

UNCLASSIFIED
CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

1. PROJECT TITLE Leprosy Control Project (OPG)	2. PROJECT NUMBER 504-0067	3. MISSION/AID/W OFFICE USAID/Guyana
4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) <u>FY 82-1</u>		
<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION		

5. KEY PROJECT IMPLEMENTATION DATES A. First PRO-AG or Equivalent FY <u>78</u> B. Final Obligation Expected FY <u>80</u> C. Final Input Delivery FY <u>82</u>	6. ESTIMATED PROJECT FUNDING A. Total \$ <u>1,450,000</u> B. U.S. \$ <u>250,000</u>	7. PERIOD COVERED BY EVALUATION From (month/yr.) <u>January 1980</u> To (month/yr.) <u>December 1980</u> Date of Evaluation Review <u>October 1981</u>
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8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
This Project will not be extended.		

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS <input type="checkbox"/> Project Paper <input type="checkbox"/> Implementation Plan e.g., CPI Network <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Financial Plan <input type="checkbox"/> PIO/T <input type="checkbox"/> Logical Framework <input type="checkbox"/> PIO/C <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Project Agreement <input type="checkbox"/> PIO/P	10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT A. <input checked="" type="checkbox"/> Continue Project Without Change B. <input type="checkbox"/> Change Project Design and/or <input type="checkbox"/> Change Implementation Plan C. <input type="checkbox"/> Discontinue Project
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11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles) W. F. Ross - Medical Director, AIM Dr. Patricia Rose - Project Director, Min. of Health David A. Cohen, Acting Director, USAID/Guyana Samuel Dowding, Program Specialist/Health, USAID/Guyana	12. Mission/AID/W Office Director Approval Signature: <i>David A. Cohen</i> Typed Name: David A. Cohen Date: December 18, 1981
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GUYANA LEPROSY CONTROL PROGRAM
Second Annual Evaluation
January - December 1980

To: Agency for International Development

Subject: Project 504-0067

Summary

The implementation of the project is proceeding remarkably satisfactorily, despite the fact that economic conditions in Guyana and the continued shortage of trained medical staff at all levels have inevitably had a serious impact on health services generally. This in turn has resulted in heavy demands for non-leprosy services being placed on leprosy projects staff.

The positive achievements of the project include the following:

1. A better data base on the incidence of leprosy and its sociological implications is being developed.
2. The level of awareness of health service staff generally of leprosy is being enhanced.
3. Substantial numbers of health service staff have received specialized training in leprosy.
4. The general public is becoming much more aware of leprosy as an objective reality.
5. No case resistant to treatment with Dapsone, (DDS), has as yet emerged.
6. Substantial progress has been made toward the closure of the Mahaica Hospital.

Evaluation Methodology

The project was evaluated by means of a personal visit for on-the-ground inspection of project activities, and by the use of the logical framework approach to measure progress to date, to discuss inputs and outputs and the continuing validity of project assumptions, purposes and goals with project staff. The implementation plan was thoroughly discussed and reviewed especially in relation to training. Changes were agreed to by all concerned.

External Factors

The project continues to be affected by the economic and medical service situations in Guyana. For instance, in respect to economic factors, the failure of electricity supply in rural areas has markedly affected the availability of gasoline for even in the countryside reliance is now placed upon electric pumps for the delivery of gas.

External factors of particular importance with respect to medical services have been as follows:

1. Consultant dermatology clinics have been held by project senior staff three times each week.
2. Forty three per cent of the mileage run by project vehicles has been undertaken on behalf of other Ministry of Health programs.
3. One vehicle was seriously damaged in an accident which occurred while it was on an unauthorized journey, and in consequence this vehicle was off the road for the last three months of the year.

4. A senior health visitor left the program in March, 1980 on promotion and had not been replaced by the end of this year.

5. Some basic supplies for the project office and clinics were unavailable through normal Ministry of Health channels and had to be purchased through project funds in order to maintain essential services for the project.

