

CHAD CHILD SURVIVAL PROJECT (677-0064)

PROJECT COMPLETION REPORT

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I. PROJECT BACKGROUND

The Chad Child Survival Project (CCSP), project number 677-0064, was designed in 1979 as a five year, \$8.5 million project. It was one of the rare occasions on which USAID has adequately realized that institutionalization of new methods of delivery of primary health care takes time, and the design was seen as the first phase of a longer project. However, the project suffered many setbacks. The first was a delayed start due to re-design of facilities. When the PP was first written it divided the project into two components: institution building at the central level of the Ministry of Public Health, and service delivery at the prefectural level. Resources were about equally provided, but the bulk of the technical assistance was to support the central level.

The project as originally designed encountered problems in contracting for a technical assistance team under the 8 (a) or Grey Amendment. It was let out for bid, four firms responded, one firm was selected, but the contract could not be negotiated. A GAO audit and litigation by the firm delayed the rebidding of the contract, although the problems were ultimately resolved almost completely in the Agency's favor. During the delay caused by this event, changes in the MOPH led the Mission to review the original design. Other donors had commenced activities, there had been changes in Ministry personnel, and the designers desired to more directly effect changes in child survival rates.

The project was then redesigned to take into account the changes in the MOPH and other donor activities, and an amendment was prepared to the original authorization and PP. The revised project added \$1.1 million to the original budget, and the total amount of \$19.6 million was programmed for a LOP of 6 years, or an increase of two years over the original design. The redesign effort shifted the emphasis away from assistance to the central level of the MOPH and towards service delivery. The geographic area for the service delivery was expanded, the number of long-term advisors was increased to three from the original one, and more emphasis was placed on restoration of health facilities. The major focus remained on selected interventions known to have an impact on the morbidity and mortality of women and children, but added two interventions to prevent and manage acute respiratory illness and malaria, both of which were known to be prevalent in the selected area.

At the central level the provision of a long-term advisor in

the area of family wellbeing remained in the revised project. Provision of contraceptives to strengthen this activity was added to the revised version. A second long term advisor was provided to assist in the improvement of the health information system for the Ministry. This was an activity which built on earlier assistance, and essentially remained unchanged in the revision.

The inability of the host-country to make any substantial financial contribution to the project was recognized, and an specific project waiver was signed by the Assistant Administrator of the Africa Bureau on July 5, 1991.

The revised project was offered bid amongst 8 (a) firms again, and again significant delays occurred, mainly at the level of the final selection of the winning firm and the fielding of the long-term advisors. It was desired to involve the senior MOPH officials in the final selection, and they visited Washington for the final negotiations. This enhanced their appreciation of the goals of the project. The three long-term advisors selected by the firm and approved by the Ministry and the Mission were not on the ground until January, 1993. However, the two long-term advisors at the central level were active throughout the process. The family wellbeing advisor had been contracted as a PSC in October, 1989 and stayed with the project until July, 1993. The technical advisor to the health information system had started work in September, 1991 and remained with the project under USAID auspices until the Mission closed the project at the end of March, 1995. After the project closure, he continued functioning in a similar capacity supported by UNICEF. Mission staff negotiated this arrangement almost a year before the project closure, recognizing that UNICEF too needs quality information on the immunization program.

The goal of the project was "to improve the quality of life and health status of Chadian infants, children and women of child-bearing age." The project purpose was "to strengthen the administration and delivery of an improved integrated package of SMI/BEF services in selected prefectures and to reinforce the capability of the MOPH to operate and maintain a national health information system." Thus the project really consisted of three separate components, albeit with some degree of overlap between them. The service delivery component was contracted out to the 8 (a) firm, while the assistance at the national level which took place in the capital, N'Djamena was implemented by the staff of the Human Resources division and personal service contractors. All major items of project procurement were the responsibility of the Mission, as was the preparation of houses for the team members in Sarh and the rehabilitation of the health structures. A KAP survey was contracted for prior to the start of the project, and was carried out successfully with a representative sample of women living in the urban and rural areas near Sarh.

As a result of the project efforts, it was anticipated that, by the end of the project, the following conditions would be

achieved:

Delivery of an integrated package of SMI/BEF services in the Moyen Chari, Salamat and Logone Oriental Prefectures would be improved through: (a) a training program for health workers, and (b) provision of services delivered in rehabilitated and equipped dispensaries.

