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## I. Introduction

In November, 1979 USAID/Y requested AID/W to initiate actions which would provide an evaluation of the officially terminated Ouham Province Rural Health Project (OPRH 676-0002). In a telegram dated 21 November 1979, Yaounde 7255, USAID/Y identified the types of technicians it desired to conduct this simple assessment and laid down the general guidelines to be followed by the evaluation team.

It was originally intended to have one team spend a total of two weeks in Bangui and Bossangoa. Instead it was necessary to have two teams: health component and a Wells component. The health team was only able to spend three days in Bossangoa Prefecture (Ouham Province) and three days in Bangui. (Appendix A lists team members).

Consequently, given the time constraints of both teams it is not possible to provide lengthy detailed quantitative analyses of the entire Project. The observations and recommendations in this paper were developed after having extensively reviewed the documents made available to us (Appendix B), interviewed persons associated with the project (Appendix C) and conducted a site visit to Ouham Province, Bossangoa Prefecture (Appendix D). This evaluation essentially focuses on two areas of primary concern: a) the technical analysis as presented in the PP and b) the specific concerns noted in Yaounde 7255. However, the evaluation team also refers

to other aspects of the PP in analysing the OPRH project as a whole, since different parts of the project, of necessity, are interrelated.

## II. Background

The Project Agreement was signed with the GOCAR on July 1, 1977. This was two years after an American Public Health Association (APHA) reconnaissance team went to Bangui to study the feasibility of AID undertaking the support of an integrated health care delivery system in the Central African Republic. A brief and concise chronology of events pre- and post- ProAg signing are found in Appendix E.

## III. Project Summary

The Project Paper (p. 31) states that this "project is designed to overcome or reduce four specific (but overlapping) constraints which impede the development of integrated rural health care in Ouham. These problems are: (1) inadequate management, planning and evaluation; (2) shortage of trained personnel; (3) inadequate mobilization of village resources; and (4) poor vehicle maintenance.

### 1. Management, Planning and Evaluation

The PP (p. 31) identifies six major problems and how the project proposed to address these problems, namely:

- Personnel Management
- Drug Distribution
- Evaluation
- Communication
- Coordination
- Inadequate physical facilities and equipment

An assumption made in addressing the needs for improved personnel management was that Peace Corps Volunteers possessed characteristics necessary to improve CAR personnel management.

Our observations do not concur with this assumption, especially when one reads Dr. Reilly's report of June 25, 1978 in which he points out the lack of technical training and motivation to work in public health on the part of the PCV's. Admittedly, some PCV's attempted to make a go of it in true Peace Corps tradition, however, to posit success, even short run success, on inexperienced PCV's is of questionable merit.

It seems contradictory that the project had in it a plan to study the drug distribution system in order to bring some basic drugs to the rural population of Bossangoa, yet the PP contains a list of pharmaceuticals that could be obtained through the project. Furthermore, the PP apparently does not allow for a needs survey of most prevalent illnesses to be conducted in Ouham, before purchasing drugs.

On this point the evaluation team concurs with Dr. Reilly's observations and his attempts to conduct such an evaluation before

proceeding to any drug purchasing stage.

The team noted that project funded drugs (Appendix F) were subsequently found in three (3) of the proposed 18 pro-pharmacies. A pro-pharmacy is a village based, run and supported pharmacy, independent of government pharmacies. They stock 7 to 10 basic drugs which are obtained from any source, usually the private sector and charges a nominal fee which allows for replenishing stock and possibly a very small profit which could be used to help support the village person having responsibility for maintaining the operation.

An assumption made in the PP is that "the GOCAR feels... the rural inhabitants do not have the financial resources..." to purchase medicines. The evaluation team is not convinced that this assumption was valid. Both the Reilly report (Appendix G) and the White report (Appendix H), not to mention the Social Soundness analysis within the PP, indicate that villagers do pay for medicines and do pay very dearly for the services of traditional healers.

Subsequently, the three pro-pharmacies visited by the evaluation team clearly demonstrated that villagers did in fact have financial resources to purchase drugs.

To the best of the evaluation team's knowledge, apart from the survey conducted by Mrs. Reilly, no evaluation was ever undertaken during the life of this project. Clearly, no administrative manual detailing how to conduct an evaluation was ever

developed. In fact, Dr. Reilly met with obdurate refusal on the part of the PCV's assigned to the project when they were asked to assist in a latrine-use evaluation. It is Dr. Reilly's contention that both the PCD in Bangui and AID (where?whom?) gave him no support in this area. The evaluation team has no evidence to believe the contrary.

The village health committees may have run into difficulty in 1978. As White observed, it was not known whether information concerning health and sanitation was understood by the villagers, that if not understood no attempt was made to present the information in another manner. Most importantly he observed then, and the evaluation team sees no reason to believe that this observation is any different now, that there was no program designed to have the people act on the information presented, there was no provision to evaluate the progress of the villagers's action in this area by even simple observation of results which would permit developing or initiating an alternate strategy.

Additionally, the evaluation team notes that in the Provisional Budget for OPR# Oct 1978 - Oct 1979 submitted by Dr. Jack Finlay (not dated) totaling \$106,000 over 37% was earmarked for fuel, vehicle repair and mobylettes - while less than 10% was budgeted for personnel to conduct special studies, baseline and evaluation research of program direction and effectiveness. We have not been able to determine whether this budget was ever approved, and if so, was such an evaluation ever conducted?

In looking at the problem of communication, the Project Paper apparently again envisioned using PCV's as glorified messengers. No attention seems to have been focused on the resources necessary to keep PCV's mobile to wit, gasoline and properly maintained modes of transportation. The PP simply says "... In the course of the project communication bottlenecks and possible solutions will have to be positively identified and dealt with."