6. The project data processing computer is still not operational because of delays in obtaining replacements for defective parts, and data continues to be processed by hand.

7. The results of social surveys--undertaken by a member of the university staff in August were not available until the end of the year.

8. Salary increases ranging from 5% to 10% have had a small but real impact on project expenditures.

Individually, these items may not seem very large, but they do add up to significant frustration and additional work load for project senior staff..

Inputs

Inputs of staff, financial resources and of supplies--with the exceptions noted under "external factors"--proceeded according to plans. Two additional casefinders joined the school survey team in May, and one additional social worker was appointed in January. Laboratory supplies obtained from the USA proved to be of different strengths from those obtained from other sources previously. This resulted in the laboratory staff having to make adjustments in the methods used to process materials for histological examination. These relatively small technical difficulties were overcome by the end of the year.

Outputs

Target 1. An improved data base on the incidence of leprosy and its sociological implications.

During school surveys, the team examined 25,787 children in 116 schools, out of a school population of 26,115. Five children were found with leprosy and 18 others are being followed up as leprosy suspects. This gives a prevalence of leprosy in school-age children in this population of 2 per 10,000. The majority of the cases found were early cases of the tuberculoid type. Seventy-seven new cases of leprosy were diagnosed in the whole program, mainly through skin clinics, examination of contacts, and other activities undertaken by leprosy control program staff. Only six of these cases had grade 2 disabilities (established, but still mobile paralysis). None had grade 3 disability. The low disability rate in these cases (8%) indicates that the registration approximates quite closely to incidence. Assuming that the population of Guyana is approximately 900,000, the overall estimated incidence of leprosy in 1980 was 1 per 10,000, or half that found on school surveys. This discrepancy, between survey and clinic figures, is not surprising. Many, if not all the cases found on school survey were likely to be self-healing within a year or two, and therefore, most unlikely to report voluntarily for treatment.

Separate sociological attitudinal surveys were carried out during the year to ascertain the attitudes of typical urban and rural Guyanese communities towards leprosy. No significant differences were found between urban and rural attitudes. In both communities leprosy is regarded as a serious and fearful disease, and one of a group of diseases that discredit their victims. In both communities younger people seem to be less aware of and less afraid of leprosy than older people. The present prevalent attitude amongst older people is that leprosy is incurable, although most people in urban and rural

communities accept the idea that scientific medicine is the appropriate mode of treatment. Not a single respondent was found who indicated knowledge of the fact that treatment of leprosy renders cases uninfectious within a relatively short time. These findings have helped to identify the need to stress the treatability of leprosy in public education, in the belief that acceptance of leprosy as treatable, will influence cases to come earlier for treatment and will influence the public to accept treated cases in the community.

Target 2. All members of the clinical health service staff will be able to recognize and refer cases of leprosy.

During the year, 420 health service staff, out of approximately 1,200 clinical staff working for the Ministry of Health, received some training in leprosy. This training ranged from 6 weeks of training attachments at the project center to 1 hour of classroom instruction. In addition, three senior members of project staff and two tutors from nursing schools attended a seminar on leprosy diagnosis and management at the United States Public Health Service Hospital, in Carville, Louisiana. The latter group will provide competent instructors in leprosy to students of nursing in their respective schools in the future.

During the year, 15% of new cases (12 cases in all) are known to have been referred to the project from general health facilities. This is a disappointingly low figure, though not an uncommon experience in countries where leprosy is endemic, and a specialized service for leprosy patients exists. It may be due either to failure of general medical staff to recognize leprosy cases when they see them or the deliberate avoidance of attendance at general medical facilities by individuals who recognize that they have leprosy. In view of the low deformity rate in cases presenting voluntarily for diagnosis in Guyana, it seems that the former is the explanation of this phenomena in Guyana, rather than the latter. It is hoped that current training activities will increase the proportion of new cases found through general clinical health staff.

Target 3. By the end of the program, an effective and widespread system for case finding by contact tracing will have been established.

