not assume the role of sole provider. It must develop its capacity to maintain surveillance, not just of the disease, but also of the services provided so that it may take action when needed interventions are not being provided. In point of fact, the bulk of the delivery of child survival services are often by non-central government organizations - the private sector of NGO's, private practitioners, missionary groups, or district and local government units.

The MOH must have the capacity to analyze incentives and impediments to other service organizations in child survival and act appropriately to change them. The MOH also cannot relinquish its responsibility for monitoring the quality of services (and drugs) provided in the non-governmental sector. Finally, the MOH must vigorously participate in discussion of non-health issues (agricultural policy, food subsidies, public works related to water supply, health education in schools, etc.) which directly affect health status of the country.

In addition the WHO Regional Office for Africa will be a recipient for regional training and information services, and UNICEF will continue to play a role in procurement.

#### **E. AID Support Requirements Capability**

To quote from II E

##### **Mission Level**

The implications of the country focus on Child Survival over the next ten years confront AID with a difficult managerial dilemma: institutionalization and sustainability require that program management of AID-financed inputs be almost totally at the country level, yet AID's cadre of Health Officers do not have resources necessary for the management required at the country level.

Perhaps the greatest single criticism of the present ACSI/CCCD project and of related Child Survival activities sponsored by the S&T Bureau (Pritech, REACH, Healthcom, etc.) is that Missions do not have a sense of "ownership" of the projects because so much of the initiative and decision-making is taken by the contractors in Washington. On the other hand, one can imagine that when virtually all managerial responsibility for implementation is assigned to the country Mission (as is being proposed in this paper) Missions will rightly argue that personnel resources are not adequate for the task.

Partial solutions to this problem may lie in one or a combination of the following:

greater use of a "lead institution" at the country level. This "lead agency" could be a U.S. school of public health, CDC or other public health agency or a private contractor. This "lead agency" would be responsible to the Mission for administering the project on behalf of AID including all buy-ins to regional and centrally funded contracts.

experimental use of TACS (Technical Assistance for Child Survival) authority under which personnel of the U.S. Public Health Service are authorized to fill USAID posts in the health field on the same basis as AID officers. Such officers must have the capability not only to oversee management of a complex assistance program but be able to carry out policy dialogue on behalf of the U.S. Government in the area of Child Survival.

#### AID Africa Level

The AFR Bureau would have responsibility for issuing guidelines to the Missions on the design, initiation, and termination of Child Survival projects and to monitor and periodically evaluate such projects.

It would also have responsibility for a) providing through PASA or contract an array of services (particularly those related to the epidemiological surveillance system but not limited to that) upon which Missions could draw for support through buy-ins and which could be used on an occasional or start-up basis in countries where the Mission opts not to have a bilateral Child Survival project; b) supporting operational research, studies, evaluations, etc. related to improving methodology and technical quality of the program; c) supporting intercountry and regional training and development efforts where warranted (e.g. in developing health education materials, intercountry training programs, conferences, etc.); and d) supporting the development of regional or subregional centers of specialization in Africa, e.g. institutional development of an Anglophone and Francophone School of Public Health in Africa.

WHO, both at the Geneva headquarters and at the AFRO Regional level have an indispensable role to play in the fostering of Child Survival activities within the context of other primary health care activities in Africa. A commendable attribute of the ACSI/CCCD project has been its consistent support of WHO policies and guidelines (as well as the active scientific participation in the development of such guidelines) related to child survival. In spite of its glaring managerial weakness in the past, WHO/AFRO is likewise in a unique position to foster and promote intercountry exchange through training programs, intercountry conferences and the exchange of information. These intercountry elements should continue to be a prominent part of AID's continuing Child Survival effort, financed and administered from the Regional Support component of the program. A full-time U.S. health specialist should be assigned to WHO/AFRO to facilitate program coordination and implementation of intercountry activities.

A senior project Manager should continue to manage the program under the supervision of the Director of the Office of Health, Nutrition, and Population in AFR/TR.

## **F. Estimated Costs and Methods of Funding**

### **G. Design Strategy**

It is important that design and implementation move rapidly. There is already activity in the field and an orderly process is essential so that the gains so far achieved will not be lost, and then restarted.

The technical elements of the project are well understood, and the interventions have been presented to an external group who did not dissent.

AFR must have the support and funding for:

- 1) training of regional significance;
- 2) operations research of regional significance;
- 3) evaluation of programs;
- 4) management of the PASA described below;
- 4) providing technical assistance to the Bureau.

The PASA with CDC has proven its value. The relationships between the two agencies have matured into a climate of mutual respect for the others abilities and responsibilities. The PASA should be renegotiated so that

Missions have the ability to use this for:

- 1) continuing management of existing child survival activities;
- 2) project design for new child survival projects;
- 3) start-up and continuing operation of new projects if in keeping with country plans;
- 4) specific technical assistance for which CDC has the expertise;
- 5) identification of other technical assistance.

The PASA should include provisions for the utilization of TACS positions by Schools of Public Health and/or Departments of Preventive Medicine and State and Local Health Departments through the provision of the Intergovernmental Personnel Act. This would provide particularly to academic institutions a stable source of support so that they would be able to provide needed technical assistance throughout the project period.

The PASA should state that in countries where the child survival activities are funded through the PASA, CDC will make maximum utilization of other AID funded contracts for specialized assistance, i.e., a right of first refusal by the centrally funded projects. The PASA should spell out that there should be semiannual meetings of the child survival centrally funded projects with the CDC to assure the best collaboration possible.

Simultaneously with the renewal of the PASA to guarantee continuity, the design described in this paper should be translated into policy guidance for the Missions. The Missions should be circularized to determine what actions they intend to take with child survival. In addition to participating in the PASA, the Missions would, of course, have the authority to develop a free standing bilateral proposal to be competitively bid.

The Missions would also be informed of the availability of TACS officers. These could be used in conjunction with the PASA or with a bilateral program, and may ease the administrative burden of the Mission.

## Evaluation Synthesis

This is an attempt to synthesize the results of 136 External and Internal Evaluations of the CCCD Country Projects. No attempt was made to directly question the countries for current information, and the synthesis and country evaluations are strictly on the basis of existing information. Probably no project has developed more objective evaluation information, but unfortunately the methods of collection and reporting varied from year to year and country to country.

In addition the past evaluations have been done to identify problems and to lead to improvement, rather than look at the current state of progress in relation to goals and targets. The evaluations have been more of a management review. This is not to say they have not been valuable, and in fact placing such frequent external review in the project cycle has led to the early identification of deficiencies and needs with their subsequent correction. The annual HIS reports of the project are models of meaningful reporting on progress and problems, and have been of the greatest help in preparing this report.

The CCCD project differs from many development projects in that there has always been an attempt to report numerically measurable goals and targets rather than process oriented outcomes. By doing this there is a danger that cause and effect relationships may be assumed when the outcomes are influenced by many factors other than those mediated through the project.

Infant and child mortality reductions are the consequence of social and economic changes as well as child survival technologies, e.g. improved transportation can lead to improved access to health services.

Improvement in the reporting and surveillance systems of a country may increase the numbers of cases reported, in spite of active prevention programs.

Social unrest such as war and famine even of short duration can temporarily reverse years of progress in health indices.

AID and CDC are to be commended for being brave enough to spell out these numerical goals and to hold themselves accountable for the efforts made to be even when the targets have not been achieved or when the goals have been too ambitious.

A few caveats are in order. The reviewers make the following statement:

- "1. The review process was evolutionary, in that the information which proved to be useful was not entirely obvious to the reviewers at the outset, and the sources from which to seek that information were not always clearly identifiable.
2. The information contained within the evaluation documents varied considerably, both across and within countries.
3. Much of the anecdotal/implied/"common" knowledge about country projects was not explicitly stated in the documents reviewed, therefore was not able to be included in the summaries or the synthesis.

4. The questions developed for the final synthesis had to be revised several times in order to extract specific, useful information which was also detectable in the country summaries. The process of extracting information for the synthesis was therefore quite rigid and resulted in a fairly small number of findings, but those findings were based on as accurate and reliable data as could be found."

The synthesis that follows has been organized in the following manner.

**EPI:**

1. Were targets established?
2. Were baselines established?
3. Were targets achieved?
4. Is there a national EPI policy?
5. What were outstanding successes or major obstacles?

**CDD:**

1. Were targets established?
2. Were baselines established?
3. Were targets achieved?
4. Were ORT demonstration units established?
5. Is ORS produced locally?
6. Do more than 50% of the (surveyed) population use ORS and/or SSS correctly?
7. Is there a national CDD/ORT policy?
8. General conclusions/obstacles to progress.

**Malaria:**

1. Were targets established?
2. Were baselines established?
3. Were targets achieved?
4. Is there a national Malaria policy?
5. What were outstanding successes or major obstacles?

**Training:**

1. Were targets established?
2. Was a needs assessment conducted?
3. Were targets achieved?
4. Were training activities/participants followed up?
5. What were outstanding successes or major obstacles?

**Health Education:**

1. Was a needs assessment conducted?
2. Was a mass media campaign carried out?
3. What CCCD programs did campaign(s) address?
4. Was health education follow-up reported?
5. Are CCCD health education materials institutionalized?
6. Did the MOH have a Health Education Unit?
7. What were outstanding successes or major obstacles?

**HIS:**

1. Were targets established?
2. Is the HIS computerized?
3. Is the HIS decentralized?
4. Is there a morbidity/mortality data base?
5. Is information disseminated?
6. General comments, outstanding results, major obstacles.

**Operational Research:**

1. Were targets established?
2. How many OR studies have been completed during LOP?
3. Have OR results impacted policy/practices?
4. Which CCCD programs have been studied?
5. Are there guidelines for conducting OR?
6. Was an OR review board established?
7. General comments, outstanding results, major obstacles

**Cross-Cutting (Supervision & Sustainability):**

1. Is there a supervision strategy?
2. Is there a cost-recovery mechanism in place?
3. Has the host government kept up with its contributions?
4. What are outstanding success or major obstacles?

**Program Management:**

1. Were CCCD workplans developed? For which components?
2. Do CCCD coordinators exist for all programs?
3. Have committees been formed (all types)?
4. Has the CCCD project been integrated into the PHC system?
5. Has the CCCD project established/improved the procurement or distribution system?
6. General comments, outstanding results, major obstacles

If this approach is considered in the future, it would be more meaningful, both to the evaluators as well as to the countries, to develop the questions that want answers and then have the project staff in country provide the answers. This would lead to uniformity and by providing back to the countries the consolidated data would serve as a learning exercise.

An intangible accomplishment that does not fit the matrix is the self confidence that has been generated in the country coordinators and program directors. This has been commented upon by several people who cite the ability to make excellent presentations in international meetings, such as the WHO TAG and SAC meetings as well as I-CORT. The leadership from CCCD countries are recognizable by their abilities in these fora.<sup>1</sup>

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<sup>1</sup>Detailed analyses on a country by country basis are found as an appendix.

## **EXPANDED PROGRAM OF IMMUNIZATION**

### **Were targets established?**

Coverage targets were established in twelve of the thirteen countries and morbidity or mortality targets in ten. In the early years of the project, the targets were overly ambitious and not all countries revised their targets in the light of realities. (However, it is better to overstate the target than establish a goal that does not strain the system.)

### **Were baselines established?**

Baselines were established in twelve of the thirteen countries

### **Were targets achieved?**

Targets were achieved as follows<sup>2</sup>:

BCG	9/12	
DPT1	7/12	(used as a surrogate marker for access)
DPT3	6/12	(used as a surrogate marker for effectiveness)
Polio1	8/12	(shows consistency with DPT, an indication that
Polio3	6/12	countries can provide appropriate coverage without campaigns)
Measles	5/12	(most recent vaccine added to programs)
TT2	5/12	

In addition to evaluating on the basis of target achievement, overall coverage is another indication of effectiveness of the programs. Figures 1, 2, and 3 show by country the level of protection against measles, the level of DPT1 which is a surrogate for accessibility, and the comparison of DPT1 and DPT3 in those countries where comparable data are available.

### **Is there a National EPI Policy?**

National Policies have been documented in ten of the thirteen original countries (Figure 4.).

### **What were the outstanding successes or major obstacles?**

The EPI efforts have been the strongest of the interventions, having built on the measles-small pox programs of the past.

The levels of coverage have undoubtedly lowered the incidence of polio and probably measles in several countries. This is difficult to prove because of the lack of surveillance systems. Although overall reporting of the diseases has improved, it is far from total, and without completeness or special studies this is difficult to document. Operations research studies such as the case control study of polio that being conducted in Zaire are necessary to determine the actual effectiveness of programs.

EPI is not completely incorporated into the primary health system of all countries. Until vaccines are developed that are not dependant upon continuous refrigeration or until there is refrigeration more universal than at present, immunization programs will be highly dependant upon logistics and transport. This latter is a major obstacle for the EPI intervention.

Another major obstacle is the difficulty in immunizing women of childbearing age against tetanus. Multiple cultural factors involving religion and the role of women are involved as well as the logistic problems.

National Immunization Campaigns remain a problem. They succeed in focusing national populace and political interest on immunization, but they detract from the orderly development of sustainable programs. In several countries there have major diversions of personnel and resources from other CCCD activities. In Cote d'Ivoire, for example, high levels of single dose vaccines such as measles or DPT1 were achieved through campaigns, but at great disruption to other CCCD activities. In countries with well established PHC programs providing EPI services, e.g., Lesthoto, the National Campaign approach added to already high levels without distracting too much from on going efforts.

# Measles Immunization

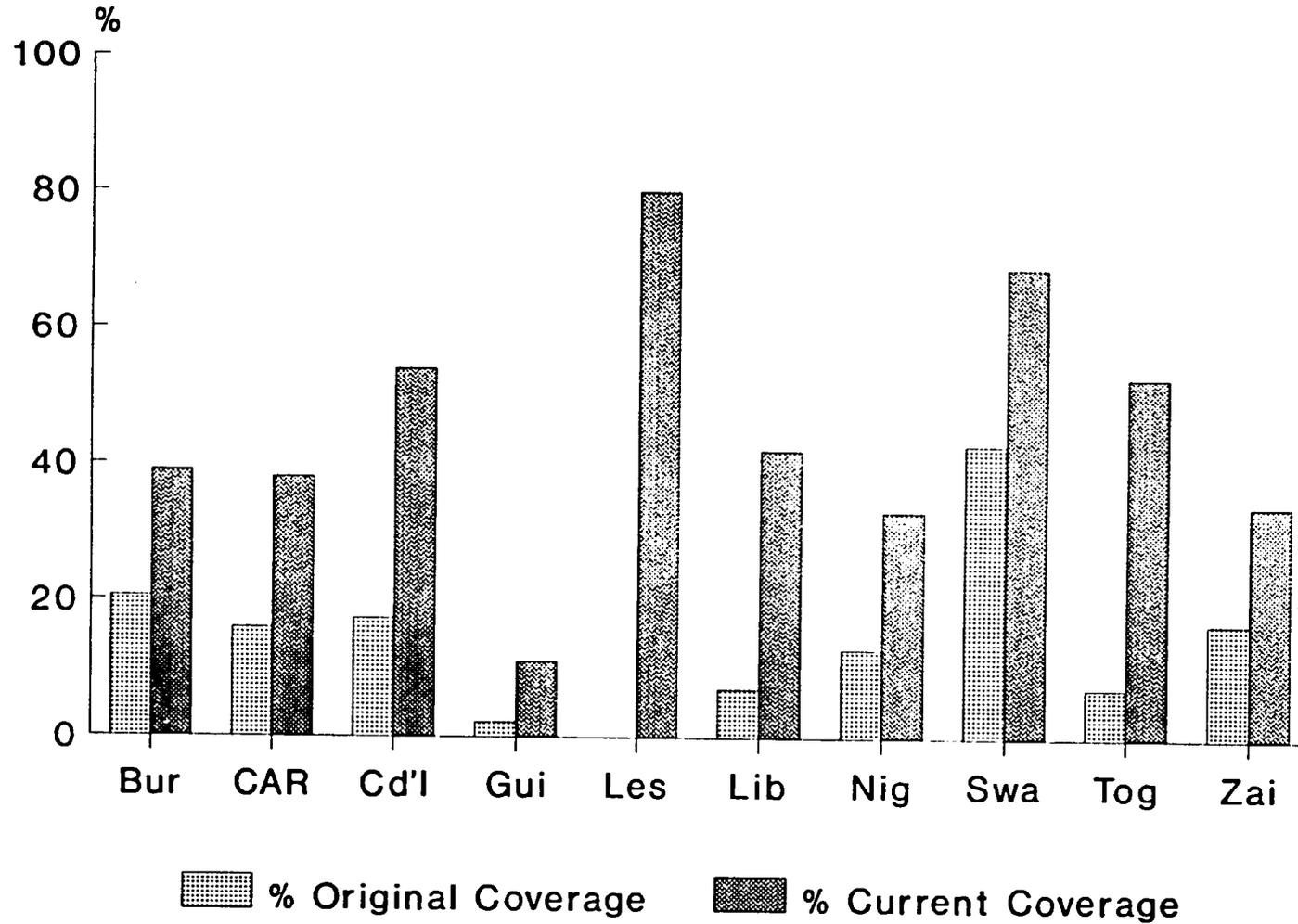


Figure 1

# Access DTP 1

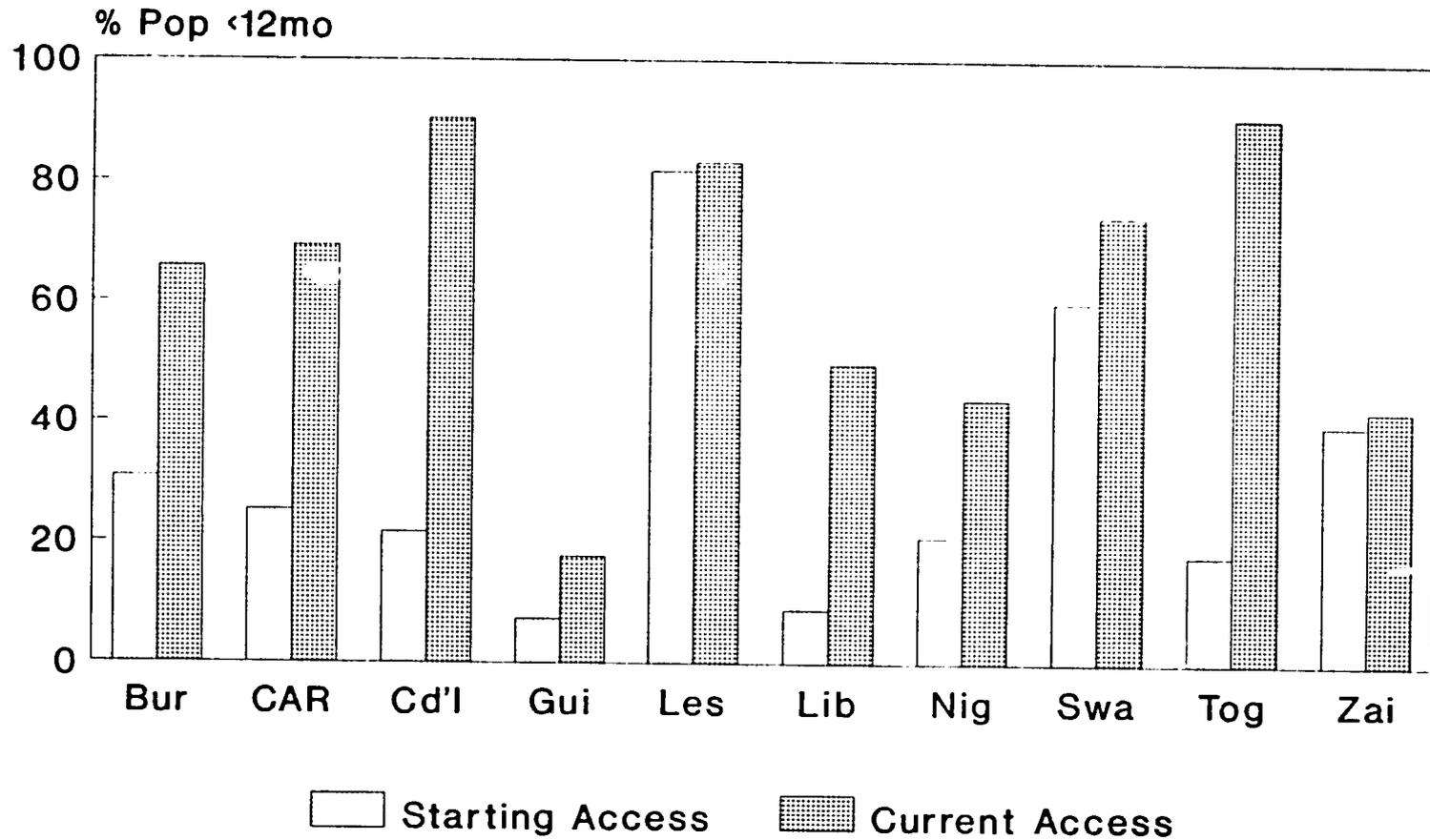


Figure 2

# DPT COMPLETION

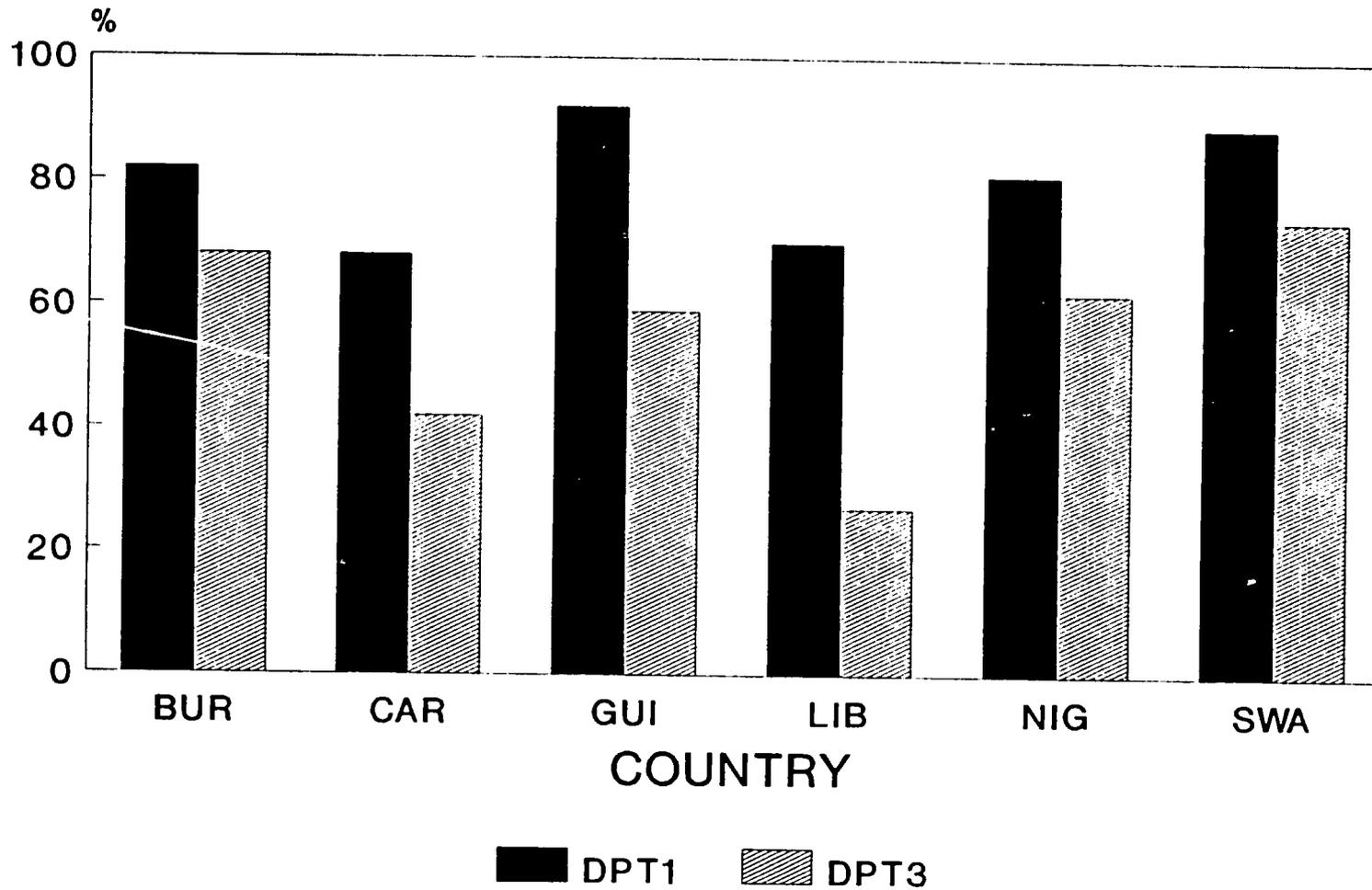


Figure 3

For countries with comparable data

FIGURE #4

	BUR	CAR	CON	CDI	GUI	LES	LIB	MAL	NIG	RWA	SWA	TOG	ZAI
EPI POLICY	Y	Y	Y	N	Y	Y	Y	Y	N	Y	Y	Y	N
CDD POLICY	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N
MAL. POLICY	Y	Y	Y	Y	Y	na	N	Y	Y	Y	Y	Y	Y

## **CONTROL OF DIARRHEAL DISEASE**

### **Were targets established?**

Clearly defined targets were established in all countries but one. The targets for the most part initially concerned reducing mortality. This was in keeping with the WHO program, yet experience gained during the project showed the difficulty in measuring this on a national basis. Emphasis in more recent years has been on targets that relate to appropriate use of ORT/SSS both at home and in facilities.

### **Were baselines established?**

Baseline data was collected in five countries at the start of the project and in seven more during the course of the project. The baseline information ranged from sampling surveys to determine incidence of diarrheal disease and estimate mortality to surveys of pharmacy practices to a review of plans and policies. The changes in targets and baseline determinations that have taken place during the project are in keeping with changing international practices.

### **Were targets achieved?**

Seven countries reported decreases in hospital case fatality rates; one no change. The other five made no mention. In nine countries where reported usage rates could be determined seven achieved or exceeded the targets. Few attempts were made to determine overall impact on mortality, since identifying cause and effect is difficult if not impossible to accomplish.

### **Were ORT demonstration units established?**

ORT training Units were established in all countries but Congo.

### **Is ORS produced locally?**

ORT is locally produced in five of the thirteen countries, but in the two most populous countries, production is either inadequate or disrupted.

### **Do more than 50% of the surveyed population use ORS and/or SSS correctly?**

In the six countries where determination of correct mixing and use of ORS/SSS could be made surveys showed that in four countries mothers mixed ORT correctly and in only one mixed SSS correctly.

### **Is there a national CDD/ORT policy?**

In eleven countries a CDD plan or program has been adopted. Specific mention of a policy on ORT is made in documents for five countries.

### **General conclusions/obstacles to progress.**

A major accomplishment has been the high level of use of ORT in health care facilities, replacing IV fluid management of diarrhea. (see Fig. 5) The use of ORS in homes is less well documented, but where it has been documented the usage is low and the ability to properly mix either ORT or SSS is lacking. Two reasons for this are 1) the lack of strong health education programs in many of the countries from the beginning, and 2) increasing leadership confusion over the best way to proceed. This is not confined to the CCCD countries but is a global issue. The initial enthusiasm for ORT/SSS is waning and being replaced by increasing emphasis on feeding and using home based solutions. Education aimed at prevention is still in its infancy.

# ORT USE IN FACILITIES

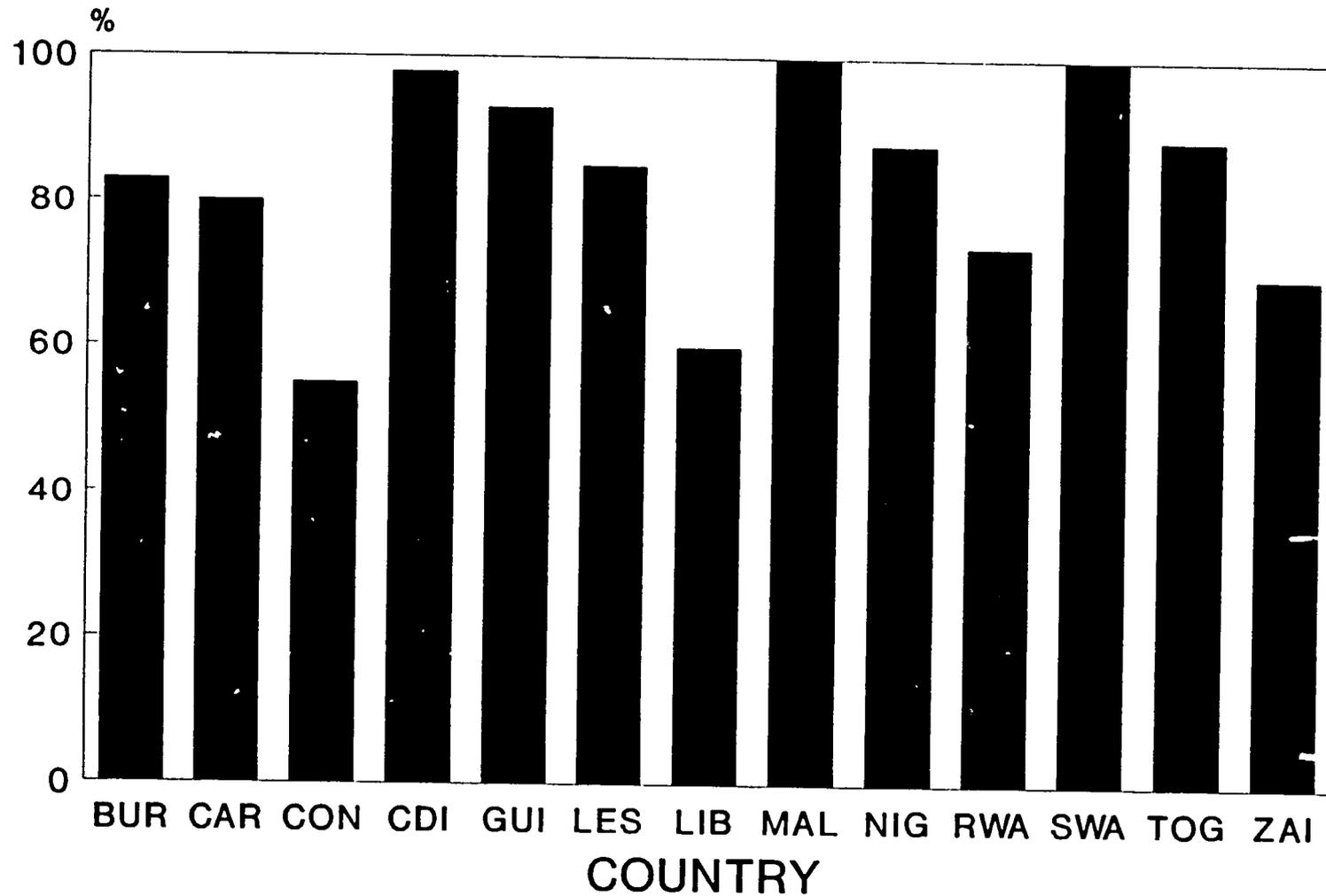


Figure 5

Most recent data

## **MALARIA**

### **Were targets established?**

Twelve of the countries are malarious. All except Rwanda established targets.

### **Were baselines established?**

Five countries have established baselines. To be meaningful, these baselines have related to provision of correct service rather than morbidity or mortality.

### **Were targets achieved?**

In most of the countries the targets were established in the too recent past to be evaluated on achievement. In Liberia, however, where targets were established in 1983 they have been exceeded. In many instances the targets included reduction in mortality from malaria that will be difficult to document except by sampling techniques.

### **Is there a National Malaria Policy?**

All malrious except Rwanda established National Policies or Plans.

### **What were the outstanding successes or major obstacles?**

The outstanding success in malaria has been the establishment of plans and policies for malaria with the emphasis on preventing childhood deaths. These plans and policies have been developed on the basis of information derived from operational research and surveillance conducted through the CCCD project and concurrent AID supported research in Africa. Malaria control activities throughout the world have been lacking in clear focus for several years, and the leadership developed in this project has stimulated concern for malaria and lead to the redesign of programs throughout the world.

## **TRAINING**

### **Were targets established?**

Targets were established in all countries. In nine the targets were quantifiable and in four were more general.

### **Was a needs assessment conducted?**

In only three countries were formal needs assessments documented.

### **Were targets achieved?**

Ten countries met or nearly met all objectives. In the three remaining achievements could not be determined from the documents available. Since much of the reporting is in terms of numbers of trainees, it is difficult to match this to needs, since turn over cannot be determined.

### **Were training activities/participants followed up?**

In only two countries were the results of follow-up documented. Performance of trainees was the method of follow-up. Supervisory evaluations were not routinely linked to previous training.

### **What were outstanding successes or major obstacles?**

A major obstacle has been the lack of an overall plan for training. This then is reflected by a lack of needs assessments, and the conduct of training on a piecemeal basis. The emphasis has been at the supervisory and basic health worker level and insufficient attention paid to training of the leadership in overall program management skills. This disproportion has been appropriate in the start-up phase where emphasis is on accomplishment but with maturing of projects, the sustainability will depend on strengthening the managerial skills of the program directors.

A major success has been in the numbers of individuals trained. In addition to the in-country training this has required close coordination with the WHO Regional Office in Brazzaville which is a major supplier of AID supported training.

An obstacle has been assuring that high enough priority is given to training when training is measured against other demands for resources, particularly transport.

## **HEALTH EDUCATION**

### **Was a needs assessment conducted?**

In only three countries were needs assessments carried out. This is probably the reason no targets were established for health education. An obstacle for evaluating the effectiveness of health education activities is that such do not function for themselves, but must be part of and support to health programs. Health education in support of combatting childhood diseases is integral to the interventions and needs of the total program must be addressed.

### **Was a mass media campaign carried out?**

Mass media campaigns were carried out in at least eight countries: six in EPI, one in CDD and two in malaria. The EPI campaigns were in support of National Campaigns and integral to their success. Yet in one The paucity of CDD campaigns is in keeping with the status of the approach to case management. The media will improve recognition of the problem, but face to face communication is important in gaining understanding.

### **What CCCD programs did campaigns address?**

See above.

### **Was health education follow-up reported?**

There is documentation of follow-up activities in seven countries. The purpose of the follow up was to assess the impact that health education had, e.g. in the Central African Republic such an evaluation led to the development of a new training module to use in in service education.

### **Are CCCD health education materials institutionalized?**

In five countries mention is made of activities that would indicate institutionalization of the activities: incorporation into curricula or as part of basic PHC. This is difficult to measure since it only indicates activity not outcome.

### **Did the MOH have a Health Education Unit?**

Ten countries reported having Health Education Units.

### **What were outstanding successes or major obstacles?**

Major successes in the media and mobilization area were in countries with successful National Immunization Day campaigns. This, however, must be weighed against the disruption to orderly program development that these cause. Another major obstacle to full utilization of health education in the broadest sense is the multitude of languages that exist in many countries. Here close collaboration between health education and training is necessary since diffusion through training of trainers is essential. In only three countries is mention of made utilizing the talents of HEALTHCOM, and Peace Corps Volunteers were used in four.

A major obstacle in evaluation is the lack of output indicators.

## **HEALTH INFORMATION SYSTEMS**

### **Were targets established?**

In all countries except Rwanda and Zaire objectives have been stated, some more quantifiable than others, ranging from "computerize the HIS," to "establish thirty surveillance sites," "establish regular CCCD Newsletter by 1985," "train 15 statisticians"

### **Is the HIS computerized?**

In at least ten of the countries computerization has taken place with training of personnel to operate systems.

### **Is the HIS decentralized?**

Decentralization is to a certain extent dependant upon the relative decentralization of the health system. Effective decentralization of HIS would mean that the information was being used to make decisions away from the national center. However, the recognition of the need for decentralization can be measured by the establishment of comprehensive sentinel surveillance sites which has taken place in five of the countries. However, in certain countries with a limited number of facilities, total coverage in contrast to sentinel is being practiced. The most decentralized of the countries is probably Nigeria, but there the HIS system is being hindered by the insistence that one all inclusive record be developed which is likely to overwhelm any system as far as analysis and decision making is concerned.

### **Is there a morbidity/mortality data base?**

Data bases exist in some form in all countries. The question should be how representative are they of the actual morbidity and mortality situation in the country. This has never been looked at in a uniform quantitative manner. In none of the evaluations is there an indication of the extent that the data bases are used in the decision making process. In one country a measure of success was the reduction of the number of reportable disease from 90 to 40! In another country where the HIS has succeeded in reducing the number of reportable conditions to 12, when program support was withdrawn, the number climbed back to 60.

### **Is information disseminated?**

Routine dissemination of information in the form of newsletters or bulletins occur in at least five of the countries. An observation made in several instances was that lack of personnel or funds prevented this from happening. This reflects a lack of recognition that if the central government expects the periphery to report, they must share the consolidated information with the providers.

### **What were outstanding successes or major obstacles?**

A major obstacle has been the fact that prior to CCCD most information collected on morbidity was hospital based and included all service statistics and was not current. The control of communicable diseases does not need this much information, but needs information upon which action will take place and needs it in a timely manner.

## **OPERATIONAL RESEARCH**

### **Were targets established?**

Five countries established numerical targets for operational research projects. Three met or exceeded the target and two almost reached the target. Three countries did not set targets.

### **How many OR studies have been completed during LOP?**

1-5 studies	6 countries
6-10 studies	2 countries
11-15 studies	2 countries
16+ studies	3 countries

### **Have OR results impacted policy/practices?**

OR studies have been the most useful method of changing and/or establishing malaria plans and policies in five countries. In Nigeria OR studies have been a useful way of involving the academic sphere with the practical problems of public health.

### **Which CCCD programs have been studied?**

Malaria studies have been conducted in nine countries; EPI studies in eight; CDD in five and cost recovery studies in four countries. Operational research techniques have been used to develop KAP instruments and in this way have brought the social scientists into the health arena.

