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**EXTERNAL EVALUATION OF THE
ACSI-CCCD PROJECT
IN THE REPUBLIC OF GUINEA**

Prepared For:

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GLOSSARY

ACSI-CCCD	African Child Survival Initiative - Combatting Childhood Communicable Diseases Project
ADB	African Development Bank
AID/AFR	Bureau for Africa, A.I.D./Washington
AIDS	Acquired Immunity Deficiency Syndrome
ATS	Trained Practical Nurse/MOH
BEPR	Studies, Planning and Research Bureau
BCG	Bacille Calmette-Guerin (tuberculosis) vaccine
CDC	Centers for Disease Control
CDD	Control of Diarrheal Diseases
CDSS	Country Development Strategy Statement
CI	Confidence Interval
CP	Condition Precedent
DPS	Prefectural Health Director
DTP	Diphtheria/Tetanus/Pertussis Vaccine
EM	Essential Medications
EPI	Expanded Program on Immunization
EPS	Health Education Section MOH
FG	Guinean Franc(s)
GDO	General Development Officer
GOG	Government of Guinea
GTZ	German Development Assistance
HET	Health Education and Training
HIS	Health Information System
IDRC	International Development Research Center of Canada
IEC	Information, Education, Communication
IRS	Regional Health Inspector
KAP	Knowledge, Attitude and Practice Surveys
LOP	Life of Project
MOH	Ministry of Health
MSF	Medecius Sans Frontieres
MSP	Ministry of Public Health and Population
NGO	Non-Governmental Organization
OR	Operations Research
ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PACD	Project Anticipated Completion Date
PASA	Participating Agency Service Agreement
PCV	U.S. Peace Corps Volunteer
PDSS	World Bank Health Services Development Project
PHC	Primary Health Care
PROAG	Project Agreement
SNIS	Systeme National d'Information Sanitaire
SSS	Sugar and Salt Solution
TA	Technical Assistance
TO	Technical Officer
TT	Tetanus Toxoid Vaccine
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO/AFRO	World Health Organization/Africa Regional Offices

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**EXTERNAL EVALUATION OF ACSI-CCCD PROJECT
THE REPUBLIC OF GUINEA**

EXECUTIVE SUMMARY

The Health Population and Nutrition Division of the Office of Technical Resources, Bureau for Africa (AFR/TR/HPN) initiated the report entitled External Evaluation of the Africa Child Survival Initiative-Combating Childhood Communicable Disease (ACSI-CCCD) Project in the Republic of Guinea, August 1989.

The goal of the ACSI-CCCD project is to improve the health status of children under five years of age in selected African countries. The project in Guinea began in 1985 and has as its purpose the reduction by 25% of the infant mortality rate of 153 per thousand live births by 1991. The reduction of infant and child mortality and morbidity in developing countries - or, conversely, improvements in child survival - is an A.I.D. priority worldwide. Improvements in health status are included in the strategy of USAID/Conakry.

The ACSI-CCCD project in Guinea, as in other countries, supports and strengthens efforts to prevent and/or treat the most common diseases of childhood. These are: diarrheal diseases; malaria, and six vaccine preventable diseases (poliomyelitis, tuberculosis, diphtheria, pertussis, tetanus, and measles). In Guinea the project is active in the capital city of Conakry and two rural prefectures. The project provides assistance in training and supervision, health education, operations research, and information systems. Technical assistance to the Government of Guinea is provided through a Participating Agency Service Agreement between A.I.D. and the Centers for Disease Control (CDC) of the Public Health Service.

This external interim evaluation was undertaken as part of the routine management of the overall project. The methodology employed was to deploy a team of three for a period of three weeks in Guinea. During this period, team members reviewed documentation, interviewed key informants, observed activities at project sites, and conducted small non-random surveys. Team members were selected because of their expertise in management, medical epidemiology and information systems, and health education and training.

The Exhibit following the executive summary summarizes project accomplishments and is based upon a review of the projected outputs and verifiable indicators in the logical framework. In the body of their report, the evaluation team organized their findings, conclusions and recommendations under ten topics.

The most urgent problems identified by the team relate to delays in implementation as a result of difficulties in disbursing GOG funds, and passive project management within the Mission resulting from the limited capacity of the Mission. A lack of communication between GOG and USAID not only results from these problems, but also exacerbates them. The evaluation recommends that senior Mission personnel take the lead in a dialogue with GOG and, if this results in the release of the promised GOG funds, that USAID/Conakry add to its staff in order to provide stronger management and leadership.

In terms of project achievements, the evaluation found that primary health services in the project areas have generally been strengthened. However, services are underutilized, resulting in excess capacity in most health centers. Greater efforts to educate families about services, through health education and outreach, are recommended.

Overall, the project has been less successful in diarrheal disease control and malaria control than in immunization against the vaccine-preventable diseases. Special efforts are needed to boost preventive and curative interventions to address these diseases. The favorable GOG

policy, combined with the lack of other donor activity, make diarrheal disease control, in particular, an attractive focus for project attention in the future.

Health education holds the key to greater appropriate use of the primary health system. The GOG is not strong in this area. Various donors are actively supporting health education efforts and the evaluation recommends closer coordination among all concerned in order to enhance synergy and avoid conflicting messages.

The sustainability aspects of the project have been quite successful and serve as a model worth reviewing for application elsewhere. The health care financing policy of GOG requires cost recovery through the collection of fees for curative care as a means of subsidizing preventive measures. A budgetary system for health centers has been introduced and elected management committees within the community seem to be working well.

As to health system management capacity within GOG, a recent decentralization initiative makes it all the more urgent that adequate numbers of officials receive the training they need and then get deployed appropriately. Supervision at service delivery sites is a priority. The national health information system has the potential of becoming a powerful management tool, but it is nowhere close to fulfilling its potential in this regard.

Operations research is a neglected component of the ACSI-CCCD project in Guinea. Many of the priority management questions and issues could be assisted through operations research. Finding the best ways to institutionalize supervision is a prime example.

The evaluation team recommends that the ACSI-CCCD project only continue in Guinea if the GOG makes available sufficient local funds and adequate staff is available at the Mission. The lack of USAID project management capacity is of deep concern and should be addressed. Clearer and more supportive communications are needed both between GOG and the U.S. Government (USG), and among the different components of USG involved in the project.

A.I.D., as an agency, needs to reconsider its own role vis a vis CDC's role as project manager. Nowhere in A.I.D. is there a clear overview at any one time of the Guinea project with regard to the project's development impact, its true total costs, and considerations of cost effectiveness and efficiencies regarding project implementation. The Mission is the logical place to look for leadership in this regard.

A change in project emphasis is recommended for the future; one that more aggressively supports and encourages initiatives in health education, training, information systems, and management improvement.

SUMMARY OF PROJECT ACCOMPLISHMENTS

By Outputs and Indicators Specified for CCD/Guinea
Amendment to Project Grant Agreement

IMMUNIZATION FOR SIX MAJOR CHILDHOOD DISEASES (EPI)

<u>PROJECTED OUTPUTS</u>	<u>CURRENT STATUS OF OUTPUTS</u>
1) "Development of a Project Strategy to assure daily immunizations services in 90% of dispensaries by 1990."	: 1) Project Strategy reflects the National Plan, developed with CCD TA. Daily immunizations are now available in 41 of 43 CCD-assisted centers.
2) "Qualitative improvement of childhood communicable disease indicators including: Reduction of neonatal tetanus mortality by 25%, Reduction of polio morbidity in children under 5 by 75%, Reduction of measles morbidity in children <24 mos. by 50%."	: 2) Though the meaning of "qualitative improvement" in such quantitative indicators is obscure: a) Record review at Donka shows that the rate of NNT is unchanged from 1985 to 1988. b) Reporting of cases has improved between 1987 and 1988 for polio and measles cases (and mortality) so that sentinel surveillance data is not yet useful for evaluation.
<u>VERIFIABLE INDICATORS</u>	<u>CURRENT STATUS OF INDICATORS</u>
1) "Number of health centers vaccinating daily;"	: 1) 41 of 43 CCD-assisted health centers provide daily vaccinations.
2) "Availability of commodities (measles vaccine, cold chain, equipment);"	: 2) Although historically a problem (especially vehicles, ORS, motorcycles, chloroquine), now all are available.
3) "Existence of a Project Vaccination Strategy/campaign;"	: 3) Project vaccination strategy exists.
4) "HIS activity monitoring and target correction."	: 4) The SNIS is actively monitoring data on vaccine-preventable disease morbidity and mortality, however data quality do not yet permit use.

CONTROL OF DIARRHEAL DISEASES (CDD)

<u>PROJECTED OUTPUTS</u>	<u>CURRENT STATUS OF OUTPUTS</u>
1) "Development of a CDD Project Strategy, part of a National Policy and Plan, to provide ORT services in 90% of dispensaries by 1990;"	1) CCCD assisted in development of National Strategy, which is reflected in project strategy. ORT is available daily in 42 of 43 CCCD-assisted centers.
2) "Reduction of inpatient diarrheal deaths by 30% and 80% improvement in effective case management of diarrheal disease incidents;"	2) More deaths are reported in 1988 than 1987 by the SNIS, as reporting becomes more reliable. Only one years' data are available from CCCD detailed reporting, and no conclusions can be drawn. 40% of cases in Conakry received adequate ORT at health centers
3) "Establishment of a National ORT Training Center."	3) Donka hospital designated as training center, but has been a poor model to date.

<u>VERIFIABLE INDICATORS</u>	<u>CURRENT STATUS OF INDICATORS</u>
1) "Number of ORT corners distributing daily;"	1) Of 43 CCCD-assisted centers, 42 provide daily ORT.
2) "Availability of commodities (ORS, equipment);"	2) Adequate ORS and containers, spoons available in all CCCD centers. One center reported absence of ORS, but had stock in storeroom.
3) "Existence of a National ORT Training Center (Organization-plan, select staff, design curricula);"	3) Donka Hospital designated as training center, but quality of service has not been upgraded.
4) "Implement Project Area CDD Strategy (preliminary PRITECH study, evaluation, final policy preparation);"	4) Project Area Strategy being implemented.
5) "HIS activity monitoring and target correction."	5) The SNIS has data available two years, CCCD for one. Data do not yet permit target corrections.

MALARIA CONTROL

PROJECTED OUTPUTS

1) "Development of a Project Malaria Control Strategy, part of a National Malaria Policy and Plan, to assure availability of malaria control services in 90% of dispensaries by 1990;"

2) "Reduction of inpatient malarial deaths by 50% and 90% improvement in effective case management of recorded malaria incidents."

VERIFIABLE INDICATORS

1) "Number of centers distributing daily;"

2) "Availability of commodities (chloroquine, laboratory equipment);"

3) "Implementation of a Project Zone Strategy (study of existing policy, prepare, distribute therapy procedures);"

4) "Studies of drug resistance (pilot study, follow-up study);"

5) "HIS activity monitoring and target correction."

CURRENT STATUS OF OUTPUTS

1) CCCD assisted in the development of the National Malaria Policy, and uses the same plan for project activities. Malaria treatment is available in 42 of 43, and prophylaxis in the 26 centers in Kindia and Telimele.

2) More deaths are reported by SNIS for 1988 than 1987 as reporting improves. Absence of consistent operational definition for "effective case management" prevents documentation of improvement.

CURRENT STATUS OF INDICATORS

1) 42 of 43 offer treatment, while 26 provide prophylaxis for pregnant women.

2) Although problems with procurement delayed services, commodities are now adequate to support service delivery.

3) Project strategy currently being implemented.

4) Drug resistance studies were completed by consultants in February-March, 1989.

5) SNIS monitors malaria morbidity and mortality.

HEALTH EDUCATION

<u>PROJECTED OUTPUTS</u>	<u>CURRENT STATUS OF-OUTPUTS</u>
1) "Increase to 90% the recognition rate of target families of the value of ORT, chloroquine and immunization to maintain child health;"	:1) No operational definition has been developed or data collected regarding "recognition of value", however evaluation survey found 42% of mothers had heard messages on diarrhea or ORT, 43% on fever/malaria, and 70% on immunization (N=53)
2) "Development of a Project Health Education Strategy, part of a National Policy and Plan for CCCD interventions;"	:2) No national policy and plan has been developed for health education. The project has used consultants to assist in development of a activity plan for health education.
<u>VERIFIABLE INDICATORS</u>	<u>CURRENT STATUS OF INDICATORS</u>
1) "Implementation of the Project Health Education Strategy (1986 Conakry survey, 88 Kindia, Telimele survey, final preparation);"	:1) Implementation of health education activities has lagged behind, although surveys have been completed as a basis for formative research
2) "Existence of education messages (ORT, CDD, EPI);"	:2) Specific messages have been developed for each intervention, however these have not been systematically communicated.
3) "Implementation of messages in media (campaign test, procure commodities, distribution);"	:3) Messages have not been communicated. An ORT poster has been developed, tested, and approved, but not printed or distributed.
4) "HIS activity monitoring and target correction."	:4) No plan has been developed for monitoring and evaluating such measures as "recognition of the value" of CCCD interventions.

STAFF TRAINING

<u>PROJECTED OUTPUTS</u>	<u>CURRENT STATUS OF OUTPUTS</u>
1) "Increase to 90% the number of Project Zone health service staff, managers and supervisors who are technically qualified and assessed to be functionally effective;"	1) No operational definition has been developed to distinguish those "technically qualified" or "functionally effective". The project is reviewing draft supervisory checklists, and has developed instruments to assess training effectiveness.
2) "Development of a Project Training Strategy, part of a National MPHP Staff Training Policy and Plan, and implemented by an MPHP permanent Training Department;"	2) A project training strategy and needs assessment have been developed by consultants. There is no national training policy and plan.
<u>VERIFIABLE INDICATORS</u>	<u>CURRENT STATUS OF INDICATORS</u>
1) "Adoption of a Project Training Strategy (needs assessment, budget, staff plan);"	1) Project training strategy, needs assessment, budget, and staff plan have all been developed and adopted.
2) "Implementation of in-country seminars (senior management skills, statistical analysis, disease therapy training for trainers);"	2) A management seminar has been scheduled for July/89; statistical analysis seminar not yet planned; 15 trainers were trained in 1987, 40 more to be trained in 1989 for ORT.
3) "Completion of short-term third country training (nine students);"	3) One person has received third country training to date, 3 more scheduled for August/89. In one case a third country national came to Guinea to conduct training for CCCD.
4) "HIS activity monitoring and target correction."	4) Project records adequately track outputs (i.e., numbers trained), however little has been done to measure effectiveness of training.

HEALTH INFORMATION SYSTEM

PROJECTED OUTPUTS

- 1) "Development of a health information system to record and assess the status of health indicators, achievements of technical and managerial interventions of the health service system;"

VERIFIABLE INDICATORS

- 1) "Existence of an adopted Project HIS strategy (1987 survey, assess requirements, budget and staff plan, prepare HIS and MIS forms, verification procedures);"
- 2) "Availability of commodities (computers, software);"
- 3) "Implementation of pilot system for selected diseases (establish sentinel system, disease analysis, service support system analysis);"
- 4) "HIS activity monitoring and target correction (cross-sectional study, number of data-supported recommendations)."

CURRENT STATUS OF OUTPUTS

- :1) Approximately 25% of health centers nationally report to SNIS, however coverage and reliability are not yet adequate to affect decisions. Classical "health indicators" such as mortality will not be obtained with this system, but will require surveys. Most data for project evaluation is obtained by consultants, not by a project-operated HIS.

CURRENT STATUS OF INDICATORS

- :1) Neither a project nor a national HIS strategy has been developed. CCCD has been requested to conduct a needs assessment for SNIS and assist with quality control and verification procedures.
- :2) Project has 2 computers (one requires repairs), and ADB provided 2 computers (both need repairs) but no software. SNIS will require custom software for routine data entry and analysis.
- :3) SNIS already working in 100 centers for 20 key diseases, although data quality needs to be assessed and improved.
- :4) Although periodic surveys and routine monitoring have been the basis of decisions for the project, SNIS will require strengthening in epidemiology, data analysis, and graphic presentation before information will be used to support recommendations and decisions.