During the year, 4,117 home visits were made, 3,727 patients were seen and 16 plus contacts referred for medical examination. Twenty-three cases (that is 30% of the total new cases) were found as a result of contact tracing. This work is undertaken mainly by full time project staff, particularly by the four health visitors. Priority is given to the examination of contacts of smear positive cases and of children. Contact tracing is arduous and time consuming work. Availability of transport for contract traces in rural areas is a must. The future of this work depends upon the Ministry of Health maintaining the cadre of district health visitors and upon the Ministry making reasonable provision for their transportation. Contact tracing requires not only competence in diagnosis but also considerable personal maturity and ability to relate to people in their homes, especially when the tracers are searching for a disease with serious sociological implications that leprosy has.

Target 4. Public attitudes to leprosy will encourage cases with early leprosy to seek help voluntarily.

The fact that the disability rate in new cases has fallen to 8%, which has already been referred to, is good evidence that at the very least current public attitudes do not prevent early case finding. On the other hand, the fact that the estimated prevalence of leprosy in school children is approximately twice that in public as a whole, does indicate a tendency to "wait and see" on the part of the public when lesions which might be suspected as being due to leprosy appear. In most cases no harm is done but possibility remains that some early cases of lepromatous leprosy remain undiagnosed a lot longer than would be the case under ideal conditions. The initiation of extensive public education programs was delayed until the social surveys (Para. 1) were completed toward the end of the year.

Target 5. The emergence of resistant strains of leprosy (that is strains resistant to treatment with DDS) will have been delayed if not entirely prevented.

So far, no case of resistance to treatment with DDS has been recognized. Energetic measures are being undertaken by the project staff, that is multiple drug therapy in all smear positive cases, to insure that no cases of resistance to therapy occur. All cases currently under treatment (729 including 180 in Mahaica) are regularly reviewed in an endeavor to detect cases of resistance, should they occur, at the earliest possible stage.

Target 6. The foundations will have been laid for the integration of leprosy patient care into general health services.

In so far as general medical staff ignorance of leprosy is a major barrier to integration efforts being made by the project to train general medical staff will undoubtedly contribute toward the achievement of this goal. However, since the leprosy program remains essentially centralized and specialized and is dependent upon projects staff and the holding of specialized skin clinics for its effectiveness, integration as a reality is still far away. It is true that most of the special clinics are held in general health facilities, but this is done with little participation by general health facilities staff in most cases. General health services are at present dependent upon the leprosy project for a substantial proportion of their services to dermatological cases generally. If the project were to cease to exist, the result would be almost complete cessation of services, not only for leprosy patients but also for patients with skin problems generally. This might be called integration in reverse. Until more staff are made available for general health services, it is probably not possible for the project staff itself to make further progress towards integration.

Target 7. Progress will have been made towards the closure of Mahaica as a leprosy in-patient unit.

Thirty eight of the forty eight cases remaining at Mahaica as in-patients have now been accessed from the point of view of their potentiality for resettlement outside the institution. Seven of them will probably need long term custodial care. It is hoped that the remainder can be resettled despite their disabilities with the assistance of an annual allowance for each individual of U.S. \$1,500 for subsistence. The current cost of maintaining the patients of Mahaica is far in excess of this figure and it is hoped that the treasury will be able to make the necessary budgetary provision.

Acceptance of the remaining 7 patients in general custodial care facilities will be extremely difficult. The attitude survey showed that the elderly tend to be more resistant to the acceptance of leprosy cases than younger people. In addition, efforts made by project staff to gain acceptance for elderly patients in such facilities have so far been frustrated by the objection of present inmates.

Purpose

The general purpose of the project is to enhance the effectiveness of existing medical services in Guyana in the treatment of leprosy patients and in leprosy control.

The very existence of an effective service for the treatment of leprosy has been dependent during the year under review to great extent upon the resources provided by the project. Project vehicles alone, for instance, have been the main means of transport for case finding and case holding activities and without them clinic work also would have been seriously curtailed. In addition, the training provided for health service staff and the development of trainers for future staff are important contributions to the effectiveness of leprosy patient care and leprosy control generally. The proportion of disabled patients amongst new cases has already fallen from 21% in 1978 to 8% in 1980 and the program is expected to reach the target figure of less than 5% disabled by the end of 1981. No cases of resistance to DDS therapy have as yet been discovered.