### **Are there guidelines for conducting OR?**

Six countries have published guidelines for operational research, using these as a method of stimulating local interest in the problems of CCCD.

### **Was an OR review board established?**

Operational review boards have been established in 6 of the countries and function not only as reviewer but provide consultation to others to improve their study design.

### **What were outstanding successes or major obstacles?**

A major obstacle in many countries is the lack of persons trained to conduct the studies needed. Those who are trained are so overburdened with program direction that they have little time for research.

PRICOR and REACH have both been involved in the OR research in four countries.

In spite of this the fact that six countries have guidelines and five have a review panel is a major success. This is in contrast to the WHO experience where they have had no response from countries to an announcement that funds were available for problem solving research.

## **CROSS-CUTTING ISSUES (SUPERVISION AND SUSTAINABILITY)**

### **Is there a supervision strategy?**

Supervisory strategies were documented in eight countries and check lists were used in seven. In the latter years of the project more attention has been paid to using supervisory visits as training opportunities rather than auditing. The program being developed in Nigeria for supervisory training is a good case in point.

### **Is there a cost recovery strategy?**

Surprisingly cost recovery strategies are in place in nine countries. None of these will fully cover the program costs, particularly cost of vaccines, but it is an indication that countries are being encouraged to begin thinking in terms of increasing sustainability.

### **Has the host government kept up with its contributions?**

From the available information four countries have maintained their planned contributions, while five have made contributions, but not to the level planned in the original project agreement. One country, Congo, was defunded because of total lack of effort to make contributions.

### **What are the outstanding successes or major obstacles?**

A major obstacle to sustainability will be the cost of off shore procurement. A lack of sufficient trained leaders is another major problem. Too frequently the trained national leader has to devote time to a multitude of programs that were not anticipated at the onset of the project, AIDS being an important example.

## **PROGRAM MANAGEMENT**

### **Were CCCD workplans developed? For which programs?**

National CCCD workplans exist in only four of the countries. This is an indication that the interventions for the most part have been initiated at different times and there is a lack of internal coordination. On the other hand workplans and/or policies have been established for the individual interventions (see Fig. 4). Seven countries have training and health education work plans.

### **Do CCCD coordinators exist for all programs?**

CCCD coordinators exist in all countries. In Nigeria the Federal CCCD coordinator is also the Director of Primary Health Services, leading to better integration of services. In all countries the CCCD coordinator also has the responsibility for EPI. In addition eight CDD coordinators are documented as are three for malaria. The title and responsibilities for individuals responsible for the functional aspects vary.

### **Have committees been formed?**

See below.

### **Has the CCCD project been integrated into the PHC system?**

In three countries all aspects of CCCD are reported to be integrated into PHC; four countries report integrations of EPI and three of CDD.

### **Has the CCCD project established/improved the procurement or distribution system?**

In eight countries the documents indicate that there are identifiable procurement and distribution systems for the CCCD project. However, it is universally documented that there are major problems in this area. Lack of transport and inadequate controls of products are of major concern.

### **General comments, outstanding results, major obstacles?**

Throughout the project a major problem has been the coordination of country and donor inputs. While this varies from country to country it should be improved everywhere. This lack of effective coordination is not limited to country programs, but to headquarters as well. In the beginning there was talk of coordination between bilateral donor agencies, but this rapidly deteriorated. Technical coordination with WHO has been strengthened in recent years, but relations with UNICEF remain a problem, particularly as it relates to the campaign approach to primary health care activities.

Countries are committed to the CCCD project, in nine there have been extensions, and in two of the three countries where the project has been terminated, the Ministries want the project reinstated.

**INTRODUCTION TO CCCD EVALUATION SUMMARY AND SYNTHESIS**  
August 1, 1989

**Evaluation Team and Session Participants:**

**USAID:** Myra Tucker, Mary Ann Micka, Gary Merritt, Randy Roeser,  
Peggy Meites, and Alan Getson  
**MSH:** David Sencer, Judy Seltzer-Stewart\*, and Michelle Volpe\*  
**CDC:** Rita Malkki\*

\*=reviewers

**DIRECTIVE:**

Review CCCD evaluation documents and official project documentation (i.e., Country Assessments, Project Grant Agreements, Internal and External Evaluations, Extension Designs, Annual MIS Reports, and CDC Annual Reports) for the extraction of pertinent data.

**METHODOLOGY:**

Introduction

The CCCD evaluation synthesis was the culmination of several steps, including: the design of a document review instrument; the review process, which included the assignment of CCCD countries to the reviewers to prepare country project summaries; the evaluation synthesis, which entailed the formulation of questions applied to the country summaries to uniformly integrate select information into the evaluation synthesis; and a series of four monitoring sessions (with representatives from the CDC, AID and MSH) to evaluate progress at appropriate intervals.

The Document Review Instrument

The document review instrument was designed by committee at AID/Washington into a matrix format and modified slightly by the reviewers. The resultant matrix was applied using a series of questions, categorized as Plans, Outcomes, and Conclusions, to the various CCCD project components, including EPI, CDD, Malaria, Training, Health Education, HIS, Operations Research, Sustainability and Supervision, and Program Management. The document review instrument was used to review and summarize documents specific to each of the CCCD countries.

The Review Process

Three reviewers were contracted to review the CCCD project documents for thirteen African countries. All project documents were reviewed in chronological order, beginning with the Country

Assessment and finishing with the Extension Design or most recent External Evaluation. An effort was made to maintain strict objectivity while reviewing the documents and completing the review instrument; the reviewers adhered closely to the questions outlined in the matrix and were careful to not extract information that did not pertain directly to the specified categories, nor to interpret any information found in the documents. All thirteen CCCD countries were reviewed and summarized over the course of five weeks. The initial seven countries reviewed were Zaire, Togo, Rwanda, Malawi, CAR, Lesotho, and Burundi. Zaire and Togo were selected as the first countries for review because they had the oldest CCCD projects; Rwanda and Malawi were chosen for their highly successful CCCD projects, despite not being extended; and the remaining countries were chosen as most representative of the majority of the country projects.

### The Evaluation Synthesis

The synthesis process began upon completion of the country summaries. The initial step in the evaluation synthesis was the formulation of a series of questions that could be applied to each of the CCCD countries for the uniform extraction of information (refer to attached list of questions). The reviewers attempted to extract primarily quantitative information which was common to most or all of the country summaries. In addition to key quantitative information, qualitative information highlighting obstacles to progress and outstanding CCCD project features or accomplishments was included. The evaluation synthesis was then completed by compiling all of the information extracted from the country summaries using the same matrix format applied to the individual country reviews (the document review instrument).

### The Monitoring Sessions

Four monitoring sessions were conducted during the course of the review. During the first monitoring session, which occurred after the initial seven countries had been summarized, reviewers presented and received feedback on four of the seven countries from the AID staff and the CCCD Project Coordinator. Written comments on the remaining three country summaries were later received from those present at the initial monitoring session. The summaries were revised according to recommendations from the session and presented in a session with the AID staff, Dr. Dave Sencer of MSH, and Myra Tucker. The third monitoring session took place upon the completion of the CCCD project summaries and elaboration of the evaluation synthesis. During this session, the synthesis matrix was presented and discussed by the reviewers and AID representatives. Recommendations were incorporated into the final draft of the evaluation synthesis, which was presented at MSH headquarters in Boston. In general, the monitoring sessions were highly constructive and facilitated the evaluation procedure without altering the approach taken by the reviewers.

## REVIEW SESSION PARTICIPANTS:

- I. Myra Tucker, Gary Merritt, Mary Ann Micka, Randy Roeser, Michelle Volpe and Rita Malkki
- II. Myra Tucker, Dave Sencer, Mary Ann Micka, Michelle Volpe and Rita Malkki
- III. Myra Tucker, Randy Roeser, Alan Getson, Peggy Meites, Judy Seltzer-Stewart and Rita Malkki
- IV. Myra Tucker, Dave Sencer, Michelle Volpe, Judy Seltzer-Stewart and Rita Malkki

## QUESTIONS FOR SYNTHESIS:

### EPI:

1. Were targets established?
2. Were baselines established?
3. Were targets achieved?
4. Is there a national EPI policy?
5. What were outstanding successes or major obstacles?

### CDD:

1. Were targets established?
2. Were baselines established?
3. Were targets achieved?
4. Were ORT demonstration units established?
5. Is ORS produced locally?
6. Do more than 50% of the (surveyed) population use ORS and/or SSS correctly?
7. Is there a national CDD/ORT policy?
8. General conclusions/obstacles to progress

### Malaria:

1. Were targets established?
2. Were baselines established?
3. Were targets achieved?
4. Is there a national Malaria policy?
5. What were outstanding successes or major obstacles?

### Training:

1. Were targets established?
2. Was a needs assessment conducted?
3. Were targets achieved?
4. Were training activities/participants followed up?
5. What were outstanding successes or major obstacles?

### Health Education:

1. Was a needs assessment conducted?
2. Was a mass media campaign carried out?
3. What CCCD programs did campaign(s) address?
4. Was health education follow-up reported?
5. Are CCCD health ed. materials institutionalized?
6. Did the MOH have a Health Education Unit?
7. What were outstanding successes or major obstacles?

**HIS:**

1. Were targets established?
2. Is the HIS computerized?
3. Is the HIS decentralized?
4. Is there a morbidity/mortality data base?
5. Is information disseminated?
6. General comments, outstanding results, major obstacles

**Operational Research:**

1. Were targets established?
2. How many OR studies have been completed during LOP?
3. Have OR results impacted policy/practices?
4. Which CCCD programs have been studied?
5. Are there guidelines for conducting OR?
6. Was an OR review board established?
7. General comments, outstanding results, major obstacles

**Cross-Cutting (Supervision & Sustainability):**

1. Is there a supervision strategy?
2. Is there a cost-recovery mechanism in place?
3. Has the host government kept up with its contributions?
4. What are outstanding success or major obstacles?

**Program Management:**

1. Were CCCD workplans developed? For which components?
2. Do CCCD coordinators exist for all programs?
3. Have committees been formed (all types)?
4. Has the CCCD project been integrated into the PHC system?
5. Has the CCCD project established/improved the procurement or distribution system?
6. General comments, outstanding results, major obstacles

**OBSERVATIONS**

1. The evaluation questions were very general. More specificity would facilitate extracting useful quantitative information.
2. The working definitions of supervision/sustainability and program management were somewhat vague. These categories were added/modified by the reviewers early in the process in order to accommodate information which did not fit in the other categories. Prior to use of this instrument in the future, these categories and the information desired in them should be defined and specified.
3. Many of the documents used in the country review process failed to reference data source. This threatens the validity of the data that is presented in the country reviews.
4. The external evaluations did not have a uniform approach to answering/researching project-related questions; not all addressed or evaluated the original objectives determined by the CCCD project.
5. Internal evaluations also lacked standardization and, although they included useful graphs, these graphs were often not accompanied by a narrative. The greatest improvement in reporting was found in the Annual Reports, which became much

## LIST OF ABBREVIATIONS

<b>ADB:</b>	<b>Africa Development Bank</b>
<b>CAR:</b>	<b>Central African Republic</b>
<b>CDC:</b>	<b>Centers for Disease Control</b>
<b>CDD:</b>	<b>Control of Diarrheal Diseases</b>
<b>CHW:</b>	<b>Community Health Worker</b>
<b>CQ:</b>	<b>Chloroquine</b>
<b>EPI:</b>	<b>Expanded Program for Immunization</b>
<b>FONAMES:</b>	<b>Fondo National Medico Sanitario*</b>
<b>F/SMOH:</b>	<b>Federal/State Ministry of Health</b>
<b>HEU:</b>	<b>Health Education Unit</b>
<b>HIS:</b>	<b>Health Information System</b>
<b>HSA:</b>	<b>Health Service Area</b>
<b>KAP:</b>	<b>Knowledge, Attitudes and Practices</b>
<b>LGA:</b>	<b>Local Government Area</b>
<b>LOP:</b>	<b>Life of Project</b>
<b>MCH:</b>	<b>Maternal and Child Health</b>
<b>MCZ:</b>	<b>Medecin Chef du Zone</b>
<b>MIS:</b>	<b>Management Information System</b>
<b>MLM:</b>	<b>Mid-Level Management/Manager</b>
<b>MOH:</b>	<b>Ministry of Health</b>
<b>MOHSA:</b>	<b>Ministry of Health and Social Affairs</b>
<b>MSPAS:</b>	<b>" " "</b>
<b>MSH:</b>	<b>Management Sciences for Health</b>
<b>MUHS:</b>	<b>Morbidity and Utilization of Health Services survey</b>
<b>N/SID:</b>	<b>National/State Immunization Day</b>
<b>OR:</b>	<b>Operational Research</b>
<b>ORS:</b>	<b>Oral Rehydration Solution</b>
<b>ORT:</b>	<b>Oral Rehydration Therapy</b>
<b>PACD:</b>	<b>Project Agreement Completion Date</b>
<b>PCV:</b>	<b>Peace Corps Volunteer</b>
<b>PEV:</b>	<b>French for "EPI"</b>
<b>PHC:</b>	<b>Primary Health Care</b>
<b>PHW:</b>	<b>Peripheral Health Worker</b>
<b>RHM:</b>	<b>Rural Health Motivator</b>
<b>SSS:</b>	<b>Sugar-Salt Solution</b>
<b>TA:</b>	<b>Technical Assistance/Assistant</b>
<b>TBA:</b>	<b>Traditional Birth Attendant</b>
<b>TO:</b>	<b>Technical Officer</b>
<b>TOT:</b>	<b>Training of Trainers</b>
<b>USAID:</b>	<b>U.S. Agency for International Development</b>
<b>VHW:</b>	<b>Village Health Worker</b>
<b>*Zaire:</b>	<b>organization for the coordination of national medical training activities</b>

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## LESOTHO

Country Assessment June 1983  
Project Grant Agreement September 1984  
First Year Project Review October 1985  
Annual Report 1985, 1986, 1987, 1988  
External Evaluation 1986  
External Evaluation (Pragma) August 1988  
Third Year Internal Review August 1987  
UNICEF Evaluation 1988  
Consultancy Report: Fourth Bi-Annual EPI/CDD/ARI Evaluation April 1988  
Extension Design 1988

## LIBERIA

Country Assessment August 1982  
Project Grant Agreement July 1983  
Project Evaluation Summary December 1984  
Annual Report 1985, 1986, 1987  
External Evaluation April 1986  
Third Year Program Review 1987  
Fee for Service Policy and Implementation Activities of the Ministry of Health and Social Welfare in Liberia August 1985  
Extension Design August 1988

## MALAWI

Country Assessment August-September 1983  
Project Grant Agreement, June 1984  
Grant Agreement Amendment #1, November 1984  
Annual Report 1985, 1986, 1987  
First Year Project Review November 1985  
External Evaluation October 1986  
Monitoring and Evaluation of CCCD Project Activities, Malawi 1987  
CCCD Consultative Visit to Malawi MOH May-June 1987  
MOH Response to CCCD Mid-Term Evaluation August 1987  
Malawi ACSEI-CCCD Supervisory Review February 1988

## NIGERIA

Country Assessment October 1985  
Project Grant Agreement December 1986

Annual Report 1986, 1987, 1988  
Quarterly Reports 1987  
First Year Evaluation November 1987  
Second Year Internal Evaluation January-February 1989  
Project Report April 1989  
Nigeria Epidemiologist Presentation March 1987  
Donor's Meeting Report June 1988  
Program Review/Yamoussoukro Consultative Meeting March 1988  
Progress and Utilization Report - UNICEF December 1988

#### RWANDA

Country Assessment June 1983  
Project Grant Agreement May 1984  
Evaluation of CCCD Project in Rwanda October 1986  
Internal Evaluation 1987  
Annual Report 1985, 1986, 1987  
End of Project Evaluation May 1988

#### SWAZILAND

Country Assessment May 1983  
Project Grant Agreement August 1985  
Annual Report 1984, 1985, 1986, 1987, 1988  
First Year Review July 1985  
External Evaluation September 1986  
Extension Design July 1988

#### TOGO

Project Grant Agreement April 1983  
Amendment to Project Grant Agreement date??  
Country Assessment July 1982  
First Annual Evaluation CCCD/Togo June 1984  
Togo/CCCD Financial and Economic Consultancy Report 1985  
Project Evaluation Summary August 1984  
Annual Report 1984, 1985, 1986, 1987, 1988  
Regional External Evaluation 1983

#### ZAIRE

Project Paper: CCCD 698-0421 September 1981  
Country Assessment July 1982  
Project Grant Agreement August 1982  
Annual Report 1984, 1985, 1986, 1987, 1988  
Midterm Evaluation 1985  
Project Evaluation Summary July 1985  
Third Year Program Review February 1986  
External Evaluation (Pragma) November 1988

EVALUATION CONTENT FOR ACSI-CCCD: SYNTHESIS

Categories	EPI	CDD
<p>Plans Needs assessment, goals, and objectives planned inputs, expected outcomes</p>	<p>o Were targets established? coverage: 12/13 countries morbidity/mortality: 10/13 countries</p> <p>o Were baselines established? at project start: 9 had baseline data from start ever established: 3 had baseline data during LOP</p> <p>o Were targets revised? 4/13 countries reported revising targets</p>	<p>o Were targets established? coverage: 11/13 countries; 2 cannot be determined from available information morbidity/mortality: 9/13 countries; 2 cannot be determined from available information</p> <p>o Were baselines established? at project start: 5 had some baseline at start ever established: 7 had some baseline during LOP</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access &amp; coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and/or mortality</p>	<p>o Were targets achieved? coverage: BCG DPT1 DPT3 Polio1 Polio3 9/13 7/13 6/13 8/13 6/13 Measles TT2 5/13 5/13 morbidity/mortality: Pertussis 4/13 Measles 6/13 Polio 3/13</p> <p>o Was a national policy established? YES: 10/13 countries NO: 3/13 countries</p> <p>o Mass vaccination campaigns: held in 9/13 countries</p>	<p>o Were targets achieved? coverage: YES=7/13; NO=2/13; 4 cannot be determined morbidity/mortality: YES=1/13; NO=4/13; 8 cannot be determined</p> <p>o Was a national policy established? YES: 5/13 countries NO: 8/13 countries</p> <p>o Are ORS packets locally produced? YES: 5/13 countries</p> <p>o Is ORS/SSS correctly used by surveyed population? (by &gt;50% of population; based primarily on KAPs) ORS: 4/13=YES; 2/13=NO; 7/13 cannot be determined SSS: 1/13=YES; 5/13=NO; 7/13 cannot be determined</p>
<p>CONCLUSIONS (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problem/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations?</p>	<p>o General comments: EPI is overall the strongest program in most countries Many countries already had immunization activities in progress at the start of CCCD</p> <p>o Program strengths EPI was generally highly supported by governments</p> <p>o Obstacles to progress: lack of funding (including salaries) poor logistical support understaffing</p> <p>o Mass vaccination campaigns had a tendency to freeze other CCCD activities - all energy and resources were generally devoted to campaigns. Question of sustainability of coverage after campaigns.</p> <p>o A number of countries cited problems with adherence to vaccination administration protocol: considered to be a supervision/training issue. Tendency to be overly optimistic with regard to coverage targets, particularly in early programs.</p> <p>o Outstanding projects/results: Swaziland: EPI was completely integrated into PHC system; supported by a strong health ed. program. Only country to achieve or exceed all targets. Liberia: Surpassed mortality reduction targets for pertussis &amp; measles; owed to well organized mass immunization campaigns.</p>	<p>o General comments: Although specific targets were not set, a number of countries made significant achievements in expansion and improvement of the CDD program.</p> <p>o Obstacles to progress: lack of standardization regarding SSS protocol (This may be related to lack of national policy in some countries) supervision cited as a problem in health facilities re: use and administration of ORS by health workers and overall case management.</p>

EVALUATION CONTENT FOR ACS1-CCCD: SYNTHESIS

Categories	MALARIA	TRAINING
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>o Were targets established? 11/12 countries had established some targets</p> <p>o Were baselines established? at project start: 3 had some baseline at start ever established: 5 had some baseline during LOP</p>	<p>o Were targets established? 9/13 countries established specific targets (i.e., numbers and categories)</p> <p>4/13 countries established general targets</p> <p>o Was a needs assessment conducted? 3/13 countries conducted training needs assessments (Liberia, Nigeria and Togo)</p>
<p><b>OUTCOMES</b> (actual v. planned)</p> <p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity and/or mortality</p>	<p>o Were targets achieved? 3/12 countries reported achieving one or more of the following targets: -access to treatment and prophylaxis -prescription of chemoprophylaxis to pregnant women -health centers using correct treatment protocol -malaria treatment coverage</p> <p>6/12 countries could not be determined</p> <p>o Was a national policy established? YES: 11/12 countries</p> <p>o Did CCCD document chloroquine resistance? 3/12 countries documented cq resistance</p> <p>o Conducted training in testing and/or monitoring: 11/12 countries reported training health workers; 1 did not report malaria training</p> <p>o More OR studies were devoted to malaria than any other topic.</p>	<p>o Were targets achieved? 3/13 countries fully met objectives 7/13 nearly met all objectives 3/13 cannot be determined with available information</p> <p>NOTE: Most countries reported training greater numbers of personnel than targeted, but type of personnel trained not always matched with target.</p> <p>o Were training activities/participants followed-up? 2/13 countries reported follow-up to training; performance indicators reported included percentage of target population using sterile technique, prescribing ORS, correctly mixing SSS/ORS, correctly prescribing chloroquine, etc.</p>
<p><b>CONCLUSIONS</b></p> <p>(1) Institutionalization: To what degree does MOH support system?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<p>o Obstacles to progress: chloroquine resistance is an increasing threat in most countries; From 1985-1988, cq resistance spread from Malawi to Guinea, although resistance in parts of West Africa is not as widespread as in the East.</p> <p>problem with clinicians using prescribed dosages, appropriate protocol.</p> <p>Nigeria: investigation found that 60% of chloroquine sold was either fake or adulterated.</p> <p>*Note: Lesotho did not have a malaria program; no indigenous malaria in Lesotho</p>	<p>o General comments: In general, countries need to conduct more management training at all levels</p> <p>o Obstacles to progress: Transportation and personnel shortages were repeatedly cited as threats to progress in the area of training</p> <p>o Outstanding projects/results: Lesotho: cited as having implemented an effective continuing ed./in-service-training program</p> <p>o CAR: training methodology handbook developed by T.O. proved to be excellent reference source</p> <p>o Note: Although occasionally reported in some countries, Training of Trainers (TOT) was not often specifically mentioned in evaluations or annual reports as distinct from other training activities; Nigeria reported an active TOT program.</p>

EVALUATION CONTENT FOR ACS1-CCCD: SYNTHESIS

Categories	HEALTH EDUCATION	HIS
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>o Was a needs assessment conducted? 3/13 countries conducted a needs assessment to determine health ed. needs</p> <p>o No targets established for health education</p>	<p>o Were targets established? All countries expressed general objectives toward developing and/or improving HIS capabilities</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access &amp; coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and/or mortality</p>	<p>o Was a mass media campaign carried out? 8/13 reported conducting at least one mass media campaign</p> <p>o What CCCD programs did campaign(s) address? EPI = 6/8 CDD = 1/8 Malaria = 2/8</p> <p>o Was health ed. follow-up reported? 7/13 countries reported doing some form of follow up study to assess health ed. impact</p>	<p>o Is the HIS computerized? 10/13 countries have computerized HIS; 2 countries cannot be determined from available information</p> <p>o Is HIS decentralized? (sentinel sites used as indicator) 10/13 countries have decentralized HIS; 3 countries cannot be determined from available information</p> <p>o Is there a morbidity/mortality data base? 5/13 countries have established a morbidity/mortality data base</p> <p>o Is information disseminated? 5/13 countries are routinely disseminating information; newsletters and bulletins most frequently cited vehicles</p>
<p>CONCLUSIONS (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations?</p>	<p>o Are CCCD health ed. materials institutionalized? 5/13 countries had institutionalized health ed. materials, implying they were used in health ctrs., school curricula, or universities</p> <p>o Did MOH have a Health Education Unit? YES: 8/13 countries</p> <p>o Obstacles to progress: chronic understaffing is an apparent constraint to progress problem of reaching illiterate population cited as a concern in some countries</p> <p>Ivory Coast: radio spots are done in only 3 of 60-70 local languages</p> <p>Outstanding projects/results: Liberia: 3 health information and promotion radio campaigns conducted - all assessed as highly successful; no specific indicators mentioned</p>	<p>o General comments: Only one country reported having a national HIS policy.</p> <p>o Obstacles to progress: Staff need further training particularly in the areas of data analysis and statistics. A lack of standardized reporting forms was cited as an issue in several countries Ivory Coast: dissemination of information is a problem despite 90% health centers reporting mortality data</p> <p>o Outstanding projects/results: Lesotho: cited as having particularly good HIS providing useful data in a timely fashion Nigeria: noted as having strong training, computerization, and decentralization features Zaire: considered to have one of the best computerized systems in the region</p>

EVALUATION CONTENT FOR ACS1-CCCD: SYNTHESIS

Categories	OR	CROSS CUTTING COMMENTS (SUPERVISION,SUSTAINABILITY)
<p>Plans Needs assessment, goals, and objectives,planned inputs, expected outcomes</p>	<p>o Were targets established?  Most countries had general targets stating the intent to strengthen capacity &amp; carry out research in a variety of CCCD program areas; some countries stated a desire to answer a certain number of "research questions."</p>	<p>o Is there a supervision strategy?  8/13 countries use supervisory checklists 7/13 countries report conducting regular supervisory visits</p>
<p>OUTCOMES (actual v.planned) (1) Outputs What was provided, accomplished?  (2) Quality How well are new systems/skills used?  (3) Effects Access &amp; coverage What are effects on KAP of pop.?  (4) Impact What is impact on morbidity and/or mortality</p>	<p>o How many OR studies have been completed during the LOP?  1-5 studies 6 countries 6-10 studies 2 countries 11-15 studies 2 countries 16+ studies 3 countries</p> <p>o Have OR results impacted policy/practices?  5/13 countries showed policy/practices impact 8/13 countries did not document impact</p> <p>o Which CCCD programs have been studied?  EPI = 8/13 countries conducted studies CDD = 5/13 countries conducted studies malaria = 9/13 countries conducted studies financial mgmt./cost recovery = 4/13 countries conducted studies</p> <p>o Are there guidelines for conducting OR?  6/13 countries have established OR guidelines</p>	<p>o Is there a cost-recovery mechanism in place?  9/13 countries reported having some form of a cost-recovery system in place</p>
<p>CONCLUSIONS (1)institutionalization: To what degree does MOH support system?  (2)Program strengths  (3)Problems/Constraints:What factors limit target achievement?  (4)Lessons learned: What worked? What did not work?  Recommendations?</p>	<p>o Was an OR review board established?  5/13 countries cited having national or belonging to regional review boards</p> <p>o General comments:  nearly every country has cited the need to increase the capacity to conduct OR</p> <p>o most OR studies are not discussed in evaluation or planning documents</p> <p>o publication of OR results is rarely reported in evaluation documents or country reports</p> <p>o Obstacles to progress:  the dependence of governments on donor support makes sustainability questionable</p> <p>o Outstanding projects/results:  In countries where OR is strong, the focus is on problem-solving research rather than basic research</p> <p>o Most countries reporting large numbers of OR studies had a resident epidemiologist on staff.</p>	<p>o Has the host government kept up with its contributions?  4/13 countries have kept up with contributions 6/13 did not keep up with contributions 3/13 cannot be determined from available information</p> <p>o Congo: CCCD project curtailed due to lack of government financial participation.</p> <p>o Obstacles to progress:  Tendency for governments to fall short of initial contribution targets.</p> <p>o Outstanding projects/results:  Ivory Coast: 1987 contribution to CCCD project far exceeded 25% requested.</p> <p>o Nigeria: Country has been financing 50-70% of vaccine costs; 30% equipment costs through fee-for-service and revolving drug fund.</p> <p>o Zaire: Government has not kept up with contributions, but cost recovery mechanisms at local level have kept programs going.</p>

EVALUATION CONTENT FOR ACSI-CCCD: SYNTHESIS

Categories	PROGRAM MANAGEMENT
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>o Were CCCD workplans developed?                      national = 4/13 developed national workplans                      EPI = 8/13 developed EPI workplans                      CDD = 10/13 developed CDD workplans                      malaria = 10/13 developed malaria workplans                      health ed. = 7/13 developed health ed. workplans                      training = 7/13 developed training workplans</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access &amp; coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and/or mortality</p>	<p>o Do CCCD coordinators exist for all programs?                      (NOTE: as stated in reports; coordinators may in reality exist for certain CCCD project programs)                      EPI = CCCD coordinators act as EPI coordinators                      CDD = 8 CDD coordinators exist                      malaria = 3 malaria coordinators exist                      health ed. = 2 health ed. coordinators exist                      training = 1 training coordinator exists                      national = 3 national coordinators exist                      o Have committees been formed?                      7/13 countries have formed one or more CCCD-related committees</p>
<p>CONCLUSIONS (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations?</p>	<p>o Has the CCCD project been integrated into the PHC system?                      3 countries reported integrating all CCCD programs into PHC system; 10 could not be determined from the reports                      4 countries reported integrating EPI into PHC system; 9 could not be determined from the reports                      3 countries reported integrating CDD into PHC system; 10 could not be determined from the reports                      o Has CCCD project established/improved the procurement or distribution system?                      8/13 countries report that the CCCD project established/improved procurement or distribution system                      o General comments:                      Donor coordination is generally functional; some countries note that coordination could be more effective.                      Documents suggest that governments are generally committed to the CCCD project.                      o Obstacles to progress:                      Common threats to progress are transportation, understaffing, and underfunding.                      o Other Comments:                      9/13 countries have extended CCCD projects (Nigeria had 1991 as original PACD)</p>

6.6

Categories	EPI	CCD
<p>Plans Needs assessment, goals &amp; objectives planned inputs, expected outcomes</p>	<p>to targets: 75% vaccination coverage by '90 50% annual coverage increase 100% access by 0-23 mo. population 60% reduction in morbidity &amp; mortality due to EPI diseases to goal: provide regular uninterrupted supplies to all health facilities, eval. coverage every 2 yrs to 1986 EPI plan approved. to baseline 1985: EPI program active in 11/16 health sectors prior to COCC (1981-1985) 70% of pop. has access to services EPI integrated into health services to Objectives and outcomes revised in 4th Amendment</p>	<p>to targets: reduce by 25% mortality due to diarrhea to 1986 CCD plan approved to baseline 1983: national pharmacy produces and distributes ORS to Objectives and outcomes revised in 4th Amendment</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access &amp; coverage What are effects on KAP of target population? (4) Impact What is impact on morbidity and/or mortality?</p>	<p>(1) to national coverage survey conducted 1986 to all centers have cold chain equipment and are provided with vaccination supplies (1987) to daily vaccination with all antigens occur everywhere; where necessary, an Outreach Vaccination Strategy developed (1987) to vaccines are available throughout the country (1987) to accelerated plan for eradication of NNT in Burundi by 1995 in process of development (1988) to completed rural health center staff training in EPI to EPI coverage is nation wide (1988) (2) to Evaluation of training performance shows: 97% vaccinators administering vaccines correctly 77% use sterile syringe for each injection 94% review vaccination cards 52% facilities maintained correct temp for vaccines 9% provided information on reactions (3) to Estimated &lt; 1 Coverage rates for 1987: DPT1-82%, BCG DPT1 DPT3 OPV1 OPV3 Msis TT1(pw)TT2(pw) 84% 82% 69% 82% 70% 54% 84% 53% TT1(14-45 yrs): 51% (pw=pregnant women) (4) to Reported incidences for influenza and chickenpox remained stable from 1985-1987. to Incidence per 100,000 1985 v.1987 (% decrease): Polio: .55 to .2 (63%) Measles: .81 to .45 (44%) Tetanus: 2.7 to 2.3 (15%) Pertussis: 100 to 40(70%) to 1988 increase in measles incidence to .60 due to epidemics in several sectors; still 50% decrease in incidence since 1982 to 1988 First report on neonatal tetanus incidence - 3/100,000</p>	<p>(1) to construction underway ('88) on diarrheal training unit at regional hospital in Gitega. to CDD coordinator named in 1988. to local production of ORS began 10/88 with funding from UNICEF to training of Directors of Health Centers in CCD completed in '88 to diarrhea training/treatment unit at Prince Regent Hospital in Bujumbura to ORT practiced at all health facilities (2) to 83% staff prescribe ORS, 63% gave packet for home treatment, 17% rehydrated child at facility to ORS used alone or in combination with IV and other antidiarrheal drugs, on average, in 90% of cases in 3 hospitals (3) to 30% of under 5's who had diarrhea in 2 week period received ORT at home (4) to No change in case fatality rate shown in 1984-86 retrospective survey of 8 hospitals - 3%. to Incidence for cases per 100,000 rose 194% between 1985 and 1987: epidemic of shigella dysentery partially accounts for high incidence</p>
<p>CONCLUSIONS 1. Institution- alization: To what degree does MOH support systems? 2. Program strengths 3. Problems/ Constraints What factors limited achieve- ment of targets? 4. Lessons learned: What worked? What did not work? Recommendations?</p>	<p>(1) to success of EPI based on following factors: 1. GRB is firmly committed to EPI goals/objectives 2. GRB provides significant and growing fin. support 3. Stable and strong National team 4. Other donor support 5. Very talented TO, strong US-based support and USAID efforts. (2) to Strongest component of project; one of strongest EPI programs in Africa in efficacy and impact (3) to Shortages are relatively frequent due to: poor estimation of needs; too frequent, small deliveries and more wastage than anticipated due to large vial sizes ordered to High dosage vials inefficient with policy of immunizing children regardless of number to be immunized at one time to EPI activities hindered initially by lack of orientation and experience in program planning and implementation. (4) to Need uniform policy for Outreach Vaccination strategy at the national level</p>	<p>(3) to no method was in use to measure reduction of mortality to primary role of ORT in the control of diarrheal disease in &lt; 5's is not understood; continuing use of antibiotics and prescribing ORS to adults ORT Unit at Prince Regent Hospital is not an effective treatment/training center</p>

Categories	MALARIA	TRAINING
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o targets: reduce by 25% mortality due to malaria in children &lt; 5 and reduce fetal wastage and low birth weight infants by a % to be determined</li> <li>o National Malaria plan developed in 7/87</li> <li>o Malaria treatment schedule adopted in 1987</li> <li>o Objectives and outcomes revised in 4th Amendment</li> </ul>	<ul style="list-style-type: none"> <li>o target: 300 health personnel to be given technical training; training materials be developed and adapted for use nationally</li> <li>o Objectives &amp; outcomes revised in Fourth Amendment</li> <li>o needs assessment performed in 1988</li> </ul>
OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of target population? (4) Impact What is impact on morbidity and/or mortality?	<ul style="list-style-type: none"> <li>(1)</li> <li>o 1988 Training of microscopist, 22 lab technicians, integrating malaria, stool and sputum microscopy</li> <li>o Assistant Director of EPI program nominated as Malaria Coordinator in 1988</li> <li>o National Malaria Plan established 1987</li> <li>(2)</li> <li>o 71% of health personnel administered anti-malarial drugs, only 49% gave correct dosage based on new malaria treatment schedule</li> <li>o in 3 hospitals, cq used alone 44.9% of time (on average) and prescribed 64.5% of time (on average)</li> <li>(4)</li> <li>o Malaria incidence rising: 1980: 3000/100,000 cases; 1987: 6000/100,000 (general population)</li> <li>o 1984-86 retrospective survey shows no change in % of deaths to cases - 0.2 % consistently</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o four microscope technicians trained in Ivory Coast in cq resistance (1986)</li> <li>o five technicians trained in cold chain maintenance in Togo (1986)</li> <li>o 361 peripheral level workers trained by 1988</li> <li>o total mid-level managers trained: 94</li> <li>o 4 regional training teams trained</li> <li>o 1988: MOH undertook extensive review of nursing and paramedical schools curriculum; Job Aids developed by CCCD used in this training</li> <li>o training schedule for 1986-1988 based on evaluation of previous training</li> <li>o by 1988, all Regional and Provincial Medical Officers had been trained at MLM training course</li> <li>o CCCD training completed for Heads of Rural Health Centers in 1988</li> <li>o Based on a needs assessment and field testing, several sets of training materials and technical guides were prepared for health worker use</li> <li>o training needs assessment of peripheral workers performed</li> <li>o total of 18 training courses conducted 1985-1988</li> <li>o National evaluation of past training conducted '88</li> <li>(2)</li> <li>o Evaluation of training in one region shows: 97% vaccinators administered vaccines correctly; 77% use a sterile syringe for each injection; 94% review the vaccination cards; 31% provide information to the mother on what vaccines are being given; 52% of health facilities maintain correct temperature of vaccines; 9% provide information on reactions</li> </ul>
CONCLUSIONS 1. Institution- alization: To what degree does MOH support systems? 2. Program strengths 3. Problems/ Constraints What factors limited achieve- ment of targets? 4. Lessons learned: What worked? What did not work? Recommendations?	<ul style="list-style-type: none"> <li>(2)</li> <li>o CCCD program benefitted from early experience in zonal malaria control</li> <li>o Malaria drugs in abundant supply at periphery</li> <li>(3)</li> <li>o Malaria not yet sufficiently integrated into other health activities</li> <li>o lack of training in diagnosis and treatment</li> <li>o insufficient diagnostic equipment</li> <li>o wide variations in actual treatment schedule, dosage</li> <li>o inappropriate use of second-line drugs</li> <li>o Malaria Coordinator post vacant until 1988; absence of appointed Coord. (long-term training) has slowed coordination &amp; progress of malaria activities</li> <li>o Considerable variation in malaria treatment practices in the health centers</li> <li>o No method in place to measure reduction of mortality</li> <li>(4)</li> <li>o Lack of rational MOH structure constrains CCCD activities in Malaria. A separate Malaria Unit located in Dept. of Health Services, has responsibility for research and anti-vector campaigns. Separate units inhibits communication and weakens efforts to coordinate. Malaria Unit should be transferred to Dept. of Hygiene and Prevention to be integrated into EPI/CCCD.</li> </ul>	<ul style="list-style-type: none"> <li>(2)</li> <li>o training of health workers and supervisors has been a major accomplishment of project</li> <li>(3)</li> <li>o paramedical training schools need to be strengthened in CCCD component activities</li> <li>o some essential practices in EPI, CDD and malaria found lacking in 1987 Evaluation observations: ORT practices, cold chain maintenance, sterilization procedures, and use of malaria drugs</li> <li>(4)</li> <li>o Central coordination needed for decentralized training teams - '87 Evaluation.</li> <li>o training efforts should focus on weaker components of project (e.g. malaria, supervision)</li> </ul>

Categories

HEALTH EDUCATION

HIS

Plans  
Needs assessment,  
goals & objectives,  
planned inputs,  
expected outcomes

- o target: use of mass media, printed materials, and community specific activities
- o Objectives to promote appropriate utilization of support provided by CCCD, promote behavior changes in the home and community which will reduce malaria and diarrhea morbidity/mortality
- o Detailed Health Education Plan of Activities for approval by MOH in 4/86
- o Objectives & outcomes revised in Fourth Amendment

- o objectives: improve collection, tabulation, and analysis of operational and surveillance data for the purpose of strengthening the HIS system
- o Objectives & outcomes revised in Fourth Amendment
- o Assessment of MOH HIS in relation to CCCD needs conducted
- o baseline 1985: Monthly Epidemiologic Bulletin Report initiated in 1980

OUTCOMES  
(actual v. planned)  
(1) Outputs  
What was provided,  
accomplished?  
(2) Quality  
How well are new  
systems/skills  
used?  
(3) Effects  
Access & coverage  
What are effects  
on KAP of target  
population?  
(4) Impact  
What is impact on  
morbidity and/or  
mortality?