Health facilities in the Moyen Chari, Salamat and Logone Oriental Prefectures would be rehabilitated (or constructed) and equipped to provide basic health services, including drugs and contraceptives.

A KAP survey would be carried out to determine training needs, and based on the results a training program would be carried out for in-service training of health workers in the selected prefectures, focussing on the selected interventions. It was expected that about 300 health workers in the zones specified would be trained.

Information, education and communication (IEC) activities as specified in the PP would be carried out in the project zone.

A regular system of supervision would be established with a minimum of two monitoring visits per year to all health facilities.

A pilot cost recovery system would be in place under local management, which recovers at least the full cost of drugs.

A baseline KAP survey would be carried out and then repeated in project year six, to be used for the planned phase-two project.

The other part of the project was designed to assist the SMI/BEF program at the central level of the MOPH. The two areas to be assisted were the reinforcement of the health information system, and strengthening of the population and family well-being program. The project was expected to continue to support the operating budget of the health information unit (at first the BSPE and then renamed the DSIS), but at a decreasing percentage of the recurrent costs. In population and family well-being the project was expected to facilitate the adoption of a national population policy, to provide a long term advisor to assist in this area, and to improve the curriculum development and training of trainers for health workers working in this area. An IEC program to support SMI/BEF was supposed to be in place.

This complex primary health care project was designed as a six-year activity in 1991. The major portion of it, the placement of the three person long-term technical team in Sarh did not occur until January 1993 or two years later than anticipated. Then in 1994 the Mission was informed that it

would be closing, as a result the PACD for this project was reduced from Dec. 31, 1997 to Sept.31, 1995. The implementation period for the project activities was planned to end March 30, 1995. No revision of the detailed expected achievements as specified in the PP was carried out. A mid-term evaluation was carried out in June, 1994.

It was probably appropriate that revised targets were not set inspite of the shortening of the project life. The major targets remained the same, and lower levels of individual in-process goals were appropriately used. One of the major changes during the project life was the restriction of the target area to only the Moyen Chari. The decision was made early in the project life to start activities in the two other prefectures only after those in the Moyen Chari were well established. Then with the project life shortened, there was insufficient time remaining to commence the work in the other two prefectures. A preliminary visit had been made to the Salamat, and it was apparent that the building refurbishing which had been foreseen in the PP was not feasible and would have to be curtailed. According to the REDSO/WCA engineer, none of the hospital buildings were sufficiently structurally sound to be refurbished. Also there were only three dispensaries which could be rehabilitated. The difficulties of working in an area which is unreachable during half of the year had also been underestimated. Thus no activities in the project were started in either the Salamat or the Logon Oriental.

II. FINANCIAL DATA.

1. Authorized LOP:	\$19.6 million
2. Amount obligated:	\$7.55 million
3. Amount committed:	\$7.55 m. (5/31/95)
4. Amount disbursed:	\$6.75 m. (5/31/95)
5. Original Estimated Costs of Individual Inputs: (millions)	
Technical services:	\$13.9
Commodity support:	\$1.7
Other direct costs:	\$1.6
Building rehabilitation:	\$1.4
Research/ Studies:	\$0.6
Evaluation/Audit:	\$0.4
Total:	\$19.6

III. PROJECT ACHIEVEMENTS.

The overall goals of the CCSP in Chad were certainly partially achieved through this project. With the early closure, as well as the late start to the project, impact has to be measured more by process indicators than by effects on morbidity and mortality.

Since the majority of the funding was devoted to the support of the service delivery aspects in the Moyen Chari, this component will be reviewed first, and the assistance to the central level of the MOPH was secondary, this will be reviewed later. The assistance given in the Moyen Chari can be viewed as falling into three categories: training and service delivery, institution building and cost recovery. Each of these will be reviewed in more detail.

Changing Politics, National, Local, and Other Donor

At the more global level of the Ministry of Public Health, during the implementation phase of the project there were some developments which had an impact on aspects of the achievements. First, the political instability of the country caused rapid turnovers key senior positions. There were nine different Ministers of Health since the GDO arrived in Oct. 1991, each with a different view of what the health policy should look like. Even at the more stable level of the Director-General, as the individual named to the position was the personal physician of the President, since he was usually travelling, there was little continuity. At the prefectural level, the project had three different medical directors during the implementation phase of the project.