Goals

In pursuit of the above purpose, goals include improving the treatment of leprosy patients, the identification of school children with leprosy, and accelerated progress towards integration of leprosy into basic health services. Improved treatment of leprosy patients is difficult to measure and in any case standards of care for individual patients were high before the project was undertaken. However, the project has enabled multiple drug therapy to be given to all smear positive cases in an effort to prevent the emergence of strains of M.Lepre resistant to treatment with Dapsone. So far this effort appears to have been successful. To date only 5 cases of leprosy in school children have been identified as a result of project activities, and the examination of 25,000 children. There are approximately 236,000 children currently attending schools in Guyana including nursery schools, primary schools and secondary schools. If the prevalence figures for leprosy found in school surveyed so far are representative of those for the whole country, then approximately 110 children with leprosy remain to be diagnosed. It is not the intention of the project to survey all schools. This work should be done by school health services as part of their general program. Progress towards integration has been commented on under item #6, Outputs, above.

Beneficiaries

The direct beneficiaries of the project include the 729 leprosy cases (77 new cases) and the 10,922 skin cases treated free of charge by the project in 1980. They also include the 54 retired patients of the Mahaica community, now granted subsistence allowances by the treasury, and other poor patients who have received financial assistance controlled and administered by project staff. Indirect beneficiaries include all who would have been exposed to actively infectious cases of leprosy, had these not been identified and placed on treatment by the project.

Unplanned Effects

So far no recognizable unplanned effects have occurred.

Lessons Learned

1. Data collection and collation is crucial to the management and evaluation of any project.

Much greater emphasis should have been placed on data collection and collation in the planning of the project. Special provision was made for financial accounting. This has worked very well, but the existing data collection system has not proved adequate to provide timely and comprehensive figures for operational aspects of program management. Neither the program senior staff, nor the private and voluntary organization consultant were familiar with the use of the logical frame sheet for the articulation, development and evaluation of program, purposes, goals, outputs and inputs at the beginning of the project.

More detailed preplanning of some aspects of the project especially in the field of training, would have been an advantage, and it would probably have been useful, if USAID could have provided a short workshop in these aspects of project design for senior project staff and the PVO consultant, before the actual project was embarked upon.

2. The difficulties experienced in the control and of the use of vehicles are not unique to the project, and although it can be said that the extra project use of the vehicles has contributed to the effectiveness of the Ministry of Health as a whole, this was not the purpose of the donor. In future projects of this type, consideration should be given to the provision of more utilitarian vehicles--small pickup trucks, with a 2-3 passenger cab, for instance--to discourage the use of project vehicles outside the project. Alternatively, it might perhaps have been more effective to use project funds on a fee for service or mileage basis, reimbursing senior project staff for the use of personally-owned vehicles for official journeys, rather than investing capital in project vehicles.

3. Inability to obtain the temporary release of a consultant for the project from a neighboring state was a serious drawback at the outset of the project. It was assumed that no problem would arise in this connection and in consequence, no formal commitments were obtained before the project was implemented. In retrospect, this was undoubtedly a mistake and formal commitments should have been obtained.

Special Comments

The integration of short term USAID funds, private and voluntary organization guidance and technical assistance, ministry of health permanent staff and locally employed temporary project staff into an ongoing program has not been an easy exercise, but the project has demonstrated that it can be done and can result in a substantial increase in program effectiveness. Whether this increase is merely temporary and will disappear once USAID support is withdrawn, remains to be seen, but from this perspective, there is at least a very good possibility that the momentum and enhanced visibility which has been imparted to the project through the assistance of the USAID will continue to

operate, provided (and this is a major concern) existing economic and medical situation in Guyana, generally, do not deteriorate.

W.F. Ross
Medical Director