MANAGEMENT AND SUPERVISION SUPPORT

PROJECTED OUTPUTS

CURRENT STATUS OF OUTPUTS

- | | | |
|---|---|---|
| 1) "Assist in preparation of the Project Work Plan and Management Performance Plan;" | : | 1) A work plan is developed annually. No "management performance plan" has been elaborated to date. |
| 2) "Increase staff productivity and work quality;" | : | 2) "Productivity" and "quality" have not been monitored, and no clear definition of these "outputs" has been established |
| 3) "Assist in development of an improved and responsive budgeting and disbursement system for Project funds." | : | 3) Project system for disbursement functions well, while the budget is in a more rudimentary state. GOG budgeting and disbursement are the major obstacle, yet it is not in the project scope to remedy this. |

VERIFIABLE INDICATORS

CURRENT STATUS OF INDICATORS

- | | | |
|---|---|---|
| 1) "Existence of a Project Work Plan and management performance plans evaluation system (supervisory checklist, assessment needs, establish work plans, monitor system);" | : | 1) Annual workplans developed. There is no comprehensive plan for evaluation of management performance, although project staff are working to adapt a supervisory checklist. |
| 2) "Existence of system to stimulate productivity and quality review (quality circles, management model test, rewards program;" | : | 2) Although health centers providing the most vaccinations and showing the greatest improvement have been rewarded, there are no "quality circles" or other systems to stimulate productivity and quality review to date. |
| 3) "Existence of responsive, secure budget and disbursement system (financial audit, assessment, budget records system);" | : | 3) Project staff are working to achieve such a system. |
| 4) "HIS activity monitoring and target correction." | : | 4) Monitoring of management and supervision functioning to a substantial extent. |

PROJECT SUSTAINABILITY PROGRAM

PROJECTED OUTPUTS

CURRENT STATUS OF OUTPUTS

- | | |
|---|---|
| <p>1) "Development of a management and supervision regime incorporating work plans, performance evaluation procedures, and improved budgeting and disbursement procedures for the Project Implementation Unit;"</p> | <p>: 1) Not achieved as such.</p> |
| <p>2) "Development of a recurrent cost finance program for dispensaries to generate income sufficient to replace recurrent cost support to local CCCD Programs provided by external donors."</p> | <p>: 2) Although CCCD is implementing a pricing system along the EPI/PHC model, however, it is unlikely that cost recovery from the three interventions will be adequate to "replace recurrent cost support."</p> |

VERIFIABLE INDICATORS

CURRENT STATUS OF INDICATORS

- | | |
|---|--|
| <p>1) "Existence of fee-for-service pilot project (Makinen initial assessment budget and staff plan, select site);"</p> | <p>: 1) Such a project would be superfluous now that EPI/SSP has achieved such progress. Project effort will be better spent encouraging prompt use of these revenues and establishing a fee-for-service system for Conakry.</p> |
| <p>2) "Existence of alternate finance strategy assessment;"</p> | <p>: 2) Not completed.</p> |
| <p>3) "Procurement of private ORS production (initial study, production study, delivery and test of order);"</p> | <p>: 3) Two consultants completed an assessment of the feasibility of local ORS production during this evaluation.</p> |
| <p>4) "Availability of financial support for replacement drugs, equipment and supplies;"</p> | <p>: 4) Although CCCD-supported centers which the EPI/PHC program is also operational appear to have resources to replace recurrent costs, there is danger of loss due to inflation if not expended promptly.</p> |
| <p>5) "HIS activity monitoring and target correction."</p> | <p>: 5) Project and EPI/PHC HIS are adequate to monitor these indicators.</p> |

I. INTRODUCTION

1. BACKGROUND OF THE PROJECT

The Africa Child Survival Initiative-Combating Childhood Communicable Disease (ACSI-CCCD) project is a regional project initiated in 1981 to strengthen the ability of a number of African countries to control vaccine-preventable diseases, to treat dehydrating diarrheas with oral rehydration therapy, and to prevent malaria among pregnant women and treat malaria among children. The project has the goal of reducing morbidity and mortality among children under five and achieving a 25% reduction of infant mortality by 1991.

The three disease interventions are promoted through strengthening five major support activities; training, supervision, health education, operations research, and health information systems. Other project activities have included the promotion of cost recovery through local financing under community control, studies of the feasibility of local production of oral rehydration salts (ORS), and improvement of management practices.

The project is being implemented through a participating agency service agreement (PASA) with the Centers for Disease Control (CDC) which provides both resident advisors and short-term technical assistance (TA) to assist Ministries of Health (MOH) with ACSI-CCCD project implementation. The project also provides intercountry and national training through a grant to the World Health Organization Africa Regional Office (WHO/AFRO), and personnel support for service delivery and health education through a PASA with the Peace Corps.

The sixth project amendment for the ACSI-CCCD project, signed in October 1988, authorized an increase in Life of Project (LOP) funding to \$123,568,000, supporting the extension of the ten current country sub-projects, and increasing the emphasis on their sustainability after the Project Anticipated Completion Date (PACD) of 1991.

The ACSI-CCCD project in Guinea (698-0421.75) was initiated in 1985, with an initial PACD of December 1987 and LOP funding of \$885,000. Under the sixth amendment of the regional project, the PACD for Guinea's CCCD activity was extended to September 30, 1991. The sub-project agreement amendment will add \$645,000 to the bilateral funding of the project for a total of \$1,530,000.

The final version of the project extension design for Guinea was developed in 1989 by ACSI-CCCD project staff in collaboration with USAID/Conakry. The project extension agreement had not been signed at the time of this evaluation, and its signing may be further delayed with the change of the Minister of Health, which occurred during the time the evaluation team was in Guinea.

The project serves the population of Conakry, and of Telimele and Kindia, two prefectures in Lower Guinea. Basic indicators for Guinea are presented in Appendix I. It is estimated that the project serves 27% of Guinea's total population of 6.8 million. Approximately 413,000 children under five and 391,000 women of child-bearing age are the target of project interventions. Guinea has an infant mortality rate of 153 per thousand live births. The project interventions address three of the most common causes of mortality--malaria, diarrhea, and vaccine-preventable diseases.

During the initial 30 months of the project (June 1985-December 1987), the Government of Guinea (GOG) restructured its MOH and secured assistance from other donors. In 1986, a five year project was initiated by the GOG in collaboration with United Nations International Children's Fund (UNICEF) (funded largely by the Government of Italy), to develop curative as well as preventive health services at the sub-prefectural health center level. The GOG has

also embraced the Bamako initiative, so that the national primary health care (PHC) program includes Expanded Program On Immunization (EPI) and essential drug services with cost recovery managed at the community level. The national EPI/PHC Program now covers 62 of the 346 subprefectures; 100 including those served by Non-Government Organizations (NGOs). Each year 72 new health centers are scheduled to be integrated into the national EPI/PHC Program.

In 1987, the GOG signed a five year project agreement with the World Bank to build central management capability and implement the national EPH/PHC program in middle Guinea. The African Development Bank (ADB), the WHO, German Development Assistance (GTZ), and the French NGO Medecins sans Frontieres (MSF) are also assisting the GOG to implement its EPI/PHC Program.

In response to the development of national policies in the health sector, and the concurrent commitment of other donors, ACSI-CCCD has shifted its focus and scope to complement the activities of the MOH and the other donors. One example of such a shift is the fact that the second phase of the ACSI-CCCD project was intended to emphasize ORT and malaria activities because EPI was receiving considerable support from elsewhere.

2. THE EVALUATION

This external evaluation of the ACSI-CCCD project in Guinea was carried out during the period June 19 through July 14, 1989. Tasks defined in the Statement of Work (Appendix II) were: (1) to evaluate the accomplishments of the project compared to the objectives specified in the relevant project agreement; (2) to identify problems which have resulted in failed objectives; and (3) to prepare recommendations for their amelioration. The evaluation was undertaken by a team composed of:

- Frank D. Correl, Management Specialist
- Jack Scott Finlay, Health Education/Training Specialist
- Sally K. Stansfield, Medical Epidemiologist

The team was assisted by Dr. Souleymane Diallo, Coordinator of the CCCD project in the Ministry of Health and key members of his staff. Dr. Lucien Prosper Haba, Regional Health Inspector for Middle Guinea accompanied the team on its visit to areas outside Conakry. Others who were most helpful include Mr. Scott McKeown, CDC Technical Officer (TO) resident in Guinea; Mr. Harry Godfrey, Public Health Consultant, CDC; and staff members of USAID/Conakry. Ms. Margaret Meites, AFR/TR/HPN, accompanied the team to Guinea and served as a resource person.

The team reviewed extensive documentation in AID/Washington and on location in Guinea. The list of documents examined is contained in Appendix III. Members of the team interviewed key persons within the GOG's MOH and at health facilities in Conakry and the prefectures of Kindia and Telimele. The team also interviewed personnel of other GOG Ministries, CDC and USAID in Guinea, and representatives of the major other donors active in the health sector in Guinea. The list of principal contacts is contained in Appendix IV. The team also conducted a survey of a convenience sample of health workers in the three project areas and made home visits to 54 families in Kindia and Telimele. Results are tabulated in Appendix V.

The team members acknowledge with sincere thanks the excellent cooperation and support they received at all stages of their work in Guinea and the United States.

3. ORGANIZATION OF THE REPORT

The report is organized into ten sections, each of which addresses a component and/or attribute of the ACSI-CCCD project in Guinea. Within these sections, the information is consistently presented in three parts:

- A discussion of the team's findings, including any important issues.
- A brief statement of the most important conclusions drawn from the evaluation.
- A list of recommendations.

The Appendices contain the supplementary material that is referred to in the body of the report.

II. FINDINGS AND RECOMMENDATIONS ABOUT IMMUNIZATION

1. DISCUSSION

The EPI program in Guinea was launched in 1980 with the help of UNICEF. Soon after ACSI-CCCD was initiated in Guinea, the project collaborated with the MOH, UNICEF, and WHO in the planning and implementation of a four month immunization campaign in Conakry (November 1986 to February 1987). The increases in coverage between CCCD's survey in June 1986 and the follow-up survey in March 1987 (Diphtheria/Tetanus/Pertussis vaccine (DTP) 23% to 92%, DTP3 8% to 64%, measles 16% to 86%, completely vaccinated to 60%) present clear testimony to the effectiveness of that effort. However, results obtained in a 1989 survey in Conakry (DTP1 43%, DTP3 28%, measles 25%, completely vaccinated 19%), provided distressing evidence that such campaign efforts offer gains that are difficult to sustain.

The ACSI-CCCD project began to give EPI assistance to the health centers in Kindia and Telimele in October-December 1987 and 1988, respectively. Forty-one of the 43 health centers are now offering daily immunization services. A survey of immunization coverage conducted in Kindia prefecture documented that 12.8% of children 12-36 months of age were completely vaccinated (Grigorian, 1988). Measures of access to immunizations as indicated by Bacille Calmette-Guerin (BCG) (tuberculosis) vaccine and DTP1 coverage were 30% and 28%, respectively, while the DTP1 to DTP3 "drop-out" rate was 41%.

Immunization procedures have clearly improved in the course of the project. Breaches in sterile procedure noted during past surveys (Grigorian, 1988) and in supervision activities, such as the inappropriate handling and reuse of syringes and needles, were addressed promptly by the project and have since been observed to be much less frequent (Godfrey, 1988). The evaluation team noted two instances of the use of unsterile procedures during visits to health centers in Conakry, Kindia and Telimele.

Logistical systems have been established and strengthened in order to provide reliable vaccine supplies to immunization centers and a viable cold chain (Godfrey 1988). Deliveries of new stock are made quarterly, and regional depots are available to prevent breaks in supply. The visits to health centers conducted by the evaluation team confirmed that, with the exception of occasional interruptions in stock of fuel for refrigerators, supply systems have mostly functioned well in Kindia and Telimele.

Obstacles to improved immunization coverage include early administration of doses, missed opportunities, the cost of vaccination, long waits in clinics, and adverse reactions (Cutts, 1989). Missed opportunities for immunization of children when they are brought for curative care have been a particular problem (Godfrey, 1988, Cutts, 1989).

In a recent coverage survey in Conakry 42% of children had experienced at least one missed opportunity for immunization (Cutts, 1989). Immunization coverage might be nearly doubled in Conakry by simply profiting from existing contacts with children of the target population.

An ACSI-CCCD objective for EPI is the provision of daily immunization services in 90% of dispensaries by 1990. That objective has been met. For the CCCD-supported health centers located in towns with very small populations, daily immunization services have not been considered practical. After the new motorbikes are delivered it is anticipated that outreach services will enlarge the size of the population served so that provision of daily services will become even more important.

In Telimele center it was observed that immunization services were interrupted to provide vaccine supplies from that depot for other health centers. Maintaining depot supplies adjacent to the health center refrigerator does, however, limit the additional burden of cold chain maintenance for depot supplies.

Immunization activities in Conakry have been associated with special problems. Although immunization campaigns in 1986-87 raised coverage, vaccinations fell to an average of less than 60 measles vaccinations per center per month in early 1986. After the MOH initiated a meeting to address the problem, the monthly average per center vaccinations increased to over 700. Since that time the numbers have fallen to around 100 per center per month. At the time of this evaluation, two CCCD consultants are working to address obstacles to improving immunization coverage for Conakry. Limitations in supplies (including fuel for refrigerators, vaccination cards, syringes, and needles) and the lack of clear guidelines and supervision for immunization activities are among the problems which have been identified. Addressing the staffing, supply, and cost recovery problems in Conakry health centers has also been delayed due to the need to establish separate policies for the distinct economic and political situation in the capital city.

2. CONCLUSIONS

The immunization component of the CCCD project is the strongest of the three health interventions. Short-term technical consultation has been used appropriately to launch service delivery, promptly identify logistical and technical problems, and to implement improvements, particularly through enhancing supervision.

Current efforts to further strengthen immunization activities are appropriate. Standard procedures should be listed (as a reference guide for immunization workers and supervisors) for sterilization, for screening immunization status at all contacts (including sick children), and for the provision of daily vaccination services at all sites.

3. RECOMMENDATIONS

The following recommendations are presented to improve immunization efforts associated with the ACSI-CCCD project in Guinea.

- Work with the MOH and other donors to establish a system for home-held documentation of tetanus toxoid status for all women of child-bearing age, and to standardize documentation for immunization status of children.
- Strengthen health education in support of immunization activities, including making mothers aware of the need to bring immunization records for all health service contacts.

III. FINDINGS AND RECOMMENDATIONS ABOUT DIARRHEAL DISEASE CONTROL

1. DISCUSSION

Much of the first experience with oral rehydration therapy (ORT) in Guinea was obtained during July through September, 1986, when CCCD provided TA to the MOH in addressing a cholera epidemic in Conakry and five surrounding prefectures. During the epidemic, the assistance provided by CCCD consultants helped to confirm the cause of the epidemic, improved the capacity of the MOH laboratory in diagnosis of diarrheal disease, provided support (including ORT) for case management, and develop recommendations and procedures to control the epidemic.

The first routine ORT services were offered by CCCD with the opening of an ORT center at Donka Hospital in Conakry in September, 1986 (MSPAS, 1987). Currently, daily ORT services are available at 42 of the 43 health facilities supported by CCCD.

After demonstration of the effectiveness of ORT during the cholera epidemic, CCCD technical consultants were able to work with MOH personnel to elaborate a national CDD policy in March and October 1987. The national Control of Diarrheal Diseases (CDD) Plan was, however, not made operational until early 1988.