Secondly, the political and economic instability led to the inability of the country to meet the payroll of the various Ministries, including Public Health. For substantial periods, the nurses and the doctors were not being paid. This led to lack of motivation during these periods. Although USAID paid the salaries of the MOPH staff in the Moyen Chari during part of the time, this had the effect of the Prefecture leadership seeing the whole health system as being dependent on Mission support, also not an entirely healthy atmosphere. At the local level, the appointment of the Medicin Delegeue of the Moyen Chari had to be seen as a political choice. There were three persons named to this position during the course of the project. All had individual strengths and weaknesses, but it meant that project staff had to spend additional time on briefing and learning to work with new appointees.

The insecurity on the roads led to a reduction in travel during some periods. The COP and the Planning Advisor were once stopped by robbers and all their goods, clothes and money taken. They were lucky not to have been hurt or to have lost the car. At times the Regional Security Officer did not permit car travel in the area, and this stopped some consultancies and inhibited supervision at the dispensary

level. At other times during the project the plane to Sarh which normally was scheduled for two or three flights per week did not fly. During one six month period the plane was undergoing repairs after running off the runway in a storm.

One of the policy areas which was undergoing extensive discussion during project implementation at the national level was decentralization of the health system. This was supposed to have been adopted at about the same time implementation started, but was never documented, nor were the supporting policies saying how far and in what policy areas was decentralization going to be carried out ever well articulated at the Ministerial level. This had positive and negative effects. In the Moyen Chari where health planning had been underway before the project started, they were in a strong position to implement budgeting and cost recovery measures without central guidance on how to do it, allowing for local latitude and adaptation. On the other hand, the legal documents to allow a health district to administer funds it collected or to bank the funds did not exist, this was definitely a negative influence.

The Moyen Chari is a prefecture with a strong donor presence. Half of all patient visits to dispensaries are seen in those with religious affiliations. This has had the advantage to the MOPH that only half the system has had to be supported by the national level. Secondly, the prefecture has a long history of a strong technical committee of mixed government and private health staff to achieve coordination, and this continued and was strengthened during the project. Thirdly, cost recovery had already been started in Catholic dispensaries, and was not new to the prefecture. However, there were also developments which were somewhat unforeseen. One donor had previously provided long term technical assistance to the medicin delegeue, who had in essence used the individual to do all the administrative tasks. While this relieved the delegeue, it did not result in a trained individual being left in place when the technician left. Also, the same donor provided a relatively large lump sum for the ongoing expenses of the prefecture sanitaire, and allowed it to be used for a variety of expenditures, with little preplanning. The USAID funding was much more tightly controlled, and this led to some resentment at the local level. Finally, other donors did not have specific plans for the extent and priority of prefectural funding. Then it became difficult to work out how shared arrangements for such items as resoration of the prefectural cold chain could be carried out. The achievements of the project have to be seen against this shifting framework of arrangements.

Since the GOC was essentially insolvent during the project tenure, the district health staff never knew if they were going to be paid, for which month or how long. It was hardly surprising that there were several strikes of different degree of severity. Some resulted in all patients being taken out of the hospital, others retained essential services, and during

others the nurses continued to attend training sessions. This obviously had a negative impact on project internal planning, as one never knew whether a planned activity could be carried through to conclusion. The achievements of the project need to be examined in the light of the political and social constraints listed above.

A. PREFECTURAL ACTIVITIES

3.1 Training and Service Delivery

The KAP study conducted before the project started gave important information on the level of knowledge of the general population with respect to the health interventions planned to be included in the project. It did not give any information on the level of knowledge of the health workers. The training officer wisely chose to give a questionnaire to health workers employed in both the public and private sector, and at different levels in the system. This questionnaire showed conclusively that there was a low level of knowledge about even elementary health practices and additionally that there was little difference between workers in the two systems, and between the different grades of nurses. This immediately showed that the same type of training was necessary for all workers, and that motivation rather than status in the system was important if management of the common ailments was to be improved.