- (1)
- o designed and tested patient ed. materials to improve home case management of diarrhea
- o designed and tested poster to promote immunization
- o developed radio messages to promote immunizations during Immunization Week
- o designed brochure to promote immunizations/use of ORT
- o UNICEF hired full-time communication specialist to assist with information, Education and Communication (IE&C) activities (1988)

- (1)
- o HIS established in 1986.
- o Chief of Statistics and an epidemiologist attended a two-month basic computer course in 1987
- o program for data entry of vaccination information prepared for EPI program in '88 which will allow cumulative monthly reporting of vaccination results and calculation of progress in individual medical sectors in meeting their goals
- o by 12/88 monthly morbidity/mortality data entered on computer through 10/88
- o by 1988, over 90% of 250 health centers report to the health sectors each month
- o effective HIS for vaccinations and reporting for 28 diseases developed; provides interim HIS service for the MOH
- o 3 personal computers purchased; computer codes assigned to each health sector and health facility; new forms prepared

- o Health education training included in all CCCD-sponsored peripheral level training courses

- (2)
- o EPI/CCCD reports have significantly improved since initiation of CCCD project: over 90% of health facilities report to health sector

CONCLUSIONS  
1. Institution-  
alization:  
To what degree  
does MOH support  
systems?  
2. Program  
strengths  
3. Problems/  
Constraints  
What factors  
limited achieve-  
ment of targets?  
4. Lessons  
learned:  
What worked?  
What did not work?  
Recommendations?

- (1)
- o MOH has an established Health Education Unit
- (2)
- o health education seen as a priority activity by health workers; make time for it in daily routine
- (3)
- o weakest of the support strategies
- o Health Ed unit needs money, training to be effective; MOH agrees only to material support from donors
- o Health ed activities inhibited by absence of approved plan of activities ('87)
- o lack of coordination among technical personnel in other government & donor agencies
- o lack of knowledge about effectiveness of health messages
- o limited baseline data available on KAPs - hard to measure impact

- (3)
- o constraint to development of National HIS is future reorganization of health structure
- o 7 reporting systems make up the Burundi HIS. 3 pertain to CCCD target diseases and are managed by the EPI/CCCD Office: Monthly Epidemiologic Bulletin Report, Monthly Vaccination Report, and Monthly Sentinel Disease Surveillance Sites Report. Large number of separate and distinct reports presents difficulties for creating single, integrated HIS.
- o Monthly Sentinel Disease Surveillance Sites Reports not functional (1987 Eval.) due to insufficient training, motivation and supervision of personnel
- (4)
- o feedback to health facilities needed to maintain informed, motivated staff
- o flexibility needs to be built into HIS to respond to changing needs

Plans  
Needs assessment,  
goals & objectives  
planned inputs,  
expected outcomes

Objectives and outcomes revised in Fourth Amendment

OUTCOMES  
(actual v.planned)  
(1) Outputs  
What was provided,  
accomplished?  
  
(2) Quality  
How well are new  
systems/skills  
used?  
  
(3) Effects  
Access & coverage.  
What are effects  
on KAP of target  
population?  
  
(4) Impact  
What is impact on  
morbidity and/or  
mortality?

o 2 projects under design, 1 completed and under publication  
o committee to review OR proposals formed, never reconvened  
o planned seminar on proposal writing cancelled

SUPERVISION  
o personnel at regional and sectoral levels have training in EPI supervisory practices  
o supervision system in place which is relatively effective in providing some level of supervision in health centers; national level supervision is especially strong

SUSTAINABILITY  
o in 1987 GRB providing more than anticipated costs and assuming increasing proportion of project costs  
o GRB made good faith efforts to find alternative financing mechanisms  
o World Bank assisting in study of feasibility of implementing cost-recovery system for all services

CONCLUSIONS  
1. Institution-  
alization:  
To what degree  
does MOH support  
systems?  
  
2. Program  
strengths  
  
3. Problems/  
Constraints  
What factors  
limited achieve-  
ment of targets?  
  
4. Lessons  
learned:  
What worked?  
What did not work?  
  
Recommendations?

(4)  
o MOH needs to take active role in defining OR priorities. Committee should review project activities, establish research priorities, put out RFPs for research.  
o OR proposals focus on disease specific issues. TA needed to demonstrate variety of topics that have bearing on the problem areas in program: health education messages, supervision forms and methods, effects of daily vs. twice weekly vaccination, etc.

SUPERVISION  
(3)  
o visits of Medecins Chefs du Secteur incomplete, cursory; practices not observed on-the-job training  
o correct practices not provided

(4)  
o provide on-the-job training to health workers  
o train MCS' and medical students in evaluation of health center activities  
o redesign supervisory forms to integrate all program activities; systematic reporting to national office and consistent follow-up on problems  
o supervision is a central factor in overcoming other problems & assuring institutionalization; training must be reinforced with strong supervision: correcting practices, motivation through on-the-job training  
o consider reorganizing supervisory system: change from responsibility of MCS - too time consuming  
o supervisor should be designated for each medical region and each medical sector  
o competition for vehicles a limitation

SUSTAINABILITY  
(1)  
o CCCD fully integrated in MOH administrative structure - builds on earlier EPI admin structure  
(2)  
o many conditions for sustainability present: high national commitment; project goals/objectives are GRB priorities; project not perceived as imposed on gov. by USAID; also, increasing absorption of costs  
o perception that project is effective  
o team is strong, highly motivated, competent  
(3)  
o vulnerability is dependence on donor support - especially vaccines from UNICEF  
o lack of clear MOH organizational structure

Categories	PROGRAM MANAGEMENT
Plans Needs assessment, goals & objectives planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o Project Agreement extended June, 1988 - Sept. 1991</li> <li>o country assessment done 1983</li> </ul>
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage. What are effects on KAP of target population? (4) Impact What is impact on morbidity and/or mortality?	<ul style="list-style-type: none"> <li>o new TO arrived end of 1988</li> <li>o MOH planning major Health and Pop project with World Bank which will coordinate donor program</li> </ul>
<b>CONCLUSIONS</b> 1. Institutional- alization: To what degree does MOH support systems? 2. Program strengths 3. Problems/ Constraints What factors limited achieve- ment of targets? 4. Lessons learned: What worked? What did not work? Recommendations?	<ul style="list-style-type: none"> <li>(1)</li> <li>o GOB committed to goals &amp; objectives of project, provides significant &amp; growing financial support, has established stable, strong national team to manage project</li> <li>o CCCD well integrated into MOH structure</li> <li>(2)</li> <li>o Dynamic leadership of TO, strong support from AID/W and CDC.</li> <li>o Excellent support from AID/W, CDC/A</li> <li>(3)</li> <li>o MOH and GOB underwent major changes in 1988: new Minister of Health appointed 10/88; tribal tensions in 8/88 hindered travel and availability of Ministry personnel for several months</li> <li>o MOH implementing extensive decentralization designed with assistance of WHO in '86. Aspects have been initiated but major re-org hadn't occurred in 1987; process has created problems in the implementation of some CCCD activities-HIS and epidemiological evaluation</li> <li>o Initial misunderstanding with USAID/Burundi re: responsibilities for supporting project</li> <li>(4)</li> <li>o Capacity of MOH to manage all the health projects undertaken simultaneously is a major concern. HIS must be strengthened and common services must be integrated across functional programs in MOH.</li> <li>o MOH projects must be coordinated to prevent duplication of effort, and key people always in training. Director General to coordinate workplans.</li> <li>o Effective use made of long and short-term TA</li> <li>o donors in constant communication</li> <li>o other donors, particularly UNICEF, provide major technical, financial, logistical support</li> </ul>

Categories	EPI	CDD												
Plans Needs assessment, goals & objectives planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>Objectives set in 1984; revised in 1985</li> <li>target: decrease mortality due to:                             <ul style="list-style-type: none"> <li>measles: 40%</li> <li>MNT: 35%</li> <li>pertussis: 25%</li> </ul> </li> <li>increase national coverage to:                             <table border="1"> <tr> <td>BCG</td> <td>DPT/OPV</td> <td>measles</td> <td>T</td> </tr> <tr> <td>55%</td> <td>40%</td> <td>45%</td> <td>45%</td> </tr> </table> </li> <li>baseline 1984:</li> <li>EPI activities ongoing since 1980; integrated into programs and services at all levels</li> <li>coordination, logistical &amp; cold chain support at central level</li> <li>EPI integrated into MCH services at periph. level</li> </ul>	BCG	DPT/OPV	measles	T	55%	40%	45%	45%	<ul style="list-style-type: none"> <li>Objectives set in 1984; revised in 1988</li> <li>target: decrease mortality due to diarrheal disease by 30%</li> <li>increase proportion of population with access to ORT to at least 55% by 1988</li> <li>increase proportion of mothers of &lt;5's who use ORT to 40% by 1988</li> <li>baseline 1984:</li> <li>before CCCD, no formal plan for a CDD program</li> <li>ORS recently available to MCH project, ORT included</li> <li>ORT included in MCH health education at centers</li> <li>ORT practice generally ineffective; no instruction</li> <li>no baseline data on cases or practices</li> </ul>				
BCG	DPT/OPV	measles	T											
55%	40%	45%	45%											
OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of target population? (4) Impact What is impact on mortality: mortality?	<ul style="list-style-type: none"> <li>(1)</li> <li>27 new fixed centers added 1987-1988</li> <li>2 mass measles campaigns in rural areas in 1986 and 1987 increased national measles coverage to 31%</li> <li>three series of National Vaccination Days in 1988</li> <li>began instituting kerosene management system (1988)</li> <li>national policy of sterilization adopted; steam sterilizers, needles, syringes distributed to all vaccination centers; practices evaluated</li> <li>national Plan for Community Mobilization developed in 1988</li> <li>implemented national in-service training program: 323 agents trained in correct EPI practices</li> <li>services extended via outreach to most heavily populated areas: 15 mobile teams in 1988</li> <li>health worker's practices evaluated in 55% of fixed posts in '88 to introduce observation of practices into supervisory routine</li> <li>hospital surveillance system in process of implementation (ready in 1989)</li> <li>(3)</li> <li>1988 national coverage levels:                             <table border="1"> <tr> <td>BCG</td> <td>DPT1/OPV1</td> <td>DPT3/OPV3</td> <td>measles</td> <td>TT1</td> <td>TT2</td> </tr> <tr> <td>84%</td> <td>68%/70%</td> <td>42%</td> <td>55%</td> <td>57%</td> <td>40%</td> </tr> </table>                             (TT in women giving birth over past 12 months)                         </li> <li>(4)</li> <li>MNT incidence: 0.8/100,000 cases in 1988</li> <li>1981 rate: 1.5; flux between 2.3 and 2.6 1984-7</li> <li>Measles incidence: 11/100,000 cases in 1988; between 1980 and 1987, incidence ranged from high of 247 in 1984 to low of 54 in 1985</li> <li>Polio incidence: 0.5/100,000 cases 1988 ; 3 year cycle: 6.4 in '81; followed by 2 yr decline 6.8 in '84 followed by 2 yr decline</li> <li>Pertussis incidence: 22/100,000 in 1988; 45/100,000 in 1981, high of 85/100,000 in 1985 steady decline in incidence since 1985</li> </ul>	BCG	DPT1/OPV1	DPT3/OPV3	measles	TT1	TT2	84%	68%/70%	42%	55%	57%	40%	<ul style="list-style-type: none"> <li>(1)</li> <li>KAP study conducted in 1985</li> <li>1985 ORT unit opened at central hospital in Bangui</li> <li>1 member of national team trained in ORT in 1985</li> <li>ORT treatment units installed in 4 prefectural hospitals and 3 outpatient facilities (1986)</li> <li>developed National Program for CDD (1986)</li> <li>baseline levels of diarrheal inpatient mortality first measured in 1987</li> <li>ORT units established in 3 prefectural hospitals (1988)</li> <li>10 ORT demonstration units established by 1988; staff assigned to units trained in appropriate case management</li> <li>detailed training plan developed 1988; implementation postponed until 1989</li> <li>trained 76 health workers in ORT, case management to staff existing ORT units</li> <li>OR study of mother's use of cereal based solutions in home completed (1988)</li> <li>patient education materials produced (1988)</li> <li>case management data from ORT units entered into HIS (1988)</li> <li>pre-test of CDD health facility survey instrument in 1988</li> <li>major reassignment of health personnel in 1988</li> <li>(2)</li> <li>data on case management limited; evaluation of 3 out of 4 units in regional hospitals showed that 70-90% of children were being treated with adequate amounts of ORS; 53-78% gained adequate weight; and 61-94% were leaving unit rehydrated</li> <li>(4)</li> <li>3 regional hospitals with functioning ORT units reported case fatality rate of 3.7% in 1987; same hospitals report 5.7% rate in 1988</li> </ul>
BCG	DPT1/OPV1	DPT3/OPV3	measles	TT1	TT2									
84%	68%/70%	42%	55%	57%	40%									
CONCLUSIONS 1. Institutionalization: To what degree does MCH support systems? 2. Program strengths 3. Problems Constraints What factors limited achievement of targets? 4. Lessons learned: What worked? What did not work? Recommendations	<ul style="list-style-type: none"> <li>EPI activities in '88 provide models for in-service training and supervision of health personnel and for community health education</li> <li>in-depth review of cold chain in 1988 revealed underestimation of kerosene needs and lack of adequate storage capacity have been addressed</li> <li>replacement needs for refrigerators being monitored</li> <li>(3)</li> <li>trend data on disease mortality rates and reduction not available</li> <li>shortages of supply in 1986 and 1987 due to funding problems between UNICEF &amp; Italian Government</li> <li>poor donor coordination caused significant delays in delivery of health services</li> <li>Ministry, UNICEF and USAID failed to adequately coordinate planning of EPI activities to ensure complementarity</li> <li>technical training of health personnel in EPI postponed in 1986 and 1987</li> </ul>	<ul style="list-style-type: none"> <li>donor conference on AIDS and WHO-sponsored seminar on health policy in CAR immediately following National Vaccination Days engaged CDD resources</li> <li>ambitious 1989 workplan</li> <li>(3)</li> <li>1988 implementation of workplan and training schedule slow due to redirection of resources for National Immunization Campaign</li> <li>shortage of health personnel impeding opening of 20 ORT rooms in out-patient facilities</li> <li>lack of adequately trained health personnel serious constraint to implementing National CDD; inappropriate therapy using variety of antibiotics widely practiced according to 1988 survey</li> <li>personnel in ORT units last trained in 1986, supervision limited to resupplying units with materials since 1986</li> <li>use of mass media and social marketing strategies should be considered for implementation of CDD at community level (from 1986 evaluation)</li> <li>training, health education, supervision following EPI model developed in 1988 needed</li> <li>high priority should be given to training of all regional level personnel so that demonstration &amp; training units may be opened in each region for</li> </ul>												

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Categories	MALARIA	TRAINING
Plans Needs assessment, goals & objectives planned inputs, expected outcomes	<p>to target: increase proportion of population with access to cq treatment/prophylaxis to 55% by 1988</p> <p>increase proportion of &lt;5's in target areas utilizing presumptive cq treatment to 40% by 1988</p> <p>increase proportion of pregnant women in target areas utilizing cq for prophylaxis to 40% by 1988</p> <p>to baseline 1984: no formal malaria control strategy malaria cases treated through MCH system and curative medical care</p>	<p>to target: 1000 people involved with project (primarily MSPAS staff) to receive technical training at different levels</p> <p>strengthening health delivery system is primary goal; training materials to be developed, adapted as needed</p> <p>to in-service training plan developed in 1988</p>
OUTCOMES (actual v. planned)	(1)	(1)
(1) Outputs What was provided, accomplished?	<p>to national program adopted in July 1986</p> <p>to cq distributed to all health facilities (1986)</p> <p>to new malaria policy announced (1986)</p> <p>to MOH is documenting resistant strains through in-vivo studies (1988)</p>	<p>to training of trainers, training design transferred to health education unit in 1987</p> <p>to national training strategy and plan for EPI developed in 1988; will be replicated for CDD and Malaria</p>
(2) Quality How well are new systems/skills used?	<p>to appropriate treatment recommendations and national policies based on studies were prepared and distributed to health workers (1988)</p> <p>to 5 health workers attended 2-month malaria training course in Zaire (1988)</p>	<p>to held workshop on conducting KAP surveys for EPI, CDD and Malaria for regional health trainers and supervisors</p> <p>to held workshop on health care financing attended by Secretary General and Dir. General of Health (1988)</p>
(3) Effects Access & coverage What are effects on KAP of target population?	<p>to in-vivo cq sensitivity studies completed in 2 different health regions; results show level of resistance to current recommended dosage is weak (1988)</p> <p>to retrospective study of hospitalized cases &amp; deaths among children under 15 attending pediatric ward of Nat'l University Hospital in Bangui completed (1988)</p>	<p>to computer training in Kinsbasa for staff of Preventive Medicine &amp; Planning &amp; Statistics, MSPAS (1988)</p> <p>to EPI Managers's workshop attended by representatives from Preventive Medicine, MCH and CCCD Technical Officer in Mali</p>
(4) Impact What is impact on morbidity/ mortality?	<p>to preliminary training materials developed for use in 1989 in-service training program for case mgmt ('88)</p> <p>to pre-tested fever/malaria health facility survey instrument for ascertaining health worker practices in malaria case management in two regions</p> <p>to baseline levels of inpatient mortality from malaria first measured in 1987 through record review</p>	<p>to implementing national in-service training program in which 323 agents from all 5 health regions are trained in correct EPI practices (current)</p> <p>to developing in-service training manual (EPI) in collaboration with regional trainers/supervisors (in progress as of 1988; finished 1989)</p> <p>to in process of training trainers in effective delivery of training (EPI) (ongoing)</p> <p>to training health workers in fixed posts in vaccine and kerosene management (ongoing)</p>
	(2)	
	<p>to 1985 KAP surveys showed incorrect dosages, history taking, and physical examination; Mivaquine alone prescribed 56% of time; quinine alone 47% of time; treatment provided only after thick smear confirmation in 50% of cases</p> <p>to 1988 11-facility survey shows little improvement; cq routinely prescribed as first-line drug, but only 1/11 used correct dosage; injectable quinine used in 50% hospitals; 20% followed monitoring guidelines; only 2 centers used alternative treatment guidelines; most facilities used proper prophylaxis for pregnant women, but half prescribe prophylactic doses for &lt;5's; correct management of cq tablets was infrequent; health education counseling found to be routine in 80% of facilities (Note: survey relied primarily on health worker reporting)</p>	<p>to preliminary training materials developed to be used in 1989 in-service training program for case management (1988)</p> <p>to 1988 Training Summary: 318 peripheral health staff trained (39% of LOP target); 167 mid-level managers trained (86% of LOP target); 11 Senior Level Officials trained (18% LOP target)</p>
	(4)	
	<p>to 1987 case fatality rate for &lt; 5's from 3 regional hospitals = 1.0%; 1986 rate = 2.7%</p>	
CONCLUSIONS		
(1) Institution- alization: To what degree does MOH support systems?		(2)
(2) Program strengths		<p>to training plan comprehensive: includes needs assessment, training materials development, training of regional trainers, evaluation</p> <p>to regional staff participated and collaborated in developing EPI training materials; created ownership &amp; constituency for updating, revising material</p> <p>to data from health facility survey conducted as part of training strategy was used effectively with Minister: demonstrates how rapidly health information can influence project management decisions</p>
(3) Problems: Constraints What factors limited achievement of targets?	(3)	(3)
	<p>to delays in developing National Strategy - approved in 1987</p> <p>to unplanned, uncoordinated Vaccination Campaigns &amp; importance placed on EPI program have diverted human resources from Malaria program since 1986</p>	<p>to training plans for intervention activities very late in coming (1988)</p>
(4) Lessons learned: What worked? What did not work?	<p>to Malaria Program without a Director for all of 1987</p> <p>to lack of adequately trained health personnel serious constraint to implementing National Malaria policy</p> <p>to great variety in dosage regimes</p>	(4)
Recommendations:		<p>to need training course in vehicle maintenance/repair</p>

Categories

HEALTH EDUCATION

HIS

Plans  
Needs assessment,  
goals & objectives  
planned inputs,  
expected outcomes

o target: health education and promotion activities will include use of mass media, printed materials, & community specific activities

o revised for 1990: assist the MSPAS in developing strategies to assist families & healthcare providers to adopt behavioral practices that would contribute to the reduction of target diseases

o baseline 1984:  
considerable capacity and level of activity in MSPAS health education unit at project start

o target: HIS will be strengthened to improve the collection, tabulation and analysis of operational and surveillance data;  
emphasis on: 1) early tracing of cases of targeted diseases; 2) rapid intervention if necessary by the services involved in the project; & 3) use of surveillance data for planning and evaluation of the program

o baseline 1984:  
before CCCD: system of routine diseases (70) and health activity reporting exists

OUTCOMES  
(actual v. planned)  
(1) Outputs  
What was provided,  
accomplished?

(1)  
o KAP survey formed basis of integrated health ed strategy

o health ed unit at 25% strength in 1986; lacking resources to produce radio/tv programs, training materials and transport

o short-term TA needed; scope of work, recruiting done in 1987

o health educators assigned to CCCD project in 1987

o Peace Corp provided TA in health ed and training

o health education services decentralized in '88 by:  
1) designating members of regional health offices as planners/trainers/supervisors of health ed. in their areas; 2) establishing 16 prefectural-based health ed. teams responsible for conducting formative research in communities, training/supervising locally identified health educators, and evaluating effectiveness of health ed. efforts; 3) establishing health ed committees at commune level to choose, organize and supervise local health educators

o health worker practices in health ed for EPI were evaluated and a health ed. module was developed and used in training 323 health workers during national in-service training program (1988)

o Health Ed. Unit developed National Community Mobilization Plan for EPI in 1988

(1)  
o National cluster survey to get baseline EPI coverage information conducted in 1985

o in-depth review of HIS conducted in 1986

o began rationalizing of data collection by simplifying reporting forms and improving reporting system (1986)

o IBM/AT PC purchased for analysis of project data

o no population based surveys had been performed to develop morbidity/mortality info of CCCD diseases

o central level computer system in place in 1987

o two computer programs for EPI developed in 1987;  
one for data entry and analysis of vaccination statistics by health center and region; other tracks EPI materials in all health centers in CAR

o comprehensive review of existing HIS completed in 1988; 2 Year plan of action developed

o data management system developed for analyzing data from health facility survey (1988)

o vaccination coverage survey designed in 1988

o National Vaccination Coverage Survey conducted (1989)

o Computer training in Kinshasa for staff of Preventive Medicine & Planning & Statistics, MSPAS

o major hospital surveillance system designed to be instituted in 16 sentinel hospitals in 1989; data management program for analyzing these data

CONCLUSIONS  
(1) Institutional-  
ization:  
To what degree  
does MOH support  
systems?  
(2) Program  
strengths  
(3) Problems/  
Constraints  
What factors  
limit-d achieve-  
ment of targets?  
(4) Lessons  
learned:  
What worked?  
What did not work?  
Recommendations?

(1)  
o Consistant, short-term TA provided thru Peace Corp. and CDC - strengthened unit in 1988.

o Peace Corp volunteer assigned to Unit and other volunteers to each of the five regions and several prefectures in 1989

o success of project depends on ability to utilize existing health ed unit - unable to until 1988

o inability to find working space impeded work significantly in health education - space acquired in 1986

(2)  
o 1986 Evaluation noted willingness of personnel to collect and report information

o problems with CDC case management system resolved in 1988

o computer operations strengthened in 1988. hardware, support materials, training of personnel provided

(3)  
o 1986 Evaluation findings:  
major constraint at health center level was consistent lack of printed forms and/or paper

o unnecessary duplication of reporting directly from regions to national Directorates

(4)  
o from 1986 evaluation:  
epidemic response capabilities need strengthening

o supervisory visits should verify HIS data

o central level should consider publishing an epidemiological bulletin

o training in all regions needed to acquaint health personnel with new HIS system

o due to relatively small number of facilities and apparent willingness of staff to collect data, 1986 Evaluation team recommends comprehensive HIS rather than sentinel surveillance system

Categories	OR	CROSS CUTTING COMMENTS (SUPERVISION,SUSTAINABILITY)
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o no targets set until 1988</li> <li>o target for 1988-1990: (1) Train CAR researchers in epidemiologic techniques for problem identification, investigation, and resolution; (2) perform specific OR studies in EPI, ORT, and Malaria</li> </ul>	<ul style="list-style-type: none"> <li>o goal for future of project is the linking of the array of support strategies, needs assessments, supervision, training, social mobilization and health education into a comprehensive system that has been institutionalized into Directorate of Preventive Medicine</li> </ul>
<p>OUTCOMES (actual v. planned)</p> <p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of target population?</p> <p>(4) Impact What is impact on morbidity/mortality?</p>	<ul style="list-style-type: none"> <li>o no OR protocols from CAR researchers have been submitted to francophone CCCD Research Board (1985)</li> <li>o OR focus in 1988 on cereal-based home solutions for preventing dehydration</li> <li>o resistance studies for the documentation of cq resistance in the CAR planned for 1989</li> </ul>	<p>ISUPERVISION</p> <ul style="list-style-type: none"> <li>o 1988 supervisory workplan developed with check-list</li> <li>o supervisory skills included to a limited degree in training</li> <li>o supervision to be emphasized in second phase of project</li> <li>o evaluating health workers' practices in 55% of all fixed posts nationwide in 1988 (for EPI)</li> <li>o regional supervisors being encouraged to visit workers regularly to reinforce new skills (EPI)</li> </ul> <p>ISUSTAINABILITY</p> <ul style="list-style-type: none"> <li>o auto-financing study in 1986 examined possibilities for self-sustaining activities in health sector - political implications</li> <li>o GOCAR has contributed 72% of its cumulative budget obligations despite stringent International Monetary Fund financial controls</li> <li>o health expenditure study performed in 1987 show 75% of respondents willing to pay for care at public centers; 75% willing to pay for drugs at government centers if availability assured; proximity cited as reason for use of public centers</li> <li>o Minister of Health requested AID help in development and implementation of a cost recovery program</li> <li>o legislation drafted in 1986 mandating payment of fees for health services in CAR</li> <li>o workshop on Health Care Financing attended by officer to Embassy in Banqui</li> </ul>
<p>CONCLUSIONS</p> <p>(1) Institutionalization: To what degree does MOH support systems?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints What factors limited achievement of targets?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<ul style="list-style-type: none"> <li>(3) o funds for OR underutilized</li> <li>(4) o wider use should be made of OR funds</li> <li>o provide assistance in preparing research protocols</li> </ul>	<p>ISUPERVISION</p> <ul style="list-style-type: none"> <li>o lack of transport, gasoline and per diem for supervisory visits limits supervision and training in the health facilities</li> </ul> <p>ISUSTAINABILITY</p> <ul style="list-style-type: none"> <li>(1) o GOCAR contributions far exceed performance of other African countries</li> <li>(2) o indicators for sustainability: <ul style="list-style-type: none"> <li>1. GOCAR meets PROAG contributions despite fiscal crisis</li> <li>2. progress in policy reform and program development in health care financing shows commitment to cost recovery and sustainability</li> </ul> </li> <li>o project extension funds will be used to replace essential vehicles and increase capital stock for ORS and cq in a revolving fund to be set up</li> <li>(4) o 1989 recommendation that TO and Directorate of Preventative Medicine develop a sustainability strategy with corresponding project indicators to document effects of GOCAR policy change and TA from REACH activities on CCCD interventions and support strategies.</li> </ul>

Categories	PROGRAM MANAGEMENT
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li> o baseline information:</li> <li> o basic health care implemented in CAR prior to CCCD through MCH Project and EPI</li> <li> o MCH integrated into PHC service</li> <li> o number of fixed PHC centers increasing nationwide in 1983, 63 MCH centers, with resources to expand to 75 by 1985; in 1982, approx. 35% of pregnant women and children 0-11 months in entire country were registered at MCH centers, received at least 1 service</li> <li> o Amplified Project Description includes methods of measurement, verifiable indicators for each target</li> <li> o country assessment done 1983</li> </ul>
OUTCOMES	<ul style="list-style-type: none"> <li>  (1)</li> <li> o GOCAR: decentralization of day to day mgmt of CCCD program; integration of CCCD activities into MCH/FP structure</li> <li> o during first 2 years of project, 5 months of TA provided; full-time TO assigned 1/86</li> <li> o all 11 of the '87 evaluation recommendations have been followed by MSPAS</li> <li> o PACD date of project extended to 9/1991 with funding of \$750,000</li> <li>  (3) Effects</li> <li> o Access &amp; coverage</li> <li> o What are effects on KAP of target population?</li> <li>  (4) Impact</li> <li> o What is impact on morbidity/mortality?</li> </ul>
(1) Outputs What was provided, accomplished?	<ul style="list-style-type: none"> <li>  (1)</li> <li> o CCCD integrated into GOPCAR PHC activities</li> </ul>
(2) Quality How well are new systems/skills used?	<ul style="list-style-type: none"> <li>  (2)</li> <li> o quality of national level program leadership and executive management noted repeatedly</li> </ul>
(3) Effects Access & coverage What are effects on KAP of target population?	<ul style="list-style-type: none"> <li>  (3)</li> <li> o delay in assigning full time T.O. (1/86)</li> <li> o technical collaboration and logistical support provided by AID Liaison Officer (ALO) in Bangui and HPN Officer in Cameroon contributed to effective program management - must be sustained; prior to ALO procurement very slow, communication poor</li> <li> o unfinished reorganization of the MOH according to WHO recommendations, and the planning of a national PHC program under WHO auspices will affect CCCD</li> <li> o due to delays in implementation, too many activities programmed for 1989 and 1990</li> <li> o shortage of professional personnel, especially nurses observed in 1986 Evaluation</li> <li> o information between national/regional levels does not flow smoothly</li> <li> o lack of formal guidance and directives from central offices allows wide variation of priorities, practices at regional level: need defined set of standards to judge performance</li> <li> o MSPAS, UNICEF, USAID failed to adequately coordinate planning EPI activities to ensure complementarity: quarterly meetings began 11/87, improvement in early 1988</li> </ul>
CONCLUSIONS (1) Institution- alization: To what degree does MOH support systems?	<ul style="list-style-type: none"> <li> o implementation of National Campaign days, an unplanned activity in EPI strategy, caused tension</li> <li> o improved coordination renewed 11/88</li> <li> o trade off between OR, HIS may be inevitable (1989)</li> </ul>
(2) Program strengths	<ul style="list-style-type: none"> <li>  (4)</li> <li> o continuity of high quality TO critical to project</li> <li> o MSPAS wants CCCD to concentrate on training, HIS; UNICEF to support EPI and other aspects of project</li> </ul>
(3) Problems/ Constraints What factors limited achieve- ment of targets?	<ul style="list-style-type: none"> <li> o 1986 Evaluation: need closer cooperation in planning and supervision of field operations between MCH/FP Directorate and Preventive Medicine/Endemic Diseases Directorate</li> </ul>
(4) Lessons learned: What worked? What did not work?	
Recommendations:	

Categories	EPI	CDD
<p>Plans needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>to target: decrease morbidity and mortality due to MNT, measles, and polio by 80% increase coverage of all vaccines to 80%</p> <p>to baseline 1983: coverage: BCG DPT/OPV1 2 3 measles full 80% 80% 80% 75% 54% 47%</p> <p>approximately 60% of population has access cold chain assessed as high quality GOPRC apparently committed to development of EPI activities</p>	<p>to target: decrease mortality due to diarrheal disease by 50% increase access to ORT to 80%</p> <p>to baseline 1983: regular distribution of ORS not yet begun focus of program has been on training and health education in 4 cities</p>
<p><b>OUTCOMES</b> (actual v. planned)</p> <p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity and/or mortality</p>	<p>(1) to conducted 6 vaccination coverage surveys (1 nat'l, 5 district) (1985) to conducted 2 measles epidemiology evaluations (1985) to developed national PEV policy (1985)</p> <p>(2) to participated in national vaccination campaign with MOH, other donors (1986) to developed national EPI protocol; not yet disseminated as of 1986 to conducted special 'mini-campaigns' for measles based on expectation of epidemic peak: expected peak did not occur (1986) to trained health workers in new EPI techniques (1986) to introduced new EPI calendar (1986)</p> <p>(2) to as of 1985, proportion of children &lt;12 mos. immunized was increasing from previous years to 1985 assessment found low percentage of incorrectly vaccinated children</p> <p>(3) to most recent coverage surveys indicate that overall coverage is not increasing significantly</p> <p>(4) to 1986 evaluation found evidence that incidence of measles, polio and pertussis appear to be decreasing slowly; no significant decrease detected in measles CFR</p>	<p>(1) to established 26 ORT centers nationwide (1985) to established national SSS recipe adapted for local conditions (1985) to conducted morbidity and mortality survey in Pointe Noire (1985) to as of 1985, ORS sachets were being imported by CCCD using UNICEF funds to noted a significant increase in # of sachets imported from 1984 to 1985 to developed training program from extension of ORT activities into the regions (1986) to continued routine supervision and data collection (1986) to CDD chief attended WHO CDD manager's meeting in Burundi (1986) to prepared health education materials for new ORT centers (1986) to MOH officially endorsed ORT as the preferred treatment for diarrhea in children (1986) to # of ORS sachets imported decreased dramatically in 1986 to as of 1986, there were 30 ORT centers in existence</p> <p>(2) to 1985 KAP survey showed that 90% of children seen at health centers for diarrhea received anti-diarrheal medication to 1985 KAP survey showed that in most areas, 1/3 of children with diarrhea were being taken to health facilities; 75% in Brazzaville, but most not treated with ORS</p> <p>(3) to as of 1986, 40% of 0-5's had access to ORT to in 1985, 25% of MCH centers, 10% of hospitals were using ORT to as of 1986, ORT use in hospitals was at 55%, but at &lt;10% in outpatient facilities</p>
<p><b>CONCLUSIONS</b></p> <p>(1) Institutionalization: To what degree does MOH support system?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<p>(1) to GOPRC is highly committed to promotion of EPI</p> <p>(3) to timing of vaccinations is not optimal in many areas to most centers do not vaccinate daily to sterile technique is not always adhered to to 1986 evaluation assessed cold chain as insufficient</p> <p>(4) to it appears that the measles 'mini-campaigns' may have played a role in the lack of expected epidemic peak in 1986; however, it is difficult to assess impact related to other, undetermined factors</p>	<p>(1) to GOPRC states commitment to CDD program, but does not reflect this in funding</p> <p>(2) to clinic staff demonstrate high level of knowledge and enthusiasm for CDD to rapid acceptance of ORT by mothers</p> <p>(3) to ORT activities temporarily stopped in 1985 due to supply failure to ORT activities in 1986 severely hampered by financial difficulties to poor monitoring and treatment of diarrheal disease cases at hospital and clinic level</p> <p>(4) to need national ORT training center to need to improve supervision</p>