A diarrhea morbidity and treatment practice survey completed in Kindia (Grigorian, 1988) documented a 17% (Confidence Interval (CI)=14.8-19.2%) two-week prevalence of diarrhea among children under five, suggesting that the average child experiences 8.9 episodes of diarrhea per year. Only 3.3% (CI=0-7.3%) of diarrhea episodes in Kindia were treated with ORT prepared from ORS sachets. However 48.5% (CI=35.6-61.4%) were treated with "ORT" when fluid-based traditional remedies were included in the definition.

In Conakry, a 1986 survey documented a 14% two week prevalence of diarrhea, 15% use of ORS, and 64% use of home solutions. At Donka Hospital in Conakry, 1987 project records documented increases in ORT use as the incidence of diarrhea went up, while IV use remained constant or declined.

The National CDD Program lacked a coordinator for some time before the ACSI-CCCD Coordinator was named National CDD Director in September 1987. Although this arrangement should help to ensure integration of ACSI-CCCD with National Program activities, the Coordinator's efforts must still be split to include CCCD's immunization and malaria control activities.

The CCCD activities in CDD were also hampered by the lack of supplies or ORS in the early phase of the project. Due to delayed shipment of ORS packets, the project borrowed ORS from UNICEF to bridge the gap and begin promotion of ORT until its own stock arrived in August 1987.

Even with CCCD's emphasis on effective case management of diarrhea in health centers, less attention has been given to supervision of ORT in health centers than to immunizations. Although the national policy calls for promotion of ORS or home-available fluids, health center workers in Conakry continue to recommend use of the sugar-salt-solution (SSS) despite consultants' recommendations against such practices (Prins, 1987). A study conducted in April 1987 by CCCD suggested that health personnel were frequently inaccurate in their assessment of degree of dehydration (32%), and were thus inappropriately treating cases of diarrhea (60%).

A major constraint to achieving ORT coverage objectives is the project's focus on the health center as the level of delivery of ORT services. It will be difficult to improve the current utilization rates for ORT without addressing the need to educate mothers in the use of ORT (whether packets or home-available fluids) in the homes and the recognition of danger signs which indicate the need to seek consultation in a health center. In view of utilization rates and distances to rural health centers, increasing real ORT coverage will require development of mechanisms to communicate with families at the village level.

Several past evaluations and consultations (Prins, 1987, Grigorian, 1988; Glik, 1988) have pointed out the importance of strengthening CCCD activities in support of ORT. Health education efforts, in particular, have been too weak to assist in changing health practices in the management of diarrhea. The absence of CCCD efforts to communicate key CDD messages to mothers outside the setting of the health center has been a key constraint to increasing the use of ORT.

2. CONCLUSIONS

The CDD/ORT interventions have not received as much attention as CCCD's immunization activities. In view of the existence of a well developed national policy for CDD and the absence of substantial activity by other donors in this area, the project has an opportunity to take the lead in promotion of ORT.

3. RECOMMENDATIONS

The following recommendations are presented to improve the diarrheal disease component of the ACSI-CCCD project in Guinea:

- Accelerate project activities in the promotion of ORT, through (a) strengthening training and supervision of health center personnel; (2) development of an information package to promote the use of ORT (including home-available fluids and refeeding practices) in the home; and (3) diffusion of this package through outreach and other mechanisms to reach the target population.
- Develop detailed operational definitions (consistent with the national policy) of "effective" or "appropriate" case management techniques to be used at home and at health centers. Such operational definitions should also serve as a guide for development of training objectives, and to form the basis for supervision and the development of instruments for evaluation surveys.

IV. FINDINGS AND RECOMMENDATIONS ABOUT MALARIA CONTROL

1. DISCUSSION

Although malaria is probably the major cause of mortality among children in Guinea, CCCD malaria efforts have been slow to develop momentum. CCCD helped to develop and now assists in the implementation of the national policy of presumptive treatment of suspected cases among children under 5 (single dose of 10 mg/kg) and prophylactic treatment (300 mg weekly) of pregnant women. The program objective is 70% coverage of febrile episodes among children under 5 and 70% coverage with chemoprophylaxis among pregnant women.

Efforts have been made by the project to strengthen the central laboratory through training and provision of laboratory supplies and equipment. To aid in refining the program, CCCD brought in TA to perform chloroquine sensitivity testing in February-March 1989.

A coverage survey in Conakry conducted in June 1986 documented a 24% two-week prevalence of fever among children under 5, 84% of whom were treated. Only 5% of episodes, however, were judged to be treated "appropriately" (Gerski, 1987). The small survey conducted during this evaluation found a 53% (29/55) one-week prevalence of fever among children under 3, while 83% (24/29) were treated with chloroquine. Less than half of these children, however, received their chloroquine from health centers.

A major constraint has been that GOG resources devoted to malaria control have been limited, and a national policy was not promulgated until 1988.

An additional constraint to the program has been the delay in obtaining supplies of chloroquine, with the first shipment being received in December 1987. Considerable concern has been expressed about CCCD's provision of chloroquine prophylaxis to pregnant women without the addition of folate and iron (all three medications are given during antenatal care according to national policy).

2. CONCLUSIONS

CCCD strategies to promote appropriate treatment and prophylaxis for malaria have been compromised by the lack of GOG resources, perceived conflict with national policy for treatment of pregnant women, and the widespread availability of medications in markets.

3. RECOMMENDATIONS

The evaluation team makes the following recommendations with regard to the malaria component of ACSI-CCCD activities in Guinea:

- Explore the feasibility, possibly through an operational research activity, of rationalizing the use of chloroquine obtained in the markets (including investigation of shelf-life and assessment of feasibility of training market vendors).
- Adjust CCCD guidelines for the treatment of pregnant women, adding folate and iron to bring the treatment regimen into line with national policy.

V. FINDINGS AND RECOMMENDATIONS ABOUT HEALTH EDUCATION

1. DISCUSSION

As with most aspects of the ACSI-CCCD project, health education interventions were to be supported through a series of short-term technical consultancies. During the period since the last evaluation, four major technical assistance consultancies in health education were made to Guinea. Three of these were made by the University of South Carolina group (Glick, Gordon et. al.) and one by a private consultant (Vodounou). Consultancies with a different focus (eg. Godfrey, Cutts) also have certain implications for health education efforts in the ACSI-CCCD project.

Though the intended proposed contributions of these short-term consultancies to the CCCD program are clear, a certain minimal in-country capacity is required to assure their effective use and to continue and extend the work accomplished during the consultants' stay. While a large number of trained medical and paramedical personnel exist in Guinea, the relevant central Government institution, the Health Education Section (EPS-Education pour la Sante) of the Division of Primary Health Care, currently appears to lack the proper support and clout to assume this important coordinating role (e.g. WHO April, 1988 Report on AIDS Control; Project CCCD Country Report, 1988 etc.). The EPS has no budget of its own and must work with the resources furnished by the departments and projects who call upon it for assistance. Even from this weak position, however, personnel from EPS did help facilitate the work of the consultancies in health education. According to the Director of EPS, the future also promises to be brighter; the Ministry has reportedly promised to provide modestly renovated additional workspace at their present locale and the Middle Guinea World Bank Project (PDSS) will provide materials to strengthen their communication activities. Though not readily apparent at the current EPS office, the AIDS country program is also said to provide some support to the unit. Yet, while these contributions to health education are laudable, it does not appear to be the principal aim of any of these projects to specifically strengthen the institution of health education in Guinea.

Activities proposed in the Project Agreement (PROAG) Amendment and brief comments on their status of implementation are summarized in Exhibit I.

Knowledge, attitude, and practice (KAP) surveys were carried out in 1986 and 1988. The latter survey reported that use of the project interventions against childhood disease had increased substantially in the target areas. Familiarity with the three types of project interventions was particularly high in the urban area of Conakry. In a household convenience sample of six health center areas in Kindia and Telimele Prefectures, the evaluation team found that 40 of 54 children (74%) possessed vaccination cards. For recent cases of diarrhea and fever, 35.3% of mothers had used ORT Therapy and over 80% had employed chloroquine for the fever. Of the 54 mothers, 37 (69%) had heard on the radio or elsewhere about the need and importance of childhood vaccination. Somewhat lower recognition rates were found for ORT (41.5%) and chloroquine (43.4%) use for diarrhea and fever respectively.

Two short-term consultancies were undertaken by University of South Carolina personnel (Gordon et al, - 4 to 24 Dec. 1988; and Glick - 14 to 29 Jan. 1989). The first of these used key informant interviewing and social network analysis to analyze health center utilization and health worker community relations as part of a baseline educational diagnosis. The second by Glick employed "focus group" methodology to help determine problems associated with low immunization rates in Conakry and to plan a comprehensive health education strategy to address them. The consultation was undertaken in conjunction with personnel from the Health Education Section.

EXHIBIT I

PROJECT PLAN OF HEALTH EDUCATION ACTIVITIES FOR PERIOD EVALUATED*

	Start	End	A.I.	D.I.	CDC	IGOG	Evaluator observations
1. "Assist Development of Nat'l Health Ed. Policy, Plan and Project Strategy							- '86, '88 KAP Surveys done
- 1986 Conakry survey	11/86	12/86			X		- Info from surveys used in Vodounou consultancy to plan project education activities
- 1988 Kindia, Telimele survey	6/88	7/88			X		- Unclear if or how they impact on national HE policy though EPS personnel are involved in CCCD surveys
- Final preparation"	2/90	7/90			X	X	consultancies
2. "Prepare Education Messages							- EPS has made many radio transmission for vaccinations, fewer for ORT and malaria
- ORT messages	1/89	2/89			X	X	- ORT poster prepared
- EPI messages	6/88	7/89			X	X	
- Malaria messages"	1/89	2/89			X	X	
3. "Implement thru Media							
- Campaign test	3/89	5/89			X	X	- ORT poster-tested/approved
- Procure commodities	4/89	12/89	X			X	- Work beginning on EPI and malaria
- Distribute messages"	6/89	-				X	
4. "HIS Activity Monitoring/Target Correction	1/10/89	-				X	- To be done in future
- ORT value recognition up from 15% to 90%							Found to be at roughly
- Increase mothers recognition to attend vaccination sessions"							40% now in Kindia/Telimele

* Taken from revised project agreement

An additional consultancy in December 1988 was made by A. Vodounou for the purpose of developing action plans for educational interventions in each the three main subject areas of the ACSI-CCCD project. This consultancy was also undertaken in conjunction with people from the EPS. Though plans for the development and use of education to support the vaccination and malaria aspects of the project were also developed, the principal contribution of the consultancy was directed toward an education intervention in ORT. The intervention employs a poster and presentation guide on ORT for use by health center personnel. Conceived during the consultancy, two versions of the ORT poster were since developed and field tested. Based on these tests, a final poster selection has been made and now awaits mass reproduction. Some consideration was being given to production overseas where the posters could be laminated with plastic. However, local production is possible and would allow the poster and educational intervention for ORT to commence more quickly. As originally conceived by the consultant, this intervention is approximately two months behind schedule.

Though proposed by the consultant and the PROAG Amendment simultaneously, it has not been possible to move forward with the educational interventions for malaria and immunizations. In July, 1989 a consultant arrived to help re-program the development of these interventions.

Radio messages on vaccinations, ORT use for diarrhea control, and chloroquine treatment by health center personnel of childhood fevers have also been developed by EPS. These messages are transmitted first in French during a 15 minute time slot each Monday morning and subsequently on Tuesday, Wednesday, and Thursday afternoons in the local languages. A preferred listening time would be between eight p.m. and midnight. As yet, such prime time has not been available for radio health programs. The Director of Health Education noted that surveys indicate more than 70% of the population have access to a radio. Due to its distance from Conakry and mountainous terrain, transmissions are sometimes difficult to receive in Telimele Prefecture.

In addition to use of radio, one member of the health education staff has, from time to time, also helped to prepare television transmissions in health.

A previous evaluation noted that EPS is one of the weakest units in the Ministry of Health (Brown & Mock, 1987). The authors also noted that the ACSI-CCCD project had deliberately not undertaken many health education activities with EPS because of its weak infrastructure and also because of other donor involvement in health education. In their conclusions, they cited a number of problem findings and subsequently recommended the immediate development of an educational strategy for immunization coverage in Conakry, and the development of education/communication strategies for each of the three CCCD project components. Exhibit II lists problem areas and current status. While ORT use by the population has increased, a number of the other problems continue to persist. Though not specifically apparent in health education objectives, vaccination coverage in Conakry has been addressed in the consultancy of Gordon (Dec. 1988) as well as those of both Godfrey (Jan. 1989) and Cutts (Feb. 1989).

The EPS of the MOH remains a unit with little self-direction, dependent on specific projects with specific needs for both operational and program funding. Poor work space allocation to house its officers has been noted in the report of nearly every consultant to visit Guinea during the past two years. The lack of materials is another frequently cited problem. A need for increased management of the unit is also apparent. To address some of these problems, the MOH is planning to renovate and quadruple the space currently allocated to the unit.

EXHIBIT II

: PROGRAM FINDINGS IN 1987 PROJECT EVALUATION AND THEIR CURRENT STATUS
(Health Education)

Problems Cited	Current Status
1. ORT used neither by population nor by health service personnel	-ORT now used by health center personnel and increasingly also by the population
2. Incorrect dosages of chloroquine for fever given both by mothers and health personnel	-Some improvement but still exists among health service personnel (e.g. see Stone, Oct. 88) -Problem persists among mothers
3. Chemoprophylaxis neither recommended nor followed during pregnancy	-National Malaria policy is under review
4. Other Problems	
a. Maternal attitude data on immunizations in Conakry not analyzed	- Material analyzed and new material collected and analyzed (e.g. Gordon, Cutts)
b HE weakest component CCCD in field	- Still appears to be true
c. Messages still being given in health centers about SSS as opposed to ORT	- Not observed in Kindia or Telimele - but SSS still being taught in at least one Conakry health center
d. Lack of one-on-one and group HE	- Perhaps only slightly better
e. Health worker need for training in techniques of HE	- Still needed
f. Project lag in the development of HE strategies	- Still behind schedule

The World Bank project, through its communications program for the development of health services (PDSS) in Middle Guinea, plans to support the provision of equipment for the unit so that it can prepare and implement the health communications effort in the region. A one-year World Bank technical assistance contract to strengthen the unit in communications has already begun. To address management and leadership needs, the World Bank project is sending the Director of EPS and another doctor to Canada to undertake a course in health education. Three Peace Corps health volunteers will soon begin training for future posting in Telimele, Kindia, and Conakry so that they may assist the integration and development of health education in ACSI-CCCD project activities.

A persistent and recurring question arises as to what extent ACSI-CCCD project activities in health education are meant to also reinforce Guinean institutions (e.g. such as EPS) and to what extent they are only directed to project goals in achieving vaccination coverage, ORT use for diarrheal control, and chloroquine treatment of childhood fevers. In the revised project agreement reference is made to the strategy as part of national policy and plan for ACSI-CCCD interventions. However, assistance in the development of national health education policy is also still listed as an activity to be undertaken.

The previous evaluation team referred to the lack of health education activity as a deliberate choice made because of the weak infrastructure at the EPS. Paradoxically, the weakness of EPS is also often noted as the reason that so few achievements of the project in health education have been made. A question thus arises as to the necessity of strengthening the EPS in order to achieve project goals. As sustained change in human behavior is crucial to the long term benefits of the project, the question is not a trivial one.

The general domain of health education is best seen in the widely used PRECEDE Health Education Planning Framework of Green *et al.* (see Appendix VI). As seen in the diagram, an effective health education program should contain components to address the predisposing, enabling, and reinforcing factors which lead to health behavior. These factors are most often addressed through program strategies in communications, community organization, and training. While some health education programs rely more heavily on one strategy than another, more often than not, interventions in all three areas are required for maximum program impact.

Currently the World Bank (PDSS) project is focussing on a communication effort in Middle Guinea which should also strengthen the communications capacity of the national health education program. At the same time, UNICEF has conducted training programs in social mobilization which are concerned with community organization. Training health personnel in the theory and methods of health education, particularly those of adult education, could be an area on which the ACSI-CCCD project may wish to concentrate.