It is the evaluation team's impression that a) Dr. Reilly acted positively by arranging 2-way radio communication between Bossangoa and Bangui (not envisioned in PP); b) Project Paper omitted detailing lines of communication (and by so doing, lines of responsibility and authority) for various participants in project. This glaring omission contributed to the PCD stating in a memo to PCV's that "the Medecin-chef in Bossangoa is in theory your boss, ... but the fact remains you work for the CAE government." (Appendix I) This in effect crippled any supervisory authority Dr. Reilly may ever have had over the project. And c) that AID complicated matters further by having a Program Officer/Bangui and a Project Manager stationed in Yaounde forwarding recommendations on the performance of the OPRH project to USAID/Y and to AID/W. The evaluation did not see a unified management approach to this project either by the PSC's or by AID. This apparent confusion lasted through 1979. In a letter to "Fritz, Eileen and Rick" PCV Rick Bradshaw notes that he would like to have a decision on whether \$3000 could be set aside for building 3 pro-pharmacies and using a local contractor. Why was he coming directly to Yaounde with this concern? He did not appear to know whom to ask or where. He prefaced his letter by pointing out with some chagrin that he had many bosses, all telling him something, but he was trying to respond to a request by the villagers in Boumentana to build a dispensary, since they had already begun some construction on the understanding that assistance for the remaining portion would receive outside help.

With respect to coordination, the team believes that from what was said above under "communication" it follows that coordination would become a problem. It was. The team failed to see evidence of appropriate coordination among project participants until 1979 when Dr. Finlay had become chief of project and began putting Humpty-Dumpty together again. Also, there began at this time, a significant shift of emphasis within the project from one of concentrating on pro-pharmacy and dispensary development to health education activities.

Again, the evaluation team questions another assumption in the PP concerning PCV's. Namely, the statement that "...they (PCV's) will have greater health expertise than all except the direct health staff..." The PCV's were not properly trained for the project and sought professional assistance during the project whenever and wherever they could. The evaluation team saw no evidence of Peace Corps produced written guidelines to assist either the Central Africans or future PCV's coming into the Project.

## 2. Training

The PP states that the project will train the following:

- a. School teachers (Health Education Techniques);
- b. Traditional Birth Attendants (basic MCH);
- c. A limited number of village level health care agents;

- d. Government health workers (i.e. management, administration, and non-clinical outreach);
- e. Three Master's level candidates in P.H. Administration and related disciplines;
- f. Four Health Educators (Africa or U. S. )
- g. Eighteen garage mechanics and six supervisors; and
- h. Government Health Staff (Participation in local and international conferences - 20 person months.

We were told that one PCV was stationed in Boguila, 109 kms via rain rutted road from Bossangoa. She was continuing her work with the help of the Church of the Brethren doctor, Dr Walker in the maternity clinic.

To our knowledge nothing was accomplished in categories e and f. There were some mechanics at the Grandes Endemies garage in Bossangoa, but we question whether they received any training of the sort intended in category g.

It is our understanding that Dr. Finlay did conduct regular meetings or conferences primarily in Bossangoa but also in Bangui. He referred to these as the "foundation" on which the project turns. Not exactly what the project designers had in mind. It is questionable as to whether any training was accomplished in these meetings since their main function was to promote coordination. Dr. Finlay did accompany 3 central Africans to an International Health Education Conference in London in September, 1979. We have not been able to obtain a copy of their presentation. Or was it Dr. Finlay's presentation ?

In Bouanssouma, Bossera and Boumentana we saw the only dispensaries built under the auspices of this project. Secourists were stationed at each. They had each participated at one meeting (content?purpose?) in Bossangoa, however there was no demonstration latrine at any dispensary and

only one had any health education visual aids. Incidentally, these visual aids were made in Yaounde. The team was led to believe that there were other packages of visual aids which were made in Zaire. (Bas-Zaire - by Dr. Courtejois). We saw no evidence of locally produced health education materials. The only conclusion the team is able to make after seeing what little is being done in health education as proposed in this project is that this particular project effort has had little or no impact on the rural population of Bossangoa prefecture. It cannot be demonstrated that this effort has improved the health of the rural population of Ouham Province. We have no reason to believe that behavior modification was effected even on the part of the secourists, who were responsible for giving health education lessons to the local villagers, as was intended in the PP.

### 3. Mobilization of Village Resources

The first statement made is (p.36) "evidence produced by the social soundness analysis suggests the possibility that Central African villagers are able to pay for basic health care..." This is an apparent contradiction of the assumption made on page 32 regarding free drug distribution.

The PP lists four approaches to mobilizing village resources.

- encouragement and support of health activities by village development committees
- short-term but periodic training of traditional birth

attendants to give them broad pre-natal and post-natal skills

- experimental training of village level health care agents selected by development committees
- development of planning for self-supporting pro-pharmacy systems

This output is tied in with another program also being supported by Peace Corps and USAID, the Community Development Program. It is also predicated on a study of existing medical practices. To our knowledge very little was done in this area apart from Dr. Reilly's initial attempts to look at or have PCV's help in a study of traditional medicines, which never materialized.

Again, this ambitious undertaking was to be linked to Drug Distribution which was addressed earlier in this paper. Our site visit to the areas where the three dispensaries had been built and staffed with a securist did not indicate that the village health committees were active in promoting latrine construction and utilization or use of clean water (even where wells were already available through a FED supported project in 1967 and 1968).

However, our observations of the pro-pharmacies in these villages indicated that this particular aspect of the project was self-sustaining by the villagers themselves.