Categories	MALARIA	TRAINING
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o target: decrease mortality due to malaria by 50% increase access to malaria treatment to 80%</li> <li>o baseline 1983: program focus has been on chemoprophylaxis of 0-6 yr-olds and pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>o target: train approximately 500 health personnel in CCCD techniques</li> <li>o baseline 1983: estimated 2000 medical and paramedical personnel in health workforce</li> </ul>
<b>OUTCOMES</b> (actual v. planned)	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>o trained National Malaria Team in Zaire to monitor resistance levels (1985)</li> <li>o conducted simplified in-vivo cq resistance studies at 5 sites (1985)</li> <li>o proposed national malaria policy (1985)</li> <li>o by 1985, 51% of pregnant women were using regular prophylaxis</li> <li>o developed, printed and distributed MOH-approved national malaria protocol (1986)</li> <li>o continued routine supervision and monitoring in Brazzaville centers (1986)</li> <li>o performed in-vivo comparative study of cq and amodiaquine; confirmed growing cq resistance (1986)</li> <li>o by 1986, 100% of hospitals and health centers sampled were using malaria treatment and prophylaxis protocol</li> </ul> </li> <li>(2)                             <ul style="list-style-type: none"> <li>o small survey in 1985 reported that 9-20% of malaria cases in children were being treated correctly</li> <li>o KAP survey in 1985 showed that 65%-90% of febrile children received cq, but approximately 20% were underdosed</li> </ul> </li> <li>(4)                             <ul style="list-style-type: none"> <li>o cases and deaths continue to increase</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>o conducted first mid-level management course for 23 mid-level managers (MLMs) from 6 regions (1985)</li> <li>o conducted MLM facilitator's course prior to MLM course (1985)</li> <li>o conducted PEV refresher course in 2 areas (1985)</li> <li>o conducted IMOJET demonstration/training course with the Institut Merieux (1985)</li> <li>o trained National Malaria Team in Zaire to monitor resistance levels (1985)</li> <li>o in 1985, trained: 25 MLMs, 11 course facilitators, 2 senior officials, 31 survey interviewers, 365 ORT workers, 9 cq resistance researchers, and 90 PEV vaccinators</li> <li>o developed in-country training strategy (1985)</li> <li>o CDD chief participated in 10-week WHO senior-level manager's course in Burundi (1986)</li> <li>o conducted variety of training activities in 1986 focused on vaccination campaign</li> <li>o conducted 2-phase TOT for vaccination campaign: these trainers trained approximately 400 peripheral level health workers in vaccination centers (1986)</li> <li>o conducted 2 "mini training programs" in ORT for introduction of ORT to health centers (1986)</li> <li>o trained health workers in new EPI techniques (1986)</li> <li>o developed training program for extension of ORT activities into regions (1986)</li> <li>o held short training session to introduce new malaria policy and monitoring methods at 1 health center (1986)</li> <li>o negotiated with National Administrative School to develop training materials and conduct TOT course; no follow-up reported (1986)</li> <li>o developed job description for training coordinator (1986)</li> </ul> </li> </ul>
<b>CONCLUSIONS</b> (1) Institutionalization: To what degree does MOH support system?  (2) Program strengths  (3) Problems/Constraints: What factors limit target achievement?  (4) Lessons learned: What worked? What did not work?  Recommendations?	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>o GOPRC states commitment to malaria program, but funding does not reflect this</li> </ul> </li> <li>(3)                             <ul style="list-style-type: none"> <li>o 1986 evaluation assessed malaria program as still very weak</li> <li>o observations revealed that a wide range of treatments are being used; there is no agreed-upon "best method"</li> <li>o program suffers from financial difficulties</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>o GOPRC indicated desire for training; no training coordinator appointed</li> </ul> </li> <li>(2)                             <ul style="list-style-type: none"> <li>o high level of competence at senior level of management</li> </ul> </li> <li>(3)                             <ul style="list-style-type: none"> <li>o no full-time training coordinator</li> <li>o training program hampered by financial difficulties</li> </ul> </li> <li>(4)                             <ul style="list-style-type: none"> <li>o need to integrate training and health education</li> </ul> </li> </ul>

Categories	HEALTH EDUCATION	HIS
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o annual workplan and budget developed</li> </ul>	<ul style="list-style-type: none"> <li>o target: improve collection, tabulation and analysis of operational and surveillance data</li> <li>o baseline 1983:               <ul style="list-style-type: none"> <li>current system inadequate</li> <li>approximately 20% reporting rate; data is delayed and incomplete</li> <li>no standard reporting form exists</li> </ul> </li> </ul>
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and/or mortality	<ul style="list-style-type: none"> <li>(1)               <ul style="list-style-type: none"> <li>o developed health education and planning strategy (1985)</li> <li>o drafted guide for conducting health education and planning sessions in MCH clinics (1985)</li> <li>o pretested SSS drawings (1985)</li> <li>o appointed health education coordinator (1985)</li> <li>o 1986 activities focused on social mobilization and education for immunization campaign</li> <li>o developed EPI television and radio messages (1986)</li> <li>o developed and distributed EPI banners, posters, fliers and T-shirts (1986)</li> <li>o conducted informal evaluation of mothers to determine how they heard about immunization campaign; radio and word of mouth cited as primary sources of information (1986)</li> <li>o developed draft CDD educational materials (1986)</li> <li>o worked with CARE on nutrition ed. project (1986)</li> <li>o produced documentary film on diarrheal disease; CCCD staff appeared on talk show when film was first aired (1986)</li> <li>o formed Health Education Consultative Committee with members of MOH, donors, CCCD; held 1 meeting (1986)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(1)               <ul style="list-style-type: none"> <li>o as of 1985, 5 sentinel posts exist in Brazzaville; 15 posts exist in 6 of 9 administrative regions; these monitor EPI diseases</li> <li>o assessed 1984 reporting as complete</li> <li>o established sentinel surveillance system to monitor cq resistance (1986)</li> <li>o extended sentinel surveillance system for CDD (1986)</li> <li>o requested consultant to study, aid HIS; no response received as of end of 1986</li> </ul> </li> </ul>
<b>CONCLUSIONS</b> (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations?	<ul style="list-style-type: none"> <li>(1)               <ul style="list-style-type: none"> <li>o MOH encourages health education activities</li> </ul> </li> <li>(2)               <ul style="list-style-type: none"> <li>o 1986 evaluation assessed health ed. activities as sustainable if allowed to proceed as planned</li> <li>o population generally seeks health care at high rate</li> </ul> </li> <li>(3)               <ul style="list-style-type: none"> <li>o funding was primary constraint cited</li> <li>o lack of planning and management was cited as a secondary constraint</li> <li>o health ed. coordinator has responsibilities in addition to health ed. coordination; cannot dedicate full time to the project</li> </ul> </li> <li>(4)               <ul style="list-style-type: none"> <li>o need to utilize Consultative Committee to much greater degree</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(3)               <ul style="list-style-type: none"> <li>o 1986 annual report assessed HIS system as "deplorable"</li> <li>o overall reporting to central level incomplete; about 20% reporting rate</li> </ul> </li> <li>(4)               <ul style="list-style-type: none"> <li>o recommend short term consultant to develop the HIS in Congo</li> </ul> </li> </ul>

Categories	OR	CROSS CUTTING COMMENTS (SUPERVISION,SUSTAINABILITY)
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	no targets specified for OR	to target: GOPRC will increase its funding by 25% per year; AID will phase out its funding by 25% per year  to baseline 1983: fees established for vaccination cards and chloroquine
<b>OUTCOMES</b>		
(actual v. planned)		
(1) Outputs What was provided, accomplished?	(1) to conducted 10 KAP surveys re diarrheal disease and malaria health practices in a variety of potential caregivers (1985)	(1) <b>SUPERVISION</b> to as of 1986, supervision and monitoring were noted as routine program components to EPI cost analysis performed in 1985
(2) Quality How well are new systems/skills used?	to conducted 3 surveys on availability of SSS ingredients (1985) to conducted lab analysis of locally available salts, sugars (1985)	(1) <b>SUSTAINABILITY</b> to USAID funds frozen in January 1986 due to lack of GOPRC contribution
(2) Effects Access & coverage What are effects on KAP of pop.?	to pretested SSS recipe and drawings (1985) to conducted cost analysis evaluation of vaccination strategies and ORT services (1985)	
(4) Impact What is impact on morbidity and/or mortality	to conducted 3 surveys on public participation in 3 vaccination coverage surveys (1985) to conducted in-vitro cq and amodiaquine resistance studies (1985)	
	to conducted simplified in-vivo cq resistance studies in 5 sites (1985)	
	to conducted vaccination coverage and KAP survey (1985)	
	to conducted diarrhea morbidity and mortality survey (1985)	
	to performed in-vivo comparative study of cq and amodiaquine; confirmed growing cq resistance (1986)	
	to conducted serologic study on optimal age for measles vaccination (1986)	
	(3) to OR confirmed increasing cq resistance and continued efficacy of amodiaquine as second-line drug	
<b>CONCLUSIONS</b>		
(1) Institutionalization: To what degree does MOH support system?	(1) to MOH encourages operations research	(1) <b>SUPERVISION</b> to need to increase supervisory activities
(2) Program strengths	(2) to results of OF can be found in available documentation	(1) <b>SUSTAINABILITY</b> to GOPRC has not made funds available for project
(3) Problems/Constraints: What factors limit target achievement?		(3) to AID lagged in expenditures due to slow start up of program activities to primary constraint in all program components was lack of financing
(4) Lessons learned: What worked? What did not work?		(4) to recommend that government develop auto-financing system immediately
Recommendations?		

Categories	PROGRAM MANAGEMENT
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>to baseline 1983:                             <ul style="list-style-type: none"> <li>PHC system resides in MOH and with WFO (EPI); considered to be "in its infancy" assessment, 1983)</li> <li>PHC system has no budget</li> <li>n transportation for supervision has been available</li> <li>currently exist approximately 500 health facilities nationwide</li> </ul> </li> <li>to country assessment done 1983</li> </ul>
<b>OUTCOMES</b>	
(actual v. planned)	(1)
(1) Outputs What was provided, accomplished?	<ul style="list-style-type: none"> <li>to established cooperation and coordination policy with all major PHC and CCCD-related health programs (1985)</li> </ul>
(2) Quality How well are new systems/skills used?	<ul style="list-style-type: none"> <li>to new Director for Preventive Health/National Coordinator appointed (1985)</li> <li>to new CDD and Malaria chiefs appointed (1985)</li> <li>to developed 1986 activity plan for CCCD (1985)</li> <li>to regularly collaborated with donors in vaccination campaign activities, health ed. activities, and other program activities (ongoing)</li> </ul>
(3) Effects Access & coverage What are effects on KAP of pop.?	<ul style="list-style-type: none"> <li>to developed PHC Coordinating Committee (1986)</li> </ul>
(4) Impact What is impact on morbidity and/or mortality	<ul style="list-style-type: none"> <li>to project ended in 1987 due to lack of cooperation and financial input from Government; remaining AID funds were transferred to UNICEF for continued Child Survival activities</li> </ul>
<b>CONCLUSIONS</b>	(1)
(1) Institutionalization: To what degree does MOH support system?	<ul style="list-style-type: none"> <li>to GOPRC did not fulfill financial commitments to project</li> </ul>
(2) Program strengths	<ul style="list-style-type: none"> <li>to lack of GOPRC financial input primary constraint to progress of project</li> <li>to lack of attention from executive level of govt.</li> <li>to lack of motivation of personnel to work outside office during regular work time without per diem</li> </ul>
(3) Problems/Constraints: What factors limit target achievement?	<ul style="list-style-type: none"> <li>to inadequate coordination within government</li> <li>to inability of central-level staff to assign productive staff or remove unproductive staff</li> <li>to lack of clear MOH objectives and policies</li> <li>to PHC poorly integrated into overall MCH systems</li> </ul>
(4) Lessons learned: What worked?	(4)
What did not work?	<ul style="list-style-type: none"> <li>to 1984 reorganization of Ministry caused delay in startup of CCCD activities</li> </ul>
Recommendations?	<ul style="list-style-type: none"> <li>to lack of formalized policies for interventions have contributed to slow progress of project</li> <li>to need to incorporate ORS &amp; cq into EPI distribution system</li> <li>to need better bookkeeping system</li> </ul>

COTE D'IVOIRE: EVALUATION CONTENT FOR ACSI-CCCD

Project Start: June 1985 LOP Funding: \$1,691,000

Categories	EPI	CDD
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes.	<ul style="list-style-type: none"> <li>o targets: (&lt;5s by end year 4)                             <ul style="list-style-type: none"> <li>measles cases and deaths 50% decrease</li> <li>pertussis cases and deaths 40% decrease</li> <li>neonatal tetanus deaths 40% decrease</li> </ul> </li> <li>o coverage targets: (by end of 1989)                             <ul style="list-style-type: none"> <li>rural areas 50% increase</li> <li>urban areas 60% increase</li> </ul> </li> <li>o baseline incidence (1983):                             <ul style="list-style-type: none"> <li>measles: 420/100,000 (400 reporting units)</li> <li>pertussis: 110/100,000</li> <li>MNT: 3.5/100,000</li> </ul> </li> <li>o baseline full coverage: 35% 12-23 mos.</li> </ul>	<ul style="list-style-type: none"> <li>o target: increase facility-based use of ORT to 75%                             <ul style="list-style-type: none"> <li>increase home-based use of ORT to 50%</li> <li>decrease diarrhea mortality by 40%</li> </ul> </li> <li>o baseline information:                             <ul style="list-style-type: none"> <li>facility-based use of ORS (1986): 50%</li> <li>diarrhea mortality (hospitalized children, 1984): 50 deaths</li> </ul> </li> <li>o goals:                             <ul style="list-style-type: none"> <li>establish ORT demonstration center at UHC Treichville</li> <li>design mass media campaigns</li> <li>ORT training for CHWs and community members</li> <li>elaborate a national ORT strategy</li> </ul> </li> </ul>
OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of target population? (4) Impact What is impact on morbidity/ mortality?	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>o 415 of 800 health centers have capacity to immunize 60% of the population (1986)</li> <li>o EPI/Ivory Coast functional in all rural health sectors (1986)</li> <li>o computerization of vaccination reports begun at Hygiene Institute (1986)</li> </ul> </li> <li>(2)                             <ul style="list-style-type: none"> <li>o &gt;50% health facilities routinely vaccinate children (1986)</li> </ul> </li> <li>(3)                             <ul style="list-style-type: none"> <li>o coverage rates (1987 children 12-23 mos): (stated in % of children having had the following groups of vaccines):                                     <ul style="list-style-type: none"> <li>DPT3;Polio3;measles;yellow fever=59%</li> <li>BCG;DPT3;Polio3;measles=38%</li> <li>BCG;DPT3;Polio3;measles;yellow fever(i.e..full)=57%</li> <li>TT1=82% TT2=63% (pregnant women)</li> </ul> </li> </ul> </li> <li>(4)                             <ul style="list-style-type: none"> <li>o decrease in morbidity/mortality due to accelerated immunization campaign started in 1987 (6 mths)</li> <li>o as of 1988 only 0-2 measles cases/month reported</li> <li>o reported cases (1986):                                     <ul style="list-style-type: none"> <li>measles: 325/100,000 (650 reporting units)</li> <li>pertussis: 70/100,000 (650 reporting units)</li> <li>MNT: 5.5/100,000 (650 reporting units)</li> </ul> </li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>o construction of ORT demonstration center at Treichville underway; 4 units established at regional hospital</li> <li>o national CDD plan and policies exist; ideas from WHO, PRITECH, HEALTHCOM evaluations incorporated</li> <li>o 3 Ivoirians received training at Kinshasa ORT center</li> <li>o CDD coordinator appointed by Minister of Health</li> <li>o mass media blitz designed with ORT, feeding &amp; hygiene components</li> <li>o 1985 Ivory Coast launches CDD campaign; 16 seminars held, 1100 people trained, ORS packets made available to all health centers</li> </ul> </li> <li>(2)                             <ul style="list-style-type: none"> <li>o as of 1987, health facility use of ORT/ORS up to 98%</li> </ul> </li> <li>(3)                             <ul style="list-style-type: none"> <li>o according to practices survey, only 16 of &lt;5's surveyed with diarrhea received ORT; of 25 mothers using ORS packets, only 1 in 25 mixed solution correctly</li> <li>o MHPH &amp; UNICEF conducted a CDD evaluation/needs assessment in &gt;200 health centers in 1988 (no results available)</li> </ul> </li> <li>(4)                             <ul style="list-style-type: none"> <li>o no overall morbidity or mortality data available since 1986</li> </ul> </li> </ul>
CONCLUSIONS (1) Institution- alization: To what degree does MOH support systems? (2) Program strengths (3) Problems/ Constraints What factors limited achieve- ment of targets? (4) Lessons learned: What worked? What did not work? Recommendations?	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>o EPI vaccination schedule revised in accordance with WHO recommendations (1986)</li> </ul> </li> <li>(2)                             <ul style="list-style-type: none"> <li>o CCCD EPI program considered great success</li> </ul> </li> <li>(3)                             <ul style="list-style-type: none"> <li>o 40% of population remain un-covered by services; require outreach and mobile services</li> </ul> </li> <li>(4)                             <ul style="list-style-type: none"> <li>o immunization campaigns consume too much time and resources to justify continuation</li> <li>o need to build immunization capacity in remaining 385 health centers</li> <li>o CCCD EPI activities should be better integrated with UNICEF</li> <li>o need to improve equipment and training in rural areas</li> <li>o need to expand and maintain sentinel surveillance systems and monitor impact</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>o Ministry has devised a CDD plan &amp; policy</li> <li>o the MCH centers have integrated ORT into regular activities in Abidjan</li> </ul> </li> <li>(2)                             <ul style="list-style-type: none"> <li>o health facilities are instituting ORT as the treatment for diarrhea</li> </ul> </li> <li>(3)                             <ul style="list-style-type: none"> <li>o despite ambitious training efforts, little follow-up on those trained in seminars</li> <li>o though an ORT center was established at Fort-Bouet (1986), it was closed after 10 months due to lack of government commitment</li> <li>o although the proportion of health centers using ORT has increased to 98%, only 35% of facilities are resupplied regularly</li> <li>o confusion exists about home-based SSS</li> <li>o CDD program still too dependent on imported ORS packets</li> </ul> </li> <li>(4)                             <ul style="list-style-type: none"> <li>o need to provide follow-up to health workers trained in ORT use</li> <li>o need to improve logistical support for delivery of ORS packets</li> <li>o demonstration unit at Treichville needs improvement</li> <li>o need to offer more hands on training to mothers and community members in the prep. and application of ORS</li> <li>o need to consider local production of ORS packets</li> <li>o national policy of home-based SSS needed</li> <li>o morbidity and mortality reporting system needs development</li> </ul> </li> </ul>

Categories	MALARIA	TRAINING
Plans Needs assessment, goals & objectives planned inputs, expected outcomes.	<ul style="list-style-type: none"> <li>o target: decrease malaria-specific mortality (0-4 yrs) by 30%</li> <li>o decrease malaria-specific spontaneous abortion and prematurity</li> <li>o increase knowledge of proper malaria chemot chemotherapy among parents to 75%</li> <li>o increase appropriate use of therapy to 50%</li> <li>o increase use of chemotherapy in pregnant women by 50%</li> </ul>	<ul style="list-style-type: none"> <li>o target: CCCD MLM course for 26 physicians-in-charge of medical sectors, 26 medical sector CCCD coordinators, 30 PMI physicians, 18 central level staff from IMSP</li> <li>o CCCD/PHC field seminars for 650 nurses, midwives, &amp; health development agents from 500 rural health facilities</li> <li>o PHC workshops for 2 VHVs from each of the 8,000 villages</li> <li>o technical training of approximately 750 Ministry health workers</li> </ul>
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of target population? (4) Impact What is impact on morbidity/mortality?	<ul style="list-style-type: none"> <li>(1) o malaria treatment policy determined at 25mg/kg over 3 days</li> <li>o international seminar on drug sensitivity testing of P. falciparum to chloroquine held (treatment policy resulted)</li> <li>(2) o 1986 survey shows that 42% facilities in Abidjan and 68% outside routinely prescribe malaria chemotherapy to pregnant women</li> <li>(3) o practices survey of mothers in Abidjan shows that 28% of children &lt;5 had fever within last 2 weeks (1988)</li> <li>o PHC workers trained to give anti-malaria chemotherapy for all febrile episodes</li> <li>(4) o no morbidity or mortality data available after 1986</li> </ul>	<ul style="list-style-type: none"> <li>(1) o as of 1987 11% of target peripheral health staff trained; 100% of the mid-level agrs. and none of the senior level officials</li> <li>o 4 trainers from IMSP have been selected and trained at TOT course in Togo in 1986</li> <li>o training materials are available at all levels including "job aids" for peripheral health workers</li> <li>o 3 MLM courses held in 1986</li> <li>o 2 peripheral level courses held in 1987</li> <li>o vaccination program training and planning course given to medical directors of 25 rural health sectors and 2 of their staff (1987)</li> <li>o rural health sector held CDD course for 17 people (1987)</li> <li>o EPI training provided in preparation of national vaccination days; 46 persons trained (1987)</li> </ul>
<b>CONCLUSIONS</b> (1) Institution- alization: To what degree does MOH support systems? (2) Program strengths (3) Problems/ Constraints What factors limited achieve- ment of targets? (4) Lessons learned: What worked? What did not work? Recommendations?	<ul style="list-style-type: none"> <li>(1) o as of 1988 national malaria policy signed by Minister of Health and plans underway to implement policy</li> <li>o draft of national treatment strategy prepared by doctors from all areas of Ministry</li> <li>o appointment of national malaria coordinator made</li> <li>(3) o survey of 54 doctors concerning malaria treatment practices shows few using 25mg/kg regimen; need for clinical treatment guidelines</li> <li>o though majority of pregnant women prescribed proper malaria treatment, compliance unknown</li> <li>o national malaria policy still not promulgated</li> <li>(4) o malaria technical advisory committee needed to work with malaria coordinator</li> <li>o need to improve malaria tracking and reporting system</li> <li>o training materials needed for training of peripheral health workers in TX protocol</li> </ul>	<ul style="list-style-type: none"> <li>(1) o a Ministry training coordinator has been assigned to help schedule and conduct training activities</li> <li>(3) o several courses were cancelled due to vaccination campaign and never rescheduled</li> <li>(4) o need more training for peripheral level health workers and senior level staff</li> <li>o MLM training in the areas of data analysis and supervision is needed</li> <li>o peripheral health workers need more training in CDD interventions</li> <li>o training should be more decentralized</li> </ul>

## Categories

## HEALTH EDUCATION

## HIS

Categories	HEALTH EDUCATION	HIS
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes.	<ul style="list-style-type: none"> <li>o targets:</li> <li>o target: preparation of health education materials for MCH center staff for patient education</li> <li>o development of mass media campaign including radio spots for CDD education, malaria treatment, and IT vaccination</li> </ul>	<ul style="list-style-type: none"> <li>o target: establishment of HIS to provide officials at every level with coherent &amp; consolidated information</li> <li>o use of reliable data for health planning &amp; programming; develop a feedback system to provide current information to health officers at all levels</li> <li>o provide HIS training to health workers responsible for monthly reporting of health center statistics</li> <li>o establish 30 surveillance sites</li> <li>o establish baseline morbidity and mortality data for CCCD target diseases</li> </ul>
OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished?  (2) Quality How well are new systems/skills used?  (3) Effects Access & coverage What are effects on KAP of target population?  (4) Impact What is impact on morbidity/ mortality?	<ul style="list-style-type: none"> <li>(1)</li> <li>o health education specialist visited in 1988 to elaborate health ed. component of CCCD project in collaboration with National Health Education Services</li> <li>o in 1987 mass media plans were developed calling for 8 media campaigns between 1987-89 covering all CCCD program areas</li> <li>o in 1987 focus group techniques were taught to 2 persons from National Public Health Institute</li> <li>o radio messages were developed and broadcast for 1987 national vaccination campaign</li> <li>o in 1988 radio spots for measles vaccine aired successfully though impact uneven</li> <li>(2)</li> <li>o health promotion of target population now receiving more attention</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o collection of morbidity data from health centers continues to improve</li> <li>o data concerning trends in vaccine preventable diseases is computerized by the Directorate of planning</li> <li>o mortality reports from government health centers submitted by over 90% of centers (1988)</li> <li>o 2 surveys have been conducted during CCCD project</li> <li>o a facility survey was conducted in 1986, and a practices survey was conducted in 1988 (Abidjan)</li> <li>o the US Bureau of Census assisted in training and design of practice surveys</li> </ul>
CONCLUSIONS (1) Institution- alization: To what degree does MOH support systems?  (2) Program strengths  (3) Problems/ Constraints What factors limited achieve- ment of targets?  (4) Lessons learned: What worked? What did not work?  Recommendations?	<ul style="list-style-type: none"> <li>(1)</li> <li>o coordinator for health ed. component identified at National Public Health Institute</li> <li>(3)</li> <li>o only 3 of 60-70 local languages used for radio spots; message impact should be monitored</li> <li>o external consultants are needed in the areas of communications &amp; evaluation</li> <li>(4)</li> <li>o despite successful airing of messages prior to national vaccination campaign, follow-up survey shows that while 45% of population listens to radio only 28% heard the vaccination campaign radio messages</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o the implementation of a HIS has helped with the collection of morbidity and mortality information</li> <li>o government encourages Ministry to continue HIS improvements</li> <li>(3)</li> <li>o no system in place to routinely collect hospital morbidity and mortality data</li> <li>o though monthly statistical reports are coming in from health centers, distribution of summaries has been delayed for administrative &amp; financial reasons</li> <li>o to date, only a fraction of the information collected has been analysed and used for decision making</li> <li>o a new HIS or better sentinel system is needed to monitor diarrhea mortality, severe malaria, measles and diarrhea morbidity</li> </ul>

Categories	OR	CROSS CUTTING COMMENTS (SUPERVISION, SUSTAINABILITY)
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes.	<ul style="list-style-type: none"> <li>o target: establish research review board conduct the following studies: 2 EPI; 5 CDD; 2 malaria; 1 ARI; 1 IH; 2 management</li> <li>fund 10 or more projects with bilateral funds during first 2 years</li> <li>conduct a baseline morbidity, mortality and health services utilization survey in first year of CCCC project</li> </ul>	<ul style="list-style-type: none"> <li>o targets:</li> <li>SUSTAINABILITY: have host country contribute at least 25% of total project costs in increasing increments over 4 yrs</li> <li>SUPERVISION: develop health workers' skills in providing effective child survival services through practice, supervision and on the job training</li> </ul>
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished?  (2) Quality How well are new systems/skills used?  (3) Effects Access & coverage What are effects on KAP of target population?  (4) Impact What is impact on morbidity/ mortality?	<ul style="list-style-type: none"> <li>(1) <ul style="list-style-type: none"> <li>o a review committee was appointed in 1986</li> <li>o in 1986 a draft brochure was prepared with info about procedures for obtaining grants</li> <li>o as of 1987, 7 OR studies had been carried out to look at the following: home preparations of SSS; mother's response to fever; maternal measles antibodies; meningococcal meningitis; ORT use in Ivory Coast following construction of demonstration unit; malaria drug treatment and prevention practices; cq (in vivo) efficacy; and risk factors associated with hospitalized measles cases</li> </ul> </li> <li>(4) <ul style="list-style-type: none"> <li>o studies have been used to make several policy decisions, including: <ul style="list-style-type: none"> <li>-need to clarify SSS components or reconsider policy</li> <li>-need to prescribe 25mg/kg v. 10mg/kg chloroquine</li> <li>-need for mothers to learn ORS preparation via practical exercises</li> </ul> </li> <li>o a practice survey conducted in Abidjan (1988) demonstrated need to increase vaccination coverage of children coming into vaccination age</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>SUSTAINABILITY:</li> <li>(1) <ul style="list-style-type: none"> <li>o GOCI permitting sales of health &amp; vaccination cards &amp; medications</li> <li>o CHWs are allowed to keep a percentage of their profits from sale of drugs</li> <li>o Ivory Coast contribution to CCCC project in 1987 was \$107,000 - well in excess of 25% requested</li> </ul> </li> <li>SUPERVISION:</li> <li>(1) <ul style="list-style-type: none"> <li>o thru HIS indirect supervision of health sectors has been enhanced</li> </ul> </li> </ul>
<b>CONCLUSIONS</b> (1) Institution- alization: To what degree does MOH support systems?  (2) Program strengths  (3) Problems/ Constraints What factors limited achieve- ment of targets?  (4) Lessons learned: What worked? What did not work?  Recommendations?	<ul style="list-style-type: none"> <li>(1) <ul style="list-style-type: none"> <li>o to date, a number of studies have been conducted with CCCC support</li> <li>o a proposal review board is in place and functioning</li> <li>o results from studies are being used to modify or develop policy</li> </ul> </li> <li>(2) <ul style="list-style-type: none"> <li>o OR component considered successful</li> <li>o proposals for studies are plentiful</li> </ul> </li> <li>(3) <ul style="list-style-type: none"> <li>o baseline morbidity &amp; mortality study never done</li> <li>o alternative financing studies need to be conducted</li> </ul> </li> <li>(4) <ul style="list-style-type: none"> <li>o statistics course needed for chief medical officers</li> <li>o feasibility study needed for local ORS production</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>SUSTAINABILITY:</li> <li>(1) <ul style="list-style-type: none"> <li>o alternative financing studies are being conducted</li> </ul> </li> <li>(4) <ul style="list-style-type: none"> <li>o need to look at different self-financing schemes (ie ORS production)</li> </ul> </li> <li>SUPERVISION:</li> <li>(4) <ul style="list-style-type: none"> <li>o need is clear for additional supervision at peripheral level</li> <li>o CCCC needs to provide technical assistance to sector health officers in the est. of functional and supportive supervisory system at peripheral level</li> </ul> </li> </ul>

Categories

PROGRAM MANAGEMENT

Plans  
Needs assessment,  
goals & objectives,  
planned inputs,  
expected outcomes.

- o target: management of CCCD/Ivory Coast program conducted by committee consisting of a national project coordinator & coordinators of each of the project components
- o coordinating committee will provide technical & logistical support as well as management guidance to all health services
- o CDC technical officer assigned to facilitate management procedures
- o review schedule: internal (1st & 3rd yrs.) external (2nd yr.) final (4th yr.)
- o country assessment done 1984

OUTCOMES  
(actual v. planned)

(1) Outputs  
What was provided,  
accomplished?

- (1) coordinators identified for all CCCD interventions (1986)
- o Technical Officer's and field epidemiologist's offices fully functional (1986)
- o program specialist hired by REDSO/WCA to do administrative management of ACSII-CCCD project (1986)
- o commodities procurement commenced (1986)

(2) Quality  
How well are new  
systems/skills  
used?

(3) Effects  
Access & coverage  
What are effects  
on KAP of target  
population?

(4) Impact  
What is impact on  
morbidity/  
mortality?

CONCLUSIONS

(1) Institution-  
alization:  
To what degree  
does MOH support  
systems?

- (1) GOCI commitment to PHC outlined in draft 5-yr. national public health plan (1986-1990)
- o as of 1988, basic PHC structure in place and functioning with 8 regions, 25 health sectors, of which 50% are equipped with to provide immunization services

(2) Program  
strengths

- (3)
- o CCCD component coordinators have multiple responsibilities, making it difficult to develop implementation plans

(3) Problems/  
Constraints  
What factors  
limited achieve-  
ment of targets?

- o yaws interventions never implemented due to inability to find yaws specialist

(4) Lessons  
learned:  
What worked?  
What did not work?

- (4)
- o vaccination campaigns need to be closely studied since the one in Ivory Coast rose other health activities for 6 months.
- o drug ordering and distribution system needs to be reorganized to reflect changes in policy (ie use of ORS v. SSS and chloroquine v. injectables)

Recommendations?

- o recommended extension of project to 1991: approved by USAID/CDC/GOCdI

Project Start: June 1985 Funding: \$885,000

Categories	EPI	CDD
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<p>target: decrease morbidity and mortality due to measles, NNT, and polio by 33-50% (proportional to target population) vaccination coverage by 1990:</p> <p>BCG 20% from 5% in 1982 DPT/OPV3 20% from 15% in 1982 measles 50% from 44% in 1982 TT 20% (in pregnant women)</p> <p>baseline information 1983: immunization has been underway in Guinea for several years EPI is centered in MCH clinics poor supply system exists vaccine wastage is high reporting is very low, unreliable MOH is plans to equip more fixed centers</p>	<p>target: decrease diarrheal disease mortality by 33-50% (proportional to target population)</p> <p>baseline information 1983: no specific diarrheal disease control program exists ORS generally not used in Guinea; some how fluids used primary GOG efforts in area of sanitation, potable water supply ORT program would be best adopted if introduced via local PHC units</p>
OUTCOMES (actual v. planned)	(1)	(1)
(1) Outputs What was provided, accomplished?	<p>assisted with 3-week WHO national EPI review (1986)</p> <p>recommended to revise national cold chain policy and procedures</p> <p>drafted strategy plan for 1986-1990; adopted by MOH (1986)</p> <p>26 health workers attended first CCCD training seminar; focus was on EPI (1986)</p> <p>4 Guineans attended study trip to Benin to observe integrated EPI-PHC program (1986)</p> <p>trained personnel from 1 health center in EPI (1986)</p> <p>conducted donor-MOH meetings to discuss accelerated EPI campaign (1986)</p> <p>began intensive vaccination campaign in Conakry (November 1986)</p> <p>trained 300 health personnel in vaccination, cold chain management, &amp; the updated WHO vaccination schedule (1986)</p> <p>completed Conakry vaccination survey (1986)</p> <p>completed first mass vaccination campaign in Conakry; campaign assessed as successful (1987)</p> <p>conducted coverage survey at end of campaign (1987)</p> <p>performed KAP study in Conakry re NNT (1987)</p> <p>trained 20 health center personnel in cold chain technique &amp; vehicle maintenance (1987)</p> <p>held coordination meetings with UNICEF, ADB (1987)</p> <p>distributed equipment to 26 centers; initiated EPI activities in those centers (1987)</p> <p>as of 1987, all centers in Conakry were vaccinating daily</p> <p>conducted baseline coverage survey in Conakry (1988)</p> <p>analyzed 1987 EPI HIS data (1988)</p> <p>intensified supervision; revised checklists (1988)</p> <p>initiated EPI activities at 28 centers; all CCCD centers now performing vaccinations (1988)</p> <p>performed study of EPI in Kindia (1988)</p> <p>conducted health center needs assessment at 6 facilities in Conakry (1988)</p>	<p>held national conference on diarrheal disease (1986)</p> <p>sponsored 3 participants at ICORT (1986)</p> <p>MOH endorsed ORT as appropriate dehydration treatment (1986)</p> <p>assigned 2 epidemiologists to improve cholera treatment and reporting (1986)</p> <p>established ORT center at University Hospital (1986)</p> <p>upgraded ORT center and Infectious Disease ward's water supply system (1986)</p> <p>completed preliminary assessment of diarrheal disease activities (1986)</p> <p>performed KAP survey of health personnel in Conakry and Forecariah (1986)</p> <p>trained 30 health personnel in ORT in 2 areas (1987)</p> <p>appointed National CDD Director (1987)</p> <p>established ORT units in 7 locations (1987)</p> <p>conducted KAP studies in 2 areas (1988)</p> <p>delivered ORT materials to all health centers in Kindia, Telimele (1988)</p> <p>collected &amp; analyzed 1987 CDD data (1988)</p> <p>trained 5 PCVs in ORT (1988)</p> <p>performed study to evaluate CDD activities in Kindia (1988)</p> <p>TO assisted in diarrhea outbreak investigation ('88)</p> <p>drafted health education plan and calendar of activities for CDD (1988)</p> <p>designed and pretested ORT poster (1988)</p> <p>trained 33 health ctr. personnel in ORT (1988)</p> <p>developed national ORT training plan (1988)</p> <p>conducted health ctr needs assessment, Conakry ('88)</p> <p>regularly received and distributed ORS packets since 1987 (1988)</p> <p>Minister of Health and CCCD Project Coordinator/ National CDD Director attended ICORT III stg. (1988)</p>
(2) Quality How well are new systems/skills used?	<p>completed Conakry vaccination survey (1986)</p> <p>completed first mass vaccination campaign in Conakry; campaign assessed as successful (1987)</p> <p>conducted coverage survey at end of campaign (1987)</p> <p>performed KAP study in Conakry re NNT (1987)</p> <p>trained 20 health center personnel in cold chain technique &amp; vehicle maintenance (1987)</p> <p>held coordination meetings with UNICEF, ADB (1987)</p> <p>distributed equipment to 26 centers; initiated EPI activities in those centers (1987)</p> <p>as of 1987, all centers in Conakry were vaccinating daily</p> <p>conducted baseline coverage survey in Conakry (1988)</p> <p>analyzed 1987 EPI HIS data (1988)</p> <p>intensified supervision; revised checklists (1988)</p> <p>initiated EPI activities at 28 centers; all CCCD centers now performing vaccinations (1988)</p> <p>performed study of EPI in Kindia (1988)</p> <p>conducted health center needs assessment at 6 facilities in Conakry (1988)</p>	<p>assigned 2 epidemiologists to improve cholera treatment and reporting (1986)</p> <p>established ORT center at University Hospital (1986)</p> <p>upgraded ORT center and Infectious Disease ward's water supply system (1986)</p> <p>completed preliminary assessment of diarrheal disease activities (1986)</p> <p>performed KAP survey of health personnel in Conakry and Forecariah (1986)</p> <p>trained 30 health personnel in ORT in 2 areas (1987)</p> <p>appointed National CDD Director (1987)</p> <p>established ORT units in 7 locations (1987)</p> <p>conducted KAP studies in 2 areas (1988)</p> <p>delivered ORT materials to all health centers in Kindia, Telimele (1988)</p> <p>collected &amp; analyzed 1987 CDD data (1988)</p> <p>trained 5 PCVs in ORT (1988)</p> <p>performed study to evaluate CDD activities in Kindia (1988)</p> <p>TO assisted in diarrhea outbreak investigation ('88)</p> <p>drafted health education plan and calendar of activities for CDD (1988)</p> <p>designed and pretested ORT poster (1988)</p> <p>trained 33 health ctr. personnel in ORT (1988)</p> <p>developed national ORT training plan (1988)</p> <p>conducted health ctr needs assessment, Conakry ('88)</p> <p>regularly received and distributed ORS packets since 1987 (1988)</p> <p>Minister of Health and CCCD Project Coordinator/ National CDD Director attended ICORT III stg. (1988)</p>
(3) Effects Access & coverage What are effects on KAP of pop.?	<p>conducted donor-MOH meetings to discuss accelerated EPI campaign (1986)</p> <p>began intensive vaccination campaign in Conakry (November 1986)</p> <p>trained 300 health personnel in vaccination, cold chain management, &amp; the updated WHO vaccination schedule (1986)</p> <p>completed Conakry vaccination survey (1986)</p> <p>completed first mass vaccination campaign in Conakry; campaign assessed as successful (1987)</p> <p>conducted coverage survey at end of campaign (1987)</p> <p>performed KAP study in Conakry re NNT (1987)</p> <p>trained 20 health center personnel in cold chain technique &amp; vehicle maintenance (1987)</p> <p>held coordination meetings with UNICEF, ADB (1987)</p> <p>distributed equipment to 26 centers; initiated EPI activities in those centers (1987)</p> <p>as of 1987, all centers in Conakry were vaccinating daily</p> <p>conducted baseline coverage survey in Conakry (1988)</p> <p>analyzed 1987 EPI HIS data (1988)</p> <p>intensified supervision; revised checklists (1988)</p> <p>initiated EPI activities at 28 centers; all CCCD centers now performing vaccinations (1988)</p> <p>performed study of EPI in Kindia (1988)</p> <p>conducted health center needs assessment at 6 facilities in Conakry (1988)</p>	<p>performed KAP survey of health personnel in Conakry and Forecariah (1986)</p> <p>trained 30 health personnel in ORT in 2 areas (1987)</p> <p>appointed National CDD Director (1987)</p> <p>established ORT units in 7 locations (1987)</p> <p>conducted KAP studies in 2 areas (1988)</p> <p>delivered ORT materials to all health centers in Kindia, Telimele (1988)</p> <p>collected &amp; analyzed 1987 CDD data (1988)</p> <p>trained 5 PCVs in ORT (1988)</p> <p>performed study to evaluate CDD activities in Kindia (1988)</p> <p>TO assisted in diarrhea outbreak investigation ('88)</p> <p>drafted health education plan and calendar of activities for CDD (1988)</p> <p>designed and pretested ORT poster (1988)</p> <p>trained 33 health ctr. personnel in ORT (1988)</p> <p>developed national ORT training plan (1988)</p> <p>conducted health ctr needs assessment, Conakry ('88)</p> <p>regularly received and distributed ORS packets since 1987 (1988)</p> <p>Minister of Health and CCCD Project Coordinator/ National CDD Director attended ICORT III stg. (1988)</p>
(4) Impact What is impact on morbidity and/or mortality	<p>completed Conakry vaccination survey (1986)</p> <p>completed first mass vaccination campaign in Conakry; campaign assessed as successful (1987)</p> <p>conducted coverage survey at end of campaign (1987)</p> <p>performed KAP study in Conakry re NNT (1987)</p> <p>trained 20 health center personnel in cold chain technique &amp; vehicle maintenance (1987)</p> <p>held coordination meetings with UNICEF, ADB (1987)</p> <p>distributed equipment to 26 centers; initiated EPI activities in those centers (1987)</p> <p>as of 1987, all centers in Conakry were vaccinating daily</p> <p>conducted baseline coverage survey in Conakry (1988)</p> <p>analyzed 1987 EPI HIS data (1988)</p> <p>intensified supervision; revised checklists (1988)</p> <p>initiated EPI activities at 28 centers; all CCCD centers now performing vaccinations (1988)</p> <p>performed study of EPI in Kindia (1988)</p> <p>conducted health center needs assessment at 6 facilities in Conakry (1988)</p> <p>vaccine wastage still unsatisfactory as of 1988</p> <p>sterile technique not always adhered to as of '88</p> <p>coverage rates steadily increasing: 1987 levels: BCG DPT1 2 3 measles full TT 79% 92% 67% 59% 79% 52% 78%</p> <p>although incidence of measles, pertussis, and polio appear to be steadily decreasing, reports repeatedly warn that data isn't sufficient to determine impact</p>	<p>performed KAP survey of health personnel in Conakry and Forecariah (1986)</p> <p>trained 30 health personnel in ORT in 2 areas (1987)</p> <p>appointed National CDD Director (1987)</p> <p>established ORT units in 7 locations (1987)</p> <p>conducted KAP studies in 2 areas (1988)</p> <p>delivered ORT materials to all health centers in Kindia, Telimele (1988)</p> <p>collected &amp; analyzed 1987 CDD data (1988)</p> <p>trained 5 PCVs in ORT (1988)</p> <p>performed study to evaluate CDD activities in Kindia (1988)</p> <p>TO assisted in diarrhea outbreak investigation ('88)</p> <p>drafted health education plan and calendar of activities for CDD (1988)</p> <p>designed and pretested ORT poster (1988)</p> <p>trained 33 health ctr. personnel in ORT (1988)</p> <p>developed national ORT training plan (1988)</p> <p>conducted health ctr needs assessment, Conakry ('88)</p> <p>regularly received and distributed ORS packets since 1987 (1988)</p> <p>Minister of Health and CCCD Project Coordinator/ National CDD Director attended ICORT III stg. (1988)</p> <p>1988 study showed that 40% of cases seen in health facilities surveyed received correct amount of ORS</p> <p>1987 study showed that rate of appropriate treatment in households was only 4%</p> <p>as of 1988, 93% of outpatient facilities, 75% of hospitals were using ORS</p>
CONCLUSIONS	(1)	(1)
(1) Institutionalization: To what degree does MOH support system?	<p>GOG supports EPI, although limited in ability to fund</p>	<p>GOG slow to implement CDD program; naming of a National Director demonstrated increased commitment</p>
(2) Program strengths	<p>close collaboration between donors, MOH and community leaders in vaccination campaign</p> <p>supervision has steadily improved; seems to have improved sterile technique problems</p>	<p>diarrheal disease reporting improved significantly in first two years of program</p> <p>acceptance of ORT by health professionals increased significantly in first 2 years</p>
(3) Problems/Constraints: What factors limit target achievement?	<p>primary constraints repeatedly cited were supply difficulties, lack of health education, lack of feedback</p>	<p>primary constraint cited was lack of national program &amp; director; activities seemed to move more quickly after these were established</p>
(4) Lessons learned: What worked? What did not work?	<p>cold chain at peripheral level needs improvement</p> <p>NNT still a major problem: CFR in 1987 was 70%</p> <p>reporting of coverage outside Conakry only 75%</p>	<p>despite improved disease reporting, reports warn that impact on disease incidence and CFR cannot be determined accurately</p>
Recommendations?	<p>while mass campaigns made great strides in coverage, sustainability of those levels is only possible with continued expansion of fixed services and a strong social mobilization/health ed. campaign</p> <p>leadership and close coordination cited as key factors in success of mass campaign</p>	