Certain health personnel in Conakry have been trained in social mobilization by UNICEF. This training has been particularly useful in the organization of health center teams to do home visits. Started initially to encourage community utilization of the center's health services, most notably their vaccination service, some centers plan to continue this practice one day per week and have added environmental and health education to their repertoire during such visits. In Conakry, where an abundance of health workers are assigned to a center, this appears to be a more productive use of manpower in the absence of patients during afternoon hours. Judging from visits to rural areas, and observation of decreased patient flow after noon, it is also conceivable that with proper training, the practice of community visits to enhance health education could be introduced in these areas as well.

Although a number of donor agencies are working in health education, no single agency is providing core support to develop the planning and management skills required of an innovative and dynamic health education unit. It is probable that such direction and guidance could only be provided through long-term TA to the unit. It is likely that only WHO would

be able to recruit the highly qualified type of professional TA to do this. However, the need for organization and direction of national health education efforts is perceived to be so great that other avenues of TA in health education program management should be pursued in the event WHO is unable or unwilling to furnish assistance. Alternative sources of long-term technical assistance would include such donors as UNICEF, World Bank, and even the ACSI-CCCD project. Consideration should be given to this in developing future projects.

Finally, it should be noted that information collected in villages and from health center personnel during the evaluation visit may not be representative since the units selected did not constitute a valid statistical random sample. In addition, local health personnel were used as interpreters in collecting the information resulting perhaps in exaggerated responses in some cases. However, the overall trend appears to be that people are aware of and are seeking vaccinations for their children, and that a growing number of mothers are learning to use ORT packets to rehydrate their children during bouts of debilitating diarrhea.

2. CONCLUSIONS

Work has begun to develop a communications campaign for ACSI-CCCD interventions; the PDSS project should strengthen EPS capabilities.

Health workers both in urban and rural areas have sufficient time to become involved in community health education.

An important contribution to the health education efforts in Guinea could be made through provision of training in health education theory and methods to health workers.

The arrival of Peace Corps volunteers to work on health education aspects of the ACSI-CCCD program is a positive step and should help focus the contribution of the central government Health Education Unit to the ACSI-CCCD project; it should not, however, be interpreted as a contribution in needed technical assistance.

There is a need for long-term TA in program planning and management to reorganize and energize the EPS.

3. RECOMMENDATIONS

- It is recommended that the health education efforts of the ACSI-CCCD project be continued and expanded. The following efforts appear to be particularly worthwhile.
 - Efforts to develop and strengthen mass communication interventions through collaboration with the PDSS project.
 - Efforts to institute a system of periodic home visits in the community to provide health education in both urban and rural project areas. Training in social mobilization and other appropriate skills should precede the program.
 - Efforts to develop and conduct workshops for health center personnel in the theory and methods of health education. Particular emphasis should be given to the development of adult education skills.
 - Initiate a meeting with MOH personnel and representatives of WHO, UNICEF, and PDSS to discuss the possibility of obtaining a long-term technical assistance position to aid in the reorganization and program development of the EPS.

VI. FINDINGS AND RECOMMENDATIONS ABOUT TRAINING

1. DISCUSSION

Training activities under the ACSI-CCCD project consist of supervision and in-service training. People undergoing this training have already completed their basic training at the medical and paramedical facilities where basic information on the ACSI-CCCD interventions is now a part of the curriculum.

Though a management tool, supervision in the ACSI-CCCD project is also used for on-the-job-training. During their periodic visits to the health centers, supervisors are to observe worker performance and correct any errors found "on the spot." One supervisor in Conakry related how he will frequently join in vaccinating children in order to demonstrate the correct technique. Center staff thus have the opportunity to learn through observation. Problems of a general nature encountered by supervisors are reported and may be formally addressed as subject areas in subsequent in-service training.

Continuing education of health workers through in-service training is carried out in the project in order to launch new programs and improve existing work performance.

The original project proposal called for varying degrees of technical training of some 500 senior, mid-, and other level personnel. As required, training materials would be developed using national resources and personnel, and funds for short-term consultancies and the purchase of training materials would also be available. In the revised PROAG, more emphasis was placed on the development of a training strategy, the implementation of in-country seminars, and support for specific third country training was added. In Exhibit III, these proposed activities are shown with evaluator comments on their progress.

In many ways, training has become the generating force for project activities. In-country training has been used extensively to launch new programs and to incorporate new ideas and methods into old ones. It has also been used to extend techniques (such as those of ORT) developed or tested in the project area to other areas of the country.

A project training strategy of decentralization has evolved through the three consultant visits of training specialist Ralph Stone, during which previous training was reviewed, a systematic analysis of training needs made by observation and interview, and training of trainer workshops conducted. These efforts appear to have contributed to, or at least are consistent with, a similar training strategy adopted by the national PHC program.

During the two years since the last evaluation, some 216 health workers have undergone project-sponsored training in eleven seminars. With the 351 people trained during the previous evaluation period, the lifetime project goal of 500 has been surpassed. In addition to these project-organized seminars and workshops, the ACSI-CCCD project also collaborated with UNICEF on a cold chain workshop and with Canada's International Development Research Center (DCIR) on a seminar in Operations Research (OR). A list of the seminars and workshops conducted by the Project during the evaluation period may be seen in Exhibit IV.

During the period under review, one person received third country training. The Assistant Director of the project attended a three-week WHO-sponsored introductory course to computers in Abidjan. The Director and the Assistant Director are scheduled to participate in a one month course on Lotus 1-2-3 and DBase III Plus in August, 1989. Proposed third country training in testing for chloroquine drug resistance was not necessary as the Zairean professor came to Guinea to conduct this training.

EXHIBIT III

TRAINING ACTIVITIES PROPOSED IN REVISED AGREEMENT

	SCHEDULE		RESPONSIBLE PARTY			EVALUATOR COMMENTS
	Start	End	AID	CDC	GOG	
Staff Training						
1. Assist develop Nat'l Training Policy, Plan, Project Strategy						
- Review Training Experience	8/88	12/88		X		done through Ralph Stone consultancies (e.g. 3) Strategy - 1st visit Aug. 88
- Develop Project Strategy	1/89	3/89		X		D. Training Needs-2nd visit Nov-Dec 88
- Implement	4/89	-			X	Training of Trainers - 3rd visit March-April 89

2. Implement In-Country Seminars						
- Sr. Mgt. Skills	2/89	10/89		X	X	Mngt. for end July 89
- Statistics analysis	6/89	10/89		X	X	Stat - not yet done
- Technical Tng.	2/87	-		X	X	Tech-Veh.Maint.(87)Cold Chain (88)
- Training for trainers	4/89	10/89		X		TOT-15 part in 87; 15 in '89

3. Short Term 3rd Country Training 4 participants.						
Drug Resistance	5/87	6/87	X	X		1 person attended WHO sponsored Ivory Coast course on use (8/88) of computers in disease surveillance
-1 to 3 parti.	1/89	2/89	X	X		Lotus & Disease Training for 3 people in Zaire for 8/89
-4 to 7 particip.	4/90	5/90	X	X		3rd Country Consultant came in 2/89 to do drug resistance training in country
B, 9th particip.	1/91	2/91		X	X	

4. HIS ACTIVITIY Monitoring/Target Correction						
- Report	10/89	-				X
- Intervention						

5. Develop and Support Nat'l ORT Training ORT Training Center						
-Organize Training Center	10/87	1/89		X	X	Not formally established. Training facilities of Donka Hospital used for training. Stone training focus on ORT.
-Budget and Staff	1/89	2/89		X	X	'87 - '89 Training in process
-Develop Curricula	3/89	6/89		X	X	ORT Training curricula developed

EXHIBIT IV
IN-COUNTRY TRAINING DURING EVALUATION PERIOD

TYPE OF TRAINING	Staff	Participants	Days
1. Training for trainers, 8 June 1987		15	5
2. Vehicle Maintenance 9 Cold chain 15-25 July, 1987		20	10
3. Training in ORT techniques, Conakry, 20-30 July, 1987	4	40	10
4. Training in ORT at Kindia, 10-15 Aug. 1987		15	
5. Training in Cold Chain, Telimele 4-10 Jan. 1988	4	26	7
6. Malaria slide identification and Drug Sensitivity, Feb. 1988		20	3
7. Training in ORT for Peace Corps Volunteers, 5 June, 1988	2	6	7
8. Training in EPI and ORT at Kindia and Telimele, Oc. 1988		33	
9. Training of trainers in ORT at N'zerekore, 26 Mar-4 Apr., 1989	3	12	7
10. Training of Trainers in ORT at Kankan, 2-9 April, 1989	3	14	7
11. Training of Trainers in ORT at Labé, 9-13 April, 1989	3	15	7
<hr/>			
<u>- TRAINING IN COLLABORATION WITH OTHER DONORS</u>			
Cold Chain with PEV/SSP/ME, 23-28 May 87-UNICEF		5	
Operations Research - IDRC		25	
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In interviews conducted with ten directors of health centers and other health workers from centers visited in Conakry, Kindia, and Telimele, the evaluation team found that, during the past two years, five of these workers had attended some type of in-service training on immunization, four on ORT, and two on malaria. Eight of the health workers indicated that they had found the training to be useful in their work. Two of the workers indicated the lack of materials and problems with transportation and time as barriers to integration of the training received into their work. Of the eight health center directors interviewed, six noted that they had conducted some type of training in EPI for their staff. Two of the directors mentioned they had trained their staff in ORT while only one mentioned malaria training. All indicated that this training was done on-the-job on a continuing basis.

At Donka Hospital in Conakry, a group has been trained in ORT. Medical and nursing students as well as other health workers in Conakry have received training at this unit.

Problems of coordinating the methods and content of training with those used in the national PHC program were cited by the previous evaluation team. Though nearly everyone interviewed indicated an improvement in coordination, UNICEF TOs noted that standardization of methods in the programs remains a problem.

Most frequent problems cited by health center chiefs to be addressed by in-service training were related to community health education.

Though much project training activity is taking place, there is no evidence of a comprehensive multi-year training plan for the ACSI-CCCD project despite the recommendation for such a plan by the previous evaluation team.

Although the content and principles of training are beginning to be passed on to personnel in the sub-prefecture centers (e.g. six of the ten center directors interviewed indicated they had conducted training in vaccinations for their personnel), considerably more training is needed at the periphery to attain the project target of technical quality and functional effectiveness in 90% of the health workers. A start toward this was made during the recent training of trainers seminar (e.g. Stone visit, March-April 1989) for regional inspectors, prefectural health directors and health center heads. However, it is unfortunate that sufficient time and funds were not available for participants to complete the field exercise for the immediate application of the educational techniques was originally envisaged.

A performance evaluation of project training conducted to date has not yet been undertaken.

There is still no visible institution responsible for training in the MOH. Currently, it has been assigned to the Department of Administration and Finance which is also responsible for personnel. The establishment of a national "Center for Health Documentation and Training" with backing of the ADB has been delayed due to more pressing priorities for ADB funding.

A recent report by a WHO consultant acknowledged the usefulness of such a National Center of Human Resources for Health but recommended, in the light of present realities, that a central task force be created to provide guidance and direction for national health training policy. A particular focus of the task force would be in-service training.

Although education administrators and faculty dispute this, most outside observers believe that medical and nurse training is too oriented toward curative medicine and not in line with the preventive needs of the country. In addition, there are over 4000 practical nurses who have completed their three-year training program during the past four years but whom the government has been unable to employ. It is estimated that at least 1500 of these health workers will require some retraining as they become employed.

Although a small unit at Donka Hospital in Conakry is used for ORT training, progress toward the development of a national training center for ORT as described in the PROAG amendment is not apparent.

The importance of having a single consultant make several visits to the project appears to benefit the project by providing continuity and baseline information to develop a coherent training strategy and plan of training activities. The latter, however, have yet to be developed.

Participation of health center personnel in a ACSI-CCCD training activity during the study period correlated directly with the emphasis given to the subject by the project during this period. Thus, more health workers interviewed attended an EPI seminar than those participating in ORT and malaria training. Since senior personnel are more likely to be invited to centralized training programs, it is not surprising that directors of health centers had more training than personnel working in their center.

Though it is perhaps too early to assess, there appears to be very little formal training being initiated at the periphery. The prefectural health directors and directors of health centers all claimed to be conducting health training in ACSI-CCCD subject areas. However, when questioned by the evaluation team about worker job descriptions and how training needs are determined, training was invariably found to be on-the-job training done during supervision. The training of trainers concept requires that the trainees then plan training programs themselves. Undoubtedly, this decentralization of training will require some central level support during the initial stages.

As noted by consultant Godfrey in his report on supervision (Jan-March, 1989), on-the-job training through good supervision is still one of the most fruitful ways of learning. Greater attention to exploiting this powerful mechanism would help toward this end perhaps through the development of teaching guides for supervisors.

It is not clear whether the establishment of a national center for ORT training, as described in the PROAG amendment, is still a required output of the ACSI-CCCD project. Little formal action is underway for the establishment of such a center.

2. CONCLUSIONS

- Training activities are being used extensively in the CCCD Project. The project goal of training 500 senior, mid, and other level health personnel has already been attained.
- The instruments developed by the training consultant to assess training needs should be used for future performance evaluation of project training.
- At present, it is unclear which central government institution is responsible for determining national health training policy.
- No multi-year training plan has yet been developed for the project.
- External consultant visits have been useful and demonstrate a logical progression toward development of a decentralized training strategy.
- The use of supervision for on-the-job training has yet to be exploited to its full extent.
- No evaluation of the effect of training on improved work performance of health personnel has yet been made.

- Little progress has been achieved toward the establishment of a national ORT training center.
- There is little evidence of project-related in-service training initiated at the prefectural level.

3. RECOMMENDATIONS

- It is recommended that the ACSI-CCCD project become more actively involved in institutionalizing training. Specifically the project should:
 - Assist in the development of a multi-year training plan based on a clear training strategy.
 - Conduct a performance evaluation of project training in six months and annually thereafter.
 - Conduct a review of the project objective to establish a national ORT training center to determine if this objective is still feasible and relevant to the achievement of project goals.
 - Support follow-up visits by consultant Stone be made to aid prefectural health directors in the actual practice of developing and implementing a training program at the Prefecture level.
 - Assist in strengthening coordination of health training, the project should strengthen coordination of training activities with those of the National EPI/PHC program.
 - Conduct a review of how supervision may more effectively contribute to health worker learning and performance.

VII. FINDINGS AND RECOMMENDATIONS ABOUT PROJECT MANAGEMENT

1. DISCUSSION

The 1987 evaluation of the ACSI-CCCD project in Guinea recommended extension of the project. Subsequently (February 1988), the Director, USAID/Conakry extended the life of the project through September 1991, and authorized an amendment increasing bilateral funding by \$645,000 to a new total of \$1,530,000, with the host country contribution increased from \$650,000 to \$1,542,000. An amended PROAG is currently awaiting signature, having been transmitted to the Ministry of Plan on June 15, 1989. The above amounts are augmented by sub-allocations from the Africa Regional Program, amounting to \$102,000 in FY 1988 and \$210,000 in FY 1989. The salary of the TO and that of consultants are an additional cost.

The project amendment provides for continuation and completion of the technical initiatives while putting greater emphasis on support to improve the institutional capability of the MOH. The new termination date of the project coincides more closely with the scheduled end of other major projects supported by UNICEF, the World Bank, and the ADB. The signing of the amendment may be delayed further with the recent change of Ministers.

Beyond the illustrative implementation plan and procurement schedule included in the project amendment, a detailed work plan for the time period covered by the amended project has not been developed yet. A work plan for 1989 is expected to be developed shortly by the project coordinator's office to augment the tasks identified in the 1988 Management Information Systems report. Similarly, as discussed in the section below, little financial detail is available beyond the illustrative financial plan contained in the PROAG amendment. Details that are currently available concerning the amounts and timing of host country contributions are fragmentary and somewhat contradictory.