#### 4. Vehicle Maintenance

The garage at Bossangoa was built under the auspices of this project. However, its location was in the back yard of the Medecin-chef of the Sector. Any other location would have guaranteed failure. It is being used by the Grandes Endemies mechanics. All G.E. vehicles are maintained here. Of the project's six vehicles, two are being used by the Medecin-chef of Sector in Bossangoa, three are in the garage at the Embassy in Bangui and one is at the Grandes Endemies headquarters in Bangui.

It is doubtful that the project gave serious consideration to the recurrent costs of this aspect of the project to the CAR government. If the project had been aware of the International truck located in Sector III, left over from the AID-supported smallpox-measles program, and the fuel it consumed, perhaps the designers would have redefined what they set out as a "low-cost" delivery system.

#### 5. Appropriateness for Time and Place

The PP recognized, in theory, that many decisions required to improve problems of management and planning at the prefectural level are made centrally. However, it was determined to place the Chief of the Project in Bossangoa and a subordinate in Bangui. As Damon Runyon once said, "The race is not always

to the swiftest nor the surest, but that's where to place your bet."

These observations of the evaluation team have tried to concentrate on the technical analysis presented in the Project Paper. Of necessity, they are what the evaluation team found singularly striking throughout the project. We also recognize that many people before us have been critical of this project. We see little sense in kicking a dead horse.

The following section is an attempt by the team to focus on the specific concerns of USAID/Y concerning this project. The format follows the guidelines noted in Yaounde 7255. There will be some repetition of what we noted in the Technical Analysis, obviously, since the project itself is composed of inter-related components and the guidelines implicitly recognize these interrelationships.

#### IV. The Role of AID Contract Personnel and Peace Corps Technical Contribution in Project to Date.

The project, as designed, was intended to address administrative management, personnel and communication/transportation problems that the GOCAR faced which were perceived to be impediments to the development of an integrated, rural, village level health care delivery system.

The Project Paper thoughtfully describes longitudinal events that should occur to appropriately effect this goal. The implementation plan sets forth the sequence of events which should take place. However, it is apparent that this proposed sequence of events were not adhered to. It was the intent of the project that the AID technicians be on board prior to the Peace Corps Volunteers. This was not the case. This timing was to affect the future relationships of AID personnel and Peace Corps throughout the life of the project, to the detriment of all involved. Although the project paper repeatedly emphasizes the importance of AID technicians arriving prior to PC volunteers to assist in their training and outline the goals of the project and determine roles of volunteers this did not occur. The PCV's arrived in country five (5) months before the first AID technicians. This event set the scene for events which were to occur later. The PCV's lacked project direction and the slack was taken up by the PCD. It was made quite clear to the PCV's that they were not working for AID but that they were working for the Central African Empire government. From our observations relations between PC and AID were strained even before the project began to be implemented.

1. Concerning the AID Technician in Bossangoa: In the approximately four months that this technician was in country the project was left with a short list of pharmaceuticals which could serve to treat some of the more common ailments of the population.

As perceived by this evaluation team these most common ailments are:

- conjunctivitis
- trauma
- diarrhea
- hookworm (~~and other worms~~)
- ascaris
- malaria

The pro-pharmacy which was part of the project benefited from the suggested list of medications and approximate cost to villagers. However, the team has not been able to definitively ascertain whether this list was determined as a result of a needs survey performed by the AID technician or simply derived from the existing pharmaceuticals already being furnished to the Government pharmacies. The government supply is duplicative but also contains additional medications.

The team believes that the quantity of ~~quinine~~ <sup>injectable anti-malarials</sup> was inappropriate. Approximately one percent of <sup>malaria</sup> patients require <sup>only oral chloroquin.</sup> injectable <sup>treatment,</sup> quinine, the remainder require <sup>large</sup> ~~quinine~~. <sup>Gandoban (sulfonamide)</sup> should not have been ordered in such quantities. <sup>is</sup> Its presence probably <sup>encouraged</sup> ~~required~~ the people to rely on drug therapy for diarrhea rather than on <sup>rehydration</sup> ~~prevention~~ through use of simply prepared electrolyte solution. <sup>Such treatment</sup> ~~quinine~~ would have been <sup>quite</sup> adequate for the majority of diarrhea ~~in children.~~

Additionally, the American Optical microscopes provided the project have had minimal use because they are dependent on electricity. The evaluation team questioned the judgement made to import such equipment and also whether the model provided was too <sup>expensive</sup> ~~sophisticated~~ for the <sup>simple</sup> task being performed.

2. The AID Technician in Bangui: There appears to be little information to go on concerning the relationship of the Bossangoa based technician and the Bangui based technician since this relationship only lasted for about four months before the Bossangoa based technician left the country.

It is the evaluation team's impression that while the Bossangoa based technician was in country, relations between the Peace Corps and the Grandes Endemies were strained, at best. Subsequent to the departure of the Bossangoa Technician, Dr. Finlay moved rapidly to smooth over relationships. At this time as well, there was a shift in program emphasis. Dr. Riley focused on development of the pro-pharmacy concept. However, Dr. Finlay organized some village committees and met more often with the Peace Corps volunteers and encouraged them to become more involved with health education activities. A number of meetings were convoked by Dr. Finlay involving the village securists and Peace Corps volunteers. Also, relations with the Grandes Endemies were improved.

3. Concerning Peace Corps contribution: From the outset it is questionable as to whether the PCV's were ever adequately prepared to deal with the situation in which they found themselves. By their own admission they were not adequately trained in the techniques of pro-pharmacy concepts and development. They were also not specifically trained to diagnose community health needs. The PCD was able to make available the PC library (modest, but comprehensive) to the volunteers and contribute some technical information, generally however, the volunteers were encouraged to make it on their own.