Categories	MALARIA	TRAINING
Plans Needs assessment, goals, and objectives,planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o target: decrease malaria mortality in &lt;5's by 33-50%</li> <li>o decrease fetal wastage and low birth weight</li> <li>o baseline information 1983: malaria is a leading cause of morbidity and mortality in Guinea</li> <li>o malaria control programs have been in existence for some time; primary strategy has been vector control</li> <li>o constraints have been lack of trained personnel, lack of petrol, electricity, and cq</li> <li>o such of current treatment is with injectables</li> </ul>	<ul style="list-style-type: none"> <li>o target: train approximately 500 health personnel</li> <li>o baseline information 1983: training of health personnel cited as a primary goal of MOH</li> </ul>
OUTCOMES (actual v.planned)	<ul style="list-style-type: none"> <li>(1) Outputs What was provided, accomplished? o 2 MOH malaria specialists participated in review of CCCD malaria training modules and instruction of MLM training seminar (1986)</li> <li>o drafted national treatment plan (1986)</li> <li>o prepared commodity list for lab equipment,cq (1986)</li> <li>o completed malaria in pregnancy study (1986)</li> <li>o malaria team of 5 Guineans participated in in-vivo testing seminar in Abidjan (1986)</li> <li>o conducted KAP study in Conakry re treatment practices in malaria (1987)</li> <li>o developed monthly case reporting forms and cq inventory forms (1987)</li> <li>o conducted health center needs assessment in Conakry (1988)</li> <li>o received and distributed supplies &amp; equipt. (1988)</li> <li>o trained 20 health personnel on slide identification techniques and drug sensitivity testing (1988)</li> <li>o developed health education plan for malaria (1988)</li> <li>(2) o KAP survey (1987) showed that only 16% of cases observed were given correct dosage, although 73% were given antimalarial drug</li> <li>(3) o 1987 survey in Kindia and Telimele showed urban cq use at 67%; rural at 37%</li> <li>(4) o malaria cases and deaths appear to have decreased from 1986 levels (which were much higher than any previous level: accurate reporting may be problem)</li> </ul>	<ul style="list-style-type: none"> <li>(1) o held seminars for senior, mid-level and peripheral-level health personnel on EPI, COD &amp; malaria (1986)</li> <li>o trained approximately 300 health workers for vaccination campaign (1986)</li> <li>o trained personnel from 1 health center in EPI(1986)</li> <li>o 2 MOH malaria specialists participated in review of CCCD malaria training module and in instruction of MLM training seminar (1986)</li> <li>o trained health personnel in OMT, cold chain management, vehicle maintenance (1987)</li> <li>o trained 30 health personnel in OMT in Conakry and Kindia (1987)</li> <li>o as of 1987, 351 of target 500 health staff received training</li> <li>o training consultant worked with MOH and donor personnel to identify current and future training needs (1988)</li> <li>o conducted 1-week training course in EPI and OMT with 33 health center doctors and nurses (1988)</li> <li>o developed national OMT training plan (1988)</li> <li>o trained 20 health personnel on slide identification techniques and drug sensitivity testing (1988)</li> </ul>
CONCLUSIONS	<ul style="list-style-type: none"> <li>(1)Institutionalization: To what degree does MOH support aystes? o GOG has supported malaria control for a number of years: still need to coordinate with health education component</li> <li>(2)Program strengths o as of 1988, significant levels of inappropriate treatment were observed</li> <li>(3)Problems/Constraints:What factors limit target achievement? o problems continue with supply and distribution</li> <li>o difficult to measure impact due to inadequacy of reporting</li> <li>(4)Lessons learned: What worked? What did not work? Recommendations?</li> </ul>	<ul style="list-style-type: none"> <li>(2) o on-the-job training has been enthusiastically advocated by MOH, although rarely implemented</li> <li>(3) o quality of training is highly variable</li> <li>(4) o appoint national training coordinator to develop national plans and coordinate implementation and standardization</li> <li>o need such more management training</li> </ul>

Categories	HEALTH EDUCATION	HIS
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>baseline information 1983: recently created Director of Health Education position in MOH currently have 12 trained health educators in MOH major constraints to health ed. progress have been lack of trained personnel, lack of equipment, and skepticism of health workers</p>	<p>goal: strengthen HIS to improve data collection, tabulation and analysis of operational and surveillance data</p> <p>baseline information 1983: reporting currently goes from regional health officials to central-level unit reporting rate is high in many areas, although usefulness of the data is questionable little analysis on data done HIS is not considered a priority area by GOC (according to country assessment)</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished?  (2) Quality How well are new systems/skills used?  (3) Effects Access &amp; coverage What are effects on KAP of pop.?  (4) Impact What is impact on morbidity and/or mortality</p>	<p>(1) developed draft document on health education and communications strategy for CCCD (1986) compiled and summarized previous health ed. study results (1986) developed health ed. plans for each CCCD intervention (1988) developed ORT posters and messages (1988)</p>	<p>(1) assessed existing HIS and initiated a surveillance system for tetanus, measles in Conakry and for infant mortality in 2 hospitals (1986) conducted health services survey (1986) conducted EPI practices survey (1986) modified HIS reporting form (1986) developed reporting format for disease surveillance (1986) regional epidemiologist assisted in design of data collection forms, data verification procedures, computerized data entry and data analysis &amp; reporting (1987-1988)</p>
<p>CONCLUSIONS (1) Institutionalization: To what degree does MOH support system?  (2) Program strengths  (3) Problems/Constraints: What factors limit target achievement?  (4) Lessons learned: What worked? What did not work?  Recommendations?</p>	<p>(1) MOH does not encourage health education activities</p> <p>(3) no coherent national health education plan health education unit director has not demonstrated great involvement in health education activities health ed. unit is chronically understaffed lack of funding is a constraint</p> <p>(4) health education component should be strengthened for all interventions, particularly malaria</p>	<p>(1) MOH has not encouraged HIS activities</p> <p>(3) constraints to improvement cited: -lack of technical support -lack of analytic capability -lack of feedback system -lack of reporting forms at middle and peripheral levels -lack of equipment</p>

Categories	OF	CROSS CUTTING COMMENTS (SUPERVISION,SUSTAINABILITY)
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>o baseline information 1983: OR is not considered a priority by GOG OR focus should be on program problems, issues</p>	<p>o target: fee-for-service and cost recovery systems will be studied and a workable program will be implemented</p> <p>o baseline information 1983: some medications are already being charged for</p>
<p>OUTCOMES (actual v. planned)</p> <p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality how well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity and/or mortality</p>	<p>(1) o special studies in NMT and malaria in pregnancy being completed in 1986 o conducted study on ORT use (1987) o conducted KAP and practices studies in EPI, CDD and malaria in 1987 o conducted EPI coverage surveys in 1987 and 1988 o regional epidemiologist conducted NMT coverage survey in Conakry to determine effective protection levels in community (1987)</p>	<p>SUPERVISION (1) o National CCCD Coordinator conducted supervisory and planning visit to Kindia (1987) o received monthly report on EPI activities from supervisors in 3 locations (1987) o CCCD supervisors in Conakry reviewed health center compliance with MOH EPI guidelines (1988) o TO spent one week with CCCD coordinator supervising 1 health center following launching of EPI/PHC/ Essential Drugs program (1988) o supervisory checklists being used in EPI since 1987 (or before; 1987 is earliest report of this)</p> <p>SUSTAINABILITY (1) o conducted preliminary cost recovery study (1986) o applied and tested fee-for-service/cost recovery system during vaccination campaign (1986)</p>
<p>CONCLUSIONS</p> <p>1 Institutional conditions: To what degree does MOH support system?</p> <p>2 Program strengths</p> <p>3 Problems/Constraints: What factors limit target achievement?</p> <p>4 Lessons learned What worked What did not work Recommendations?</p>	<p>(1) o GOG has not encouraged CF</p> <p>(4) o given the relatively high proportion of physicians in Guinea, efforts to strengthen in-country capability to do operations research should be made</p>	<p>SUPERVISION (4) o need to continue to revise and improve supervisory checklists o supervision still needs considerable improvement</p> <p>SUSTAINABILITY (1) o GOG highly committed to charging for health services, as shown by extensive cost recovery studies encouraged by Government o GOG has committed adequate funds to PHC development</p> <p>(3) o cost recovery systems slow to start o lack of timely release of local funds</p>



LESOTHO: EVALUATION CONTENT FOR ACS1-COCC

Project Start: May 1984 LOP Funding: \$415,600

Categories	EPI	CDD
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>to target: reduce measles morbidity/mortality by 40%</li> <li>to revised: reduce morbidity/mortality due to MNT, Polio and measles by 30%</li> <li>to target: increase coverage to 80% for measles, 75% for DPT, Polio</li> <li>to revised: increase coverage to 70% for measles, 65% for DPT, Polio</li> <li>to 1987 target: increase full coverage to 75% dec. measles morbidity to 3500 cases</li> <li>to 1988 target: increase full coverage to 85% dec. measles morbidity to 2500 cases</li> <li>to plan for 100% of fixed ctrs. to have vaccination capability</li> <li>to 5-yr plan developed in 1985</li> </ul>	<ul style="list-style-type: none"> <li>to target: reduce diarrheal disease mortality by 50%</li> <li>to increase ORT use by 50%</li> <li>to revised: increase access to ORT to 80% of target pop</li> <li>to increase maternal awareness of ORT</li> <li>to 1987 plans: decrease hospital diarrheal disease CFR to 6%</li> <li>to finalize national policy on correct ORS, SSS, home fluid use</li> <li>to improve packet production/distribution</li> <li>to 5-year plan developed in 1985</li> </ul>
OUTCOMES (actual v. planned)	<ul style="list-style-type: none"> <li>(1) to developed protocol for regional EPI/CDD survey</li> <li>to assisted MOH in developing 5-yr. accelerated EPI plan</li> <li>to developed procedures to monitor/improve injection practices</li> <li>to conducted a 1-day workshop on measles epidemiology, vaccination and surveillance</li> <li>to increased supply of sterile needles</li> <li>to supported implementation of new vacc. schedule (per WHO recommendations)</li> <li>to facilitated 3-mo. immunization campaign</li> <li>(2) to 95% of immunizations given with sterile needles, 70% with sterile syringes as of 1986</li> <li>(3) to 1986: coverage increased between 3 &amp; 16% for all antigens; full coverage at 65% from 40% in '82 (76% of target)</li> <li>to 1988: coverage targets for DPT, Polio exceeded</li> <li>to measles coverage target nearly met (w/in 2%)</li> <li>to full coverage steady at 65%</li> <li>(4) to measles incidence decreased from approximately 52/10,000 to 10/10,000 (1985 - 1986);</li> <li>to polio decreased significantly</li> </ul>	<ul style="list-style-type: none"> <li>(1) to developed/conducted ORT symposium for physicians</li> <li>to established ORT training &amp; treatment unit at national referral hospital</li> <li>to developed protocol for regional EPI/CDD survey</li> <li>to conducted a diarrheal disease symposium with LMA</li> <li>to ORTUs in 16 hospitals by 1987 (giving 90% of all hospitals ORT capability)</li> <li>to established CDD coordinator position (1986)</li> <li>to completed 3-week eval of EPI &amp; CDD regional program</li> <li>to supported training of &gt;80% of medical staff in ORT units</li> <li>to doubled local production of ORS from '86-'87</li> <li>to assisted in development/implementation of national policy and workplan for CDD</li> <li>(2) to health center staff knowledge of ORT very high</li> <li>to community level of awareness of SSS at 96%, but proper mixture only at 39%</li> <li>(3) to community use of ORS at 74% in 1988</li> <li>(4) to hospital CFR decreased from 12% to 3% 1983-1988</li> <li>to total # of cases seen in 6 ORTUs decreased by 30% from 1987 to 1988; 85% received proper treatment</li> <li>to average # of cases and deaths due to diarrheal diseases decreased dramatically after inception of ORTU at OE II hospital: 310 admissions, CFR=7.9% 1984; 170 admissions, CFR=5.5% 1986-88</li> <li>to (possibly due to weather, fees or other conditions) not related to decrease in incidence</li> </ul>
CONCLUSIONS	<ul style="list-style-type: none"> <li>(1) Institutionalization: To what degree does MOH support system? <ul style="list-style-type: none"> <li>to EPI well integrated into Nat'l Child Health program</li> <li>to cold chain well-maintained</li> <li>to supplies of vaccination materials, equipmt. adequate</li> </ul> </li> <li>(2) Program strengths <ul style="list-style-type: none"> <li>to mothers are highly motivated toward EPI</li> <li>to peripheral staff highly committed to EPI</li> <li>to donors well coordinated in support efforts</li> </ul> </li> <li>(3) Problems/Constraints: What factors limit target achievement? <ul style="list-style-type: none"> <li>to reporting difficulties have caused confusion with respect to impact of coverage</li> <li>to correct dosages not always given</li> </ul> </li> <li>(4) Lessons learned: What worked? What did not work? <ul style="list-style-type: none"> <li>to need for continuing external support for supplies, equipment</li> <li>to mass campaigns in addition to regular access appears to have improved coverage</li> </ul> </li> <li>Recommendations: <ul style="list-style-type: none"> <li>to enlist services of long-term consultant, medical epidemiologists</li> <li>to improve reporting</li> <li>to provide training in correct dose administration</li> <li>to provide outreach into rural areas via nurses, VHVs</li> <li>to train nurses to identify children's vacc. status</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(2) to ORT activities well organized, coordinated</li> <li>to increased community acceptance</li> <li>to ORS distribution widespread, coordinated</li> <li>(3) to underreporting of diarrheal disease</li> <li>to need more feedback from ORTUs</li> <li>(4) to health ed. messages appear to have been able to influence community in positive way</li> <li>to recommendations: <ul style="list-style-type: none"> <li>-incorporate traditional healers into system</li> <li>-prepare annual workplans with tracking system</li> <li>-increase staffing</li> </ul> </li> </ul>

Categories	MALARIA	TRAINING
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>o malaria not considered a problem in Lesotho</p>	<p>o target: train approx. 1040 personnel in CCCD 10 district workshops on planning and management by end of 1987 o 1987 target: train 2800 health workers in CCCD o 1988 target: train 2000 health workers and community leaders in CCCD  o annual budgets/workplans developed</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished?  (2) Quality How well are new systems/skills used?  (3) Effects Access &amp; coverage What are effects on KAP of pop.?  (4) Impact What is impact on morbidity and mortality?</p>		<p>(1) o conducted 7 regional level inservice training workshops, 1 3-day TOT workshop o conducted first regional continuing education workshop for 38 CCCD/HSA facilitators (1985) o conducted 3 continuing ed. workshops in 1986 for HSA trainers o conducted symposium on diarrheal disease with Lesotho Medical Association o sponsored national symposia on ORT for 110 health personnel o supported training for 41 nurses in ORT at national facility o co-sponsored 2 cont. ed. workshops for HSA trainers o supported training of &gt;80% of medical staff in ORTUs o supported training of 8 Basotho in CCCD mid-level management o trained &gt;2800 HSA-level staff from '86 - '87 o developed CCCD training materials for EPI, CDD o developed agreement w/ UNICEF for VHW training o integrated family planning training into CCCD o trained 2800 HSA-level staff w/ UNICEF in '87</p>
<p>CONCLUSIONS (1) Institutionalization: To what degree does MOH support system?  (2) Program strengths  (3) Problems/Constraints: What factors limit target achievement?  (4) Lessons learned that worked? that did not work?  Recommendations?</p>		<p>(1) o training given high priority in MOH  (2) o VHW's are effective, particularly in CDD o continuing education excellent: provides for high quality training with minimal disruption of work o training is decentralized, service-level (3) o management training needed o need system for tracking, evaluating training o transportation is most frequently cited constraint (4) o recommendations: -coordinate and standardize HSA training -revise &amp; update training modules -improve vehicle use policies -strengthen VHW, TBA training</p>

Categories	HEALTH EDUCATION	HIS
<p>annual assessment, plans, and objectives, planned inputs, expected outcomes</p>	<ul style="list-style-type: none"> <li>o 1987 target: adopt/transmit standardized EPI, CDD messages</li> <li>o annual workplans developed as of 1987</li> </ul>	<ul style="list-style-type: none"> <li>o target: establish baseline morbidity &amp; mortality rates for EPI diseases, diarrheal diseases by end of 1984</li> <li>o establish regular CCCD newsletter by 1985</li> <li>o 1987 target: establish more timely &amp; responsive HIS</li> <li>o annuals plans developed as of 1987</li> <li>o assessment performed 1985</li> </ul>
<p><b>ATTAINMENT</b></p> <p>1) Outputs that was provided, accomplished?</p> <p>2) Quality: How well are new systems/skills achieved?</p> <p>3) Effects: Access &amp; coverage: What are effects on KAP of pop.?</p> <p>4) Impact: What is impact on morbidity and mortality?</p>	<p>(1)</p> <ul style="list-style-type: none"> <li>o developed CCCD community health education materials</li> <li>o developed 9 locally adapted CCCD training modules</li> <li>o developed plan for mass media improvement</li> <li>o developed agreement with MOH, AID, and Peace Corps for PCV assistance</li> <li>o supported the development of 3 Sesotho booklets for VHVs and other community health workers</li> <li>o with new PCV, improved HEU graphics dept.</li> <li>o printed &amp; distributed improved imm. schedules and diarrheal disease treatment charts</li> <li>o added HEALTHCOM communications project to CCCD</li> <li>o developed and printed materials for ORTVs</li> <li>o distributed projectors &amp; slides to HSA training teams</li> <li>o completed evaluation plan for decentralized continuing education system</li> <li>o sponsored 2 MOH participants at 1987 ARBEC</li> <li>o supported HEU and HEALTHCOM in conducting social marketing seminar</li> <li>o developed standardized ORT messages</li> <li>o designed &amp; printed ORS/SSS pamphlets</li> <li>o created health ed./ORT policy &amp; workplan</li> <li>o conducted KAP study on immunization, ORT practices</li> <li>o assembled EPI, CDD reference library</li> <li>o developed broadcast messages</li> </ul>	<p>(1)</p> <ul style="list-style-type: none"> <li>o collated and analyzed 1984 HIS data</li> <li>o produced EPI/CDD quarterly report covering '81-'85</li> <li>o began monthly Lesotho Health Information Newsletter</li> <li>o established sentinel surveillance system using nurse-clinicians in &gt;50 health centers</li> <li>o produced regular and timely EPI quarterly reports</li> <li>o monitored sentinel surveillance system in 56 hospitals</li> <li>o supported HIS unit processing of 1986 EPI/CDD survey results</li> <li>o made recommendations for 1986 HIS external eval.</li> <li>o assisted in development &amp; distribution of new reporting form</li> <li>o co-sponsored 2 HSA immunization coverage surveys</li> <li>o funded printing of 1st EPI Bulletin in 2 yrs ('87)</li> <li>o assisted health stats unit in identifying needs and drafting workplan</li> <li>o assisted in hiring of new personnel</li> <li>o intensified disease surveillance activities per 1986 recommendation</li> <li>o improved timeliness &amp; accuracy with increased staff</li> <li>o switched from hand tally method to computerized reporting system in 1984</li> </ul>
<p><b>CONCLUSIONS</b></p> <p>(1) Institutionalization: To what degree does MOH support system?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<p>(1)</p> <ul style="list-style-type: none"> <li>o Health Education Unit well established in MOH</li> </ul> <p>(2)</p> <ul style="list-style-type: none"> <li>o overall impressive level of activity</li> </ul> <p>(3)</p> <ul style="list-style-type: none"> <li>o staffing shortages, space cited as major constraints</li> </ul> <p>(4)</p> <ul style="list-style-type: none"> <li>o PCV, HEALTHCOM tremendous assets</li> </ul>	<p>(1)</p> <ul style="list-style-type: none"> <li>o Health Statistics Unit is in the MOH</li> </ul> <p>(2)</p> <ul style="list-style-type: none"> <li>o reporting delays improved significantly over time, particularly with added staff</li> <li>o overall excellent system</li> </ul> <p>(3)</p> <ul style="list-style-type: none"> <li>o still need improvements in accuracy</li> <li>o staffing shortages remain a constraint</li> </ul> <p>(4)</p> <ul style="list-style-type: none"> <li>o switch to computerization may have been responsible for reported decrease in vacc. coverage in 1984</li> </ul> <p>o recommendations:</p> <ul style="list-style-type: none"> <li>-provide training in use of data, planning and administration/procurement</li> <li>-develop VHV data collection system</li> </ul>

LESOTHO: EVALUATION CONTENT FOR ACSI-CCCD

Project Start: May

Categories	OR	COMMENTS: SUPERVISION, SUSTAINABILITY
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>to target: answer 5 of 7 research questions enumerated in Project Grant Agreement by 1987</p>	<p>to plan to continue decentralization to plan to initiate some fee-for-service mechanisms</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access &amp; coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and mortality?</p>	<p>(1) to conducted diarrheal disease study in CS's to developed protocol for regional EPI/CDD survey to completed assessment of health &amp; socioeconomic impact on nutrition &amp; diarrheal disease to supported 1 Basotho in regional review committee to completed/assisted in 3 special studies to collaborated with MOH to review 3 proposals to assisted the review and revision of coverage survey proposal to completed HSA coverage, family planning and ARI assessment to studied ORT unit impact on admissions &amp; deaths to met targetted number of OR activities; however, did not perform KAP studies as planned</p>	<p>SUPERVISION (1) to MOH reorganized, CCCD placed in Family Health section to began development of supervisory checklist</p>
<p>CONCLUSIONS (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned What worked? What did not work? Recommendations?</p>	<p>(4) to need to generate more interest in performing operations research</p>	<p>SUPERVISION (4) to need to complete &amp; implement supervisory checklist to supervision requires strengthening to management training needed  SUSTAINABILITY (1) to project well integrated into PHC system (2) to reorganization seen as helpful to decentralized planning considered a strength (3) to OR funds not used to government was unable to increase contribution as planned to recommendations: -add cost data to HIS -charge for health registration card -commercially market ORS -charge for well-baby visits</p>

LESOTHO: EVALUATION CONTENT FOR ACSI-CDCD

Categories	PROGRAM MANAGEMENT
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>to plan for annual evaluation, annual work plans to plan to continue decentralization to country assessment done 1983</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished?  (2) Quality How well are new systems/skills used?  (3) Effects Access &amp; coverage What are effects on KAP of pop.?  (4) Impact What is impact on morbidity and mortality?</p>	<p>(1) to continued to decentralize activities</p>
<p>CONCLUSIONS (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations?</p>	<p>(1) to project well integrated, well supported by MOH (2) to project generally well-managed to MOH, project leaders responsive to recommendations to donors well coordinated, effective (3) to staffing shortages and transportation continue to be constraints on program progress (4) to recommendation: -continue to improve donor coordination -increase staffing in administration and HIS -shift T.O. responsibilities to management skills transfer and field activities -develop evaluation schedule -extend project from original PACD of 1988 to 1991: extension approved by USAID/CDC/GOL</p>

Project Start: July 1983 Funding: \$655,000

Categories	EPI	CDD										
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o target: mortality reductions:               <ul style="list-style-type: none"> <li>measles 40%</li> <li>pertussis 30%</li> <li>NTT 25%</li> </ul> </li> <li>coverage increases:               <ul style="list-style-type: none"> <li>antigen 1987 1983(baseline)</li> <li>BCG 65% 40% (&lt;5's)</li> <li>measles 45% 20% (9-24 mos.)</li> <li>DPT/OPV 40% 15% (3-12 mos.)</li> <li>tetanus 40% 15% (pregnant women)</li> </ul> </li> <li>o baseline information (1982):               <ul style="list-style-type: none"> <li>cold chain inadequate (lack of funding cited as primary reason)</li> <li>inappropriate age groups receiving vaccine (lack of training cited as primary reason)</li> <li>estimated incidences: measles 28/1000; pertussis 2/1000; tetanus 7/1000</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>o target: decrease mortality due to diarrheal disease by 20%</li> <li>increase proportion of facilities using ORT from 10% (1983) to 70% (1987)</li> <li>increase proportion of pop. with access to ORT from 20% (1983) to 50% (1987)</li> <li>increase proportion of &lt;5's who have utilized ORT from 5% (1983) to 25% (1987)</li> <li>increase proportion of mothers of &lt;5's who have knowledge of preparation &amp; administration of ORS from 5% (1983) to 35% (1987)</li> <li>o baseline information (1982):               <ul style="list-style-type: none"> <li>ORT is well-established concept in Liberia</li> <li>ORT training is included in nursing, physician's assistant curricula</li> <li>GOL thus far not very committed to ORT</li> <li>diarrheal disease incidence estimated at 57/1000</li> </ul> </li> </ul>										
OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and/or mortality	<ul style="list-style-type: none"> <li>(1)           <ul style="list-style-type: none"> <li>o developed policies, procedures and guidelines for funds accountability, vehicle use/maintenance, cold chain maintenance, and vaccine schedules by 1984</li> <li>o began delivery of immunization services in target area clinics (1985)</li> <li>o completed outreach schedule planned for National Immunization Week (NIW) (1985)</li> <li>o implemented new 5-year plan (1985)</li> <li>o conducted national vaccination week; activities highly decentralized (1985)</li> <li>o completed 15 immunization coverage surveys (1986)</li> <li>o defined role and position of Project Manager within MOH (1986)</li> <li>o added 5 counties to EPI project area (1986)</li> <li>o revised the LOP commodity requirement plan (1986)</li> <li>o held TOT course, planned and conducted by national staff (1986)</li> <li>o conducted second NIW (1986)</li> <li>o 1987 focus was decentralization of planning and implementation to county level; generally successful</li> <li>o conducted third NIW; majority of activities locally funded (1987)</li> <li>o completed national vacc. coverage survey (1987)</li> <li>o drafted national immunization policy (1987)</li> <li>o developed supervisory checklist (1986)</li> </ul> </li> <li>(2)           <ul style="list-style-type: none"> <li>o coverage as of end of 1987:               <table border="1" style="margin-left: 20px;"> <tr> <td>BCG</td> <td>DPT/OPV</td> <td>DPT/OPV3</td> <td>measles full</td> <td>TT</td> </tr> <tr> <td>65%</td> <td>70%</td> <td>27%</td> <td>60%</td> <td>22%</td> </tr> </table> </li> <li>o (all coverages achieved or exceeded targets except DPT/OPV3)</li> </ul> </li> <li>(3)           <ul style="list-style-type: none"> <li>o 1988 estimates of reductions in mortality:               <ul style="list-style-type: none"> <li>NTT: 21.6% = 72% of target</li> <li>pertussis: 32.4% = 130% of target</li> <li>measles: 44.4% = 111% of target</li> </ul> </li> </ul> </li> <li>(4)           <ul style="list-style-type: none"> <li>o 1988 estimates of target achievement:               <ul style="list-style-type: none"> <li>ORT use: 15.7% nationwide; target was 25%</li> <li>o as of 1986, approximately 60% of health centers and clinics using ORS</li> </ul> </li> </ul> </li> </ul>	BCG	DPT/OPV	DPT/OPV3	measles full	TT	65%	70%	27%	60%	22%	<ul style="list-style-type: none"> <li>(1)           <ul style="list-style-type: none"> <li>o began study re use &amp; efficiency of home fluids (1984)</li> <li>o began implementation of national diarrheal disease control policy (1985)</li> <li>o constructed ORT demonstration unit at major health center (1986)</li> <li>o began training ORT unit staff for new unit, trained trainers (1986)</li> <li>o developed, through local contractor, policy, procedures and forms for fee-for-service/revolving drug plans (1986)</li> <li>o implemented plan to distribute motorcycles for purchase (1986)</li> <li>o conducted review and evaluation of training activities (1986)</li> <li>o implemented National Diarrheal Disease Control policy (1986)</li> <li>o new Director of Diarrheal Disease Control unit appointed (1987)</li> <li>o continued training peripheral health workers at ORT Demonstration &amp; Training unit (1987)</li> <li>o established Diarrheal Disease Technical Advisory Committee (1987)</li> <li>o unit director attended 1-month training course in development of health ed. and promotion activities for CDD (1987)</li> <li>o opened second ORT Demonstration/Training Unit (1987)</li> </ul> </li> <li>(2)           <ul style="list-style-type: none"> <li>o in '88, some hospitals still using IV and drugs</li> </ul> </li> <li>(3)           <ul style="list-style-type: none"> <li>o 1988 estimate of target achievement:               <ul style="list-style-type: none"> <li>ORT use: 15.7% nationwide; target was 25%</li> <li>o as of 1986, approximately 60% of health centers and clinics using ORS</li> </ul> </li> </ul> </li> <li>(4)           <ul style="list-style-type: none"> <li>o not possible to assess impact of ORT on diarrheal disease mortality</li> </ul> </li> </ul>
BCG	DPT/OPV	DPT/OPV3	measles full	TT								
65%	70%	27%	60%	22%								
CONCLUSIONS (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations:	<ul style="list-style-type: none"> <li>(1)           <ul style="list-style-type: none"> <li>o GOL is committed to expansion of EPI nationwide; EPI is under preventive services in MOH, but is managed as an independent program</li> </ul> </li> <li>(2)           <ul style="list-style-type: none"> <li>o program has succeeded in generating much local financing for national immunization weeks</li> <li>o exceptional leadership of CCCC County Supervisors and PCV counterparts in national immunization weeks</li> </ul> </li> <li>(3)           <ul style="list-style-type: none"> <li>o lack of sufficient funds is primary constraint</li> <li>o chain of command is unclear due to independent nature of the EPI program</li> <li>o cold chain still inadequate with respect to WHO standards</li> </ul> </li> <li>(4)           <ul style="list-style-type: none"> <li>o social mobilization and exceptional leadership considered to be most significant factors in success of national immunization weeks</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(1)           <ul style="list-style-type: none"> <li>o GOL initially not very active in promoting ORT; appointment of permanent Director has helped improve and increase activities</li> </ul> </li> <li>(2)           <ul style="list-style-type: none"> <li>o delay in implementing national policy a constraint</li> <li>o delayed arrival of CCCC T.O. a factor in early lack of progress</li> <li>o lack of adequate personnel, health education materials and methods</li> <li>o 1987 evaluation cited failure to meet ORT training target due to administrative and personnel problems</li> </ul> </li> <li>(3)           <ul style="list-style-type: none"> <li>o lack of progress in part related to focus on EPI activities</li> </ul> </li> </ul>										

Categories	MALARIA	TRAINING
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o target: decrease mortality due to malaria by 20%</li> <li>o increase proportion of pop. with access to cq treatment &amp; prophylaxis from 20% (1983) to 50% (1987)</li> <li>o increase proportion of &lt;5's who have utilized presumptive cq treatment for fever from 15% (1983) to 40% (1987)</li> <li>o increase proportion of pregnant women who utilize cq for malaria prophylaxis from 10% (1983) to 30% (1987)</li> <li>o baseline information (1982)</li> <li>o program currently plagued by lack of funds for control activities</li> <li>o GOL plans for malaria program to become part of PBC system</li> <li>o malaria incidence estimated at 173/1000</li> </ul>	<ul style="list-style-type: none"> <li>o baseline information (1982)</li> <li>o MOH desires training and health education in all areas and at all levels</li> <li>o comprehensive training needs assessment done 1986</li> </ul>
OUTCOMES		
(actual v. planned) (1) Outputs What was provided, accomplished?	<ul style="list-style-type: none"> <li>(1)</li> <li>o presented final draft of National Malaria Control policy to Minister (1986)</li> <li>o trained 4 national-level staff in methodology of in-vivo monitoring of cq resistance (1987)</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o conducted TOT course for mid-level managers (MLMs) for 4 county-level &amp; 5 national-level supervisors (1985)</li> </ul>
(2) Quality How well are new systems/skills used?	<ul style="list-style-type: none"> <li>o developed plans for monitoring introduction of CRPF - plans approved by Malaria Technical Committee ('87)</li> <li>o developed plan to train more health workers in in-vivo testing (1987)</li> </ul>	<ul style="list-style-type: none"> <li>o developed training materials for clinic-level workers in immunization delivery, ORT, and malaria presumptive treatment (1985)</li> <li>o trained clinic level workers for national immunization week (NIW) (1985)</li> </ul>
(3) Effects Access & coverage What are effects on KAP of pop.?	<ul style="list-style-type: none"> <li>(2)</li> <li>o as of end of 1986, approximately 80% of health facilities sampled were using correct treatment; about 70% were using correct prophylaxis</li> </ul>	<ul style="list-style-type: none"> <li>o as of 12/85, 56 clinic level workers had received training in immunization, diarrheal disease and malaria control; 22 TBAs had received training in counseling of mothers and social mobilization; and 900 clinic and hospital workers were trained for the NIW campaign</li> </ul>
(4) Impact What is impact on morbidity and/or mortality	<ul style="list-style-type: none"> <li>(3)</li> <li>o 1988 malaria treatment coverage estimated at 68%, vs. 30% target</li> <li>(4)</li> <li>o apparent decrease in death-to-case ratio; increase in number of cases overall (1986)</li> </ul>	<ul style="list-style-type: none"> <li>o conducted workshop on decentralization and planning and accountability of resources for immunization activities; 60 managers &amp; supervisors attended (1985)</li> <li>o completed training of health workers to conduct OR study for CDD (1985)</li> <li>o trained ORT unit staff, trained trainers for ORT unit (1985)</li> <li>o by 1986, had trained 972 EPI, 48 CDD/malaria peripheral health staff; 9 MLMs; 1 senior official; 3 PCVs; and 11 interviewers</li> <li>o completed comprehensive training needs assessment (1986)</li> <li>o revised LOP training plan (1986)</li> <li>o trained national county and supervisory staff in fee-for-service system (1986)</li> <li>o ORT unit director attended 1-mo. training course in developing health ed. &amp; promotion activities for CDD (1987)</li> <li>o trained 4 national-level staff in methodology of in-vivo monitoring of cq resistance (1987)</li> <li>o held 10-day TOT course for national-level inservice education staff (1987)</li> <li>o produced job aids on mixing ORS and using sterile injection equipment; distributed to all clinics and hospitals (1987)</li> <li>o as of '88, approx. 2000 health personnel trained</li> </ul>
CONCLUSIONS		
(1) Institutionalization: To what degree does MOH support system?	<ul style="list-style-type: none"> <li>(1)</li> <li>o GOL states commitment to malaria control, but has not been very active in funding or policy development</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o GOL supports training goals, but has difficulty with financing training activities</li> </ul>
(2) Program strengths	<ul style="list-style-type: none"> <li>(2)</li> <li>o supplies of chloroquine are adequate</li> </ul>	
(3) Problems/Constraints: What factors limit target achievement?	<ul style="list-style-type: none"> <li>(3)</li> <li>o lack of inservice training in treatment and prophylaxis</li> </ul>	
(4) Lessons learned: What worked? What did not work?	<ul style="list-style-type: none"> <li>(4)</li> <li>o lack of national policy caused program to move slowly</li> </ul>	
Recommendations?		