Four ACSI-CCCD-supported health centers in Kindia and Telimele prefectures have been granted status as national health centers. In the other centers in these two prefectures, as well as in Conakry, the ACSI-CCCD project's emphasis on elements of management facilitates these centers' eventual absorption into the national system under the phased approach. In theory by putting in place a comprehensive management and health education system in the ACSI-CCCD/health centers, staff will be exposed to the principles and practices that strengthen work performance, facilitating the development of the national PHC health center system.

Consistent with this approach, it is the intent of the MOH to have the project continue as long as possible while the national program expands from its current 100 centers to the full 360 planned. This policy is designed to permit ACSI-CCCD to contribute to the priority of the GOG to expand vaccination coverage as quickly as possible. The project as currently designed is able to serve as a model for the national program.

The GOG structure to administer the ACSI-CCCD immunization, ORT, and malaria programs is in place at the central level. The ACSI-CCCD Coordinator functions autonomously and is located within the Ministry's Division of Preventive and Primary Health Care. Following the 1987 evaluation, the Coordinator was designated also as the Diarrheal Disease Control Coordinator. Construction of a project office building has been delayed for over a year because of a series of procedural disputes with the Ministry of Housing and delays in contracting. The project is housed in limited space in a shared sub-standard building.

The structure at the prefectural level remains weak. The prefectural health directors in Kindia and Telimele function with virtually no staff except personnel assigned to the health centers. In Conakry, by contrast, there is an excess of staff members assigned to health

centers but only a small percentage appear to be functioning. The three prefectural health directors in Conakry benefit from the proximity of the three supervisors assigned to the ACSI-CCCD Coordinator's head office.

Team members were struck by the relatively small numbers of people served by the health centers. Outreach activities have been rare due to tardy motorcycle procurement and delivery (shipment arrived during the evaluation). A system of charges for vaccination cards and ORS packets has been introduced as a first step toward cost recovery but details of administration and disbursement of funds remain to be determined. Unlike the national programs, funds are not managed by a community-based elected committee but are being held under the control of the ACSI-CCCD Coordinator.

The March 23, 1989, Presidential decentralization decree provides for a more extensive health management staff at the prefectural level. However, the necessary appointments are awaiting action by the Minister of Health and may be delayed by the recent change of ministers. Three Peace Corps Volunteers will be assigned before year-end to provide coverage until all of the new staff arrives. For the present, the virtually staff-less prefectural health directors continue to provide as much supervision as possible. Training of health center staff continues only as a part of supervision visits to individual health centers. Attention to health education is minimal, and while information is collected and forwarded at individual health centers, there is no effort made for tabulation and analysis at the prefectural level nor is there capacity to do so. The supply of vaccines, ORS packets, and medicines (except chloroquine) is based primarily on periodic allotments directly from Conakry (either from the central essential drugs depot - Pharmaguinee - or from ACSI-CCCD stocks, depending on the items and whether or not a center is a national EPI/PHC center). Supply within the individual prefectures is dependent on a largely informal system closely tied to the schedule of individual visits of supervision.

In Conakry, the ACSI-CCCD Coordinator's supervisors provide extensive coverage of health centers, sometimes visiting a center two or three times per week. In the up-country project areas, given the workload of the prefectural health director, it is remarkable that the system of supervision works as well as it does. A supervisory check list has been developed and is in use in Kindia prefecture but has not been distributed to Telimele, where the director has fashioned his own. Supervisory visits are scheduled semi-monthly or monthly while the prefectural health directors are available. However, during absences resulting from leave, training or other special assignments, the schedule is not always adhered to. Both prefectural health directors received training under the ACSI-CCCD project, and have been used to carry out supervision of the national program in other regions.

GOG support has been strong in human terms, but less clear in financial terms. Excellent leadership has been provided at the central level by the ACSI-CCCD Coordinator and staff while very limited numbers of the prefectural staff has been compensated for by well-qualified effective prefectural health directors. The project has benefitted from a remarkably low turnover in staff since its inception. The project has also benefitted from the keen personal interest of the Minister of Health who has been a dedicated partisan of Primary Health Care. The major problem in this area is the lack of sufficient funds at the necessary times, caused by the wide gap between budgeted amounts and actual availabilities and the delays inherent in the excruciating process of fund releases.

After a lengthy hiatus covered in part by short-term assignments, a competent TO was recruited by CDC and commenced duties in July 1988. He has quickly established excellent working relationships with the ACSI-CCCD Coordinator and MOH staff at all levels and is effective and highly regarded by the GOG and USAID. Discharge of his regular responsibilities has been complicated by the project's chronic funding and administrative problems caused by delayed availability of the GOG contribution for local costs and by serious delays in procurement of U.S. commodities. These many distractions keep him from

important responsibilities; in particular, the management side of the project and the building of Guinean capacity and confidence. On occasion, the TO also has had to spend considerable time handling A.I.D. documentary requirements as Mission personnel have not been available. He also fills in as de facto Mission health officer by answering cables and furnishing advice and information on health subjects at the request of the Mission's Project Office.

CDC has provided extensive supervisory support through frequent visits, both to project headquarters in Conakry and to the two project areas up-country, and through recruitment and scheduling of a substantial number of short-term consultants. Notwithstanding the many consultancies, some of them of a repeat nature, little emphasis appears to be placed on ensuring the development of greater Guinean capacity and follow-up in the areas of the health education, information systems, and operations research.

The total number of TA visitors to the project and the repetitive nature of several of the visits raises the question of whether it would be more efficient to consider placement of a second resident technical person in Guinea. This matter apparently has not been considered by CDC.

The USAID stance and level of support of the project is a matter of considerable concern. Contact between project and Mission personnel has been less than optimal in some respects. Some of the problems in the past were caused by the inexperience and marginal competence of personnel on both sides. Although largely overcome by personnel changes, problems persist due to chronic personnel shortages at the Mission, the absence of any Mission officer with a background or particular interest in health, and what appears to be an ambivalent attitude toward the project as a part of the Mission's portfolio. Two problems have been especially serious and have delayed achievement of project objectives: (1) delay in procurement caused by an unfortunate series of circumstances including errors in documentation, and (2) the Mission's difficulties in helping resolve the budgetary allocation dilemma for local costs. The latter is part of a greater general problem in Guinea of counterpart fund programming and release, and has dogged other mission activities and projects of other donors.

USAID is kept informed of project developments and routinely receives consultants' reports and briefings. Logistic support by the Mission to the project and its many visitors has been commendable. Contact between USAID and GOG seems limited to the negotiation of agreements and implementation letters and the many meetings related to counterpart programming and fund release.

It appears that the Mission does not have a comprehensive overview of the ACSI-CCCD project and that its monitoring of the project has been somewhat passive. There is little evidence that the Mission exercises independent judgment or initiative concerning the project. The Mission does not appear to have enough information or a sufficiently broad perspective to make such judgment. It does not play a genuinely active role in assessing overall project progress or individual aspects of project implementation unless it is a direct unavoidable Mission responsibility, e.g. commodity procurement. Thus, for instance, the Mission may be aware of consultants' visits, but plays no role in reviewing the overall program of consultants' services or assessing their effectiveness.

Part of this state of affairs is due to the severe personnel problems the Mission has encountered, both with respect to availability of personnel and quality. Although Guinea is now considered a Class I program by the Africa Bureau, staffing has been very difficult to obtain. There is a 10-month hiatus between the departure of the project officer who previously was the Mission's primary contact with the project and the scheduled arrival of his successor. In addition, communications and sharing of information can be slow and haphazard at times. A prime current example is the delay in resolving the issue of paying salary supplements to selected Guinean project personnel with counterpart funds.

There is considerable concern, also, about a pattern of scattered project management responsibility on the U.S. side among CDC, the resident TO, A.I.D./Washington, and the Mission. This has led to a lack of: (1) coordinated project planning, monitoring, and review; (2) knowledge concerning true total costs of the project; and (3) opportunity to streamline or consolidate operations, effect cost savings, and increase project efficiency.

The Mission needs the services of an individual with a health background or at least the capability to deal convincingly with health issues within a broader range of responsibilities. This will contribute to improved project monitoring, and effective Mission participation in health donor coordination and planning of Guinean Primary Health Care development.

Moreover, there is an urgent need to clarify the respective roles and management responsibilities of USAID and the ACSI-CCCD TO. Project management has been needlessly complicated as a result of the TO's anomalous position as he struggles with a multiple identity as CDC project manager, part-time USAID staff resource, and general workhorse and fixer for the ACSI-CCCD Coordinator's office. This confusion has led to conflicting demands on his time and has tended to detract from his overall effectiveness in addressing the body of project work. The scramble for funds, the need to scrounge for equipment, and the need to help devise a secure place for funds and commodities, make it all the more difficult to create a well-functioning sustainable Guinean institution. This conclusion is not intended to make light of the TO's dedication and competence and interpersonal skills. The hiring of a qualified broad-gauge Administrative Assistant should relieve the TO of the bulk of his documentary and routine administrative responsibilities and strengthen the administrative management capability of the project coordinator's office. Differing perceptions between the TO and USAID concerning the functions and location of this position has delayed recruitment. It should be emphasized that the question of this position is an issue quite apart from the question of augmenting the Mission's capability in overseeing the project.

A.I.D., as an agency, needs to reconsider its own role vis a vis CDC's role as project manager. Nowhere in A.I.D. is there a clear overview at any one time of the Guinea project with regard to the project's development impact, its true total costs, and considerations of cost effectiveness and efficiencies regarding project implementation. The Mission is the logical place to look for leadership in this regard.

Donor coordination is another important aspect of the ACSI-CCCD project management. While no formal mechanism exists to date for donor coordination, considerable efforts have taken place. The GOG has taken the lead in two significant respects. First, a technical committee of the MOH holds meetings that deal with matters of planning and implementation of the various donor supported projects. Donors are represented on the committee. In the case of the United States, the ACSI-CCCD TO attends; representatives from the Mission do not.

Second, the government is planning to hold a conference under the aegis of the consultative group of active donors or those interested in supporting Guinea's health development effort. The purpose of this conference, which is to be held at the end of 1989 or early in 1990 and which parallels a similar subgroup of donors in agricultural development, is to serve as the forum in which the GOG will unveil its plans for health sector development in the post-1991 period. The GOG planning document is currently in preparation and will be available within a few months.

Regarding project operations, the ACSI-CCCD project has been able to keep in effective touch with other donors, in particular UNICEF but also with the World Bank, WHO, and the ADB. An important purpose of this contact has been mutual assistance to help solve problems encountered in donors' respective projects. In the case of ACSI-CCCD, three main topics of this effort have been to compensate for the delayed commodity procurement, to coordinate training activities and logistics, and to overcome shortages of funds. Also, by sharing and

ernately funding the services of an exceptionally able and operational consultant (Harry Odfrey), both UNICEF and ACSI-CCCD have been able to profit from many productive visits to Guinea. UNICEF and USAID also keep each other informed on project matters; for instance, the results of a recent UNICEF evaluation were shared with the team and this valuation will be made available to UNICEF.

onor coordination, while largely internal, is adequate and has furthered accomplishment of project objectives.

CONCLUSIONS

The ACSI-CCCD project currently provides services for the three project interventions. There is an acceptable basic organization in place and decentralization provides the means for strengthening the system at the prefectural and local levels. Given the paucity of human resources available to them, the prefectural health directors in the up-country prefectures are doing a very creditable job. The project is now in a position to put heavy emphasis on strengthening the system's management, information, and other support functions and to perfect an outreach system to ensure wider utilization of services. With approval of decentralization, the ACSI-CCCD project can sustain and extend coverage and benefits by helping put into place a more effective prefectural level management system with the requisite ability to provide support services. The new arrangements will reduce the heavy comprehensive training and supervision activities and provide an initial capability for data analysis to strengthen program management. Possibly, GOG will consider accelerating absorption of more centers in Kindia and Telimele as CCCD succeeds in helping build capacity in those prefectures, and enables the GOG to expand its vaccination coverage at a faster rate than it is able to expand its national program.

3. RECOMMENDATIONS

The following recommendations are made with regard to ACSI-CCCD project management:

- That, with the delegation of authority to the prefectures under the decentralization decree, the ACSI-CCCD project should put particular emphasis on helping create an informed and task-oriented staff with development of organizational charts, job descriptions, and a program of in-service and on-the-job training.
- That the three supervisors currently assigned to the ACSI-CCCD Coordinator's office in Conakry be assigned to help cover supervision of Kindia and Telimele, when the respective prefectural health officers are on an outside assignment, to ensure continuous coverage, at least until the expanded prefectural health structure is in place.
- That USAID, together with the ACSI-CCCD TO and Coordinator explore the possibility of phasing a greater number of CCCD health centers into the national EPI/PHC system thereby applying national standards and practices, including the cost recovery system under community management, to more project health centers.
- That consideration be given to modifications in ACSI-CCCD project management by A.I.D. and CDC. Specifically:
 - Modification of Mission staffing with the addition of an officer informed in health matters and possessing strong planning and management skills, either as a direct hire or contractor. Until such a position is established, provide temporary assistance, possibly from the Regional Health Officer,

REDSO/Abijan from A.I.D./Washington, or under contract. This person should work with the Mission Director and GDO in the interval before a health officer position is established and filled. Concurrently, Bureau for Africa, A.I.D./Washington (A.I.D./AFR) should endeavor to accelerate the arrival of the General Development Officer assigned to Conakry, thereby reducing the currently foreseen 10-month hiatus in Mission staffing and attention to ACSI-CCCD project implementation matters.

- Increased contact by the Mission with the project to collect and analyze data with regard to dollar costs (from all sources, bilateral and regional) and local costs. This will enable it to monitor more effectively the project costs and to make informed judgments on the extent and quality of host country compliance with project provisions for local cost support, thus strengthening Mission interventions with the GOG to resolve the counterpart allocation problem.
- Initiation of a Mission assessment if necessary with temporary assistance as recommended above, to include local program operations, past and future consultant needs, and project administration to permit an independent Mission judgment on project strengths and weaknesses.
- Consideration by CDC of the addition of an Associate TO resident in Guinea to provide greater continuity, administrative depth, and more effective development of Guinean institutional capacity to profit from substantive consultancies.
- Selection and hiring of the agreed-upon Project Administrative Assistant for the ACSI-CCCD project as soon as the project agreement amendment is signed. This process should seek out an individual in the requisite broad skills and should be by mutual agreement between the TO and the Mission.

VIII. FINDINGS AND RECOMMENDATIONS ABOUT PROJECT FINANCING

DISCUSSION

The GOG continues to be in a very difficult financial position, subject to the pressures of inflation and the absolute priority of supporting economic restructuring activities. Except for salaries and some in-kind contributions, the Government's ACSI-CCCD contributions come from counterpart funds generated by U.S. aid programs. As part of putting its economic affairs in better order, the Government has recently undertaken a major budget reform by formulating a more comprehensive national budget and by endeavoring to obtain more effective control of expenditures. Unfortunately, this very worthwhile objective has complicated rather than facilitated the smooth and timely availability of funds to the ACSI-CCCD project.

The evaluation team was not able to reliably determine the actual GOG contribution to the project. According to the financial plan provided with the project agreement amendment now awaiting signatures, actual disbursement of the GOG contribution as of July 31, 1988, was \$173,800 (including \$114,000 in non-counterpart regular GOG revenues for payment of MOH salaries). This is in contrast with the Government contribution of \$650,000 (\$190,000 in counterpart fund and the remainder from GOG regular budget sources or in kind) provided for in the original project agreement and the figure of \$354,844 cited by the 1987 Evaluation as "the total GOG cash contribution as of May 1987." Appendix VII contains more project financial data. The GOG Public Investment budget carries a line item No. 4105 for the project but it is impossible to predict actual support levels since only the current year's figure is shown, rather than figures for the out years.