The necessary training for each module was developed in all cases using an outside consultant with substantial practical experience in the field. The training advisor to the project had very little practical involvement in the treatment of common complaints in the field in any developing country, although she had excellent training in the teaching of adults. The advisor started with the modules on the subjects developed by WHO, and then in cooperation with the national advisor on this subject and the local chiefs of the district medical offices examined local beliefs, practices and management. While this process was both slow and expensive, it resulted in substantial interest and adoption of the modules at the national level.

It should be stressed that the training was focussed on training of trainers in all six districts of the Moyen Chari, having determined that the skill levels of those in public and private sectors was approximately equal. Each district was then supposed to be in a position to further spread the training amongst the staff of their district. The inclusion of the district medical chiefs in the initial training was thus very important so that they recognized the need for the training and its relevance for their district.

Training commenced with the module development and training of the trainers in the following months. This was usually followed by health worker training the following month.

October, 1993

Basic training techniques

October, 1993	Acute respiratory illness treatment
February, 1994	Oral rehydration therapy (ORT) and Diarrheal disease management (DMD)
April, 1994	Essential drug management
June, 1994	Malaria management and treatment
August, 1994	Management of dispensaries
February, 1995	Lactation management

Before each training a pre-test was conducted to ascertain the level of knowledge on the treatment of each complaint, and afterwards a post-test was given, allowing a certain measure of the increase in correct information assimilated by each trainee. This was substantial in most cases. However, the system of regular post training field supervision was lacking. It was stated that three quarters of all nurse trainees had received one supervisory visit within three months of their training.

While some visits were paid, they were often not scheduled in advance, nor was there a systematic attempt to assess whether the newly learnt skills were being practiced with patients. The short time for the implementation of the project did not allow for field testing on the quality of patient care being given after training on the above modules. There was no question that the level of knowledge had increased, and motivation of health workers improved with their participation in the training. But further field reinforcement should be given if these skills are to be practised and retained.

Another problem with the training was that too many of the modules were crammed into a short time period at the end of the project. Certainly it took time for the training advisor to get established, and the review of current skill levels prior to training was important. However, as can be seen from the above listing, the number of training sessions held in 1994 was large. The training advisor departed early, and the last session was arranged by a consultant who had participated in three of the topics covered earlier. The early closure of the project was partly responsible for this overly concentrated training program.

The prefecture medical chief named a woman as head of the Training office. She was motivated and competent, but held a lower status than was desirable locally as she was a nurse-midwife by background. However, with the national shortage of physicians this choice was probably most appropriate. She was not given reinforcement by attending outside courses on how to train, and during the time that the training advisor was on the ground, the training advisor tended to take the lead in all decision-making, rather than having a program of on-the-job training which allowed for gradual assumption of responsibility by the Chadian staff members. This was also true of the relationship with the Peace Corps member assigned to the Training Center. The relationships were seen by the training advisor as largely hierarchical rather than cooperative. The administrative head of the Training Center was appointed later in the project, and similar comments could

be made about his training.

Finally, if the health workers were to practise newly learnt skills, having the necessary tools to put them into use was also important. The kits for dispensaries were in local storage at the beginning of the training. There was a reluctance to hand them out before the health workers were trained, and the decision of the district medical chief kept delaying their distribution to dispensaries. The situation with drugs and medical supplies was different, the vast majority of the drugs only arrived in Sarh in December, 1994, and thus the nurses were being asked to treat complaints for which they did not have the correct medications in hand, and could only give a prescription to a local pharmacy. Further discussions of the reasons for the delay in the delivery of drugs can be found in the section under cost recovery.

3.2 Institution Building

In comparison with other prefectures in Chad, the Moyen Chari has had a history of better management and donor coordination, due largely to the establishment and functioning of a strong Technical Committee which had met quite regularly prior to the project starting. This tradition was now reinforced, and for the first time a formal division of health planning created. The technical advisor in planning did most of his training on-the-job rather than in formal sessions, and this appeared to be efficacious. The need for this training started with the prefectural medical chief, and involved all the senior administrative and medical staff. A three-year plan was developed for the prefecture, and on the basis of this, district level plans were developed.

With respect to the health information system developments, the staff person assigned to the prefectural data collection and analysis substantially enlarged his area of responsibility into the area of using information for planning purposes. Also, in conjunction with the decentralization of the national health information system to the district level, computers to summarize district level data were supplied to Sarh and Moissala and staff were trained in their use.