The evaluation team recognizes the varying philosophies of AID and Peace Corps. The implementation plan of the project paper appears also to at least implicitly recognize these differences, for it was clearly the intention of the designers to have the AID technicians in country at least 6 months before the arrival of the PCV's and to have the AID technicians participate in the training. The PCV's could not have been expected to grasp the overall objectives of the project and the context in which they would be contributing unless AID guidance was present.

Generally, PCV technical contributions to the project were minimal except for the construction of the garage in Sector III and assistance in constructing the dispensary in Boumentania.

V. AID-Peace Corps and Ministry of Health - Peace Corps Administrative Relations to Date and Recommendations for the Future.

1. Relationships between AID and Peace Corps were strained and without harmony. Early in the life of this joint venture (July 25, 1977), the Peace Corps Director instructed "All CAE Health Volunteers" that "you are officially working for the Ministry of Health and as such AID really has no authority over you...It is a very different concept from most foreign assistance programs and I think helps make the Peace Corps unique. I will do all I can both here in Bangui and in Bossangoa to get this point across and to clarify the fact that you do not work for AID. There will obviously be numerous occasions for you to do the same."

In the report Dr. Philip C. Reilly, MD submitted to USAID/Yaounde on June 25, 1978, he clearly asserts that he was fired by USAID/Yaounde because of his attempts to assert technical supervision over the Peace Corps Volunteers and because of his insistence that their activities should relate to the project and not be self-determined by the relatively untrained volunteers.

Subsequent to the firing of Dr. Reilly on June 9, 1978, relations between AID and the Peace Corps appear to have remained at arms length.

The poor AID-Peace Corps relationship was initially, partly due to the fact that the Peace Corps was in the field prior to the arrival of the AID contract personnel and, feeling the need for

immediate action, initiated activities which seemed to the volunteers to be appropriate without awaiting technical direction from the AID contract professionals.

## 2. Relationships between the Ministry of Health and Peace Corps

Relationships are not documented apart from the remarks made by the Director General, Dr. Thimosat at the conference in Bangui. However, interviews with Peace Corps personnel and with significant others in Bangui and in Ouham Province give the impression that the relationship was tenuous. Each Peace Corps Volunteer seemed free to shape his or her own assignment, in light of the Director's view that activities in health were "good".

In mid-1978 White noted in his report (page 22) that "the administrative organization of the program has become a major point of confusion for both Americans and Central Africans. It is the most important and most challenging aspect of the program and the one that deserves the greatest attention at this time." However, it was not until 1979 that efforts would be taken to try and improve these relationships.

## VI. GOCAR Priorities in Public Health, Absorptive Capacity and Implications for Future Project Activities

The activities, expenditures and statements of the Government of the Central African Republic were focused on curative health

services. The apparent preventive activities consist primarily of childhood immunization services and some environmental sanitation activities.

The Ouham Rural Health Services Project was designed to overcome or reduce four specific (but overlapping) constraints which were perceived as impediments to the development of integrated rural health care in Ouham Province. These problems were: 1) inadequate management, planning and evaluation; 2) shortage of trained personnel; 3) inadequate mobilization of village resources; and 4) poor vehicle maintenance.

It appears that the project design was not in concert with GOCAR priorities in health. The design of the project did not include or relate to the Grandes Endemies system which was and still is the only health delivery system for the rural areas, and which concentrates its activities in preventive health services.

The Grandes Endemies system was and is the only system which could absorb and support a project of this scope and nature.

#### VII. Problems for Recruiting Skilled Professionals for Bossangoa

It is the observation of the evaluation team that the outlook for family living in Bossangoa is spartan, at best.

In the implementation of this project, four months were required to field a Chief of Project.

After the Project Paper document was approved in June, 1977:

a) Dr. Reilly began work in February 1978 and was fired in June 1978; whereupon

b) Mr. Finlay, recruited as Bangui Liaison in December 1977, assumed total responsibility for the project until his departure in October 1979.

It is probably extremely difficult to recruit experienced professional personnel at the level specified in the project paper (M.D., M.P.H. with significant experience) to work in the setting of Bossangoa because: 1) ~~few~~<sup>few</sup> professionals at that level have had day-to-day working experience at this level of an underdeveloped system, and 2) few professionals are motivated to make the family sacrifices required to work and live in the community of Bossangoa, where there are few resources outside of one's household to leaven or soften a physical and cultural ecosystem which seems bleak to the alien observer.

#### VIII. General Feasibility of Project as Conceived as a Unit and By Components

The team is of the conclusion that the project paper presents an inadequate analysis of the absorptive capacity of the RCA MOH. We do not concur with the economic determination that the GOCAR was in a position to absorb the recurring costs in this project. The proposed budget for the MOH for 1980 bears this out. (Appendix J) As was pointed out earlier, it is questionable that the design team even examined the absorptive capacity of the

MOH to continue operating the 6 international trucks and 12 ped-o-jets that were provided in the earlier small-pox measles program funded by AID. Irrespective of the political events that were shaping up to effect all programs in RCA the evaluation team cites this as an oversight on the part of the PP designers. These outstanding costs were to be gasoline and spare parts for the six Toyota vehicles and petrol for refrigerators. The analysis presented showed an increase in the Ministry of Public Health's Budget over the time period 1970 to 1976. In real dollars (CFA) this budget does not appear to allow for the accompanying inflation rate besetting this country. In any event the 1980 budget indicated approximately a 55% reduction over the 1976 figure. Even then, the evaluation team was advised that this is only a paper figure and that the government will be fortunate if it can obtain enough funds to pay the salaries of MOH personnel.