It has been standard practice for the amounts actually made available by the Ministry of Finance to the ACSI-CCCD project each year to be substantially lower than the amounts allocated in the budget. Occasionally, however, such as in the case of construction of a new building for the project, the allotment made has not been used and has been carried forward to the next year. Funds are made available only after the annual budget is approved, usually some four to six months after the beginning of the year, and are blocked when work begins on the next year's budget in the Fall. Thus, there is a very narrow period of access to the funds during each year.

Ironically, the decision to fund the Government's contribution to the project from counterpart funds generated by U.S. programs has made the process even more complex as lengthy delays occur in joint programming by the Government and USAID. Since the beginning of the project, delays in availability and shortfalls in allocation of budgeted amounts have been chronic and have tended to retard project progress. However, the situation seems worse than usual this year as no joint programming agreement has yet been concluded between USAID and the Ministry of Plan despite repeated USAID approaches and approval of the budget by the Ministry of Finance. The Mission has generally relied on the Food-for-Peace Officer to handle the contacts to obtain counterpart releases. The evaluation team believes that a higher level approach is called for, certainly by the Mission Director.

Thus, none of the planned GOG contributions for 1989 have been released and consequently some project employees have not been paid since January of this year. In addition, training scheduled for 1989 has largely had to be deferred or switched to other donors and vehicle and equipment spare parts are lacking. The project Coordinator and the TO both have had to deflect attention from their normal duties to devote much time to finding extraordinary means to permit the project to move ahead, utilizing a combination of formal and informal budget advances, borrowing of funds and equipment from other projects, and obtaining some funding with dollars from the suballotment, and various other means. The team noted that

the TO has on various occasions lent his personal funds for project use and that the Guinean-national Administrative Assistant currently is owed the equivalent of \$800 by the project.

It must be emphasized that the funding difficulties encountered by the project are hardly unique; they are of universal concern among donors and project managers.

The team noted that the 1987 evaluation referred to government efforts to find a workable solution and that the report had proposed that a 50% advance on annual allocations be made a requisite for project extension. At the suggestion of the Mission that such a Condition Precedent (CP) was unrealistic, this was not done. However, the Mission did not devise an alternate strategy to extract the funds and continues to believe that attempts to tie up dollar releases will not be successful since the leverage exerted by delays in dollar releases is not sufficient to obtain GOG cooperation.

During the course of this evaluation, the Director of Public Investment at the Ministry of Plan indicated that a new allocation system providing for wider use of budget allowances against post audit rather than exhaustive a priori justification was being finalized. The system should be in place within three months, barring any delay caused by the change in Ministers.

2. CONCLUSIONS

Whatever the reasons, the pattern of reduction of budget availabilities, the chronic lengthy delays in obtaining project funds, and the failure to resolve these problems over time has hindered project implementation and management and has served to adversely affect the GOG commitment. Since the problem affects the U.S. program across the board, a solution must be sought in the context of the overall program rather than for the CCCD project alone. If the Mission is indeed correct that withholding of dollar funds is not sufficient leverage to obtain action on counterpart releases -- for this project or any other approved activity -- it is obviously necessary to take a close look at the entire premise of the U.S. aid program in Guinea.

To make the representations for counterpart programming and allocations more meaningful and effective, it is urgent for both the Mission and the GOG to have a more complete and accurate understanding of the financial needs of the project beyond the national figures included in the PROAG Amendment.

3. RECOMMENDATIONS

The following recommendations are made with regard to project financing:

- That the Mission, preferably in consultation with other affected donors, tie the release of dollar funding to prompt programming and release of counterpart according to a schedule of payments that corresponds to Ministry of Finance timing for funding releases. If the "window" is only open for six months per year, releases must be scheduled 100% during that time with an initial tranche of at least 30%. Such a provision should be the subject of a CP prior to disbursement of further dollar funds for the ACSI-CCCD project and any other U.S. funded activity in Guinea. Alternatively, the Mission must seek clarification from A.I.D./Washington concerning the rationale, consistency, and integrity of its entire program in Guinea, and not focus simply on the vagaries associated with this project.
- That the Mission under the direction of the Controller and Program Officer as appropriate: (1) undertake, possibly with temporary duty assistance, a careful investigation of available records at the ACSI-CCCD project and the Ministries of Plan and Finance to ascertain an accurate picture of the GOG contributions;

(2) recalculate, together with the above GOG parties, a reasonable level of GOG support to the project; and (3) negotiate an agreement to confirm this level of support, both in financial and material terms for the remaining life of the project after signature of the pending project agreement amendment.

IX. FINDINGS AND RECOMMENDATIONS ABOUT SUSTAINABILITY

1. DISCUSSION

The health care financing policy endorsed by the GOG is among the strongest factors supporting the sustainability of ACSI-CCCD activities in Guinea. The principles of this policy include government payment of salaries of health workers, payment by the beneficiaries of all other operating costs of the system, and the use of receipts from curative services to pay the costs of preventive care. These approaches to addressing recurrent costs and incorporation of cost recovery place Guinea ahead of most African countries in the development of a sustainable health care system. In the opinion of UNICEF officials, Guinea is considered to be ahead of other African countries in implementing the Bamako initiative.

A budgeting system for local health centers has been introduced in two of Guinea's four regions on a pilot basis. Detailed but easy to understand instructions and cost guidelines have been issued to enable health center directors to calculate replacement costs of vaccines, medicines and supplies, fuel for vehicles and refrigerators, vaccination cards, and other expenses and to compare these costs with earnings from services. A system of community participation through an elected management committee has been incorporated. Members of the committees in two prefectures displayed impressive knowledge and interest. A system of modest salary supplements of health center directors and medical personnel has been introduced to be financed from receipts.

Charges for services are being levied at the 100 health centers that are part of the national primary health care system, including the four ACSI-CCCD centers in Kindia and Telemele. A schedule of fees has been prepared and charges are collected and carefully recorded in semi-monthly ledgers that show receipts by type of service. Receipts are turned over to the locally elected Health Center Management Committee, which is responsible for depositing the money into a bank account, except for authorized monthly salary supplements and a small amount for routine minor expenses, which the center may pay for directly. The MOH is aware that early action must be taken to put in place a system for withdrawing deposited funds from the accounts to pay for costs of materials and center expenses since inflation is fast reducing the purchasing power of the amounts collected. A working group has just completed a series of recommendations for orderly, supervised releases but this was not available to the evaluation team. The ordinary ACSI-CCCD-supported centers have not instituted this system.

The importance of supervision in the sustainability of services has been well recognized by the project. Supervisory visits scheduled within a month of launching health centers in Telimele, for example, found fee collection and record-keeping in good order, while delays in supervision of the Kindia health centers were associated with the discovery that the system was improperly maintained in nearly half of the centers (Godfrey, 1989).

Experience to date has shown that some of the national centers have been very successful in covering their costs through fees. The ACSI-CCCD Coordinator mentioned that in Kissidougou (in the Forest Region) the health center was currently earning funds sufficient to cover costs of vaccines, medications plus other expenses, as well as contributing to the amortization of the refrigerators and motorcycles. Other centers have done far less well.

By decree of the Minister of Health, the ACSI-CCCD project health centers have also been authorized to collect fees for vaccination cards and ORS packets in the up-country prefectures. In Conakry, a system of higher charges has recently been introduced in selected health centers, a first step in tackling the special difficulties of providing improved health administration and care in the capital city.

In addition, a Government committee is exploring the possibility of generating revenue from non-health related activities. A fee for well use is one proposal under consideration. The ACSI-CCCD Coordinator claimed that the recent cost recovery study supported by A.I.D. provided key impetus to GOG efforts in this area.

Financial well-being of individual health centers and the system as a whole is closely linked to the need to increase coverage. The evaluation team was concerned about the relatively limited geographic coverage of the centers and the incidence of non-use by mothers living in reasonably close proximity. In the ACSI-CCCD area the late arrival of motorcycles has inhibited the undertaking of outreach activities. That would address utilization problems.

The evaluation team's rating of sustainability indications contained in the draft ACSI-CCCD sustainability strategy have been under consideration in A.I.D. since August 1988 and is provided in Appendix VIII.

2. CONCLUSIONS

The Government has made significant strides in the initial development of a cost recovery strategy and a related system of local health budgets. Extending coverage of health center services and health information to a greater proportion of the population, including those living some distance from centers, will be a key element needed to ensure success of the program. In the next two years, the ACSI-CCCD project would be strengthened by the adoption of the national system in its own centers and thus would contribute to a more rapid spread of sound budgeting and cost recovery techniques. As ACSI-CCCD centers are also designated as National EPI/PHC centers, the national cost recovery system will automatically be applied. ACSI-CCCD can also serve as a training area for the budgeting exercise and address the question of differentials in earning capacity of centers.

3. RECOMMENDATIONS

- It is recommended that GOG continue and expand its approach to cost recovery and sustainability. Specific approaches include:
 - Initiate user fees equivalent to the national program scale in all ACSI-CCCD centers in Kindia and Telimele. Institute the budget procedure, with training and supervision to be provided by project personnel. Integrate the ACSI-CCCD Centers into the national system as soon as feasible.
 - Give priority concern to initiating operations research regarding social marketing and strengthening the system of incentives to broaden health care coverage.
 - Assess the feasibility of more widespread reliance on private pharmacies for distribution, through sales, of ORS packets and chloroquine, and undertake selective trials.

X. FINDINGS AND RECOMMENDATIONS ABOUT INFORMATION SYSTEMS

DISCUSSION

comprehensive surveillance system for 20 priority diseases, initially designed by ACSI-CCCD, has been adapted for use by the Studies, Planning, and Research Bureau (BEPR) of the MOH. The ADB has provided assistance to develop BEPR capacity to enter and analyze the data provided by this National Health Information System (SNIS). UNICEF is supporting the implementation of the system at the health center level. Approximately 100 centers are already using the SNIS system.

API and malaria treatment information for the ACSI-CCCD project is managed at SNIS, while the system for monitoring diarrheal disease interventions developed by the ACSI-CCCD project which includes information regarding severity of dehydration and numbers of ORS packets (used) has been managed by ACSI-CCCD project staff. A special form for diagnosis and clinical management of diarrheal disease in ACSI-CCCD-supported health centers was distributed in the last quarter of 1988. Thus, one year's data will soon be available.

The quantifiable objectives promoted for use by CCCD projects are frequently too difficult to measure accurately. The project has not been able to document progress toward the objectives which are stated in terms of morbidity and mortality reductions (McKeown, 1989). The immunization coverage objective of 80% by 1991 has been considered unrealistic, and progress toward the tetanus toxoid coverage objective (60% by 1991) has been impossible to document due to the lack of home-held vaccination records for women of child-bearing age.

Calculating coverage based on doses delivered and population estimates has been suggested as a method to evaluate program effectiveness. Pitfalls of this method where population size cannot be accurately ascertained are illustrated by the measles coverage estimate of 106% for Conakry in 1988 (compared to survey data of 86% after the campaign in 1987, and 25% in 1989). A portion of the error may, however, be due to inaccurate reporting of ages of children vaccinated (Godfrey, 1989).

The objectives for "effective case management" at health centers for diarrhea and malaria are quite measurable, although no clear criteria have been established to reduce inter-observer variation in the assessment of "effective" case management. Similarly, for "appropriate case management" at the community level there is no clear operational definition of what may be "appropriate".

Data collection efforts by the project have been frequent, although mostly designed and conducted by consultants rather than by project staff in-country. Due perhaps to the multiple special interests encountered in using a series of consultants, data collection efforts have frequently failed to address project data needs for evaluation, and have produced data that are not comparable. Existing data, such as those available in Conakry hospitals, have not been exploited by project staff for monitoring and evaluation.

The SNIS has been hampered by a lack of adequate personnel trained in epidemiology, statistics, and computer analysis, as well as by shortages in hardware and software for data entry and analysis. Although the progress made by the SNIS is encouraging, these obstacles must be addressed to prevent the wasteful underutilization of already available data.

2. CONCLUSIONS

The SNIS, developed by the GOG with ACSI-CCCD project support, holds promise of becoming a powerful tool for improving management in the health sector. The opportunity to encourage this development may be lost, however, if central and peripheral capacity for the analysis, presentation, and use of this information is not promptly strengthened.

Morbidity and mortality data have a limited role in the evaluation of the ACSI-CCCD project, especially when coverage with program interventions remains at low levels. Establishing and improving disease surveillance systems should not be neglected. However, trends due to program interventions may be reflected by such systems only after several years. Meanwhile, coverage data will provide the most useful indicator of project effectiveness.

It is also necessary to establish clear operational definitions of "appropriate" care in the community and "effective" case management in the home if these are to remain the objectives for malaria and diarrheal disease interventions. (Instruments and criteria for these indicators should be the same for baseline and follow-up measures. WHO/CDD has created instruments and quantitative criteria for assessment of effective case management at the health center level which may be adapted for project use.)

3. RECOMMENDATIONS

The following recommendations are made with regard to information systems:

- Reassess the plan for project monitoring and evaluation outlined in the PROAG Extension, retaining morbidity and mortality reductions as project goals, stating quantifiable objectives (e.g. coverage objectives for project interventions), and clarifying outputs as measures that can be easily obtained from routine project records.
- Use ACSI-CCCD project resources to strengthen central as well as peripheral GOG capabilities for analysis and use of the data for management, including provision of epidemiologic expertise, improving presentation of data for use in policy and programming, and by strengthening feedback to regional, prefectural, and health center levels.

XI. FINDINGS AND CONCLUSIONS ABOUT OPERATIONS RESEARCH

1. DISCUSSION

CCCD has worked to develop capacity for operations research (OR) in the MOH, primarily through a seminar on OR co-sponsored with IDRC in May, 1989. A total of 43 persons attended from the MOH and other institutions and agencies with a potential interest in OR. Additional plans are being developed for a more in-depth review of OR techniques in November, 1990.

The research section of Studies, Planning and Research Bureau (BEPR) contains plans to develop a program to encourage institutions and researchers, provide technical consultation (including that for the development and review of protocols), assist in identifying sources of financial support, and assure the diffusion and application of the results.

The BEPR has no budget for OR, and the funds that were available were exhausted in cosponsoring the seminar. The seminar provided a brief review of basic research methods, rather than exploring research techniques directed to solve management or operational problems. \$4,000 is included in the PROAG Amendment for OR.

Although several projects are listed as OR activities in project reports, no clearly "operational" research has been conducted by the ACSI-CCCD project using the OR budget. The project reports cite the lack of proposals submitted as the reason for the lack of activity in the OR component of the project. Yet there have been no procedures established for identifying operational problems to be addressed by such decision-oriented research.

Two projects occasionally cited as "OR" were conducted under the supervision of the ACSI-CCCD Regional Epidemiologist, rather than the resident TO. Both these studies were hospital-based and conducted by students with no clear link to decision-making for either ACSI-CCCD project management or MOH policy or program planning.

2. CONCLUSIONS

The OR component of the project has not been exploited to solve ACSI-CCCD operational problems and build Guinean capacity for management problem-solving. Yet, the OR component represents a major opportunity for this sub-national project to be used as a model or proving ground for assessing solutions to problems in national health policy or planning, and to improve national capacity for management in the health sector.

3. RECOMMENDATIONS

The following recommendations is made with regard to OR:

- Develop the OR component of the ACSI-CCCD project by systematically identifying operational problems which may be addressed by ACSI-CCCD-funded OR projects. Examples are: testing health education messages; exploring various incentives for health workers and others aimed to achieve broader coverage of the population; and cost-benefit analysis. Consider encouraging the development of BEPR by requesting that protocols be reviewed and funding awarded through BEPR mechanisms. If necessary, raise the amount available for OR above the \$4,000 budgeted.