The long term advisor also conducted training for the district senior staff in how to budget for their activities. The districts all had different mixes of private and public health facilities, and the degree to which they were responsible for the administration of their own budgets was not spelled out by top management of the MOPH. Decisions prior to the start of the project on budgetting tended to be made at the prefectural level on the basis of money available at any moment, rather than with pre-planning for specific activities. The advisor trained, supervised, and monitored a practical exercise for district staff in the area of budgeting.

3.3 Cost Recovery

Project staff first reviewed prior cost recovery experiences in Chad, paying particular attention to the private sector experience in the Moyen Chari. The cost recovery consultant then prepared information on the pricing necessary under a wide variety of assumptions. After discussions the prefectural senior staff decided to adopt a three-tiered drug supply system based on a PVO-assisted clearing and transport system to Sarh, government run public pharmacy locally, and private contractors to deliver drugs from the pharmacy to dispensaries.

Based on these assumptions, a pilot system was launched in five dispensaries in the Sarh area with the generally used fee-per-illness/episode pricing. However, it quickly became apparent that it may be more desirable to switch to a cost recovery system based on drug costs. There was insufficient time to explore this option.

The arrival of the drugs suffered from a long delay due to USAID difficulties. The Mission placed the order in April, 1994 after lengthy discussions with USAID/Washington on the problems associated with US source/origin drugs in a French-speaking country. Eventually it was agreed that the order would be placed with UNICEF. The order was amended in June to take care of increased costs, but then was delayed in Washington until August due to various administrative problems. Delivery eventually took place in December, 1994.

The time taken to get the drugs was not all wasted. A pharmacist was selected, trained locally on how to handle a drug pricing module, and how to manage the inventory using a computer program. The pharmacist visited Benin to study how they managed drugs under the Bamako initiative. Finally, the prefectural drug store was refurbished and arranged for the drug reception. During the waiting period, the cost recovery was launched in two dispensaries using drugs supplied by ITS. Community health associations were started, but the legal framework giving these associations sufficient autonomy in decision-making was lacking. The project long-term staff provided comments to the national level on the need for changes in the existing legislation. A total of 10 health centers were restructured to allow for a minimum cost recovery package to be started, thus leaving the possibility of rapid expansion to another 5 dispensaries.

B. NATIONAL ACTIVITIES.

The two activities which were programmed at the national level were assistance to the family wellbeing program and to the national health information program. Both these areas had been supported prior to the project by USAID-funded activities. Centrally funded activities had started family planning training and design in Chad. They had paid for two years of support by a long-term advisor before this project started. Likewise in the health information system, a Harvard grant had already funded the design of the basic system.

However, with the decentralization decree which passed about the same time as this project started it was obvious that further support would be needed if the health information system was to be tied to the changes at the prefectural and district levels. Also, without additional financial support to the recurrent costs of running the HIS unit, any continued activities would only be at a minimal level. In all units of the MOPH, only salaries are paid, and as discussed earlier, even this present problems during the tenure of the project.

4.1 Family Wellbeing and population assistance.

The Family Health Initiatives II project (which was centrally-funded) had provided a year's support for a long-term advisor to help the MOPH in the above areas prior the inception of the CCSP. After that year until June, 1993 she was supported by the project. Her main objectives were to develop a population policy and to pass a new law which would replace the 1965 anti-contraceptive law restricting the sale of contraceptives. She was able to do a great deal of the background work to changing the law, and indeed there was substantial support from women's groups and influential persons. However, even after the new law was drafted, there seemed to be great reluctance to send it to the ruling body for ratification. In the end, it was not the efforts of USAID, but the World Bank who were able to get it passed. They wished to fund a large population program and told the MOPH senior officials that passing the new law was a precondition. It was passed. USAID can take the credit for having done all the preliminary spadework.

The family wellbeing advisor was able to utilize centrally funded projects such as Johns Hopkins University/Population Contraceptive Services to develop and advise on the use of IEC materials to promote family planning. Other central funding sources were used to upgrade the curriculum of the nursing school, develop a course on reproductive health and family planning, and hold workshops on educational skills and IEC. Project funds were used to buy-into contraceptive procurement, and USAID donated contraceptives have constituted the bulk of those used since the project started. However, their conditions of storage and logistic management have been poor, inspite of the efforts of an advisor who did short term training. Additionally, accountability for their use has been almost non-existent, inspite of repeated demands for information on the users.