It is significant that given the heavy orientation towards health education in the project, the project was nonetheless approved when in a 1975 project review committee meeting Herman Marshal said "the economic base of the CAR is so low that a project is not feasible under the original DEIDS guidelines."

Within the PP it is not clear what the lines of authority are and participant roles are not defined. This critical aspect of program implementation appears to be ambiguously dealt with

leaving each participant to translate implementation in his own terms.

Conspicuous by its absence is any tie in or role for the Service des Grandes Endemies and Catholic and Protestant missions already providing services at the village level. The evaluation team feels that this oversight may have contributed indirectly to some early strained relations, since not until the project began to falter or run into difficulty did the project turn to these sources for assistance.

General feasibility of the project was brought into question by the evaluation team where in the project paper it is envisioned that AID would provide a Physician to act as a technical advisor to the Medecin Chef du Bureau de Sante de Base. One has to question the reasoning behind this decision since the French physician based in Bossangoa has and still is the coordinator, administrator and manager for rural health services. How was this assignment perceived by the Chief of the Grandes Endemies in Bangui? How was it perceived by the Physician in Bossangoa? Did the design team ferret out French reaction to this proposed personnel placement? Unless the physician was assigned to the MOH and officially recognized by the Chief of the Grandes Endemies in Bangui, the evaluation team can only suggest that this project attempted to create a parallel system of health care delivery.

## IX. Feasibility of Construction Program

The evaluation team found no evidence to suggest that the proposed dispensaries construction was put out for competitive bidding. How was N'gassio selected as the contractor of choice for dispensaries planned in Bossangoa prefecture when he was based in Bangui? The evaluation team spoke to the Catholic fathers in Bossangoa and saw two buildings they were constructing (not ~~to~~<sup>to</sup> mention all the buildings comprising the Mission). It was our impression that they were never consulted as to whether they might be interested in bidding on the construction of the proposed dispensaries.

The evaluation team is favorably disposed to the construction of a few simply built dispensaries however, the wisdom of having such work done from Bangui and the obvious problem and costs that this decision subsequently led to should be examined closely if it is decided to continue this aspect of the project.

Generally, the dispensaries constructed were too big for the purpose originally intended. There is no reason to have them built as large as they were. Spatial setting was appropriately done and it was consoling to the evaluation team that the village chief and village elders were consulted prior to their construction as to appropriate location within the village.

## XI. Recommendations

1. The Ouham Project as currently described in the PP not receive further AID support.
2. The Pro-pharmacy aspect of this project has merits that could be explored for possible AID support. A PVO, possibly the Catholic Fathers in Bossangoa or the Protestant Church of the Brethern would be quite suitable to undertake activity in this area.
3. Where possible, goods financed under this project should be turned over officially to the Ministry of Health to be used, as appropriate, in the Service des Grandes Endemies.
4. AID refrain from supporting any health project in CAR that relies on the use of gasoline or kerosene for success.
5. The Catholic Fathers in Bossangoa have requested financial assistance to reconstruct the outpatient department burned down in 1978, at the ~~FAO~~ government hospital. This may be a feasible effort for AID support which has possibilities of minimizing AID direct hire or American personnel in CAR while at the same time assisting in the development of the CAR Primary Health Care System. The ancillary question of a few simple dispensaries for rural outreach coupled with pro-pharmacy support could also be considered as part of the total funding support.
6. Recognizing possible contradictions with item 4 concerning this recommendation there is nonetheless merit. AID could consider supporting, through the Service des Grandes Endemies

(Appendix K) a national Goitre eradication campaign. Our observations and some statistical notes (Appendix L) indicate that there is a 25 to 43% incidence of visible goitre in Northern CAR. The technology for such a campaign is well known. Such programs have been successfully carried out in Zaire, Bolivia and parts of New Guinea. The Chief of the Grandes Endemies is willing to add this component to their existing program. Two of the 3 team members have had previous experience with operational Ipiodol (iodine in oil base) injection programs and believe that such a program is feasible in CAR. Again, no American presence would be necessary or an American technician could be assigned to the Ministry of Health's Grandes Endemies in Bangui.

7. The evaluation team unequivocally recognizes the importance of access to safe water and the inherent effects such access has in improving health. If feasible, we support the provision of safe water to the <sup>Ouhang and</sup> Ouhang-Pende Provinces, if not to all CAR. This action would probably have more beneficial effects on health for more people than any other <sup>health</sup> project activity AID could at this time associate itself with in CAR.

8. Programming with Peace Corps should be one of intimate collaboration with job descriptions for PCV's as clearly defined AS POSSIBLE. AID SHOULD BE INVOLVED in reviewing Peace Corps Programming documents (104) to be assured that both parties have the same objectives. Annex I, part IV, paragraph 4 of the ProAg does not clearly set forth

the respective lines of responsibility and authority for PCV's and AID technicians. Indeed, this omission vindicates the Woodbury action.