XII. FINDINGS AND RECOMMENDATIONS ABOUT CCCD AS AN INSTRUMENT OF U.S. POLICY

1. DISCUSSION

This evaluation comes at an opportune time for both the Mission and the GOG. Work is beginning on a new Country Development Strategy Statement (CDSS) for the Mission while the Government is facing the scheduled end of a number of donors' major health projects in 1991. The Government is currently quite far along with preparation of a plan for public health development beyond 1991 and expects to publish its document shortly, prior to seeking a donor-wide conference at year end or early 1990.

The ACSI-CCCD project poses some interesting challenges to the U.S. with regard to its aid policies toward Guinea. The Mission's conceptual dilemma is that the project seems to lie outside its interim strategy of support for economic restructuring. Mission staffing constraints prevent it from giving the project the detailed attention it should have, both in conceptual terms and with respect to operational matters. An example of this is the continuing near-stalemate regarding counterpart allocations and the Mission's unfamiliarity with key aspects of project implementation, in particular the part financed with Africa Regional funds. Neither is the Mission at present adequately equipped to address in depth the larger issue of Guinean health development in the near term or the period beyond 1991.

Yet, as the Mission Director points out, the project is a distinct asset in the portfolio despite its status: it enables USAID to gain insights into how the GOG works, especially regarding financial and administrative support. It is appreciated by the Guineans and, moreover, the U.S. is able to show some concrete results in welcome contrast to a number of terminated activities. The evaluation team agrees with this assessment and considers the project a wise investment of A.I.D. funds.

The policy initiatives undertaken by the GOG with respect to integration of health services and cost recovery pursuant to the Bamako Initiative strongly correspond with U.S. policy interests world-wide. Development of a largely self-sustaining health service in Guinea will help reduce budgetary strains and foster the cause of economic reform while offering solid hope of eventual sustainability. Being the sponsor of the ACSI-CCCD project should assure the U.S. an opportunity for participation in the forthcoming dialogue as a potential major voice in the direction of sustainability. Concurrently, we might also help dampen possible temptation toward premature reductions in Government health expenditures as a result of unrealistic expectations regarding self-sufficiency achievement.

Accordingly, the evaluation team believes that the ACSI-CCCD project is consistent with the Mission's current strategy and the Agency's policy concerns. However, to play an effective role in this process, the Mission must be able to make an appropriate effort at both the technical and managerial level, and have the capacity and will to intervene in a coordinated way at sufficiently high levels in Guinea and with donors. To do this, Mission personnel must become more conversant with the issues and problems associated with the task of putting an effective health care program in place in Guinea. On its side, the GOG must show the will to resolve once and for all the dilemma of adequate and timely financial support of the project.

With \$1.5 million of bilateral funds and substantial regional funds invested in the ACSI-CCCD project through 1991, it would be unfortunate if the U.S. were to terminate its role while useful things remain to be done through the project. However, the staffing dilemma on the U.S. side and the funding problem on the GOG side require resolution if the effort is to have a prospect of success. If these problems cannot be resolved, it seems appropriate to leave the field to other donors.

With the ACSI-CCCD project, the U.S. became the first major donor in the primary health care field in Guinea. With several other large donors now on the scene, the U.S. role could usefully change to strengthen the support elements of the system while redoubling efforts to promote ORT. Success of the cost recovery campaign will also open the door to possible commercial or other non-project procurement of equipment and commodities.

These considerations also must be addressed as A.I.D. approaches the task of the design of the entire Africa-wide ACSI-CCCD project. The evaluation team believes that there is little if any exchange of information and experience among Missions and considers it essential that greater interaction take place with regard to policy, design, and operational issues.

2. RECOMMENDATIONS

- That A.I.D. take a firm position with regard to continued support of the ACSI-CCCD project based on the resolution of outstanding and debilitating problems. Specifically long-term health assistance to Guinea through a ACSI-CCCD project extension should not be provided unless: (1) adequate staff is available at the Mission in Conakry; and (2) acceptable financial resources are furnished by the GOG in a timely manner.
- If A.I.D. does support a project extension this should stress health education, training, health information systems (HIS), and management assistance to strengthen the national system while sharply curtailing commodity procurement.

APPENDICES

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APPENDIX I
 BASIC POPULATION, HEALTH AND NUTRITION INDICATORS
 FOR GUINEA

Area (sq. Km)	245,900
Mid-1985 population (in millions)	6.331
Average annual population growth rate (%)	
1960 - 70	1.5
1970 - 82	2.0
1982 - 88	2.8
Population density per Km ²	25.7
Urban Population, 1988	22.0
Population aged 0-14 (%), 1988	43.0
Total fertility rate	6.0
Crude birth rate per thousand, 1988	50.0
Crude death rate per thousand, 1988	24.0
Life expectancy at birth, 1988	40.0
Infant mortality rate per thousand, 1988	53.0
Child death rate per thousand, 1988 (age 1-4)	34.0
Adult literacy rate, 1980 (%)	20.0
Enrollment (%) in Primary school, 1988	32.0
Secondary school, 1988	13.0
Population with access to safe water 1988 (%)	20.0
Annual growth in labor force, avg. for 1980-2000	3.2
Population per physician, 1988	8,100
Population per nursing person, 1988	6,200
Daily per capita calorie supply as percentage of requirement, 1988	82.4
GNP per capita U.S. dollars, 1988	340.0
Average annual growth rate, 1987-88	5.8
MHSA BUDGET AS % of National Budget: (Personnel =37%	1.7
Pharmaceutical = 45% and other 23%	

*Source:

(1) World Bank Report N. P-4805-GUI, May 24, 1988 and concerning recommendations for a second structural adjustment program for Guinea.

(2) GOG Documents as reviewed and extrapolated by USAID/Conakry

APPENDIX II

STATEMENT OF WORK

ACSI-CCCD 1989 EXTERNAL EVALUATIONS

BACKGROUND

Evaluation of the Africa Child Survival Initiative - Combatting Childhood Communicable Diseases (ACSI-CCCD) project will be conducted this year in four African countries: Guinea, Togo, Burundi and Malawi. Scheduling for each country is critical in that itineraries must coincide with availability and accessibility of country officials.

OBJECTIVE

To evaluate the accomplishments of four ACSI-CCCD Projects and to compare each's accomplishments against the objectives specified in the project agreements; to identify problems which have resulted in failed objectives; and to prepare recommendations for their amelioration.

STATEMENT OF WORK

A. The contractor shall select four teams to evaluate the ACSI-CCCD projects in Guinea, Togo, Burundi and Malawi. Evaluations shall measure the extent to which ACSI-CCCD activities have met country objectives and, been integrated into the existing primary health care structure. Evaluations shall include recommendations to improve the quality of ACSI-CCCD services (including operational research, training, health education and health information systems development), to increase delivery of services and to facilitate their integration into the primary health care delivery system. Specifically, teams shall review and report the following:

1. Management and Support: a) the development of plans of operation and the adequacy of those plans to guide and support field activities, b) the capacity of government structures to manage and administer programs for immunization, ORT and malaria treatment, c) the adequacy of A.I.D. and CDC administration and project support and d) the presence of the country project management structure and its functions with particular emphasis on its capacity to sustain project activities and benefits once A.I.D. assistance has ended.

2. Program Operations: status of current delivery system used to deliver PHC services including CCCD services, (supervision, personnel, communications, supply and logistics, and management of funds and supplies).

3. Information Systems: a) availability of a management information system and its data (regarding supervision, logistics, supplies and financing) that enables decision makers to manage and to monitor the delivery of health services, and b) the adequacy of information systems to provide data necessary to determining project impact, (specifically if the project had an influence in lowering morbidity and mortality).

4. EPI Program Components: a) the establishment of and adherence to immunization policies and schedules, b) immunization coverage and quality of immunization practices such as, sterilization of injection equipment, immunization of ill children, frequency of immunization sessions at clinics, and provision of immunizations at times other than during immunization sessions.

5. Diarrheal Disease Control Program Components: a) the establishment of and adherence to diarrheal disease policy, b) access to ORT, c) case management of diarrheal diseases in facilities and homes, d) quality of treatment practices including adequacy and frequency of use of ORT and other rehydration practices.

6. Malaria Control Program: a) the establishment of and adherence to national malaria treatment policies, b) quality of case management of fevers in facilities and homes, c) availability of chloroquine, and second line antimalarial drugs, d) quality and availability of laboratory services.

7. Training: a) types and magnitude of training provided, b) amount and appropriateness of training materials developed, c) numbers and types of personnel trained and evaluation of their performance, d) training plan for remainder of project life, e) institutionalization of training activities (preservice and in - service), and national, regional and local training policies and plans and their appropriateness.

8. Health Education: a) health education structure, plans and activities to date, b) staffing and institutional capacity for delivering health education services, c) type of health education provided and evaluation data for behavior change, d) adequacy of technical assistance provided (including Peace Corps assistance) to health education activities, and e) adequacy of public information and community education.

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9. Financing: a) amount and sources of funding for current program activities, b) efficiency and responsiveness of budgeting and funding process, c) extent and effectiveness of autofinancing systems, and d) government's ability to finance recurrent project costs in 1989 and 90, and future financing of recurrent costs.

10. Sustainability: a) existence of a country specific sustainability strategy, b) status of strategy indicators reflecting progress achieved in sustainable child survival programs, (use attached strategy and indicators if country specific strategy does not exist), and existence and effectiveness of donor coordination.

- B. Three-person evaluation teams for each country will be required to incorporate the necessary professional skills in a) management and health finance, b) epidemiology, c) childhood communicable diseases, d) health education and training, and e) health information systems.
- C. Evaluation teams shall review the ACSI-CCCD project paper, the ACSI-CCCD project grant agreements, extension designs, recommendations of previous evaluations, and associated reports regarding ACSI-CCCD project performance.

Additionally, teams will:

- 1. Interview national program officials, field ACSI-CCCD and USAID staff, and other donors active in health.
- 2. Make field visits to observe program implementation.
- 3. Study relevant country reference documents at central and regional levels.
- 4. Review survey, surveillance, and health information system data.

REPORTS

- A. A draft report shall be prepared in 10 copies two working days prior to departure from country. Report length should be no longer than 50 pages (both sides) and include no more than 20 recommendations. Report shall include an executive summary. For the francophone countries, the executive summary will be written in French.

- B. 20 copies of the final country report will be prepared and submitted within three weeks after completion of country visit. French language (as well as English) will be submitted to Togo, Burundi and Guinea.

TECHNICAL DIRECTIONS

Technical Direction during the performance of this delivery order will be provided by the respective Missions via telex and when necessary, by AFR/TR/HPN. Missions will be responsible for reviewing and selecting team members with concurrence provided by AFR/TR/HPN.

APPENDIX III

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APPENDIX IV

LIST OF PERSONS CONTACTED

MINISTRY OF HEALTH AND SOCIAL AFFAIRS

Dr. Fofona	Minister
Mamadou Pathé Diallo	Minister until June, 30, 1989
Kandioura Dramé	National Coordinator EPI/SSP/ME
Boubacar Deing	National Director of EPI
Alpha Telli Diallo	Director BEPR
Souleymane Diallo	Coordinator ACSI-CCCD Program and Diarrheal Disease Control Program Director
Antonette Helal	Assistant CCCD Coordinator
Mrs. Diaby	Administrative Assistant
Mr. Kandas	Accountant
Moussa Kéita	National Malaria Director
Fatoumata Binta Diallo	Chief Operations Research
Kabiné Souaré	Director, Essential Medicines Program
Fatou Barry	Pharmacist, Essential Medicines Program
Adama G. Dia	Chief Epidemiology and Statistics in PEV/SSP/ME
Fassou Haba	Director Health Education
Sylla Mariétou	Health Educator
Wann Fatoumata	Health Educator
Bah Aissatou Mourou Baldé	Health Educator
Tamba Solo	Health Educator

CONAKRY

Johanna Austin	Prefectural Health Director
Dr. Camille	Director Boulbinet Health Center
Adama Conté	Health Worker, Boulbinet Health Center
Abdoulaye Bah	Health Worker, Boulbinet Health Center
Doumbouya Kadiatou	Health Worker, Boulbinet Health Center
Zenabou Diallo	Director, Madina Health Center
Fatoumata Camara	Health Worker, Madina Health Center
Mariam Condé	Health Worker, Madina Health Center
Saliou Bella Diallo	Assistant Medical Director, Pediatrics, Donka Hospital

KINDIA PREFECTURE

Lucien Prosper Haba	Inspector General Middle Guinea Region
Mamadou Malal Diallo	Director, Kindia Health Center
Hassimou Thiaye	Vice-President, Kenda Health Center
Gnatta Camara	Midwife, Kindia Health Center
Aye Touré	Nurse, Kindia Health Center
Mr. Nyabaly	Director, Friguiabge Health Center
A. Benia	Health Worker, Friguiabge Health Center
M. Barry	Director, Songneta Health Center

TELIMELE PREFECTURE

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Ahmadou Baldé
Georges Abouasse
El Hadj Garanké
Bah Ibrahimama
Zozo Sakou
Ibrahima Sory Souaré
Mohamed Kéita
Alimou Diallo
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Adama Sako
Younoussa Baldé
Mamadou Cissé

Prefect
Prefectural Health Director
Sous prefect, Sinta
Treasurer, Sinta Health Center
Assistant subprefect Sinta
Health Technician Sinta Health Center
Director, Telimele Health Center
Treasurer
Director, Gougoudje Health Center
Nurse, Gougoudje Health Center
Chief, Sarekaly Health Center
Health Worker, Sarekaly Health Center
Nurse, Sarekaly Health Center