Service delivery of family planning services in the capital remained at a low level, reaching under 1 percent of the women of childbearing age during the initial years. The senior MOPH staff in charge of this area were not interested in supporting services. One part of USAID's conditions for supporting the family planning advisor was that she would be provided an office in the Ministry. In 1993 she was told the office was needed for other programs. The decision was made to discontinue her role and she left in June, 1993. Provision

of contraceptives through CCSP funding was continued through 1995. The majority of the contraceptives in the final order were sent to Sarh where the training of midwives under the project had resulted in a substantial increase in their use. Mission project staff were instrumental in assuring a continued supply of contraceptives after project closure through a World Bank project.

4.2 Support to the Health Information System.

USAID provided support to the Bureau de Statistiques, Planification et Etudes (BSPE) in the MOPH during the period 1985 to 1988 through a Harvard Grant. The support was continued to strengthen the unit under the CCSP for substantially similar activities. In August, 1991 the unit was upgraded to the Division du Systeme d'Information Sanitaire (DSIS). During the period of its support under the project it published each year an annual yearbook, summarizing all the health data of the country broken down by prefectures. The yearbook made improvements in the quality and quantity of information published, and each year was issued earlier in the year than on the prior one.

The long-term advisor functioned as the technical advisor to the head of the unit. During the final year, 1994 to 1995 he turned over an increasing role in the management and decision-making to his counterpart. His counterpart had sufficient experience to continue routine activities without support. The unit was responsible for implementing the decentralization decree and training staff in the prefectures in the new data entry and summarization procedures necessary for preparing the summaries at a local level. The development was started on a solid base, and new summary programs were prepared by a consultant provided by the project.

Each year new information was added, on maternal health and family planning, a hospital referral sheet with information on the management and follow-up of patients, and finally on cost recovery. An inventory of human and physical resources in each prefecture was issued at intervals, this too improved in both quality and quantity of data recorded.

The MOPH was not in a position to support this unit, the running costs of which amounted to about \$100,000 per year. Though the project as designed wanted to see the Mission pick up a decreasing share of the overhead, there was no indication at the early closure of the project that this could be attained at any time in the foreseeable future. A substantial portion of the upkeep was the maintenance of two vehicles which were used to take the staff out to train the staff at the prefectural level. Without the project, training would not have been done. The importance of adequate statistics was realized better by the donors than by the senior ministry officials. UNICEF agreed to continue the contract of the advisor for a year after the project closure.

IV LESSONS LEARNED

1. With shifting personnel occupying the most senior staff positions in the MOPH, it could have been desirable to form an Oversight Committee of senior staff able to make policy decisions to discuss the impact of existing regulations or lack thereof on the project.
2. The MOPH could have been asked to sign an undertaking not to change the chief medical officer in the target prefecture without notification of the donor and mutual consent. (This change was suggested to the world Bank and incorporated by them in a recently signed project agreement).
3. In projects such as this, located a long distance from the capital, it is not feasible for the USAID office to prepare housing for technical staff. The selection and refurbishing of housing should be made part of the contract for the firm selected to undertake the contract. Likewise, the reconstruction of existing facilities should be undertaken by the contractor. Especially when few structural changes are anticipated, and the individual building reconstruction is of low cost, using the normal local engineering standards is inappropriate. The cost and time involved for USAID specifications, bidding procedures, award selection and engineering supervision is out of all proportion to the amount of construction work being done.
4. In French-speaking Africa where all drugs used in the health system are of French origin, the insistence on drugs of U.S. source/origin may actually be dangerous. Health workers are poorly trained, partially literate, and certainly cannot follow English instructions, often with changed drug potency and physical appearance. Arrangements should be made outside the USAID system, such as provision of drugs by other donors, before a project dependent on drugs is undertaken.
5. The inclusion of the Director-General Adjoint, or the senior health-trained individual as the leader of the mid-term assessment assured that the findings were reported back to the MOPH and utilised as they saw fit. This strategy may be useful in other projects. Likewise the inclusion of the national leader of specific disease programs on the team leading the module production for training may result in its adoption at the national level.