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- I. WOODBURY MEMO TO ALL CAE PCV'S - JULY 25, 1977
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## APPENDIX A

### TEAM MEMBERS:

1. Richard Brown, M.D., M.P.H.  
Regional Medical Officer, USAID/Yaounde
2. Thomas Georges, M.D., M.P.H.  
African Bureau  
Director, Health, Nutrition Office  
AID/Washington
3. John McEnaney, M.P.A.  
Public Health Advisor  
Development Support Bureau  
Office of Health  
AID/Washington

### WELLS COMPONENT

1. Michael Glaze
2. Richard Thornton  
Public Health Advisor  
Former OPRH Project Manager,  
USAID/Yaounde

## APPENDIX B

### DOCUMENTS REVIEWED

1. OPRH Project Paper
2. OPRH Project Grand Agreement
3. Brief History of OPRH Project
4. Philip C. Reilly, Jr., M.D., Report, June 25, 1978
5. Jon C. White, Report, August 1978
6. Memorandum from PCD Woodbury to PCV's CAR, July 25, 1977
7. MOH Project Budget 1980
8. Finlay Report 10 May - 30 November 1978; February 1979
9. Finlay Final Report December 1978 - September 1979; undated
10. Barnet Memo to Koehring, March, 1977
11. OPRH files in USAID/Yaounde
12. CY 1979 Budget for CAE, June 25, 1979
13. Roger Clapp Report, January, 1980
14. MOH Request to President of CAR for Immediate Financial Assistance for MOH to Function, November 27, 1979
15. Thornton Trip Report to Williams, May 10, 1979

## APPENDIX D

### PLACES VISITED BY HEALTH TEAM

1. Bangui
2. Bossangoa
3. Bouansouma
4. Boussera
5. Boumentana

APPENDIX F

LIST OF DRUGS AND THEIR COST FOUND IN 3 PRO-PHARMACIES IN BOSSANGOA  
PREFECTUR

DRUG	COST
Combatrine	110 CFA
Mintizol	50 CFA
Aspirin	5 CFA
Nivaquine	15 CFA (2 tablets)
Ganidan (sufanimide)	5 CFA (1 pill)
Permanganate	5 CFA
Quinimax 20%	60 CFA (per ampule)
Quinimax 10%	45 CFA (per ampule)
Aureomycine 3%	450 CFA (per tube)
Aureomycine 1%	275 CFA (per tube)

## memorandum

DATE: February 13, 1980

REPLY TO  
ATTN OF: Richard L. Thornton, Public Health Advisor, USAID/Y

SUBJECT: Reaction to OPRH (676-0002) Evaluation Teams Draft Report

TO: Richard C. Brown, M.D., Director, HNPO, USAID/Y

After reviewing the draft report I have the following general observations:

1. It appears that the team had not done their necessary background preparation before initiating the field phase of the report. Most of the materials in the briefing packet prepared by USAID/Y were apparently not read.
2. As a result the report contained several serious factual errors as well as unfounded observations.
3. The document as presented is basically a trip report which not only does not follow the AID PFS format but more importantly does not evaluate the projects planned v.s. real progress to date in a disciplined manner. There is some discussion of outputs but no discussion of inputs or the relation between them.
4. The team made their field trip and observations four (4) months after all project activities had been abruptly cut off.
5. While the report does conclude that the project did not reach its goals, it is not clear whether this was because the project concept was not valid to begin with or because the inputs never materialized.
6. The recommendations do not seem to relate to any of the OPRH goals or outputs but suggests activities to address needs of non-GOCAR elements.
7. The evaluation team takes the position that because of time constraints it was unable to do what USAID/Y had originally requested: A detailed analysis of the



Buy U.S. Savings Bonds Regularly on the Payroll Savings Plan

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entire project.

The teams lack of preparation noted in general observation #1 is evident throughout the report. The most glaring specific examples are shown in their comments on:

- a) The lack of a previous evaluation. (The USAID/Y October 1978 evaluation was listed on their orientation memo and was part of the briefing packet as was the Finlay final report which gives that contractor's evaluation of the project as of 30 September 1979.)
- b) The Ngassio Selection as contractor for health post construction. (The Ngasso contract correspondence was included in the briefing packet.)
- c) The scope of work of the Grandes Endemies and its relation to the project. (Grandes Endemies has been an organization run by the French military to prevent certain communicable diseases through mass vaccination campaigns. As of October, 1979, their mission did not include basic rural health services, community development, or village animation/health education.)
- d) The positions and scheduling of pro-pharmacies in the project. (As noted in both Finlay's reports, these were to be set up as the last step in a series of health education, village animation activities.)
- e) The suitability of electric microscopes. (All microscopes can use natural or electric illumination.)
- f) The comments on page 5 regarding village animation and health education. (This was well covered in Dr. Finlay's final report which was apparently not read.)
- g) The observation on page 6 that they did not see a unified management approach the project by either PC or AID, and the confusion in addressing problems. (The team did not appear to be aware of or to have understood the constraints under which this project was forced to operate; i.e. the decision by AID/W to not send a direct hire AID/rep to Bangui in September 1977.)

the observation on page 8 that there were no latrines at the three (3) health dispensaries that they did visit. (The 1978 evaluation and Finlay's final report showed 1100+ latrines constructed.)

The observation that there was an absence of any tie in for Grandes Endemias or the Religious missions in the project. (Finlay notes in his report the formation of the Health Coordinating Committee in Bossangoa which met monthly and which gave each member the opportunity to discuss what each was doing in the field of health and how they may coordinate with other members. Grandes Endemias and the various missions were regular members. The project did work with them to the extent it was feasible.)

The construction of three (3) dispensaries. (Actually there were five (5) as noted in the Finlay and Clapp reports in the briefing packet.)

MINISTRE DE LA SANTE PUBLIQUE,  
DES AFFAIRES SOCIALES, DE L'ORGANISATION DE  
L'ECOLE ET DE L'ENFANT,  
DU DOMAINE

Conseil. Techniques  
M. général VOISIN

MINISTRE

Secr. Technique

Cabinet

Secrétaire d'Etat Santé  
et Affaires Sociales

Cabinet

D.G.S.P.A.S.