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APPENDIX V

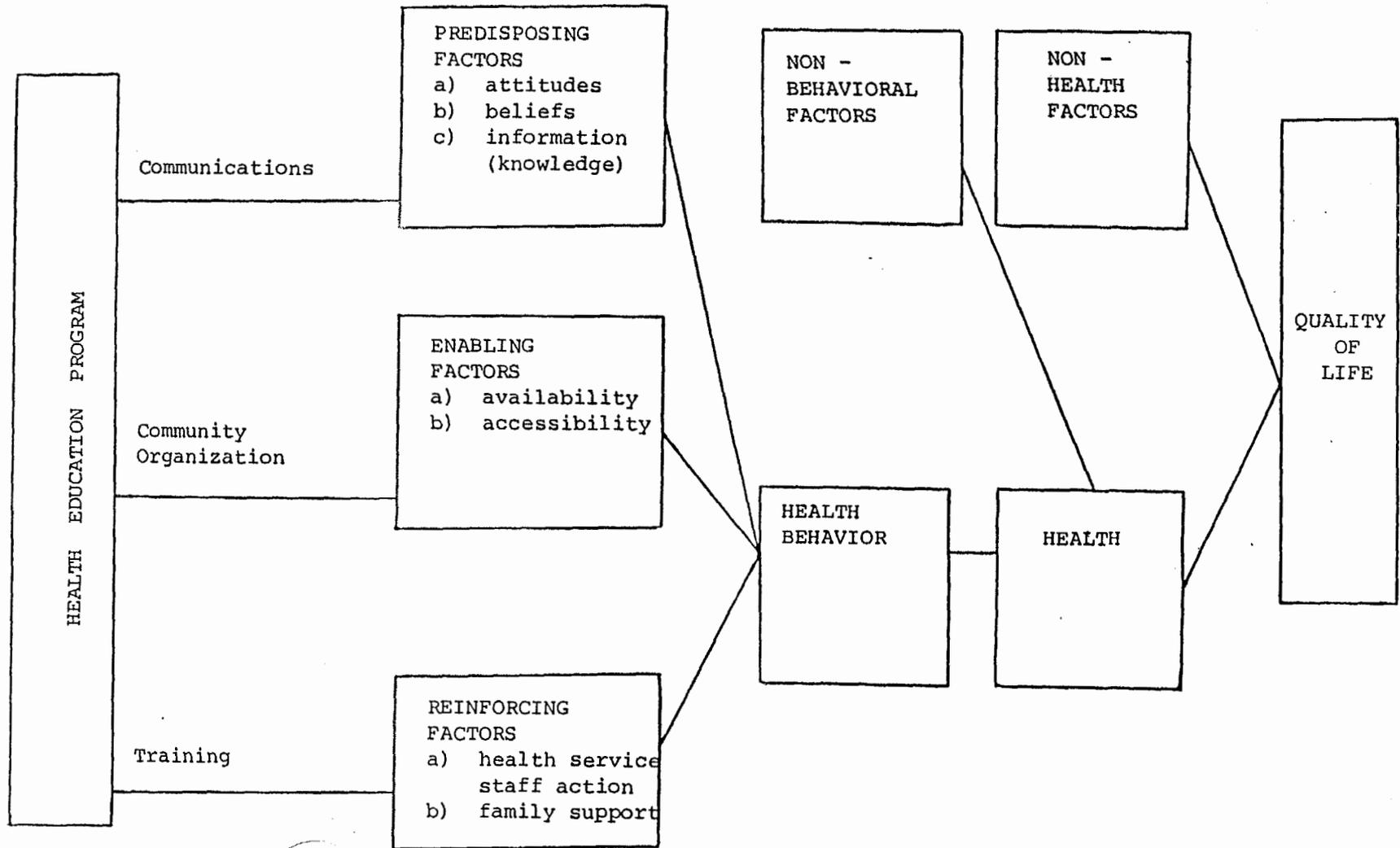
EVALUATION SURVEY:
SUMMARY OF RESULTS OF HEALTH CENTER AND HOME VISITS

<u>Health Centers</u>	<u>Number Yes</u>	<u>N</u>
Daily immunization services	9	10
Daily ORT services	9	9
Daily malaria treatment/prophylaxis	8	10
Adequate supplies of medications	8	10
No expired medications	10	10
History of breaks in stock (medications or commodities)	6	10
Refrigerator temperature recorded (twice per day over past 2 weeks)	9	10
Adequate record-keeping (to track commodities sold, cases seen)	8	10
Workers supervised within past 2 weeks	12	16
Sterile procedure for immunizations (needles/syringes apparently sterile)	8	10
Immunization education with vaccination (adverse reactions, next dose scheduled)	6	10
Appropriate definition of diarrhea (duration, vomiting, blood in stools)	9	10
Education regarding diarrhea treatment (feeding instructions, dehydration signs)	7	10
Weighing of children with presumptive malaria	9	10
Correct dose given for presumptive malaria	6	8
Education given with malaria treatment (fever control, indication for return)	9	10

<u>Home Visits</u>	<u>Number Yes (%)</u>	<u>N</u>
Children under 3 with vaccination card	40 (73%)	55
Infants (0-12 mos) up to date for age	11 (42%)	26
Children 12-23 mos completely immunized	5 (38%)	13
Children 24-35 mos completely immunized	7 (43%)	16
Children <3 immunized or up to date	23 (42%)	55
Mothers with vaccination card	17 (31%)	55
Mothers with 2 doses of TT documented	17 (31%)	55
Children <3 with diarrhea during past 2 wks	17 (31%)	55
Children with diarrhea treated with ORT	6 (35%)	17
Mothers reporting continued feeding	53 (98%)	54
Children <3 with fever during past 2 wks	29 (53%)	55
Children with fever receiving chloroquine	24 (83%)	29
Children <3 who have ever used health center	48 (87%)	55
Mothers reporting occasional radio listening	31 (61%)	51
Mothers reporting receiving education on:		
diarrhea or ORT	22 (42%)	53
fever or malaria treatment	23 (43%)	53
vaccines or immunizable disease	37 (70%)	53

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APPENDIX VI
HEALTH EDUCATION PLANNING FRAMEWORK



Green et. al., Health Education Planning, A Diagnostic Approach, Mayfield Publishing, Palo Alto, 1980

APPENDIX VII

CCCD Project Financial Data

Table 1. CCCD/Guinea Obligations/Subobligations
(As of 5/31/1989)

Item	Pro Ag 5/22/85	Pro Ag. Revised	Commitments 5/31/89	Disbursement 5/31/89
Vehicles	242,000	333,000	307,035	103,845 1)
Cold Chain	45,000	109,000	66,500	66,371
Office Equipment & Supplies	26,000	60,000	34,957	33,218
Vaccination Supplies	8,000	61,000	28,484	20,920
Health Education Materials	23,000	23,000	5,714	5,714
Training Materials	5,000	5,000	649	649
Operations Research	6,000	6,000	-	-
ORS Packets	210,000	140,000	88,100	16,212
Chloroquine	260,000	93,000	63,000	51,247
Gasoline, Spare Parts	60,000	17,000	10,121	7,924
Health/Center Equipment	0	40,000	40,000	30,951
TOTAL	885,000	805,000	634,464	339,051

Source: Office of Controller, USAID/Conakry

1) Amount will increase sharply as disbursement is recorded for motorcycles received in Guinea in June 1989.

APPENDIX VII

CCCD Project Financial Data

Table 2.

ILLUSTRATIVE FINANCIAL PLAN

(2.) U.S. Government Contribution, Disbursement Plan

BUDGET ELEMENT	ACTIVITY	DISBURSED	P L A N N E D			TOTAL
		AS OF 07/31/88	1989	1990	1991	
1.	Vehicles	\$105,821	\$230,000	\$112,179	- 0 -	448,000
2.	Cold Chain	66,386	49,000	9,614	- 0 -	125,000
3.	Office Equip.	34,994	25,006	- 0 -	- 0 -	60,000
4.	Vaccination Supplies	20,916	30,084	- 0 -	- 0 -	71,000
5.	Health Education	- 0 -	10,000	40,000	- 0 -	50,000
6.	Training/Materials	649	15,351	19,000	10,000	50,000
7.	Operations Research	- 0 -	6,000	4,000	- 0 -	10,000
8.	Oral Rehydration Salts	16,211	195,000	136,789	100,000	448,000
9.	Chloroquine	51,538	59,462	55,000	- 0 -	168,000
10.	Gas/POL/Repairs	4,581	12,419	- 0 -	- 0 -	17,000
11.	Health Center Lab.	32,439	- 0 -	7,561	- 0 -	40,000
12.	Audit Services	- 0 -	- 0 -	20,000	- 0 -	20,000
13.	Admin. assist.	- 0 -	5,000	15,000	10,000	30,000
TOTAL		\$ 333,535	\$ 657,322	\$419,143	\$120,000	\$1,539,00

Source: Project Grant Agreement Amendment

APPENDIX VII

CCCD Project Financial Data

Table 3. ILLUSTRATIVE FINANCIAL PLAN

(1) U.S. GOVERNMENT CONTRIBUTION

BUDGET ELEMENT	ACTIVITY	CURRENT BUDGET	AMENDMENT IN PROCESS	REVISED BUDGET
1.	Vehicles	\$333,000	\$115,000	\$448,000
2.	Cold Chain	107,000	18,000	125,000
3.	Office Equipment	60,000	- 0 -	60,000
4.	Vaccination Supplies	61,000	10,000	71,000
5.	Health Education/Supplies	23,000	27,000	50,000
6.	Training/Materials	5,000	40,000	45,000
7.	Operations Research	6,000	4,000	45,000
8.	Oral Rehydration Salts	14,000	308,000	448,000
9.	Chloroquine	93,000	73,000	116,000
10.	Gas/PDL (*) Repairs	17,000	- 0 -	17,000
11.	Health Center Lab. Equipment	40,000	- 0 -	40,000
12.	Audit Services	- 0 -	20,000	20,000
13.	Administrative Assistant	- 0 -	30,000	30,000
TOTAL		\$885,000	\$645,000	\$1,530,000

N.B. (*) This element is transferred to the GOS Local Currency Budget.

Source: Project Grant Agreement Amendment

APPENDIX VII

CCCD Project Financial Data

Table 4. ILLUSTRATIVE FINANCIAL PLAN

(3.) Grantee Contribution, Local Currency Budget

BUDGET ELEMENT	ACTIVITY	CURRENT BUDGET	CHANGE	REVISED BUDGET
I. INVESTMENT				
1.	Office Building ORT Corner Construction	\$ 80,000	\$ 62,000	\$ 142,000
2.	ORT Unit Supplies	- 0 -	28,000	28,000
3.	Office Equipment Supplies	- 0 -	38,000	38,000
II. RECURRENT COSTS				
4.	Salaries, MOH Civil Servants	220,000(*)	126,000	346,000
5.	Staff Incentive bonus	- 0 -	41,000	41,000
6.	Salaries, Temporary Staff	30,000	-13,000(**)	17,000
7.	In-Country Training	30,000	65,000	95,000
8.	Vehicle Maintenance, Gas/ POL/Parts	140,000	293,000	572,000(**)
9.	Housing, Utilities Peace Corps Assist.	10,000	62,000	72,000
10.	Operations Costs, Tel. Postage, Utilities	140,000	-126,000-(**)	14,000
11.	Handling Storage	- 0 -	8,000 ¹	8,000
12.	Surveys, Studies	- 0 -	66,000	66,000
13.	Vaccination Campaign	- 0 -	32,000	32,000
14.	Inflation, Contingency	- 0 -	71,000	71,000
TOTAL		\$650,000	\$892,000	\$1,542,000

N.B: (*) All GOG contributions are from the GOG/USAID jointly programmed PL 480 Counterpart Fund, with the exception of salaries for MFHP civil personnel.

(**) Funds deleted from Elements No. 6 and 10 are reassigned to Element No. 8

Source: Project Grant Agreement Amendment

APPENDIX VII

CCCD Project Financial Data

Table 5.

LOCAL CURRENCY EXPENDITURES
(Government of Guinea Contribution)
June 1985 - December 1988
(in Guinean Francs)

Line Item	1985	1986	1987	1988	1989 Request 7/11/89
Construction	-	-	-	7,269,900	25,443,950
Office Renovation and Materials	511,415	1,296,185	699,025	4,473,500	5,383,000
Salaries Incentive Bonus	381,990	3,141,040	1,637,500	2,940,000	3,300,000
Fuel and Maintenance	90,000	466,000	10,025,585	19,025,585	27,700,000
ORT Equipment	-	-	728,875	5,392,800	9,016,400
Studies and Training	-	-	4,420,000	5,767,850	11,785,000
Miscellaneous	-	-	-	-	3,911,650
Total	1,983,405	4,903,225	17,510,985	45,356,319	89,000,000

* Figures for 1989 request did not add up to total GF 89 million requested. Amount of request for this item for which documents were available was only GF 6,260,950, leaving GF 22,372,250 unaccounted for.

Rate of Exchange:

\$1 = 25.056 until 1/86

\$1 = 340 as of 12/86

\$1 = 410 as of 3/87

\$1 = 425 as of 5/31/87

\$1 = 460 as of 7/88

\$1 = 515 as of 12/88

\$1 = 595 as of 7/89

Source: CCCD Project records

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APPENDIX VII

CCCD Project Financial Data

Table 6.

ILLUSTRATIVE FINANCIAL PLAN

(4) Grantee Contribution, Disbursement Plan

BUDGET ELEMENT	ACTIVITY	DISBURSED OF 07/31/88	AS P L A N N E D 1988(**)	1989	1990	1991	TOTAL
I. INVESTMENT							
1.	Office Building ORT						
	ORT Corner's const'n	- 0 -	\$118,000	\$ 24,000	- 0 -	- 0 -	\$ 142,000
2.	ORT Unit Supplies	1,800	22,200	4,000	- 0 -	- 0 -	28,000
3.	Office Equipment Supplies	- 0 -	8,000	18,000	6,000	6,000	38,000
II. RECURRENT COSTS							
4.	Salaries, MOH (*) Civil Servants	114,000	55,000	57,000	59,000	61,000	346,000
5.	Staff Incentive bonus	4,000	9,000	9,000	9,000	9,000	41,000
6.	Salaries Temparary Staff	4,200	4,800	5,000	3,000	- 0 -	17,000
7.	In-Country Training	3,600	20,000	30,000	25,000	15,000	95,000
8.	Vehicle Maintenance, Gas/ PDL/Parts	39,000	121,000	150,000	223,000	39,000	572,000
9.	Housing, Utilities Peace Corps Assist.	- 0 -	- 0 -	24,000	24,000	24,000	72,000
10.	Operations Costs, Postage, Utilities*	4,400	4,600	3,000	2,000	- 0 -	14,000
11.	Handling Storage	- 0 -	2,000	3,000	3,000	- 0 -	8,000
12.	Surveys, Studies	- 0 -	6,000	24,000	32,000	4,000	66,000
13.	Vaccination Campaign	1,800	10,000	5,000	10,200	5,000	32,000
14.	Inflation, Contingency	- 0 -	15,400	20,600	25,000	10,000	71,000
TOTAL		\$173,800	\$396,600	\$376,600	\$421,000	\$174,000	\$1542,000

Source: Project Grant Agreement Amendment

(*) GOG contribution from regular revenues and not from jointly programmed PL480 Counterpart Fund

(**) GOG Budget Request for the year 1988 to be disbursed in Calendar Year 1988 and 1989

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APPENDIX VIII

SUSTAINABILITY INDICATORS

<u>Effectiveness of Technical Interventions</u>	<u>GUINEA</u>
Proportion of health workers who correctly assess dehydration status of diarrhea patients AND administer ORS at the correct frequency and quantity (TARGET: 75%)	40% ¹
Proportion of health workers who correctly weigh, take temperature, and administer drugs to malaria patients (TARGET: 75%)	n/a
Proportion of health workers who administer all immunizations with sterile needles and syringes AND tell mothers attending immunization sessions when and where to take their children for the next required immunization (TARGET: 75%)	80% ²
Proportion of health facilities given effective supervision (using a checklist) at least four times in the past year (TARGET: 90%)	100% ³
 <u>National Leadership and Commitment</u>	
Proportion of recommended items in national immunization policy (four items, identification of: target age groups; coverage objectives; disease reduction; vaccine schedules) (TARGET: 100%)	0
Proportion of recommended items in national policy on control of diarrheal diseases (five items: ORT coverage objectives; mortality reduction target; plans for local production and/or importation of ORS; home treatment strategy; community practice targets)	0
Proportion of recommended items in national malaria control policy (four items: mortality reduction targets for facilities; plans for local production and/or importation of chloroquine; home treatment strategy; community practice targets)	0
Proportion of relevant technical and support interventions (CDD, EPI, malaria, health education, operational research, training) for which national coordinators have been identified. (TARGET: 100%)	50% ³
 <u>Management Systems and Capacity</u>	
Proportion of regions or zones which prepared annual workplans for each relevant intervention for the current year. (TARGET: 50%)	0 ³

Number of OR studies completed in the past twelve months.
(TARGET: 3)

0³

Date on which annual HIS data were available for the most recent year.
(TARGET: March 31)

03/31³

Proportion of units reporting HIS data within four weeks of the end of the most recent reporting period.
(TARGET: 90%)

75%³

Number of feedbacks to reporting units in past year.
(TARGET: 4)

0³

Financial Resources and Systems

Proportion of required ORS that is locally produced,

0

Proportion of local currency recurrent costs covered by government, community groups, users or other private sources.
(TARGET: scaled increase to 100% by PACD)

0⁴

Proportion of required chloroquine that is locally produced.

0

Behavior Change and Demand

Proportion of children with diarrhea episodes whose mothers correctly prepare and administer ORS at home.
(TARGET: 75%)

n/a

Proportion of children with malaria who are correctly treated at home.
(TARGET: 75%)

n/a

Macroeconomic Indicators

Proportion of government budget allocated to Ministry of Health in the current year.

1.7%⁵

Proportion of MOH budget allocated to preventive health in the current year.

n/a

Sources:

1. CCCD Study, April 1987
2. Team Observation
3. Team Observation and Interview
4. Data not available. System is in process of design and introduction
5. World Bank Report Number P-480J-GUI, 05/24/88