Categories	HEALTH EDUCATION	HIS
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o baseline information (1982)</li> <li>o MOH desires health education and training in all areas and at all levels</li> </ul>	<ul style="list-style-type: none"> <li>o goal: to have a fully operational HIS by the End of the Project</li> <li>o baseline information (1982)</li> <li>o health statistics currently compiled by Division of Health and Vital Statistics</li> <li>o monthly reports sent to county medical directors' office, then to MOH</li> <li>o methods and quality of reporting vary greatly</li> <li>o approximately 40% reporting rate</li> <li>o lack of transportation, communications, training of reporters, and supervision a problem</li> <li>o reporting methods do not accurately assess morbidity and mortality</li> </ul>
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and/or mortality	(1) <ul style="list-style-type: none"> <li>o formed Health Education Subcommittee; held 3 meetings in 1984</li> <li>o MOH approved proposed reorganization of the Health Education unit (1984)</li> <li>o developed MLM training module (1985)</li> <li>o developed mass media messages for national immunization week (1985)</li> <li>o developed posters, training aids for NIW (1985)</li> <li>o conducted 3 health information and promotion radio campaigns; assessed as highly successful (1985)</li> <li>o planned national radio campaign on diarrheal disease; produced and field-tested messages (1987)</li> <li>o reorganized the Information, Education and Communication (IEC) Division in the Ministry to include both health education and training (Oct. 1987)</li> <li>o produced training materials and HIS manual; field tested in 10 clinics (1987)</li> </ul>	(1) <ul style="list-style-type: none"> <li>o CCCD subcommittee formed to evaluate the HIS (1984)</li> <li>o conducted mortality and use of health services (MUHS) survey; determined baseline mortality data (1984)</li> <li>o completed initial HIS review (1986)</li> <li>o developed first phase plan for HIS (1986)</li> <li>o developed draft sentinel surveillance system; selected 30 clinics to start (1987)</li> <li>o revised morbidity surveillance forms (1987)</li> <li>o produced training materials and HIS manual; field tested in 10 clinics (1987)</li> <li>o produced and distributed newsletter providing feedback to counties (1987)</li> <li>o assigned full-time epidemiologist to refine and implement strong HIS (1987)</li> <li>o released MUHS results in March 1987</li> </ul>
<b>CONCLUSIONS</b> (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations?	(1) <ul style="list-style-type: none"> <li>o Health Education unit now established as part of Ministry</li> </ul> (4) <ul style="list-style-type: none"> <li>o although reorganization caused slow progress in health ed. activities, ultimately this action was considered a positive factor in later health ed. achievements</li> </ul>	(1) <ul style="list-style-type: none"> <li>o GOL not active in promoting HIS; very weak component overall</li> </ul> (3) <ul style="list-style-type: none"> <li>o significant lack of trained staff, resources</li> </ul> (4) <ul style="list-style-type: none"> <li>o need to train and increase number of staff</li> </ul>

LIBERIA: EVALUATION CONTENT FOR ACSI-CCCD

Categories	OR	CROSS CUTTING COMMENTS (SUPERVISION, SUSTAINABILITY)
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>baseline information (1982) operations research in Liberia is directed toward solving programmatic problems</p>	<p>goal: to have cost recovery systems and revolving funds implemented at all 3 health service levels: health post, health center, &amp; hospital</p> <p>GOL will increase funding contribution from \$0 in year 1 to \$157,000 in year 4</p> <p>baseline information (1982) Liberian economy struggling; MOH budget is very limited; no new personnel can be added for CCCD Project hopes eventually to involve enough Liberian health facilities to allow for institutionalization</p>
<p>OUTCOMES (actual v. planned)</p> <p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity and/or mortality</p>	<p>(1) began work on ORT operational research project; had to stop due to political unrest, to restart at a later date (1985) performed 2 measles outbreak investigations (1987) began chloroquine resistance study (1987)</p>	<p>SUPERVISION (2) as of 1988, programs were using supervisory checklists</p> <p>SUSTAINABILITY (1) successfully lobbied for Development Budget funds (1986) trained national county and supervisory staff in fee-for-service system (1986) began implementation of local health care financing activities (1986-87) appointed new, permanent Project Manager (1987) tested fee-for-service and revolving drug fund systems in counties (1987)</p> <p>(3) as of 1986, registration fees/cost recovery mechanisms implemented in 9 of 13 counties</p>
<p>CONCLUSIONS</p> <p>(1) Institutionalization: To what degree does MOH support system?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<p>(1) OR activities are not promoted by MOH</p>	<p>SUPERVISION (2) generally excellent EPI supervision, particularly in 1985 vaccination campaign CCCD supervision very active and effective increase in vehicles has enhanced supervision to a great degree on-the-job supervision/training is extensively promoted</p> <p>(3) main constraint to improved supervision is transportation</p> <p>SUSTAINABILITY (1) GOL highly committed to development of auto-financing and decentralization</p> <p>(3) main constraint to auto-financing system is lack of local peoples' ability to pay as the Liberian economy worsens; fear exists that mothers will stop taking children to health facility because of fees</p>

## LIBERIA: EVALUATION CONTENT FOR ACS1-CCCD

Categories	PROGRAM MANAGEMENT
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o country assessment done 1982</li> <li>o baseline information (1982)</li> <li>o GOL has embraced concept of PHC</li> <li>o foundation of PHC system considered to be VHWs and TBAs, supported by PAs, midwives, health inspectors</li> <li>o CCCD and PHC system goals found to be compatible</li> </ul>
OUTCOMES (actual v. planned)	
(1) Outputs What was provided, accomplished?	<ul style="list-style-type: none"> <li>(1) year 1 (1984) was devoted primarily to building a central infrastructure for CCCD activities</li> <li>o formed Technical Advisory Committee composed of 20 individuals from CCCD, MOH and other donors; met 11 times in past 14 months (1984)</li> </ul>
(2) Quality How well are new systems/skills used?	<ul style="list-style-type: none"> <li>o developed draft CCCD workplan (1984)</li> <li>o implemented motorcycle distribution plan (1987)</li> <li>o obtained commitment from GOL Development Budget for operating funds (1986)</li> </ul>
(3) Effects Access & coverage What are effects on KAP of pop.?	<ul style="list-style-type: none"> <li>o held workshop on planning for county level medical directors and CCCD supervisors (1987)</li> </ul>
(4) Impact What is impact on morbidity and/or mortality	
CONCLUSIONS	
(1) Institutionaliza- tion: To what degree does MOH support system?	<ul style="list-style-type: none"> <li>(1) GOL/MOH committed to PHC and CCCD</li> <li>(2) GOL/MOH focus turning to preventive medicine</li> <li>o overall mechanisms for planning and coordination appear well-developed</li> </ul>
(2) Program strengths	<ul style="list-style-type: none"> <li>o thorough, detailed workplans developed for each program, each year</li> </ul>
(3) Problems/Con- straints: What factors limit tar- get achievement?	<ul style="list-style-type: none"> <li>(3) 1985-6 was fraught with difficulty due to political unrest, economic upheaval, health worker strike</li> <li>o T.O. spent nearly 100% of time in operations vs. in advisory, management capacity</li> </ul>
(4) Lessons learned: What worked? What did not work?	<ul style="list-style-type: none"> <li>o lack of transportation regularly cited as major constraint to progress (particularly supervisory)</li> <li>o lack of funding, personnel cited as constraints</li> <li>o lack of foreign exchange for purchases</li> <li>o poor maintenance of and inadequate equipment</li> </ul>
Recommendations?	<ul style="list-style-type: none"> <li>o deficiencies in health education, training and HIS cited as constraints to progress</li> <li>(4) Prog needs to be rewritten to reflect current realities</li> </ul>

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## MALAWI: EVALUATION CONTENT FOR ACSI-CCCD

Project Start: June 1984 LOP Funding: \$1,038,448

Categories	EPI	CDD										
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o target: 80% coverage for all antigens by 1990</li> <li>o reduce morbidity/mortality by: pertussis: 40%/30%; polio: 60% (morbidity)</li> <li>o measles: 40%/30%</li> <li>o 5-year EPI plan developed 1985</li> <li>o annual plans developed as of 1986</li> </ul>	<ul style="list-style-type: none"> <li>o target: increase ORT use by 60% in health facilities and homes</li> <li>o conduct 2-3 diarrheal disease studies</li> <li>o 5-year CDD plan developed in 1985</li> <li>o annual plans developed as of 1986</li> </ul>										
<b>OUTCOMES</b>												
(actual v. planned)	(1)	(1)										
(1) Outputs What was provided, accomplished?	<ul style="list-style-type: none"> <li>o helped establish "model" clinic in major hospital for EPI/ORT training</li> <li>o provided supplies, equipment, and training in cold chain, sterile technique to majority of health facilities</li> <li>o developed improved recording system</li> <li>o improved quality of coverage surveys</li> <li>o aided MOH in development/implementation of national policy on immunization</li> <li>o coordinated w/ MOH, donors in all aspects of improving coverage, access, and quality of EPI</li> </ul>	<ul style="list-style-type: none"> <li>o established ORTUs in majority of health facilities</li> <li>o conducted KAP survey and used results to design appropriate community-level and health ctr. educational materials</li> <li>o developed national guidelines for CDD</li> <li>o sponsored regional ORT seminars</li> <li>o helped establish "model" clinic in major hospital for EPI/ORT training</li> <li>o procured ORT equipment and supplies for most health facilities</li> <li>o distributed 30,000 ORS containers to community, imprinted with instructions and health messages</li> <li>o assisted in orienting community leaders in ORT technique</li> <li>o helped develop E. Africa Regional ORT Training Center</li> <li>o facilitated interministerial collaboration for ORT community interventions</li> </ul>										
(2) Quality How well are new systems/skills used?	<ul style="list-style-type: none"> <li>o cold chain, sterile technique assessed as maintained at high quality in 1987</li> </ul>	<ul style="list-style-type: none"> <li>o I.V. treatment decreased 7-fold from 1983 to 1988</li> </ul>										
(3) Effects Access & coverage What are effects on KAP of pop.?	<ul style="list-style-type: none"> <li>o increased &amp; maintained vaccination coverage levels</li> <li>o 75% of target population had access to immunization by 1987</li> <li>o coverage estimates in 1988 nearly met or exceeded LOP targets:</li> </ul> <table border="1" style="margin-left: 20px;"> <tr> <td>BCG</td> <td>DPT3</td> <td>OPV3</td> <td>measles</td> <td>TT2</td> </tr> <tr> <td>99%</td> <td>70%</td> <td>56%</td> <td>66%</td> <td>45%</td> </tr> </table>	BCG	DPT3	OPV3	measles	TT2	99%	70%	56%	66%	45%	<ul style="list-style-type: none"> <li>o all health facilities were using ORS by 1986</li> </ul>
BCG	DPT3	OPV3	measles	TT2								
99%	70%	56%	66%	45%								
(4) Impact What is impact on morbidity and mortality?	<ul style="list-style-type: none"> <li>o steady decrease in dropout rates: 35% to 24% for DPT, 1984-1987 38% to 21% for TOPV, 1984-1987</li> <li>o decreases in mortality from 1982 to 1988: measles: 2/100,000 to 1/100,000 polio: 3.5/100,000 to 1/100,000 MNT: 6/100,000 to 2/100,000 pertuss.: 380/100,000 to 210/100,000 all tetanus: 8/100,000 to 2.2/100,000</li> </ul>	<ul style="list-style-type: none"> <li>o 50% decrease in pediatric diarrheal disease admissions</li> <li>o cases, deaths in &lt;5's: 40% decrease in mortality -decrease from 6,300 to 4,400 cases from 1983 to 1987</li> </ul>										
<b>CONCLUSIONS</b>												
(1) Institutionalization: To what degree does MOH support system?	<ul style="list-style-type: none"> <li>o high government commitment</li> <li>o cold chain already established at start of project</li> </ul>	<ul style="list-style-type: none"> <li>o government actively promotes CDD activities</li> <li>o all CDD activities institutionalized in MOH by 1988</li> </ul>										
(2) Program strengths	<ul style="list-style-type: none"> <li>o EPI program in Malawi strong prior to CCCD</li> </ul>	<ul style="list-style-type: none"> <li>o high level of awareness in public, MOH</li> </ul>										
(3) Problems/Constraints: What factors limit target achievement?	<ul style="list-style-type: none"> <li>o difficulties in achieving/maintaining desired coverage levels (for some antigens) and daily immunization</li> <li>o inadequate supplies, staffing, space</li> <li>o polio supplies exceptionally difficult to maintain</li> </ul>	<ul style="list-style-type: none"> <li>o community involvement still low as of 1987</li> </ul>										
(4) Lessons learned: What worked? What did not work?	<ul style="list-style-type: none"> <li>o exceptionally difficult to measure impact due to CCCD vs. any other conditions; perhaps need different indicators</li> </ul>	<ul style="list-style-type: none"> <li>o as of 1987, improved supervision greatly improved ORT results</li> </ul>										
Recommendations?												

Categories	MALARIA	TRAINING
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o target: 30% increase in chloroquine utilization in children; 45% increase in pregnant women</li> <li>o conduct 2-3 research activities</li> <li>o 5-year Malaria plan developed in 1985</li> <li>o annual plans developed as of 1986</li> </ul>	<ul style="list-style-type: none"> <li>o target: train 260 PHW's, 180 TBA's, 1800 Village Health Committee members in CCCC</li> <li>o LOP training plan developed in 1987</li> </ul>
OUTCOMES (actual v. planned)		
(1) Outputs What was provided, accomplished?	<ul style="list-style-type: none"> <li>(1)</li> <li>o developed and distributed treatment guide; all health facilities using guide</li> <li>o conducted numerous research projects, clinical studies</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o adapted WHO and CCCC manuals for CDD, malaria</li> <li>o assisted other donors in CDD, malaria training</li> <li>o developed growth monitoring manual</li> <li>o supported regional workshops in planning and implementation of CCCC activities</li> </ul>
(2) Quality How well are new systems/skills used?	<ul style="list-style-type: none"> <li>o revised national malaria treatment and prophylaxis policy</li> <li>o assisted in development of Mangochi study (see OR)</li> <li>o assisted in developing management structure for control activities</li> </ul>	<ul style="list-style-type: none"> <li>o assisted in training/trained &gt;3300 personnel in CDD, malaria control; mid-level management; work planning; statistics; audio-visual equipment; malaria case management and survey techniques; surveillance operations; and cold chain review</li> </ul>
(3) Effects Access & coverage What are effects on KAP of pop.?	<ul style="list-style-type: none"> <li>o supplied technical support for community interventions</li> <li>(3)</li> <li>o promoted availability of second-level drugs to all hospitals</li> </ul>	<ul style="list-style-type: none"> <li>o conducted introductory computer course</li> <li>o supported participation of PCV's, nurses, and other health personnel in conferences, workshops</li> <li>o oriented senior-level managers, medical officers in CCCC initiatives and strategies</li> </ul>
(4) Impact What is impact on morbidity and mortality?	<ul style="list-style-type: none"> <li>(4)</li> <li>o decrease in malaria cases, deaths in &lt;5's from 1986 to 1987, but overall morbidity and mortality continue to rise</li> </ul>	<ul style="list-style-type: none"> <li>o provided training materials to district-level supervisors, health workers</li> <li>o conducted evaluation of Priority Disease Training impact on service delivery</li> <li>o trained 3730 PHW's &amp; 39 TBA's; no follow-up on training of Village Health Committee members</li> </ul>
		<ul style="list-style-type: none"> <li>(2)</li> <li>o management training evaluated as useful, desirable</li> </ul>
		<ul style="list-style-type: none"> <li>(4)</li> <li>o impact: significant improvement in HIS operations</li> <li>o significant improvement in vacc. practices</li> <li>o significant improvement in diarrhea case management</li> <li>o improvement in malaria case management</li> </ul>
CONCLUSIONS		
(1) Institutionalization: To what degree does MOH support system?	<ul style="list-style-type: none"> <li>(1)</li> <li>o MOH states malaria control as a high priority</li> <li>(2)</li> <li>o regular, effective coordination among donors, MOH</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o MOH states training as high priority</li> <li>o promoted integration of ORT and malaria training into health professional curricula</li> <li>o slow institutionalization at MOH level</li> </ul>
(2) Program strengths	<ul style="list-style-type: none"> <li>(3)</li> <li>o chloroquine resistance increasing</li> </ul>	<ul style="list-style-type: none"> <li>(2)</li> <li>o shift in focus from general to problem-solving</li> <li>o wide variety of training materials, methods</li> </ul>
(3) Problems/Constraints: What factors limit target achievement?		<ul style="list-style-type: none"> <li>(3)</li> <li>o personnel shortages decrease training effectiveness</li> </ul>
(4) Lessons learned: What worked? What did not work?		
Recommendations?		

Categories	HEALTH EDUCATION	HIS
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o LOP health education plan developed in 1987</li> </ul>	<ul style="list-style-type: none"> <li>o target: train 15 health statisticians, 27 district inspectors</li> <li>o establish baseline morbidity &amp; mortality data</li> </ul>
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and mortality?	(1) <ul style="list-style-type: none"> <li>o developed malaria posters, radio messages re treatment and prophylaxis</li> <li>o developed educational materials for ORT</li> <li>o coordinated well with HEALTHCOM, oriented H.Com TO</li> <li>o procured health education equipment</li> <li>o reprinted and distributed posters</li> <li>o completed formative research on CDD &amp; used results in developing messages</li> <li>o conducted malaria intervention study</li> <li>o collaborated with HEALTHCOM in mass media study and production</li> </ul> (2) <ul style="list-style-type: none"> <li>o health ed. unit established in MOH prior to CCCD</li> <li>o extensive donor coordination</li> </ul> (3) <ul style="list-style-type: none"> <li>o health ed. remains weak at community level</li> </ul> (4) <ul style="list-style-type: none"> <li>o lessons learned: What worked? What did not work?</li> <li>o Recommendations?</li> </ul>	(1) <ul style="list-style-type: none"> <li>o established and monitored 12 sentinel surveillance sites</li> <li>o established list of indicators for monitoring CCCD interventions</li> <li>o established baselines for &lt;5 morbidity &amp; mortality from 1978 - 1984 for measles, polio, diarrheal disease, and malaria</li> <li>o developed curriculum for 10-month epidemiology training course</li> <li>o procured and installed computer system for HSU</li> <li>o assisted Health Statistics Unit in computerizing immunization data for 1985 - 1986</li> <li>o assisted in training 79 staff in data collection &amp; analysis</li> <li>o demonstrated usefulness of HIS data</li> <li>o provided access to computers, software and training for increased utilization and demand for HIS data</li> <li>o conducted impact study of ORT use on &lt;5 morbidity &amp; mortality using HIS data</li> <li>o conducted sentinel surveillance survey on age distribution &amp; vaccination status for measles</li> <li>o by 1986, had sentinel surveillance established in all districts</li> <li>o encouraged MOH to hire full-time health statistician</li> </ul>
<b>CONCLUSIONS</b> (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations?	(1) <ul style="list-style-type: none"> <li>o MOH has established health education unit with full-time health educator</li> </ul> (2) <ul style="list-style-type: none"> <li>o health ed. unit established in MOH prior to CCCD</li> <li>o extensive donor coordination</li> </ul> (3) <ul style="list-style-type: none"> <li>o health ed. remains weak at community level</li> </ul> (4) <ul style="list-style-type: none"> <li>o lessons learned: What worked? What did not work?</li> <li>o Recommendations?</li> </ul>	(1) <ul style="list-style-type: none"> <li>o MOH states development of HIS as high priority</li> <li>o integrated throughout MOH, Health Statistics Unit as focal point</li> </ul> (2) <ul style="list-style-type: none"> <li>o project began with monthly reporting from approx. 400 sites</li> <li>o high % reporting</li> </ul> (4) <ul style="list-style-type: none"> <li>o computerization has made significant improvements in timeliness, usefulness of data</li> </ul>

Categories	OR	COMMENTS: SUPERVISION, SUSTAINABILITY
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>o goal: conduct research activities in CDD, malaria</p>	<p>o target: GOM will increase contribution throughout the life of the project</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access &amp; coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and mortality?</p>	<p>(1) o 29 studies completed or ongoing o began Mangochi study on effects on birthweight of chemoprophylaxis in pregnant women (an important research activity which will ultimately affect policy) (4) o all studies have influenced policies, procedures or health messages</p>	<p>SUPERVISION (1) o established list of indicators for monitoring CCCD interventions o developed MOH checklist to evaluate quality of activities  SUSTAINABILITY (1) o cost recovery studies begun o developed pilot community intervention mechanisms for cost recovery. o revised government financial contributions schedule o MOH expressed desire to extend project, willingness to pay maximum possible</p>
<p>CONCLUSIONS (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations?</p>	<p>(4) o need to achieve national capability to conduct research</p>	<p>SUPERVISION (4) o need continued supervision and education to ensure quality  SUSTAINABILITY (1) o GOM committed to project and to PHC, but has difficulty with funding (3) o government unable to increase contribution based on current economic situation o little financial accountability</p>

MALAWI: EVALUATION CONTENT FOR ACSI-CCCD

Categories	PROGRAM MANAGEMENT
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o country assessment done 1983</li> <li>o baseline information: no initial budget or workplan detailed LOP plan developed in 1988</li> <li>o Malawi project was not extended: no explanation given in any of the evaluation documents</li> </ul>
<b>OUTCOMES</b>	
(actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and mortality?	(1) o achieved good donor coordination through persistent efforts o compiled bilateral contributions budget for remaining funds (1986) o compiled expenditures record for project showing breakdown of contributions (1986) o designed computer budget format to facilitate updating o oriented new CDD/malaria manager T.O. and AID worked out system for management of resources, finances, and procurement o developed procurement and distribution process for vaccines, cold chain supplies, ORT supplies, and malaria pharmaceuticals (4) o CCCD has improved overall service delivery
<b>CONCLUSIONS</b>	
(1) Institutional- zation: To what degree does MOH support system? (2) Program strengths (3) Problems/Con- straints: What factors limit tar- get achievement? (4) Lessons learned: What worked? What did not work? Recommendations?	(1) o CCCD well integrated in PHC system (2) o well-established MCH system an asset o donor coordination generally functional, regular o government has changed focus from curative to preventive services o government committed to decentralization o PCV's have successfully integrated into PHC system o prior to CCCD, 80% of population had some access to care (3) o MOH delay in developing budget/workplan seen as a hindrance to progress o AID lack of management capability to backstop project o CDC lack of T.O. training in AID administrative procedures, lack of sensitivity to AID management load

Categories	EPI	CDD																																
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<p>to targets: current(1985) 1990</p> <table border="1"> <tr> <td>IMR</td> <td>60-120/1000</td> <td>25% dec.</td> </tr> <tr> <td>1-4 MR</td> <td>10-20/1000</td> <td>25% dec.</td> </tr> <tr> <td>NNT mort.</td> <td>5-20/1000</td> <td>50% dec.</td> </tr> <tr> <td>Measles mort.</td> <td>20-80/1000</td> <td>50% dec.</td> </tr> <tr> <td>Vacc. Coverage</td> <td>10%</td> <td>80%</td> </tr> <tr> <td>NNT protection</td> <td>5%</td> <td>50%</td> </tr> </table> <p>to target: by end '87, all 304 LGAs will have received vehicles, equipment, supplies</p> <p>to vaccination coverage 1986 (baseline):</p> <table border="1"> <tr> <td>DPT1</td> <td>DPT3</td> <td>OPV1</td> <td>OPV3</td> <td>Measles</td> <td>TT1</td> <td>TT2</td> </tr> <tr> <td>30%</td> <td>17%</td> <td>29%</td> <td>17%</td> <td>18%</td> <td>18%</td> <td>12%</td> </tr> </table> <p>to as of 11/86, EPI already established in 170/304 LGAs</p>	IMR	60-120/1000	25% dec.	1-4 MR	10-20/1000	25% dec.	NNT mort.	5-20/1000	50% dec.	Measles mort.	20-80/1000	50% dec.	Vacc. Coverage	10%	80%	NNT protection	5%	50%	DPT1	DPT3	OPV1	OPV3	Measles	TT1	TT2	30%	17%	29%	17%	18%	18%	12%	<p>to target: increase ORT use in health facilities from 1% (1986) to 50% (1990) revised (1988): to 90% by 1990 increase community ORT use from 1% (1986) to 20% (1990) revised (1988): to 75% in 1990 reduce mortality by 50% and morbidity by 20% in &lt;5's (1989)</p> <p>to goal: 5-year plan: establish demonstration units develop training programs community mobilization increase awareness in schools</p> <p>to baseline: ORS is already being used in some areas ORS not produced locally to health facility assessment conducted in 3 states in 1988</p>
IMR	60-120/1000	25% dec.																																
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OUTCOMES (actual v. planned)	<p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity and/or mortality</p>	<p>(1)</p> <p>to assisted Borno State in conducting series of 1-week workshops for ORT startup (1987)</p> <p>to developed procedures for training personnel in 7 LGAs in Cross River State (1987)</p> <p>to assisted Niger State in formulating strategies to improve ORT service quality (1987)</p> <p>to developed country-specific training materials (1987-1988)</p> <p>to trained 50 physicians at Massey St. hospital in hands-on ORT (1987)</p> <p>to conducted a 2-week ORT course for 70 health workers in Borno State (1987)</p> <p>to local physician recruited as ORT ops. advisor (1988)</p> <p>to surveys conducted to identify weaknesses of program in low-achievement states (1988)</p> <p>to supervisory checklist was developed; in process of field-testing as of March 1988</p> <p>to training module for ORT managers was developed and pretested in 1988</p> <p>(2)</p> <p>to use of I.V. therapy has decreased significantly</p> <p>to 86% of mothers knew of SSS; 62% knew contents; and 35% knew correct recipe in 1989 study</p> <p>(3)</p> <p>to ORT demonstration units are in all states; ORT corners are in most LGAs (1987)</p> <p>to by February 1989, more than 722 health units were providing ORT and demonstrations</p> <p>to by 1987, 84% of cases were being treated with ORS</p> <p>to # of locally produced ORS packets remained steady at approximately 900,000 since 1985</p> <p>(4)</p> <p>to reported decrease in hospital admissions and deaths due to diarrheal disease: CFR decreased from 4.4% to 1.4% at Massey St. hospital</p>																																
CONCLUSIONS	<p>(1)</p> <p>to EPI extremely well integrated into PHC system, strongly supported by FMOH and SMOHs</p> <p>(2)</p> <p>to EPI is the most advanced of the interventions in Nigeria</p> <p>(2) Program strengths</p> <p>to FGM is meeting 70% of capital and recurring costs (including vaccines)</p> <p>to UNICEF/WHO/CCCD/ROTARY external inputs are highly coordinated</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>to program has initiated increased NGO participation</p> <p>(3)</p> <p>to although greatly improved, still experiencing difficulty in transport, cold chain maintenance</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>to certain (geographical) areas still inaccessible</p> <p>to management/supervision still weak</p> <p>to weakening economy threatens FGM's ability to continue funding at current level</p> <p>(4)</p> <p>Recommendations?</p> <p>to NIDs assessed to have increased coverage and awareness and decreased dropout rates</p> <p>to must consider the role of NIDs/SIDs and CCCD to establish whether Immunization Days are beneficial in an overall, long-term sense</p> <p>to need to increase, improve surveillance of immunizable diseases; gather impact data</p> <p>to need to improve standardization of procedures</p>	<p>(1)</p> <p>to ORT has been institutionalized in the PHC system as "self-reliant, affordable, available and scientifically sound solution to endemic diarrhoea"</p> <p>to all health facilities in Nigeria promoting ORT use</p> <p>(2)</p> <p>to emphasis has moved toward hands-on training</p> <p>to study has shown CDD/ORT to be cost-effective (reported in 1989)</p> <p>(3)</p> <p>to despite improvements, transportation and lack of manpower remain limitations to progress</p> <p>to supervision and management still somewhat weak</p> <p>to diarrheal disease reporting system still poor</p> <p>(4)</p> <p>to CDD is not as strong an intervention as EPI</p> <p>to knowledge and use of SSS by mothers at home has been attributed to reduction in cases seen (1989)</p> <p>to need to encourage more operations research in CDD</p> <p>to need to increase education at all levels</p> <p>to need defined national training strategy for ORT</p> <p>to need to increase supervision at service delivery level for quality assurance</p> <p>to need to improve ORS packet distribution system</p> <p>to need to focus more on prevention of diarrhoea rather than solely on treatment</p>																																

Categories	MALARIA	TRAINING
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o target: increase presumptive malaria treatment from 20% (1986) to 70% (1990) revised (1988): to 80% in 1990</li> <li>o baseline: lack of good planning, goals, and basic resources (country assessment, 1985)</li> <li>o general workplan established 1987</li> </ul>	<ul style="list-style-type: none"> <li>o general objective: assist in training and in the funding of training</li> <li>o training plans for CDD developed (1989)</li> </ul>
<b>OUTCOMES</b>		
(actual v. planned)		
(1) Outputs What was provided, accomplished?	<ul style="list-style-type: none"> <li>(1)</li> <li>o developed national malaria treatment policy (1987)</li> <li>o formed National Malaria Committee and convened for first time in 1987</li> <li>o a hospital-based sentinel surveillance system was ready to launch in 1987</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o by 1988, had trained approximately 55,000 health system personnel; over 40,000 were volunteers, vaccinators, mobilizers and helpers with MIDs</li> <li>o assessed status of Youth Corps Epidemiological Service program (YES); determined that good supervision would be critical to its success (1985-86)</li> <li>o assisted in developing/printing 2 sets of inservice management training materials (1988)</li> <li>o trained 90 senior level professionals by end of 1987</li> <li>o in process of developing several training plans and strategies during 1989/90 budget cycle</li> <li>o developed country-specific EPI and ORT training materials (1987-88)</li> </ul>
(2) Quality How well are new systems/skills used?	<ul style="list-style-type: none"> <li>o a monitoring and supervisory scheme was adopted in 1988</li> <li>o conducted a 5-week, 26-participant malaria surveillance methodology training course (1988)</li> </ul>	<ul style="list-style-type: none"> <li>o assisted in developing/printing 2 sets of inservice management training materials (1988)</li> <li>o trained 90 senior level professionals by end of 1987</li> <li>o in process of developing several training plans and strategies during 1989/90 budget cycle</li> <li>o developed country-specific EPI and ORT training materials (1987-88)</li> </ul>
(3) Effects Access & coverage What are effects on KAP of pop.?	<ul style="list-style-type: none"> <li>o formed National Malaria Surveillance Network;</li> <li>o developed workplan and budget (1987-88)</li> <li>o conducted study to assess P. falciparum sensitivity to pyrimethamine in pregnant women (1988)</li> <li>o participated in series of technical conferences re efficacy of malaria therapy (1988)</li> </ul>	<ul style="list-style-type: none"> <li>(2)</li> <li>o despite large amount of attention/resources devoted to training, results have been "sketchy" (1987)</li> </ul>
(4) Impact What is impact on morbidity and/or mortality	<ul style="list-style-type: none"> <li>o assisted universities and the FMOH initiatives to assess level of cq resistance in Nigeria (1988)</li> <li>o draft (updated) policy paper prepared in early 1989; expected to be approved in Fall 1989</li> </ul>	<ul style="list-style-type: none"> <li>(3)</li> <li>o health worker performance in EPI was good, less success in CDD and malaria service delivery (1989)</li> </ul>
	<ul style="list-style-type: none"> <li>(2)</li> <li>o treatment of fever by health workers, 1988: pills 8.9%; injection 10.7%; syrup 35.7%; syrup &amp; inj. 39.3%; tabs &amp; inj. 3.6%; no cq 1.8%</li> </ul>	
	<ul style="list-style-type: none"> <li>(4)</li> <li>o no determination of impact on morbidity or mortality made</li> </ul>	
<b>CONCLUSIONS</b>		
(1) Institutionalization: To what degree does MOH support system?	<ul style="list-style-type: none"> <li>(1)</li> <li>o malaria component of CCCD seems to be functioning in concert with FGN malaria control program</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o training is primarily decentralized; well-integrated at the LGA level</li> <li>o need to develop a national training strategy at FMOH level</li> </ul>
(2) Program strengths	<ul style="list-style-type: none"> <li>(2)</li> <li>o comprehensive review in mid-1988 determined that National Malaria Surveillance Network was functioning smoothly</li> </ul>	<ul style="list-style-type: none"> <li>(2)</li> <li>o specialized training is conducted at state, zonal and LGA levels</li> <li>o an "impressive" level of health professionals exists at Ministerial, academic and service delivery levels</li> </ul>
(3) Problems/Constraints: What factors limit target achievement?	<ul style="list-style-type: none"> <li>o financial practices determined sound, funding mechanisms satisfactory (1988)</li> <li>o intensive operation research in malaria</li> </ul>	<ul style="list-style-type: none"> <li>(3)</li> <li>o weaknesses exist largely at the health facility level; need supervision</li> </ul>
(4) Lessons learned: What worked? What did not work?	<ul style="list-style-type: none"> <li>(3)</li> <li>o increasing cq resistance inhibiting progress in reduction of morbidity/mortality</li> <li>o 60% of cq sold in Nigeria determined to be either fake or adulterated (1988)</li> </ul>	<ul style="list-style-type: none"> <li>o difficulty in coordinating training among all donors and across all levels</li> <li>o no follow-up on fate of the YES</li> <li>o management/supervision training still lacking</li> </ul>
Recommendations?	<ul style="list-style-type: none"> <li>(4)</li> <li>o need to make public aware of problem with bad cq</li> <li>o must develop regulatory system for monitoring drug quality</li> <li>o further operations research on chemoprophylaxis in pregnant women recommended</li> </ul>	<ul style="list-style-type: none"> <li>(4)</li> <li>o delays in implementation of training may be due to reorganization of the FMOH</li> <li>o still need to set up continuing education and routine supervisory training systems (sustainability)</li> <li>o need to develop national training strategy</li> <li>o need to adapt training materials to address management/supervision as well as technical issues</li> <li>o recommendation to establish a field epidemiology training course in Nigeria</li> </ul>

Categories	HEALTH EDUCATION	HIS
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>o initial goals: fund 2 communications experts to work with FMOH and Healthcom test and produce materials o workplans for 5 states in place by 1987</p>	<p>o goals: strengthen at all levels develop youth corps epidemiology service acquire computers hire field epidemiologist for &gt;= 2 years integrate national PI reporting perform epidemiologic assessments, plans collect impact data: at least 4 surveys from 1986-1989</p>
<p>OUTCOMES (actual v. planned)</p>	<p>(1) o Healthcom reported much activity in '87-'88: -recruited and hired Health Education Unit (HEU) personnel -acquired and installed equipment, vehicle -trained users on equipment -carried out baseline survey -finalized and distributed EPI materials -established mass media committee -trained 43 health workers in Niger state in EPI health education -assisted with TOT workshop; workshop was assessed as successful o supported a 2-week materials development workshop o implemented plans drafted for 5 states o ARHEC courses held (1987 and 1988) o Healthcom directed national and state level activities: materials development seminars, ethno-medical studies, health facility surveys, community practice assessments, and on-the-job training (1988) o established Child Survival units in all 21 of the State television stations by 1989 o developed mass media messages for social and political mobilization</p>	<p>(1) o installed 4 PCs in CCCD offices (1987) o hired full-time computer specialist (1987) o trained staff in data entry (1987) o developed software programs to input and analyze EPI and ORT data (1987) o ongoing discussions re sentinel surveillance, assessment at all levels o distributed 2 quarterly reports (1987) o EPI reports being produced by PHC zone, state, and LGA by 1988 o target populations updated, encoded (1988) o developed software to monitor trends (1988) o completed entry/analysis of EPI data from 1/86-4/88 o continued to provide hardware, software and training</p>
<p>CONCLUSIONS</p>	<p>(1) o firm base has been established within the Federal Health Education Division (FHED) (2) o excellent mass media efforts for social and political mobilization o media and health ed. focus during NIDs/SIDs has served to "galvanize and reinforce political and community commitment" and mobilize the population (3) o staffing shortages were common complaint o indecision about whether/how to include family planning in CCCD health education o FHED graphic artist resigned in 1988: hodes still for institutionalization (4) o Healthcom and FHED need to be more involved in sub-contractor activities o educational materials appear to be easily transferrable o need to increase technical cooperation among donors</p>	<p>(1) o CCCD has assisted in establishing the Primary Health Care Monitoring and Evaluation Unit (PHCMEU) in FMOH o PHCMEU has developed into cornerstone of Project (2) o training program and computerization have been exceptional o decentralized management information system works very well (3) o delays in planned consultancies, equipment delivery and training caused HIS to stagnate until 1987 o lack of consistent strategy to collect data o lack of epidemiologists to conduct reliable surveillance activity o PHCME system not totally institutionalized (4) o need to examine, monitor PHC Monitoring and Evaluation reporting sys to ensure usefulness of data o need to hire epidemiologist(s) to conduct surveillance activity</p>