Dir. Santé  
bains de  
Bancou

Direction  
Santé Rurale  
et Gr. End.  
Directeur  
Adjoint

Dir. Scs  
Pharmaceuti-  
carmacie  
d'Approvis.  
Direct. Adj.  
Inspection  
des Pharmac.

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B. Bangui  
ce Santé  
col. niv.  
Bangui

Hop. Gén. Préf.  
C.S. ruraux  
S.M.I. rurale  
Sect. C.C. et  
de la lutte  
anti-Tuberc.  
S.N.H.E.S.  
Sce du Dévelop.  
Soins Primaires  
et de la Santé  
Scolaire Rurale

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Personnel  
Service des  
Finances  
Service Maté-  
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ge UNICEF

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et de la Planifi-  
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Sce de la Docum.  
et des Statisti-  
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Sce Coop. Inter.  
Santé Publique  
Relations Org.  
Inter. Fonds d'Ai-  
de, subvention  
Bourses Etrang.

Sce de l'Assist.  
et des Secours  
Sce des Services  
Sociaux Spécia-  
lisés  
Sce Protection  
de l'Enf. et  
Centre de la Mere  
et de l'Enfant  
Formation Profea-  
sionnelle et Ar-  
tisanale  
Coordination  
des Sect. Soc.  
et des Projets

EVECHE de BOSSANGOA

B. P. 7

BOSSANGOA, LE 31 janvier 19 80

~~REPUBLIQUE~~ CENTRAFRICAINEMonsieur le Directeur  
C. R. S.  
New York ( U.S.A.)

2002

*Jean G. Du Thomas Georges*

Objet : Demande pour une aide à la reconstruction du dispensaire de PAOUA détruit par un incendie

Monsieur le Directeur ,

PAOUA est une Sous-Préfecture de la région de l'OUHAM-PENDE dans le Nord Ouest de la République Centrafricaine . Elle fait partie du Diocèse de BOSSANGOA .

Cette région fait frontière avec la République du Tchad D'ailleurs, couvertes de savanes pauvres, elle appartient géographiquement au bassin du lac Tchad .

Avec 67.000 habitants environ pour quelques 11.000 Km<sup>2</sup>, c'est une des deux régions les plus peuplées de la République Centrafricaine . Pourtant cette région est très pauvre elle souffre bien plus que le sud ( le sud , plus riche , est synonyme de bois, café, tabac, diamants ) du marasme et de la pauvreté, conséquences de la gestion de l'ancien gouvernement ; sa seule production est le coton , avec les cultures vivrières . Des agro-sociologues ont estimé le P.N.B. par an et par habitant à 3.000 CFA ( = 13 dollars); c'est le 1 / 10 du P.N.B. de la République ( 129 dollars ; ( N.B.: 7.060 dołars pour les USA ) .

Le centre de la Sous-Préfecture est la petite ville de PAOUA ( environ 5.000 habitants ) . Il est équipé d' un Centre d'Assistance Médicale , ou Centre de Soins , dépendant de la préfecture , Bozoum . C'est le seul Centre de Soins dans un rayon d'environ 100 Kilomètres et pour la population de 67.000 habitants . Il n'existe que quelques petits dispensaires de secours ( 4 ) dirigés par la Mission Protestante .

En 1976 ( ? ) le bâtiment principal de ce Centre a brûlé intégralement . Jusqu'à présent, étant données les circonstances politiques et économiques , rien n'a été reconstruit et il semble que vues les conditions économiques actuelles du pays, rien ne sera fait avant longtemps .

C'est pour aider cette région pauvre mais relativement peuplée et bien travailleuse ( N.B.: c'est la seule région de Centrafrique qui se soit mise à la culture attelée ) que la Mission catholique désirerait redonner aux gens le Centre de Soins pour distribuer les soins primaires et développer la médecine préventive . Mais si la Mission

# EVÊCHÉ de BOSSANGOA

B. P. 7

BOSSANGOA, LE

19

EMPIRE CENTRAFRICAIN

peut faire le travail, le préparer et le diriger , elle n'a pas les ressources nécessaires pour financer la construction . Nous avons déjà les permissions nécessaires pour construire si nous obtenons les moyens . Après la construction par la Mission , le bâtiment sera remis au Gouvernement Centrafricain .

Nous sollicitons votre aide pour la construction .  
Le budget de celle-ci est évalué

-selon le devis ci-contre - a

16.472.745 CFA  
82.365 dollars

La Mission Catholique ( Evêché de Bossangoa) apportera une participation locale par l'étude du projet , du plan, par le travail du Frère Constructeur et de son équipe avec son matériel, et enfin par le travail d'une Religieuse Infirmière qui travaillera dans le Nouveau Centre ;  
toute cette participation est évaluée à

4.000.000 CFA  
20.000 dollars

Comme l'incendie a tout détruit , nous osons encore vous demander, si vous en avez la possibilité une aide supplémentaire pour l'équipement et l'aménagement ( armoires, bureaux, tables, chaises, bancs, etc. ... )  
le tout peut- être évalué à

8.000.000 CFA  
40.000 dollars

C'est l'évêché de BOSSANGOA qui est le demandeur de ce projet réalisable à PAOUA; le représentant du diocèse est le R.F. Jean COSTEPLANE , Responsable du Bureau diocésain de Développement .