Categories	OR	COMMENTS: SUPERVISION, SUSTAINABILITY
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	o goal: fund at least 10 proposals per year	o Federal Govt. of Nigeria (FGN) will support 42% of recurrent costs in yr. 1; will increase share as project progresses o FGN must be contributing at least 66% by 1990  o goal: help train nationals in financial management skills o identify and develop counterparts at most levels o collaborate with universities, professional schools  o workplan drafted in 1987  o baseline: some facilities charging for service and/or supplies in 1985 o Ogun state had revolving drug fund in 1985
OUTCOMES		SUPERVISION
(actual v. planned)	(1)	(1)
(1) Outputs What was provided, accomplished?	o developed "Guidelines for CCCD Operations Research Activities in Nigeria" (1987) o established CCCD Operations Research Review Committee; held first meeting (1987)	o developed supervisory checklist for CDD; still in field testing as of March 1988 o efforts to include more supervisory training in training activities are ongoing
(2) Quality How well are new systems/skills used?	o made promotional visits to schools, universities, and SMOHs o total of 17 out of 30 proposals submitted had been approved by 1989	SUSTAINABILITY
(3) Effects Access & coverage What are effects on KAP of pop.?	o provided technical and financial support for 2 National Research Meetings and for various proposal development/assessment activities o conducted training course on OR (1989)	o instruments for assessing PHC activity costs developed (1987) o completed assessment of health care delivery costs at various levels (1988) o conducted financial management needs assessment in Niger and Lagos states (1988) o collaborated with World Bank to develop activity to improve drug stock management & quality control of revolving drug funds (begun 1989) o FMOH policy on supply and distribution of ORS packets has evolved (1989)
(4) Impact What is impact on morbidity and/or mortality	(4) o used findings from malaria OR to design national malaria policy	
CONCLUSIONS	(1)	SUPERVISION
(1) Institutionalization: To what degree does MOH support system?	o OR enthusiastically received by government and academia	o FGN shows strong support for training; emphasis on the need to train Nigerians to replace managers, technicians and experts of all kinds
(2) Program strengths	(2) o OR assessed as very successful over all o no lack in number of proposals submitted	(2) o efficacy of EPI & CDD programs seems high
(3) Problems/Constraints: What factors limit target achievement?	(3) o most OR has focused on malaria control	(3) o need for increased, better supervision repeatedly cited
(4) Lessons learned: What worked? What did not work?	(4) o need to encourage wider variety of research topics; need more on EPI, CDD	(4) o need to work toward institutionalizing PHC monitoring & evaluation system
Recommendations?		SUSTAINABILITY
		(1)
		o institutional capacity for implementation of interventions exists o most health care costs already borne by state, local governments o financial sustainability of EPI appears possible
		o there appears to be a strong constituency for project activities o FMOH has sense of ownership of project
		(2) o FMOH & states have been financing 50-70% of vaccine costs and 30% of equipment costs
		(3) o high rate of inflation, lack of foreign exchange makes financial sustainability increasingly difficult
		(4) o FMOH sense of ownership due to FMOH input into policy decisions
		o need to increase activities in cost recovery

Categories	PROGRAM MANAGEMENT
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>to plan to externally evaluate in '87, '89 &amp; '91</li> <li>to baseline (pre-1985):                             <ul style="list-style-type: none"> <li>-emphasis on curative/tertiary care</li> <li>-critical shortages in rural areas</li> <li>-poor preventive &amp; environmental health services</li> <li>-high fertility, high population growth</li> <li>-lack of clear national policy</li> </ul> </li> <li>to implementation plan to be developed within 6 months</li> <li>to provide technical assistance in drug supply analysis and planning</li> <li>to established annual plan/priorities for 1987</li> <li>to country assessment done 1985</li> </ul>
<b>OUTCOMES</b> (actual v. planned)	<ul style="list-style-type: none"> <li>(1) Outputs What was provided, accomplished? to conducted study on development of a senior management training program</li> <li>to established procedures to improve communications between donors, MOH (1987)</li> <li>(2) Quality How well are new systems/skills used? to established offices, hired and trained local staff, purchased and received vehicles, computers, and equipment, and established a management system within 1st 6 months of project (1987)</li> <li>to office space &amp; transport problems improving (1987)</li> <li>(3) Effects Access &amp; coverage What are effects on KAP of pop.? to work schedules developed for all components for the year (1988)</li> <li>to established an International Coordinating Committee (ICC) (1989?)</li> <li>to principal management tasks were identified (1986)</li> <li>(4) Impact What is impact on morbidity and/or mortality to private sector ORS production and public distribution system was revived (1987)</li> </ul>
<b>CONCLUSIONS</b>	<ul style="list-style-type: none"> <li>(1) Institutionalization: To what degree does MOH support system? to FMOH has sense of ownership of project</li> <li>to ministers support the ICC</li> <li>(2) Program strengths to coordination &amp; cooperation of donors impressive</li> <li>to vehicle maintenance/transportation and lack of staffing seem to be perpetual problems</li> <li>to PHC system not well coordinated initially</li> <li>(3) Problems/Constraints: What factors limit target achievement? to planning occurred mainly at federal level initially</li> <li>to key to effective program appears to be management, supervision and coordination rather than pure technical expertise</li> <li>(4) Lessons learned: What worked? to need to improve control of consultant flow</li> <li>to need to better integrate Pritech and Healthcom</li> <li>to need another epidemiologist on staff</li> <li>What did not work? to need to achieve local self-sufficiency in ORS production</li> <li>Recommendations? to need to increase social marketing of ORS/SSS</li> <li>to need to increase staff; locally recruit staff as much as possible</li> <li>to USAID and MOH should focus on policy and program oversight, not day-to-day management</li> <li>to CDC program manager (Nigeria) &amp; Nigeria project director should supervise all short- and long-term specialists (except UNICEF T.O.)</li> </ul>

RWANDA: EVALUATION CONTENT FOR ACS1-CCCC

Project Start: June 1984 LOP Funding: \$400,902

Categories	EPI	CDD
Plans	to well designed national EPI plan	to well designed national CDD plans
Needs assessment, goals & objectives	to clear project objectives and targets	to clear project objectives and targets
planned inputs, expected outcomes.	to baseline 1983: BCG 49% DPT3 36% OPV3 25% Measles 53%	
OUTCOMES	(1) to KAP survey on EPI formed baseline data	(1) to met target to increase utilization of ORT as primary therapy for diarrhea; ORT is treatment of choice; ORS is available in 100% of health facilities
(actual v. planned)	to vaccination coverage surveys conducted in 10 regions	to activities toward meeting objectives to increase utilization of SSS discontinued
(1) Outputs	to not possible to evaluate compliance with general objective to reduce infant and child mortality by 25%; no inexpensive method to measure in Rwanda	to 2 ORT training centers established; 20 ORT units opened in regions; training assessed as effective
What was provided, accomplished?	to drop out rates rose slightly 1986-87 for DPT	to baseline data on ORT KAP collected
(2) Quality	to drop out rates for tetanus toxoid among pregnant women declined	to ORS supply is adequate, continuous
How well are new systems/skills used?	(3) to 1987 coverage: BCG 90% DPT3 79% OPV3 79% Measles 75%	to studies underway on sorghum solutions
(3) Effects	to met target to immunize 25% of pregnant women for tetanus toxoid; immunized 32% of targeted women	(2) to KAP showed great variation in preparation of SSS; potentially dangerous, not therapeutic: of 65 mothers who prepared SSS, 54 different formulas prepared; of 17 analyzed, 76% had unsafe sodium levels; of 8 HCW's, 8 different recipes taught
Access & coverage	to vaccine coverage targets met for OPV, DPT, BCG	to 74% of diarrhea cases treated with ORT
What are effects on KAP of target population?	to measles coverage just below target	(3) to 95% of children have access to ORT
(4) Impact	(4) to target to decrease morbidity/mortality for target diseases by 40 and 30%, respectively, largely met	(4) to project impact unclear: hospital data does not show decline in incidence or deaths from diarrhea
What is impact on morbidity/mortality?	to decrease in morbidity/mortality for target diseases: Measles-54%/26%; Pertussis-85%/90%; tetanus-6% decrease in mortality for all ages	to indicators may not be sensitive enough to detect declines, or increased & improved training, health
CONCLUSIONS	(1) to EPI component was the strongest of the three, and is sustainable at the end of project	(2) to logistics system works well-no reported stockouts, or ruptures in stock
(1) Institution- alization:	to primary health care infrastructure well established - EPI activities well integrated into it	(3) to not all ORT units have demonstration materials available - ORS preparation explained orally
To what degree does MOH support systems?	(2) to cold chain works effectively at all levels	to no standardized measure for ORS
(2) Program strengths	to sterilization procedures known, generally followed	to problem re: access to safe water need for ORS
3. Problems/ Constraints	to children vaccinated at correct ages, according to treatment schedules	to anecdotal information collected suggest that ORS not accepted by health professionals as effective treatment
What factors limited achievement of targets?	to factor for success is existing, strong EPI program in Rwanda since 1978	to underutilization of hospital-based unit
(3)	to operations decentralized to regions	to training in ORT needs to be developed; KAP must be reinforced
(4) Lessons learned:	to weakness in placement of EPI activities within the MOHSA structure	to barrier to setting up ORT Units after training is necessity to find own space, supplies
What worked?	(4) to fixed strategy of immunization effective in increasing coverage in cost-effective way; social mobilization is a key factor in strategy	(4) to ORT available, infrastructure exists: improvements in training, supervision, health education necessary to achieve morbidity/mortality impact
What did not work?		
Recommendations?		

Categories	MALARIA	TRAINING
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes.	<ul style="list-style-type: none"> <li>o national Malaria strategy and treatment policy established</li> <li>o no specific project targets</li> </ul>	<ul style="list-style-type: none"> <li>o no training needs assessment conducted</li> <li>o national training plan developed, approved</li> <li>o evaluation of performance not included in training plan</li> <li>o target: train 40 mid-level managers, 400 heads of centers, and 288 health workers in CCCD techniques</li> </ul>
OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of target population? (4) Impact What is impact on morbidity/ mortality?	<ul style="list-style-type: none"> <li>(1)</li> <li>o baseline data on malaria gathered in KAP</li> <li>o study on sensitivity of antimalarials conducted</li> <li>o 2 sentinel labs established to monitor chloroquine resistance</li> <li>o 18 trained in monitoring chloroquine resistance</li> <li>(2)</li> <li>o compliance unknown for chemoprophylaxis treatment of pregnant women</li> <li>o all health facilities had treatment poster, but policies not being fully implemented; personnel do not know efficacy of different drugs; not convinced of efficacy of recommended drugs</li> <li>(4)</li> <li>o 94% increase in malaria incidence since 1984</li> <li>o 26% increase in mortality due to malaria</li> <li>o 57% increase in hospital admissions</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o training targets nearly met: output: 78 mid-level managers, 88 heads of centers, &amp; 600 health workers trained</li> <li>o training materials adapted for Rwanda</li> </ul>
CONCLUSIONS (1) Institution- alization: To what degree does MOH support systems? (2) Program strengths (3) Problems/ Constraints What factors limited achieve- ment of targets? (4) Lessons learned: What worked? What did not work? Recommendations?	<ul style="list-style-type: none"> <li>(2)</li> <li>o no shortages of chloroquine reported at health facilities; no other anti-malarials available there</li> <li>(3)</li> <li>o unavailability of Fansidar makes it hard to follow standard treatment</li> <li>o standard procedure for chemoprophylaxis treatment for pregnant women difficult to implement; not as effective as first thought; treatment abandoned except for in 4 test regions</li> <li>o chloroquine supply complicated - difficult to manage</li> <li>(4)</li> <li>o pressing need for MOHSA to establish a malaria coordinating unit to promote malaria plans; coordinate surveillance, research, supervision, training, health education activities in malaria</li> <li>o training efforts should give priority to malaria treatment, prevention</li> <li>o health education efforts should give priority to malaria treatment/prevention</li> <li>o need training in lab techniques</li> <li>o Rwanda in great need of external support to assist in determining cause in increased incidence, surveillance, emergency funding for treatment, and prevention</li> <li>o supervision for malaria practices should be given priority</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o CCCD policies and treatment plans not integrated into medical and para-medical school curricula</li> <li>(2)</li> <li>o training decentralized to regional level; central level personnel train regional level personnel who in turn train peripheral level personnel</li> <li>(3)</li> <li>o training of trainer component of MLM course not adequate.</li> <li>o peripheral training criticized: too little time to learn too much material, not enough time to develop skills and knowledge adequately</li> <li>o training didn't reach enough heads of centers</li> <li>(4)</li> <li>o need to emphasize training role of heads of centers and beef up training of trainers component</li> <li>o PCVs can be used to do TOT courses</li> <li>o health workers spend too much time in training and away from daily service duties; need to integrate training into continuing education program</li> <li>o must provide training to instructors to update them in national policy and treatment plans; provide instructional materials</li> </ul>
	<ul style="list-style-type: none"> <li>o malaria problem beyond the scope of CCCD project</li> <li>o disseminate results of drug sensitivity studies</li> </ul>	

Categories	HEALTH EDUCATION	HIS
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes.	no stated targets for health education	no stated targets for HIS
<p>OUTCOMES (actual v. planned)</p> <p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of target population?</p> <p>(4) Impact What is impact on morbidity/mortality?</p>	<p>(1)</p> <ul style="list-style-type: none"> <li>o materials developed</li> <li>o health workers trained to utilize health ed inputs</li> <li>o outstanding component of project: skilled team implemented formative studies, developed and distributed health ed. materials; conducted an effective mini-campaign for EPI</li> <li>o target to develop coordinated strategy and workplan for health education was met</li> </ul> <p>(4)</p> <ul style="list-style-type: none"> <li>o dropout rates for pregnant women for tetanus vaccine dropped from 67% to 37%; linked to health education efforts</li> </ul>	<p>(1)</p> <ul style="list-style-type: none"> <li>o achieved target to establish baseline morbidity/mortality of data relevant to CCCD</li> <li>o developed HIS to collect coverage and impact data</li> <li>o developed supervision information system which provides status data on health center performance to regional medical officers</li> <li>o developed pilot HIS to simplify, improve collection, analysis, printing, and distribution of HIS data</li> </ul>
<p>CONCLUSIONS</p> <p>(1) Institutionalization: To what degree does MOH support systems?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints What factors limited achievement of targets?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<p>(1)</p> <ul style="list-style-type: none"> <li>o institutionalization of sound Health Education programming is very significant achievement of project</li> <li>o Health Education activities integrated in CCCD planning</li> </ul> <p>(2)</p> <ul style="list-style-type: none"> <li>o work very visible throughout country</li> <li>o extensive TA inputs were well used in developing competency in several new skill areas</li> </ul> <p>(4)</p> <ul style="list-style-type: none"> <li>o should include training programs to develop health workers skills in health education</li> <li>o need to develop malaria messages based on formative studies</li> </ul>	<p>(2)</p> <ul style="list-style-type: none"> <li>o very positive feedback from pilot HIS system</li> <li>o HIS relating to EPI program well-developed from early in project</li> </ul> <p>(3)</p> <ul style="list-style-type: none"> <li>o no standardized diarrheal disease reporting form</li> </ul> <p>(4)</p> <ul style="list-style-type: none"> <li>o each activity needs additional technical assistance to be integrated fully into a functioning national HIS</li> </ul>

Categories	OR	CROSS CUTTING COMMENTS (SUPERVISION,SUSTAINABILITY)
Plans needs assessment, goals & objectives planned inputs, expected outcomes.	to target: fund 5 OR studies during life of project	to project was designed to be implemented in 3 phases, 3 pilot regions, expand to include 4 more regions, and add last three regions; plan worked well, except that final three regions not included soon enough to benefit from training, supervision
<p>OUTCOMES (actual v.planned)</p> <p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of target population?</p> <p>(4) Impact What is impact on morbidity/mortality?</p>	<p>to national review board set up to review and approve research protocols</p> <p>to 4 proposals reviewed, 2 approved with minor revisions; funds not improved in time for disbursement during LOP</p> <p>to failed to meet objective of funding 5 projects</p>	<p>SUPERVISION:</p> <p>to effective national level supervisor team with innovative check-list approach</p> <p>SUSTAINABILITY:</p> <p>to project failed to develop a self-financing approach</p> <p>to project sustainable by the following criteria:</p> <ol style="list-style-type: none"> <li>1) GOR committed to priorities of project, has ownership of project, doesn't feel it was imposed by AID</li> <li>2) project activities well integrated into MOH structure</li> <li>3) project perceived as successful in achieving in reaching objectives and targets</li> </ol> <p>to GOR slow to commit funds and personnel to project</p>
<p>CONCLUSIONS</p> <p>(1) Institutionalization: To what degree does MOH support systems?</p> <p>(2) Program strengths</p> <p>3. Problems/Constraints What factors limited achievement of targets?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<p>(2)</p> <p>to OR too narrowly defined to focus on medical and public health issues to the exclusion of administrative and implementation issues</p>	<p>SUPERVISION:</p> <p>(2)</p> <p>to impact of CCCC project due in part to improvements in supervision that new system has achieved</p> <p>(3)</p> <p>to insufficient time to observe practices, provide on-the-job training; supervision isn't a substitute for continuing education and basic training program</p> <p>to variety of supervisory systems on regional level makes in difficult to integrate national regional systems; uniform model would help this</p> <p>(4)</p> <p>to strengthening supervision may be the key to improving impact of ORT, Malaria activities; system not fully implemented in all provinces; must be strengthened at regional level</p> <p>SUSTAINABILITY:</p> <p>(1)</p> <p>to UNICEF, WHO, World Bank will assume AID's % of contributions; ability of GOR to assume cost of project not critical to sustainability of project</p> <p>to what was achieved during the life of the project will be sustained; project was on the verge of far exceeding expectations- momentum will stop</p> <p>(3)</p> <p>to little additional GOR resources available for Child Survival activities</p> <p>(4)</p> <p>to self-financing mechanisms must be developed</p> <p>to single donor dependence (UNICEF) shouldn't be encouraged</p> <p>to current proposals for cost-recovery should be acted on by Ministry as soon as feasible</p> <p>to receipts for any increase in medical charges should stay within community, be used entirely for health care</p>

Categories	PROGRAM MANAGEMENT
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes.	<ul style="list-style-type: none"> <li>o annual project workplans, monthly calendars</li> <li>o very effective: acts as a model for other CCCD projects</li> </ul>
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished?	
(2) Quality How well are new systems/skills used?	<ul style="list-style-type: none"> <li>(1)</li> <li>o CCCD established good working relationship with MOHSA: technical assistance from CDC well-received, Ministry vocally supported project</li> </ul>
(3) Effects Access & coverage What are effects on KAP of target population?	<ul style="list-style-type: none"> <li>o project very successful in integrating activities into Ministry structures at several levels</li> <li>(2)</li> <li>o Technical Officer role is to begin project as initiator and shift to supporter once govt. shows commitment to project: shift effectively done - critical to future sustainability of project</li> </ul>
(4) Impact What is impact on morbidity/mortality?	<ul style="list-style-type: none"> <li>(3)</li> <li>o USAID expenditures didn't reflect declining pattern of US and increasing GOR contributions: US funded several crucial components, question as to future resources for these components</li> <li>o GOR never established regular accounting system to routinely account for contributions; total amount funds from GOR - \$795,461, \$461,497 of which is salaries: ProAg called for \$810,402, exclusive of salaries; only provided \$49,209 of expected \$181,984 for chloroquine, and \$0 of \$480,000 expected for vaccines; contribution for vehicle maintenance, petrol, etc exceeded expectations: \$189,615 instead of \$125,000</li> </ul>
<b>CONCLUSIONS</b> (1) Institutionalization: To what degree does MOH support systems?	<ul style="list-style-type: none"> <li>o T.O. counterpart first two years was very busy with no time for project</li> <li>o administrative bottlenecks inhibited cold-chain repair, and getting spare vehicle parts</li> <li>o administrative fragmentation and insufficient institutionalization of coordination mechanisms have been an obstacle to implementation</li> </ul>
(2) Program strengths	<ul style="list-style-type: none"> <li>o no effective mechanism for coordinating overall donor activity; committee on Public Health inactive for over a year</li> </ul>
(3) Problems/Constraints What factors limited achievement of targets?	<ul style="list-style-type: none"> <li>o under PASA administrative and technical functions shared in a complex way between AID, CDC; system not understood sufficiently to assure smooth operation of project, difficulty in maintaining distinction between admin. and technical roles</li> <li>o decentralization of MOHSA requires that project implementation and effectiveness depends on interests, skills and motivation of Regional Officers, which makes coordination of activities very difficult</li> </ul>
(4) Lessons learned: What worked? What did not work?	<ul style="list-style-type: none"> <li>(4)</li> </ul>
Recommendations?	<ul style="list-style-type: none"> <li>o EPI, ORT and Malaria interventions should be administered under one administrative unit which is integrated into the rest of MOHSA PHC programs</li> <li>o MOHSA must take initiative to develop plan to integrate donor participation in health sector</li> <li>o T.O. assumed more administrative responsibilities than should have, in part due to MPH officer lack: chains of command should be clarified</li> <li>o first year visit should be scheduled earlier so MOH knows that T.O. has strong CDC support</li> <li>o CDC and USAID supervisors should coordinate closely and routinely to discuss T.O.'s performance.</li> <li>o both USAID project manager and T.O. should receive monthly status reports on project budget</li> </ul>

SWAZILAND: EVALUATION CONTENT FOR ACS1-CCCC

Project Start: June 1984 Funding: \$703,000

Categories	EPI	CDD												
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<p>to target: fully immunize 70% of &lt;1's by end of 1987 from 28% in 1983</p> <table border="1"> <tr> <td>BCG</td> <td>Polio</td> <td>DPT3</td> <td>Measles</td> </tr> <tr> <td>85%</td> <td>60%</td> <td>60%</td> <td>50%</td> </tr> <tr> <td>82%</td> <td>34%</td> <td>39%</td> <td>39%</td> </tr> </table> <p>1987 target 1983 levels</p> <p>by 1987, reduce morbidity mortality by Pertussis 50% 30% Polio 50% Measles 50% 50%</p> <p>to goal: supply all vaccines to 0-24 mo. olds supply cold chain equipment and vaccines to fixed centers</p> <p>to baseline information (1983) EPI completely integrated into PHC system EPI in 50 (76%) of fixed centers; 16 ctrs. remain</p>	BCG	Polio	DPT3	Measles	85%	60%	60%	50%	82%	34%	39%	39%	<p>to target: make ORT available to 90% of &lt;5's decrease mortality due to diarrhea by 50% in &lt;5's by end of 1987 increase use of ORT by mothers to 50%</p> <p>to baseline information: CDD completely integrated into PHC system ORT recently instituted; 300,000 ORS packets distributed in 1982 most physicians still use antibiotics and I.V. traditional chiefs &amp; healers expressed willing- ness to participate in CDD program GOS committed to CDD program</p> <p>to plan to train a variety of health workers in CDD program planning, management and administration</p>
BCG	Polio	DPT3	Measles											
85%	60%	60%	50%											
82%	34%	39%	39%											
OUTCOMES (actual v. planned)														
(1) Outputs What was provided, accomplished?	<p>(1) to performed vaccination coverage survey (1984); found 20% nurse error rate re target ages, vaccines to cold chain assessed as working well (1985)</p>	<p>(1) to conducted formative research (1985) to developed and aired radio messages (1985) to trained health service delivery personnel (1985)</p>												
(2) Quality How well are new systems/skills used?	<p>to performed 4 studies &amp; used results to improve EPI: 1) KAP of clinic nurses 2) KAP of mothers, community 3) cold chain inventory &amp; logistics review 4) vaccine ordering and distribution system review (1985) to worked with MMHP in EPI initiatives (1984-85) to formed EPI task force (1985) to prepared EPI poster (1986)</p>	<p>to produced &amp; distributed educational materials (1985) to as of First Year Review, CDD evaluated as best of the three interventions (1985) to # of ORS packets imported increased by 50% from 1983 to 1985 to local production of ORS steady at 5000 packets/yr to established National ORT Demonstration Unit at Mbabane Government Hospital (1986) to 5-year workplan in draft form as of 1986 to constructed National ORT Training Center (1987) to sponsored 2 instructors from National ORT Training Center in out-of-country training (1987) to trained 10 ORT instructors in-country to conduct regional-level instruction (1987) to established a CDD task force (1987) to developed CDD 3-year plan (1987) to developed curriculum and training plan for National ORT Training Center (1988)</p>												
(3) Effects Access & coverage What are effects on KAP of pop.?	<p>to developed and conducted EPI school-based education program; conducted pre-, post-tests and planned parental interviews (1986) to conducted EPI campaign days in all 4 regions (1986) to draft of 5-year plan begun (1986) to held mid-level managers course for 25-30 nurses in EPI (1985) to completed cold chain network &amp; vaccine ordering and distribution system (1987) to implemented new sterilization technique (1987) to developed 3-year EPI plan (1987) to completed EPI immunization coverage survey (1987) to conducted mass measles vacc. of 5-12 yr. olds (1987) to supervisory checklists being used as of 1987 to issued national EPI policy statement (1988) to revised imm. schedule to current WHO stds (1988) to sentinel surveillance system established through- out Kingdom as of 1988 to established outbreak investig./control mechanisms to developed school vaccination/assessment plan (1988) to established EPI specific budget in MOH (1988) to conducted national measles study (1988)</p>	<p>to assigned training staff to new Center (1988) to implemented improved, revised system of ordering, distribution and monitoring of ORS inventory (1988) to developed 1989 CDD workplan (1988) to MOH established CDD specific budget (1988)</p>												
(4) Impact What is impact on morbidity and/or mortality	<p>(3) to coverage 1987: BCG DPT1 DPT3 OPW1 OPV3 Measles 91% 89% 74% 89% 74% 74%</p> <p>(4) to dropout rates 1986: 23% for DPT; 22% for OPV</p> <p>(4) to incidence decreases from 1982 to 1987: polio: 11 to 4/100,000; pertussis: 140 to 100/100,000 measles: 1000 to 300/100,000; tet.: 65 to 30/100,000 no diphtheria cases reported in past few years *pertussis at 42/100,000 by 1988</p>	<p>(2) to MMHP project increased knowledge of mothers re ORS use, but 54% still mixing SSs incorrectly (1986)</p> <p>(3) to 100% of hospitals using ORS in 1985, vs. 50% in '84 to nearly 100% of outpatient facilities using ORS in 1985, vs. 60% in 1984</p> <p>(4) to # of diarrheal disease cases steadily decreasing: went from 2000 to 1200 reported cases 1982-1985 and continued decreasing through 1986 to CFR steadily decreasing: went from approximately 85 to 40 reported deaths 1982-1985 (exceeded 50% target decrease); decrease continued through 1986</p>												
CONCLUSIONS														
(1) Institutionaliza- tion: To what degree does MOH support system?	<p>(1) to EPI completely integrated into PHC system to GOS states strong commitment to EPI</p> <p>(2) to excellent manual exists on EPI for health care providers to MOH responded promptly to most recommendations, and presented logical reasons for rejecting any</p>	<p>(1) to GOS expressed commitment to CDD project; has integrated CDD activities well</p> <p>(2) to an excellent manual on management of diarrheal disease episodes exists and is used</p>												
(2) Program strengths														
(3) Problems/Con- straints: What factors limit tar- get achievement?	<p>(3) to vaccine wastage is high to nat'l EPI coordinator left in '84 w/o replacement to until mid-1 85, attention focused on MMHP project, leaving EPI with few resources to lack of supervision routinely cited as a problem to until 1988, had no outbreak investigation system</p>	<p>(3) to as of end of 1986, found that some physicians still prefer I.V. treatment of diarrhea vs. ORT to as of 1986, still experiencing difficulties in ORS supply and distribution to consistent lack of uniform data collection to end of the MMHP project caused shift in emphasis from CDD to EPI</p>												
(4) Lessons learned: What worked? What did not work?	<p>(4) to once health ed., training were focused on EPI, program seemed to improve rapidly to recommend screening &amp; immunization of all children who present to health facility to decrease missed opportunities</p>	<p>(4) to government's work on safe water supply, pit latrines in addition to ORT seem to have contri- buted to success of CDD program to need to develop uniform data collection system</p>												

SWAZILAND: EVALUATION CONTENT FOR ACS1-CCCD

Categories	MALARIA	TRAINING
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>to target: establish mortality rates that can be associated with malaria by 1987</li> <li>to target stated in 1985: reduce malaria mortality in children &lt;5 by 50% from 1984 (baseline level)</li> <li>to baseline information:               <ul style="list-style-type: none"> <li>malaria activities not well integrated into PHC system; exists as vertical program</li> <li>responsibility resides in Malaria Control Unit</li> <li>no cq resistance detected as of 1983</li> </ul> </li> <li>to plan to train coordinators, assistants, supervisors and one long-term technical officer</li> </ul>	<ul style="list-style-type: none"> <li>to target: by end of 1987, have trained:               <ul style="list-style-type: none"> <li>1200 Rural Health Motivators (RHMs)</li> <li>63 health assistants</li> <li>500 traditional healers</li> <li>300 mid-level health workers</li> <li>10 statistical clerks</li> <li>in EPI, CDD, Malaria control, HIS, Health Ed., and Operational Research</li> </ul> </li> <li>to baseline information:               <ul style="list-style-type: none"> <li>633 nurse-midwives (largest group of health care providers), approximately 400 RHMs in Swaziland</li> </ul> </li> <li>to training plan developed in 1983</li> </ul>
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and/or mortality	<ul style="list-style-type: none"> <li>(1)</li> <li>to confirmed cq resistance (1985)</li> <li>to completed 1st phase of cq efficacy study; results suggest dose change from 10mg/kg to 25mg/kg (1985)</li> <li>to developed malaria poster, radio messages (1986)</li> <li>to 5-year plan in draft as of 1986</li> <li>to reestablished DDT, larvicidal spraying of vector breeding sites (1987)</li> <li>to reinstated active case detection (1987)</li> <li>to printed &amp; distributed national malaria poster (1987)</li> <li>to developed 3-year malaria plan (1987)</li> <li>to completed in-vivo cq resistance study (1987)</li> <li>to 3-year malaria plan approved by MOH (1988)</li> <li>to introduced new MOH malaria treatment and prophylaxis policy (1988)</li> <li>to received approval for malaria budget request to South Africa (1988)</li> <li>to conducted extensive spray program in lowveld (1988)</li> <li>to as of 1988, malaria included in sentinel surveillance reporting system</li> <li>to provided malaria vector control workers with protective clothing &amp; equipment (1988)</li> <li>(3)</li> <li>to as of 1988, 100% of hospitals were using the malaria treatment policy; 25% of hospitals were using the prophylaxis policy; 100% of other health facilities were using both</li> <li>(4)</li> <li>to impact data from documents is very inconsistent; difficult to determine whether reported decreases in cases and/or deaths, when they occur, are real, and impossible to determine whether attributable to CCCD</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>to trained &gt;400 RHMs, traditional healers, and clinic personnel in CRT techniques (1985)</li> <li>to conducted 3-week CCCD mid-level mgmt. course (1985)</li> <li>to trained 600 RHMs &amp; traditional healers in EPI (1985)</li> <li>to conducted 10 3-day EPI workshops for nurses and nursing assistants (1985)</li> <li>to trained 80 health workers in 2 5-day malaria control refresher courses (1985)</li> <li>to sponsored approximately 26 Swazis for CCCD International Workshops (1985)</li> <li>to conducted Diarrheal Disease Symposium with the Swaziland Medical Association (1985)</li> <li>to held mid-level managers course for 25-30 nurses in EPI (1985)</li> <li>to achieved 96.8% of 1985 training target: trained 968 staff; target was 1000</li> <li>to trained 130 health personnel at 6 separate sessions in EPI, Malaria, TB, and PHC (1986)</li> <li>to sponsored 2 nurses on a study tour of Lesotho CRT Demonstration Unit</li> <li>to as of 1986, have trained approximately 1000 RHMs (50% of target of 1000 by end of project)</li> <li>to provided on-site training to all sentinel surveillance staff (1988)</li> <li>to trained EPI mobile outbreak control teams in measles investigation and outbreak control strategy (1988)</li> <li>to trained, on-site, malaria sprayers and case-finders (1988)</li> <li>to provided out-of-country training for CDD managers and trainers at the National CRT Center (1988)</li> <li>to conducted Child Health workshops in conjunction with PHC project (1988)</li> <li>to conducted EPI, CDD and malaria MLM course (1988)</li> <li>to as of 1988 evaluation, cumulatively trained 136 mid-level managers, 64 senior health officials, and 606 peripheral health staff (as well as others mentioned above)</li> </ul>
<b>CONCLUSIONS</b> (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations:	<ul style="list-style-type: none"> <li>(1)</li> <li>to MOH/GOS expressed strong commitment to the malaria program; however, the program has not been well integrated into the primary health care system</li> <li>(3)</li> <li>to major problem in malaria control in Swaziland is influx of Mozambican refugees</li> <li>to increasing cq resistance</li> <li>to no national policy until 1988</li> <li>to cq distribution difficulties</li> <li>(4)</li> <li>to need a health education campaign to urge the population to seek immediate treatment for fever</li> <li>to cq distribution problem could be alleviated in part by giving cq to Rural Health Motivators for community distribution</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>to government willing to send staff to training both in and out of country</li> <li>(2)</li> <li>to program generally responsive to training needs</li> <li>(4)</li> <li>to need more MLM training</li> <li>to need training of trainers</li> <li>to need training on HIS as a management tool</li> <li>to need to add training to MOH budget to assure continuity of training</li> <li>to need more inservice training</li> </ul>

Categories	HEALTH EDUCATION	HIS
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<ul style="list-style-type: none"> <li>o baseline information: GOS recently established a Health Education Unit (HEU); considerable capacity and experience exists in-country</li> <li>o MOH hopes to incorporate traditional chiefs, healers into health ed. system</li> </ul>	<ul style="list-style-type: none"> <li>o goals: improve specificity of the HIS</li> <li>o establish baseline morbidity/mortality data by age groups for immunizable diseases</li> <li>o establish a regular CCCD newsletter and mailing system to all health staff</li> <li>o baseline information: currently computerized</li> <li>o MOH has recently instituted sentinel surveillance</li> <li>o high rate of reporting: approximately 80% from 200 reporting units</li> <li>o HIS currently being 'redesigned'</li> </ul>
<p>OUTCOMES (actual v. planned)</p> <p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity and/or mortality</p>	<ul style="list-style-type: none"> <li>(1) <ul style="list-style-type: none"> <li>o collected information on initiative for vaccination coverage (1985)</li> <li>o completed an assessment of audio-visual production capability for Swaziland (1985)</li> <li>o developed plans for improving EPI and CDD mass media components (1985)</li> <li>o completed community and clinic-based survey to determine priority areas for EPI health education and in-service training (1985)</li> <li>o developed numerous health ed. materials for EPI &amp; CDD (posters, pamphlets, flags, shirts, etc.) (1985)</li> <li>o produced community radio health program (1985)</li> <li>o reprinted 500 health worker manuals (1985)</li> <li>o developed malaria poster, radio messages (1986)</li> <li>o developed and conducted EPI school-based education program; conducted pre-, post-tests and planned parental interviews (1986)</li> <li>o printed &amp; distributed national malaria poster (1987)</li> <li>o printed and distributed malaria treatment guide for health workers (1988)</li> <li>o developed and aired malaria prevention &amp; treatment messages</li> <li>o established CCCD/health education link via AID assistant Project Officer (1988)</li> <li>o developed plans for use of health education consultancy (1988)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(1) <ul style="list-style-type: none"> <li>o produced EPI survey results (1985)</li> <li>o conducted HIS training for hospital and clinic staff (1985)</li> <li>o Assisted in CCCD/EPI training of nurses, nursing assistants (1985)</li> <li>o transferred health data to new IBM computers (1985)</li> <li>o as of 1986, had 88% reporting rate</li> <li>o national census begun in order to obtain accurate denominators (1986)</li> <li>o hired consultant to work with MOH to develop common baseline data (1987)</li> <li>o completed EPI immunization coverage survey (1987)</li> <li>o established HIS in Manzini region (1988)</li> <li>o established sentinel surveillance network in 28 sites to provide prompt outbreak notification (1988)</li> <li>o conducted 21 measles outbreak investigations in '88</li> </ul> </li> </ul>
<p>CONCLUSIONS</p> <p>(1) Institutionalization: To what degree does MOH support system?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<ul style="list-style-type: none"> <li>(1) <ul style="list-style-type: none"> <li>o Health Education Unit functions well, but . . . needs clarification</li> </ul> </li> <li>(2) <ul style="list-style-type: none"> <li>o health ed. program assessed as most successful in CDD by end of first year; indicators were general awareness by mothers of the importance of ORT, the MOH and clinic personnel enthusiasm for the program and the successful training of 2 MOH staff in CDD</li> </ul> </li> <li>(4) <ul style="list-style-type: none"> <li>o belief is that health education component was key to success of national ORT initiative early on</li> <li>o need to clarify role of HEU</li> <li>o need to increase work with the traditional sector</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(1) <ul style="list-style-type: none"> <li>o government expressed commitment to development and improvement of HIS; sentinel surveillance sites appear to be representative</li> </ul> </li> <li>(2) <ul style="list-style-type: none"> <li>o reporting is complete and timely</li> <li>o computerization has been successful</li> </ul> </li> <li>(3) <ul style="list-style-type: none"> <li>o reports from Statistical Unit are often delayed</li> <li>o initial lack of accurate denominators</li> </ul> </li> <li>(4) <ul style="list-style-type: none"> <li>o difficult to determine from evaluations what contributed to success of the Swazi HIS</li> <li>o recommendation from 1986 to hire full-time medical epidemiologist to aid the HIS was not acted upon</li> </ul> </li> </ul>

Categories	OR	CROSS CUTTING COMMENTS (SUPERVISION,SUSTAINABILITY)
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>to goal: to have answered 5 operational research questions by the end of 1987</li> </ul>	<ul style="list-style-type: none"> <li>to target: increase MOH contribution for PHC from 14.3% in 1984/85 to 20.3% in 1990/91</li> <li>GOS contribution should increase from \$11,000 in '84 to \$137,000 in '87</li> <li>to baseline information:                             <ul style="list-style-type: none"> <li>GOS currently funds approximately 80% of recurrent costs in mission health facilities</li> <li>GOS has established fees for outpatient visits, health cards, hospitalization</li> <li>sustainability is feasible according to country assessment</li> </ul> </li> </ul>
<p><b>OUTCOMES</b> (actual v. planned)</p> <p>(1) Outputs What was provided, accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity and/or mortality</p>	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>to completed phase 1 of cq efficacy study (1985)</li> <li>to conducted study assessing level of cq resistance in lowveld (1985)</li> <li>to hosted Eastern, Central, and Southern Africa OR review meeting (1985)</li> <li>to supported Swazi member of CCCD Regional OR Review Committee (1985)</li> <li>to conducted CCCD activity cost analysis (1985)</li> <li>to completed in-vivo cq resistance study (1987)</li> <li>to conducted pilot study of new cold chain monitoring system (1988)</li> <li>to conducted national measles study (1988)</li> </ul> </li> <li>(2)                             <ul style="list-style-type: none"> <li>to OR studies have influenced policy or practice</li> </ul> </li> </ul>	<p><b>SUPERVISION</b></p> <ul style="list-style-type: none"> <li>(2)                             <ul style="list-style-type: none"> <li>to supervisory checklists being used for EPI by 1987</li> </ul> </li> </ul> <p><b>SUSTAINABILITY</b></p> <ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>to cost-effectiveness study performed in 1985</li> <li>to cost study performed which determined that daily immunization of children is supportable even with high vaccine wastage (1986)</li> <li>to uniform fee schedule has been adopted for government &amp; missions services for diarrheal disease and malaria treatment and inpatient treatment as of 1986</li> </ul> </li> </ul>
<p><b>CONCLUSIONS</b></p> <p>(1) Institutionalization: To what degree does MOH support system?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>to Swaziland still lacking in national capacity to perform operational research</li> </ul> </li> <li>(2)                             <ul style="list-style-type: none"> <li>to Swazi nationals involved in review process</li> </ul> </li> <li>(4)                             <ul style="list-style-type: none"> <li>to need to increase national capacity to do OR</li> </ul> </li> </ul>	<p><b>SUPERVISION</b></p> <ul style="list-style-type: none"> <li>(2)                             <ul style="list-style-type: none"> <li>to supervisory systems have improved during the course of the project</li> </ul> </li> <li>(3)                             <ul style="list-style-type: none"> <li>to supervisory systems need continued improvement</li> <li>to 1986 evaluation found that managers spend too much time in operations, not enough time in planning, supervision and monitoring</li> </ul> </li> </ul> <p><b>SUSTAINABILITY</b></p> <ul style="list-style-type: none"> <li>(1)                             <ul style="list-style-type: none"> <li>to PHC system is well-established; EPI and CDD are completely integrated into system</li> </ul> </li> <li>(2)                             <ul style="list-style-type: none"> <li>to initial problems with funds disbursement solved</li> </ul> </li> <li>(3)                             <ul style="list-style-type: none"> <li>to economic growth in Swaziland has not kept pace with population growth; government requires continued external support for program activities</li> </ul> </li> <li>(4)                             <ul style="list-style-type: none"> <li>to commercial marketing of ORS and cq recommended</li> </ul> </li> </ul>

Categories	PROGRAM MANAGEMENT
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	baseline information: PHC system well-established GOS has committed to decentralized planning and management over next 5 years road network is extensive, well maintained shift from curative to preventive focus has already begun drug procurement system is inefficient, lacks coordination general quality, staffing and utilization of health facilities is impressive country assessment done 1983
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity and/or mortality	(1) developed annual training plan and budget for CCCD inservice training (1985) established CCCD Coordinating Committee; met 7 times in 1985 developed agreement with UNICEF for co-funding CCCD workshops and cold-chain equipment (1985) revised project documents to clarify CCCD role; to avoid duplication of efforts (1985) GOS constructed T.O. office space (1986) by 1986, Regional Health Management Teams set up in all 4 regions vaccine distribution decentralized; working well by 1986 applied to Rotary International for Polio Plus grant to fund additional EPI activities (1988)
<b>CONCLUSIONS</b> (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned: What worked? What did not work? Recommendations?	(1) GOS expressed commitment to decentralization and to CCCD ACS1-CCCD extension approved in 1988 (2) standard administrative procedures work very efficiently overall (3) project shared technical officer with Lesotho until 1988 shortages in staffing and occasionally in supplies have been consistent constraints (4) lack of T.O. cited as primary reason for MOH's limited capacity to utilize resources need to train Swazis in monitoring and evaluation

Project Start: April 1983 LOP Funding: \$1,140,000

Categories	EPI	CDD
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o target: 85-90% coverage of &lt;5 yr olds by end of project</li> <li>o goal: establish 100 new vaccination centers nationally</li> <li>o baseline information 1983: coverage: BCG      DPT3      TOPV3      measles 74%      21%      15%      8%</li> <li>o workplans developed 1983</li> </ul>	<ul style="list-style-type: none"> <li>o target: 30% of target population covered by ORT services by 1984</li> <li>o 10% reduction per year in diarrheal disease morbidity and mortality</li> <li>o goal: establish 26 ORT units nationally</li> <li>o workplan developed 1983</li> <li>o baseline incidence 13.3/100; CFR 8.2%</li> </ul>
OUTCOMES (actual v. planned)	(1)	(1)
(1) Outputs What was accomplished?	<ul style="list-style-type: none"> <li>o conducted baseline coverage survey</li> <li>o expanded EPI activities to all districts</li> <li>o 87% of all potential facilities had vaccination capability by 1987</li> <li>o by 1987, 340 vaccination centers in operation, from 147 in 1984</li> </ul>	<ul style="list-style-type: none"> <li>o established ORT use baselines</li> <li>o supported ORT training at University Hospital</li> <li>o ORS available in all health facilities by 1985</li> <li>o ORT used in 89% of hospital diarrhea cases by 1987</li> <li>o draft training plan developed, site chosen for ORT training and demonstration unit</li> </ul>
(2) Quality How well are new systems/skills used?	<ul style="list-style-type: none"> <li>o cold chain, sterilization equipt. supplied</li> <li>o conducted mass campaign in 1987-88</li> </ul>	(4)
(3) Effects Access & coverage What are effects on KAP of pop.?	(3)	
(4) Impact What is impact on morbidity AND mortality?	(4)	
	<ul style="list-style-type: none"> <li>o 1987 coverage estimates: BCG      DPT3      TOPV3      measles 95%      62%      60%      74%</li> <li>o 48% of &lt;5's were fully vaccinated by 1988</li> <li>o 72% of women received full tetanus toxoid regimen by 1988</li> </ul>	<ul style="list-style-type: none"> <li>o number of cases/CFR decreased steadily until 1987, then increased slightly: 1500 cases in 1988</li> </ul>
	<ul style="list-style-type: none"> <li>o incidence of target diseases decreased over LOP: Pertussis: 150/100,000 to 35/100,000 Polio: 6/100,000 to 0.6/100,000 Measles: 2/100 to 0.5/100 Tetanus: 18/100,000 to 8/100,000 MNT: 8.5/100,000 to 2/100,000 (1983-1987)</li> </ul>	
CONCLUSIONS	(1)	(1)
(1) Institutionalization: To what degree does MOH support system?	<ul style="list-style-type: none"> <li>o MOH supports system, but limited by personnel and fund shortages</li> </ul>	<ul style="list-style-type: none"> <li>o University Hospital using &amp; teaching ORT</li> </ul>
(2) Program strengths	<ul style="list-style-type: none"> <li>o wide knowledge of EPI</li> <li>o daily vaccination in some facilities</li> <li>o comprehensive educational materials</li> </ul>	<ul style="list-style-type: none"> <li>o ORS widely available</li> </ul>
(3) Problems/Constraints: What factors limit target achievement?	<ul style="list-style-type: none"> <li>o vaccination campaign disrupted other activities</li> <li>o vaccination target ages (WHO recommendation) not adhered to</li> </ul>	<ul style="list-style-type: none"> <li>o despite good facilities, ORT use still low</li> <li>o lack of enthusiasm for and ignorance of ORT by medical staff and general public</li> <li>o supervision not regular enough</li> <li>o training didn't seem to affect home use of ORT very greatly</li> <li>o lack of supervision, poor reporting practices cause difficulty in evaluating effectiveness</li> </ul>
(4) Lessons learned What worked? What did not work? Recommendations?	<ul style="list-style-type: none"> <li>o including intensive vaccination campaigns</li> <li>o in addition to ongoing access helped achieve target coverage rates; sustainability of results is questionable</li> <li>o social mobilization strategies were effective</li> <li>o supervision helped solve target age problem</li> </ul>	<ul style="list-style-type: none"> <li>o recommendation: replace CDD coordinator</li> </ul>

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Categories	MALARIA	TRAINING
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>to targets: 30% expansion of services to target pop. decrease malaria morbidity &amp; mortality by 50% in 45's to workplan developed 1983</p>	<p>to target: # graduates/yr added to MOH staff. 16 physicians, 70 nurses, 35 midwives, 28 health assts., 28 lab techs, 30 health aides, 100 agents itinerants to initial training plan established 1982 to needs assessment performed (1987)</p>
<p>OUTCOMES (actual v. planned) (1) Outputs What was accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access &amp; coverage What are effects on KAP of pop.? (4) Impact What is impact on morbidity AND mortality?</p>	<p>to established baseline treatment data to established national treatment policy to completed in-vivo chloroquine sensitivity testing to documented cq resistance for 1st time in Togo 1987 to MOH adopted new dosage policy (25 mg/kg vs 10 mg/kg) to reinforced sentinel surveillance &amp; monitoring to developed questionnaire for pharmacy practices (2) to 90% of children diagnosed were being treated properly by 1986 (3) to 82% of preg. women were using malaria prophylaxis by 1987 (4) to number of cases and deaths continued to increase due to chloroquine resistance</p>	<p>(1) to 88% of LOP targets achieved by 1985 to increased number of physicians &amp; PAs working in MOH to implemented mid-level management training to trained HIS staff in computer use to trained medical officers in needs assessment and workplan development to developed CDD training plan (1987) to Used PCV's to help rewrite curricula, initiate TOT workshops to trained community leaders in EPI education to developed &amp; implemented national training for field staff to all training targets except senior-level management training were met by 1988</p>
<p>CONCLUSIONS (1) Institutionalization: To what degree does MOH support system? (2) Program strengths (3) Problems/Constraints: What factors limit target achievement? (4) Lessons learned What worked? What did not work? Recommendations?</p>	<p>(3) to chloroquine resistance is increasing malaria incidence</p>	<p>(1) to CCCD training materials integrated into medical school curricula (3) to transportation logistics, personnel shortages, and low morale were constraints (4) to need senior-level management training in French</p>

Categories	HEALTH EDUCATION	HIS
Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o needs assessment performed 1984</li> <li>o budget and workplan developed 1984</li> </ul>	<ul style="list-style-type: none"> <li>o target: computerize the HIS</li> </ul>
<p><b>OUTCOMES</b> (actual v. planned)</p> <p>(1) Outputs What was accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity AND mortality?</p>	<ul style="list-style-type: none"> <li>(1)               <ul style="list-style-type: none"> <li>o collected baseline data (1985)</li> <li>o rewrote health ed. curricula</li> <li>o used PCV's to help develop materials for EPI, CDD and malaria programs</li> <li>o trained community leaders in EPI education</li> <li>o established full-time health educator position</li> <li>o developed extensive EPI materials for mass campaign</li> <li>o introduced health education materials to school teachers</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(1)               <ul style="list-style-type: none"> <li>o established and monitored 21 sentinel surveillance sites</li> <li>o conducted surveys in malaria and diarrheal disease</li> <li>o conducted child mortality survey in 1 region</li> <li>o periodically reviewed and strengthened HIS</li> <li>o computerized system and trained users by 1987</li> <li>o reduced number of reportable diseases on reporting list from 90 to 40</li> <li>o drafted new hospital reporting form</li> <li>o supported training for 2 statisticians</li> <li>o improved annual report data</li> <li>o conducted and followed up MUHS survey</li> </ul> </li> <li>(2)               <ul style="list-style-type: none"> <li>o determined monthly reports to be accurate</li> </ul> </li> <li>(3)               <ul style="list-style-type: none"> <li>o by 1987, regularly collected data from 356 reporting sites, from 312 before project inception</li> </ul> </li> <li>(4)               <ul style="list-style-type: none"> <li>o demonstrated a decrease in measles, polio &amp; diarrheal disease using HIS data</li> </ul> </li> </ul>
<p><b>CONCLUSIONS</b></p> <p>(1) Institutionalization: To what degree does MOH support system?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>(4) Lessons learned What worked? What did not work?</p> <p>Recommendations?</p>	<ul style="list-style-type: none"> <li>(1)               <ul style="list-style-type: none"> <li>o EPI health education materials being used by school teachers</li> </ul> </li> <li>(2)               <ul style="list-style-type: none"> <li>o coordination among donors and MOH occurred regularly</li> <li>o Peace Corps Volunteers used well</li> </ul> </li> <li>(4)               <ul style="list-style-type: none"> <li>o EPI mass education campaign materials appeared to contribute to increased coverage</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>(2)               <ul style="list-style-type: none"> <li>o MOH had already begun HIS development at project's inception</li> <li>o regular, consistent supervision</li> </ul> </li> <li>(3)               <ul style="list-style-type: none"> <li>o hardware and personnel limitations in processing data</li> </ul> </li> <li>(4)               <ul style="list-style-type: none"> <li>o recommendation: establish record review in all hospitals, for all CCCD target diseases</li> </ul> </li> </ul>

Categories	OR	COMMENTS: SUPERVISION, SUSTAINABILITY
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>		<ul style="list-style-type: none"> <li>o plans to train many levels of health personnel, including supervisors/managers as well as technical</li> <li>o plans to establish and/or renovate health facilities</li> <li>o GOT to increase financial contribution by 25%/year</li> <li>o training of "agents itinerants" cited as best way to assure continuity at local level</li> </ul>
<p><b>OUTCOMES</b> (actual v. planned)</p> <p>(1) Outputs What was accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity AND mortality?</p>	<p>(1)</p> <ul style="list-style-type: none"> <li>o conducted 13 special studies</li> <li>o developed policy &amp; guidelines for protocol review</li> <li>o completed health financing needs assessment</li> <li>o completed cost studies</li> <li>o identified potential review board members</li> </ul>	<p><b>SUPERVISION</b> (1)</p> <ul style="list-style-type: none"> <li>o increased supervisory visits for EPI</li> </ul> <p><b>SUSTAINABILITY</b> (1)</p> <ul style="list-style-type: none"> <li>o cost recovery mechanisms (user fees, vaccination card fees) established by 1986</li> </ul>
<p><b>CONCLUSIONS</b></p> <p>(1) Institutionalization: To what degree does MOH support system?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<p>(3)</p> <ul style="list-style-type: none"> <li>o lack of protocol submissions</li> <li>o lack of national capacity to conduct research</li> <li>o results of studies often not followed up in later evaluation documents, plans</li> </ul>	<p><b>SUPERVISION</b> (2)</p> <ul style="list-style-type: none"> <li>o strong supervision in HIS</li> </ul> <p>(3)</p> <ul style="list-style-type: none"> <li>o supervision in CDD lacking (not known why CDD supervision was so poor; possibly political issues related to this position?)</li> </ul> <p><b>SUSTAINABILITY</b> (1)</p> <ul style="list-style-type: none"> <li>o government was unable to increase its contribution to the target level as of end of 1987</li> </ul> <p>(4)</p> <ul style="list-style-type: none"> <li>o project extension to 1991 approved by USAID/CDC/GOS</li> </ul>

Categories	PROGRAM MANAGEMENT
<p>Plans Needs assessment, goals, and objectives, planned inputs, expected outcomes</p>	<p>plans to have 65% CCCD services coverage by 1985 (this target was not followed up in subsequent documents)</p>
<p><b>OUTCOMES</b> (actual v. planned)</p> <p>(1) Outputs What was accomplished?</p> <p>(2) Quality How well are new systems/skills used?</p> <p>(3) Effects Access &amp; coverage What are effects on KAP of pop.?</p> <p>(4) Impact What is impact on morbidity AND mortality?</p>	<p>(1) no technical officer posted in 1983; no gaps in T.O. coverage over life of project</p>
<p><b>CONCLUSIONS</b></p> <p>(1) Institutionalization: To what degree does MOH support system?</p> <p>(2) Program strengths</p> <p>(3) Problems/Constraints: What factors limit target achievement?</p> <p>(4) Lessons learned: What worked? What did not work?</p> <p>Recommendations?</p>	<p>(1) donor and MOH coordination generally effective</p> <p>(2) well-developed infrastructure MOH committed to, planning for decentralization program management generally satisfactory donors have divided responsibilities (e.g., UNICEF supplies materials, CDC/AID supplies technical assistance)</p> <p>(3) no established PHC system for CCCD to fit into at program inception; program not well integrated initially MOH country programs not well coordinated</p> <p>(4) need better control over accounting/finances need better system for supplies procurement</p>

Categories	EPI	CDD
Plans Needs assessment, goals & objectives planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o targets revised 1986: mortality reduction measure abandoned</li> <li>o revised targets: increase national immunization coverage to at least 80% for BCG, 75% for measles, 70% for DPT and OPV by the end of 1990</li> <li>o baseline 1982: BCG DPT3 OPV3 measles TT2 55% 39% 38% 41% 27%</li> </ul>	<ul style="list-style-type: none"> <li>o 1986 revised targets from mortality reduction measure</li> <li>o revised targets: (1) increase the national % of fixed facilities using ORT as first line treatment for diarrhea and rehydration from less than 5% in 1982 to at least 65% by 1990 (2) increase % of the population with access to appropriate treatment for diarrhea from less than 20% in 1982 to more than 80% in project zones by 1990 (3) increase % of acute cases that are treated correctly with ORT from less than 20% in 1982 to greater than 80% in project zones by 1990</li> </ul>
OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of target population? (4) Impact What is impact on morbidity and mortality?	<ul style="list-style-type: none"> <li>(1)</li> <li>o cold chain working at all levels in 200 zones</li> <li>o increase in zones participating in PEV to 206/306; # zones participating at start of project unknown</li> <li>o vaccination survey conducted in '88 in the 30 clusters from 1984 MUHS survey</li> <li>(2)</li> <li>o sterilization procedures understood; needles changed but not syringes due to shortages</li> <li>o staff understanding of vaccinal calendar uneven</li> <li>o over 80% DPT vaccine given to correct age group 1988</li> <li>(3)</li> <li>o coverage 1988: BCG DPT3 OPV3 measles TT2 80% 70% 70% 75% 51%</li> <li>o 1988: 174 zones covered, 60% population has access to vaccines</li> <li>(4)</li> <li>o decrease in case incidence - between 1981 and 1987: measles: 30% decrease; polio: 75% decrease, Tetanus: 47% decrease</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o Mamo Yemo ORS center is focus of treatment, training in ORT treatment</li> <li>o appropriate SSS recipe developed</li> <li>o frequent ruptures in stock at antenna &amp; zonal levels in 1988</li> <li>o ORS production at LAPAKI 310,000 units in 1983; 602,880 in 1987; production at temperature stand-still in 1988 due to GOZ overdue balance</li> <li>o supply of ORS distributed in 1988 decreased</li> <li>o 1985 4 additional ORT units established in urban areas</li> <li>o training in CDD treatment since '86: Mamo Yemo- 14 courses, Bukavu &amp; Lubumbashi-6 courses since '87</li> <li>o OR project evaluated effective case management at Mamo Yemo in 1987</li> <li>(2)</li> <li>o data on diarrhea cases seen/treated with ORS from monthly vaccination reports first time available in 1985: estimated 42% cases treated with ORT in '85</li> <li>o 1985 supervisory questionnaires on 48 rural zones show 83% of hospitals regularly using ORS; 60% of health centers regularly using ORS; increase over '84: 47% and 25% respectively</li> <li>o 73% of ambulatory cases treated with ORS in 1988</li> <li>(3)</li> <li>o 70% reported cases treated with ORT: target is 80%</li> <li>(4)</li> <li>o 1988 v. 1984 hosp. cases/deaths: 4650/319 v. 8939/357 (43 hospitals reporting in '88, 40 in '84)</li> <li>o in 1988 reported deaths from diarrheal disease decreased from 14% to 2% of hospital intake in Kinshasa</li> </ul>
CONCLUSIONS (1) Institutional- ization: To what degree does MOH support systems? (2) Program strengths (3) Problems/ Constraints What factors limited achieve- ment of targets? (4) Lessons learned What worked? What did not work? Re commendations	<ul style="list-style-type: none"> <li>(2)</li> <li>o 1984: quantity and stock of vaccines adequate</li> <li>(3)</li> <li>o EPI objectives overly ambitious in relation to GOZ resources</li> <li>o Vaccine coverage static since '85</li> <li>o measles vaccine disrupted at central level in 1984</li> <li>o problem with vaccine distribution at peripheral levels</li> <li>o two of most important constraints to EPI activities: non-payment of salaries and lack of supervision due to insufficient operating funds - (1988 evaluation)</li> <li>o no systematic follow-up method for children who have had incomplete vaccine doses</li> <li>(4)</li> <li>o stagnation between '83-84 corresponds to change in vaccination schedule to first two years of life from three years</li> <li>o 1985: well developed zones show high rates of vaccination coverage; newer zones show slight decrease after switching from mobile to fixed center vaccination strategy</li> <li>o rapid increase in first years of program reflect new immunizations as well as data collection on infants already being immunized; more accessible zones have been all brought into orbit of PEV, leaving more difficult areas where coverage rates are likely to be lower (1988 evaluation)</li> <li>o 1985 Cold Chain recommendations: need maintenance data sheet at central level; freeze indicators are not often used, not well understood; training in use important</li> <li>o vaccines/supplies should come from GOZ budget, as well as recurrent costs to ensure sustainability</li> <li>o implementation should be slowed to be compatible with the GOZ's ability to pay</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o cost recovery for ORT part of national strategy</li> <li>(2)</li> <li>o Mamo Yemo is internationally recognized ORT training center - health workers from 12 countries trained there</li> <li>o project aided in establishing in-country ORS production</li> <li>(3)</li> <li>o health personnel not following ORT instructions; interruption in stock possible due to this problem</li> <li>o low success in promotion of home SS solution</li> <li>o acceptance of ORT slower than expected</li> <li>o program impeded by low levels of motivation by staff due to GOZ's inability to pay salaries</li> <li>o low level comprehension of the causes of diarrhea and the use of ORS</li> <li>o 97% messages on ORS communicated face-to-face: difficult to reach population target and obtain behavioral changes</li> <li>o antenna revolving funds for purchase of ORS were decapitalized to pay salaries in 1988</li> <li>o no information on % increase fixed facilities using ORT; target is to improve from 5% to 65% in '90</li> <li>o follow-up of training participants show major impediment to implementation of training of head nurses and the establishment of ORT corners in hospitals is the lack of materials (goblets, bowls, spoons) - 1988</li> <li>(4)</li> <li>o training, supervision, health education inputs needed</li> <li>o slow use of ORS by '85 attributed to inadequate/delayed health ed campaigns and reluctance of users</li> </ul>

Categories	MALARIA	TRAINING
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o revised targets: (1) increase % of pop. with access to appropriate treatment for acute malaria from &lt; 20% in 1982 to &gt; 80% in project zones by 1990 (2) increase % of pregnant women with access to malaria chemoprophylaxis, from &lt;20% in 1982 to &gt;80% in project zones by 1990 (3) increase the % of children receiving appropriate treatment for acute malaria from &lt; 20% in '82 to &gt; 70% in project zones by 1990 (4) increase % of pregnant women using Malaria chemoprophylaxis from &lt; 5% in '82 to &gt; 65% in project zones in 1990</li> <li>o National Policy and 5 yr plan developed in 1985</li> </ul>	<ul style="list-style-type: none"> <li>o no targets specified</li> </ul>
OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of target population? (4) Impact What is impact on morbidity and mortality?	<ul style="list-style-type: none"> <li>(1)</li> <li>o number of clinics/hosp using national policy for treatment of cases and use of prophylaxis of for priority individuals has fallen -1987</li> <li>o began producing chloroquine locally in 1985</li> <li>o variability in presumptive therapy (dosing of cq) 1987 surveillance data on cq resistance collected from 3 sites: results: continued rise in resistance</li> <li>o 2 in-vivo cq sensitivity courses held in '86</li> <li>o anti malarial drug sensitivity monitoring network expanded</li> <li>o trained 30 lab techs in cq sensitivity testing('85)</li> <li>o 1985 training on cq sensitivity monitoring held for 45 specialists from 4 countries</li> <li>o lab staff from 8 zones trained in techniques of in-vivo testing for cq resistance in 1986</li> <li>o Decision tree for Malaria treatment distributed in 1988 in response to 1987 evaluation that knowledge of national policy on treatment not standardized at peripheral level</li> <li>o 3 Malaria drug sensitivity surveillance sites equipped in 1987; 4 more sites planned</li> <li>(2)</li> <li>o 1985 survey of 19,000 kids show 50% cases receive appropriate treatment</li> <li>o data on malaria cases seen/treated with cq collected from 1985; 61% cases treated with cq</li> <li>(3)</li> <li>o 70% of hospitals/outpatient facilities providing treatment in 1987</li> <li>o 39% hospitals/49% outpatient facilities providing malaria prophylaxis in 1987</li> <li>(4)</li> <li>o Malaria cases, deaths in 1988 dropped from elevated 1987 rates but data based on 75% reporting rate from sentinel hospitals: &lt;5 cases/deaths: 1988: 7448/398; 1987: 9,674/535; 1984: 9,682/203</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o by 1986 100 senior level officers trained; 174 MCZ's trained; 1206 peripheral personnel</li> <li>o more recent information not available</li> <li>o % of head nurses trained ranges from 20% in Haut Zaire to 60% in Bas Zaire</li> </ul>
CONCLUSIONS (1) Institutional- ization: To what degree does MOH support systems? (2) Program strengths (3) Problems/ Constraints What factors limited achieve- ment of targets? (4) Lessons learned What worked? What did not work? Recommendations	<ul style="list-style-type: none"> <li>(1)</li> <li>o cost recovery of cq part of national strategy</li> <li>(3)</li> <li>o CCCD strategy not widely accepted by doctors - 1985 evaluation recommends research on topic</li> <li>o malaria strategy delayed initially</li> <li>o access goals on schedule by '85 but not incidence reduction</li> <li>o prophylaxis for pregnant women not widespread</li> <li>o widespread reluctance to spend money on preventive medicine; late pre-natal consultations</li> <li>o significant increase in pediatric cases, deaths since 1984, despite decrease in cases in 1986 and deaths in 1988</li> <li>o a study of malaria prophylaxis in pregnancy did not show an increase in birthweight for children of women taking malaria prophylaxis</li> <li>(4)</li> <li>o presumptive treatment must be standardized, prophylactic treatment for pregnant women must be encouraged until results conclusive (1987 evaluation)</li> <li>o difficult to assess implementation - curative treatment predates project; different sources of chloroquine available; variety of anti-malarials used</li> </ul>	<ul style="list-style-type: none"> <li>(2)</li> <li>o field staff at all levels receiving good quality training, but too little of it</li> <li>o training modules developed for MCZ course effective: high level of knowledge in the field demonstrated</li> <li>o technical training quality high; cold chain well maintained, vaccines well kept, instructions for sterilization, inoculations largely followed</li> <li>(3)</li> <li>o satellite training weak: decentralized system, zonal chiefs responsible- hampered by financing/ lodging</li> <li>o problem with distribution of training materials: unavailable at most health centers</li> <li>o training capability is lacking at regional/ subregional levels</li> <li>o confusion among PEV staff re: role in training since '86 when FONAMES became overall coordinating agency; training has been limited to ORT, chemosensitivity</li> <li>o PEV has not adopted decentralized training in regions except in ORT</li> <li>o data collection in training not used for decision-making</li> <li>o antenna chiefs and regional coordinators have not received training as trainers or supervisors</li> <li>(4)</li> <li>o training plans should include clinical training</li> <li>o must conduct in-depth training needs analysis</li> <li>o need to strengthen training component</li> <li>o coordination w/FONAMES critical</li> <li>o need TOT for zone medical officers and nurse supervisors</li> </ul>

ZAIRE: EVALUATION CONTENT FOR ACSI-CCCC

Categories	HEALTH EDUCATION	HIS
Plans Needs assessment, goals & objectives planned inputs, expected outcomes	<ul style="list-style-type: none"> <li>o no workplans for Malaria/EPI programs</li> <li>o plans for CDD Health Education made in '84</li> <li>o conducting needs assessment to define health education objectives; developing training and work plans for various levels: 1988</li> </ul>	<ul style="list-style-type: none"> <li>o no targets stated for HIS</li> </ul>
OUTCOMES (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of target population? (4) Impact What is impact on morbidity and mortality?	<ul style="list-style-type: none"> <li>(1)</li> <li>o little progress towards targets</li> <li>o lack of planning, structure, strategy at all levels</li> <li>o HealthCom representative in Zaire works with PEV</li> <li>(4)</li> <li>o impact of health ed efforts very low: not less than 1/3 zones have Village Health Agent; few have memory of messages</li> </ul>	<ul style="list-style-type: none"> <li>(1)</li> <li>o surveillance data on chloroquine resistance collected from 3 sites</li> <li>o publish excellent epidemiology bulletin regularly;</li> <li>o anti-malarial drug sensitivity study conducted in 1986</li> <li>o monitoring network expanded; 121 reporting units in 1988 up from 90 reporting units in 1982</li> <li>o country data are collected and analyzed in standard way</li> <li>o in support of national campaign to eradicate polio, standard case definition developed for diffusion to reporting sites</li> <li>o new HIS software to be installed in 1989</li> <li>o system gives indication of progress, deficiencies in immunization coverage and to a lesser degree for ORT/CO</li> </ul>
CONCLUSIONS (1) Institutionalization: To what degree does MOH support systems? (2) Program strengths (3) Problems/Constraints What factors limited achievement of targets? (4) Lessons learned What worked? What did not work? Recommendations	<ul style="list-style-type: none"> <li>(2)</li> <li>o materials are of high quality</li> <li>(3)</li> <li>o difficult to reach rural parents due to illiteracy and variety of dialects</li> <li>o technical side of PEV is fully operational, yet demand for services by target population remains low, communication side is barely functional</li> <li>o health education component limited to display of materials at health functions, revision of technical materials</li> <li>o constraints: delay in release of CPF; departure of key staff member; time spent in in-service training by chief; lack of managerial and technical support</li> <li>(4)</li> <li>o additional long-term or repeat short-term TA called for in 1989 Evaluation.</li> <li>o CR in health ed should be a priority</li> <li>o budget must be increased; current budget reflects low priority of Health Education component; goals in other project areas will not be attainable unless more resources put into health education</li> </ul>	<ul style="list-style-type: none"> <li>(2)</li> <li>o HIS allows for study of epidemiology of diseases</li> <li>o quality of EPI info is excellent, ORT/Chloroquine data is not as good</li> <li>o HIS generating large amounts of valuable program data</li> <li>o HIS relating to EPI is well developed; information flows from health center - zones - antenna - PEV/K</li> <li>o leader in use of micros in HIS of CCCC countries</li> <li>(3)</li> <li>o provides outcome indicators (morb/mort) for EPI but not ORS, malaria</li> <li>o HIS does not monitor implementation/quality/impact; MUHS very costly- can be done under different contract</li> <li>o intervention strategies based on HIS data, but can't be implemented due to funding constraints</li> <li>(4)</li> <li>o personnel better trained at antennae level in analysis of data than zone and health center level personnel</li> </ul>

Categories	GR	CROSS CUTTING COMMENTS (SUPERVISION,SUSTAINABILITY)
Plans Needs assessment, goals & objectives planned inputs, expected outcomes	no targets set for OR	5 year plan developed in 1988 not realistic regarding funding
<b>OUTCOMES</b> (actual v. planned) (1) Outputs What was provided, accomplished? (2) Quality How well are new systems/skills used? (3) Effects Access & coverage What are effects on KAP of target population? (4) Impact What is impact on morbidity and mortality?	(1) study of malaria prophylaxis in pregnancy completed (1988) completed series of studies of severe malaria (1988) performed in-vitro studies of cq sensitivity with University of Kinshasa physician (1988) developed instrument for KAP of malaria in collaboration with PRICOR (1988) distributed PEV guide to OR (1988) began case-control study of polio (1988)	<b>SUPERVISION</b> supervision is one of PEV's major deficiencies; linked to lack of operating funds; supervision is key to monitoring the qualitative aspects of activities transport: troubled by cost of petrol, distribution of spare parts. poor transport=poor supervision/training insufficient per diem affects supervision supervision carried out by central office regional supervision variable supervision of zones improved thru use of standard supervisory forms and participation of zonal medical officers with PEV/CCCD teams  <b>SUSTAINABILITY</b> costs recovered through the sale of ORS and chloroquine most health centers using cost-recovery schemes
<b>CONCLUSIONS</b> (1) Institutionalization: To what degree does MOH support systems? (2) Program strengths (3) Problems/Constraints What factors limited achievement of targets? (4) Lessons learned What worked? What did not work?  Recommendations	(2) OR component well-thought out; properly focused on areas of maximum CCCD concern objectives (solution to problems in PEV's field interventions; training Zairian scientists to conduct scientific studies in ORS) are valid; progress being made (4) should establish formal relationship with PRICOR training needed in establishing research protocols	<b>SUPERVISION</b> (3) condition of vehicle fleet, lack of funds/decapitalization of revolving funds resulted in very little peripheral level supervision in '88 (4) replace vehicles w/high running costs with bikes and motorcycles need to increase # of trained supervisors regional teams need well trained MD per team to complete training/supervision duties  <b>SUSTAINABILITY</b> (1) integration of CCCD activities good at zonal levels and below; less integration at central level (responsibility of FONAMES) (2) 1985 evaluation showed that PEV activities recovered some costs in 9/13 zones visited (3) project unlikely to be self-sufficient before 2000 (4) USAID should continue support to PEV but not substitute self for GOZ; no expansion or new recurrent costs should be assumed need OR into true cost of ORS production, and price sensitivity zones may have to pay for central PEV services as they become more self-sufficient need to help zones with cost-recovery strategies use of sales proceeds from ORS/Chloroquine to pay salaries sabotages self-financing

Categories	PROGRAM MANAGEMENT
Plans Needs assessment, goals & objectives, planned inputs, expected outcomes	no program management targets established
<b>OUTCOMES</b>	
(1) Outputs What was provided, accomplished?	(1) Division of Administration and Finance reorganized, staff added, financial system revised in 1988 in accord with 1988 audit
(2) Quality How well are new systems/skills used?	WHO provided software to aid computerization of logistics operations; UNICEF staff helping to adapt software Steering Committee meets twice yearly to review past year's operations and to plan coming year; broad issues discussed, no formal subcommittee structure; no other formal Donor Coordination mechanism
(3) Effects Access & coverage What are effects on KAP of target population?	moratorium imposed on addition of zones (above 206) until 1989 unless GOZ meets financial obligations (as per 1988 Evaluation)
(4) Impact What is impact on morbidity and mortality?	
<b>CONCLUSIONS</b>	
(1) Institution- alization: To what degree does MOH support systems?	(2) project is well-monitored in substance by AID/CDC; room for improvement in style (3) PEV understaffed due to long-term training of staff; key AID project backstops are CDC employees on loan; impression that AID defers to CDC/A over USAID missions in matters of project management; lack of clarity of authority of USAID over CDC employees
(2) Program strengths	communication between different agencies is hectic and leads to misunderstandings
(3) Problems/ Constraints What factors limited achieve- ment of targets?	epidemiologists spend too much time on program administration use of PCV's unsatisfactory when functioning as managers/trainers at regional level
(4) Lessons learned What worked? What did not work?	shortfalls in GOZ contributions undermines morale of field personnel thru nonpayment and/or delays in salary payment, transportation and supervision, training and health education efforts, regular shipment of vital vaccine/ort supplies from capital to field; net effect is stagnation in vaccination tallies
Recommendations	delay in computer order stalling computerization of commodity inventory, personnel & payroll systems; procurement, stock management of vaccines, ORS, CQ is not satisfactory
	(4) if GOZ doesn't make CCCD priority and increase CCCD services should be continued on as a relief project instead of development project PEV staff should be trained in budgeting need formal evaluation of PCV contribution discuss need for permanent US staff v. specialized short-term assistance given maturity of project AID/CDC/PEV-GOZ should meet together regularly

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