Dans l'attente d'une réponse favorable à la population de PAOUA , veuillez agréer, Monsieur le Directeur, l'assurance de ma très haute considération

Copies:  
Dr TH Georges - Washington  
Dr R. Brown - Yaoundé

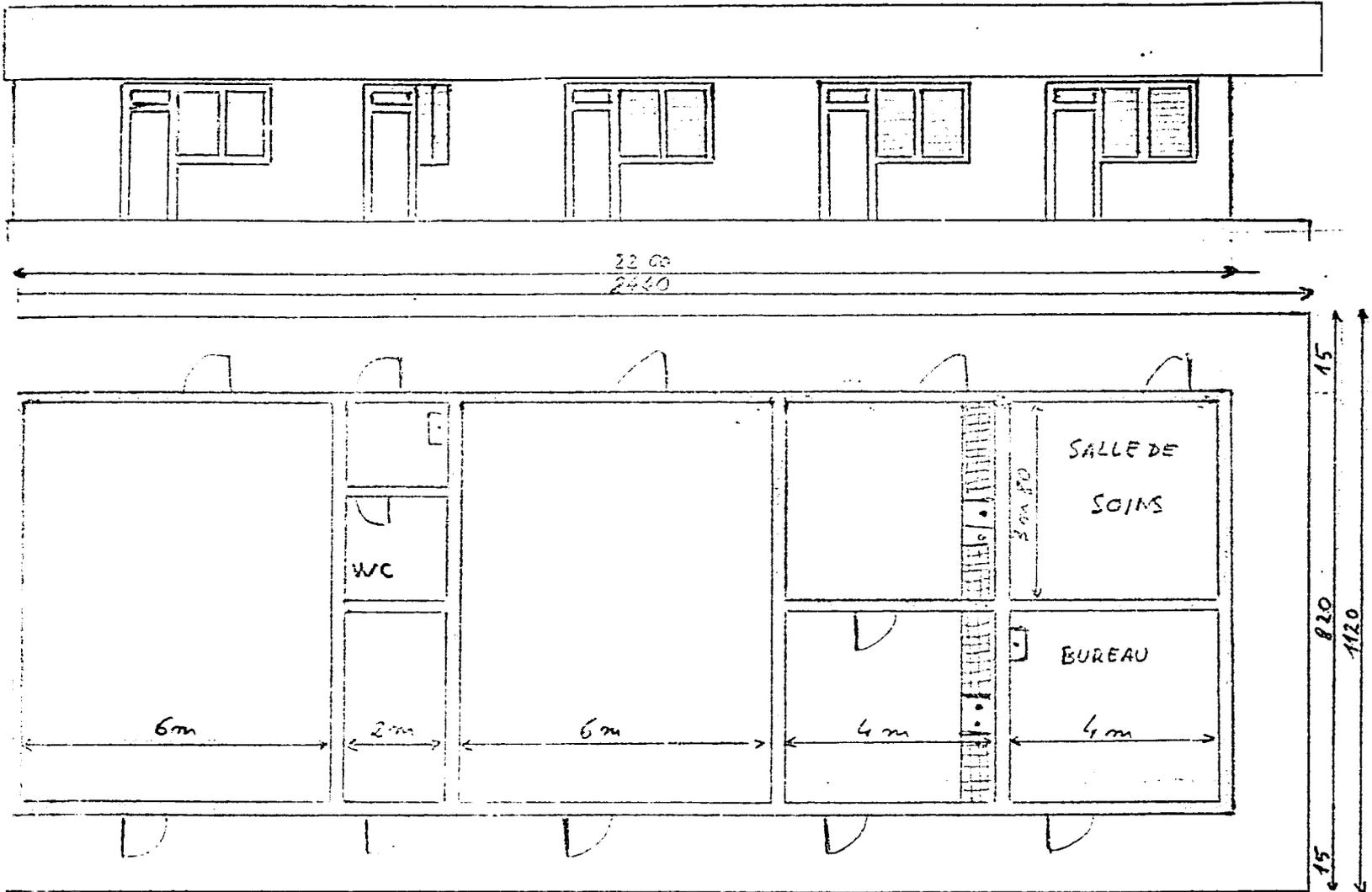


DISPENSARE

PAVILLON PRINCIPAL

PAOUA

(R.C.A.)



PROJET : Re-construction du Dispensaire de PAOUA ( R.C.A. )

(NB / Paous - Bangui = 500 Km )

DEVIS PREVISIONNEL

		unité	total
forfait	340 enlever le bâtiment brûlé préparation , implantation		120.000
m3	45 Fouilles en rigole	1.585	71.325
m3	70 Remblai d'apport	5.230	366.100
m3	5 Béton de propreté	33.000	165.000
m3	7 Béton armé pour semelle	133.000	931.000
M3	30 Maçonnerie en fondation	23.674	710.220
m3	20 Maçonnerie en élévation	32.000	640.000
m3	22 Béton armé de dallage	65.500	1.441.000
220 m2	Maçonnerie d'aggle 20x40	7.350	1.617.000
m3	6 Béton armé ,chainage , linteaux	170.000	1.020.000
440 m2	Enduit intérieur et extérieur	2.100	924.000
m3	5 Charpente et Pannes	95.650	478.250
250 m2	Couverture alu 6 IO/IO	2.835	708.750
M3	2 Ossature plafond	95.650	191.300
220 m2	Frises à plafond avec traitement	3.180	699.600
440 m2	Peinture huile	1.920	844.800
10	Cadres , Portes ,Serrures	38.000	380.000
10	Fenêtres chassis NACO	44.000	440.000
3	Lavabos	108.000	324.000
2	Eviers paillasses	168.000	336.000
2	W.C.	140.000	280.000
1	Fosse septique d'aisance	420.000	420.000
1	Puits perdus	110.000	110.000
14	Points lumineux	16.000	224.000
220 m2	Chappe lisse	2.600	572.000
70 tonnes	Transports Bangui- Paoua (500 km)	25.000	1.750.000
4 mois	Immobilisation camion	250.000	1.000.000

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16.472.745 OFA

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