CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) — PART I

Report Symbol U-447

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
Southern Primary Health Care	650-0019	USAID/Sudan

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) 650-82-03

☐ REGULAR EVALUATION ☒ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES	6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY 78	A. Total $ 5,315,000	From (month/yr.) April, 1981
B. Final Obligation Expected FY 81	B. U.S. $ 3,686,315	To (month/yr.) March, 1982
C. Final Input Delivery FY 83		Date of Evaluation Review

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
1. Review rate of project expenditures in 6 months to determine whether project completion date should be 9/30/83 (AMREF - RMOH Agreement) or 6/30/83 (OPG Agreement). Take appropriate action to make both documents consistent.	Micka/Paton	10/82
2. Review progress toward outputs and purpose in 6 months to determine which ones need to be carried over into Rural Health Support Project.	Micka/Paton	10/82
3. Review health manpower training needs for E.&W. Equatoria Province to determine the appropriate use of the CHW Training School at Lirya.	Noel	10/82
4. Develop implementation plan for outputs 10-12. Submit to USAID and RMOH SW.	Campbell	6/82
5. Develop plan for continuing logistics technical assistance under Rural Health Support Project.	Micka/Paton	1/83
6. Conduct knowledge, apptitude and practice evaluation of refresher and orientation. Submit report to USAID and RMOHSW.	Asante	6/83
7. Review recommendations of evaluation entitled "Implementation of Primary Health Care in selected Province of Sudan in relation to implementation planning for RHS Project.	Parmena/Paton	10/82
8. Turn over training school and dispensary at Akot to RMOHSW.	AMREF	7/82

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☐ Financial Plan
- ☐ Logical Framework
- ☒ Project Agreement
- ☐ Implementation Plan e.g., CPI Network
- ☐ PIO/T
- ☐ PIO/C
- ☐ PIO/P
- ☐ Other (Specify) _____
- ☐ Other (Specify) _____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. ☐ Continue Project Without Change
- B. ☐ Change Project Design and/or ☒ Change Implementation Plan
- C. ☐ Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

Dr. Mary Ann Micka, Project Officer, USAID
Dr. Parmena Marial, Director PHCP, RMOHSW
(see page 2 of PES - Part I for list of evaluation team)

12. Mission/AID/W Office Director Approval

Signature

Typed Name: Arthur W. Mudge, II USAID/DIR

Date: 4/22/83

AID 1330-15 (3-78)

9.	Turn over dispensary at Lirya to RMOHSW	AMREF	5/83
10.	Develop new implementation plan upon arrival of new community development officer (CDO), re outputs 3&4. Submit to USAID and RMOHSW.	CDO	7/82
11.	Select RMOH counterpart for training officer and community development officer.	Parmena	9/82
12.	Hold PHC coodinating conference.	Parmena	8/82

MEMBERS OF THE EVALUATION TEAM AND RESOURCE PERSONNEL

Outside Evaluations	Agency	Speciality
Dr. Robin Barlow	APHA	Recurrent Costs
Ms. Catherine Ada Beckley	UNICEF	Maternal Child Health
Dr. Helmy M. Bermawy	Consultant	Community Organization
Mr. A.G.T. Carter	UNICEF	Health Information Systems
Dr. A. Deria	WHO	Public Health Advisor
Ms. Dayl Donaldson	APHA	Recurrent Costs
Mr. Vic Evans	Consultant	Logistics and Supplies
Dr. Brooks Ryder	APHA	Team Leader
Dr. May Yacoob	Consultant	Health Management
Dr. Enaam Abou Youseff	Consultant	Personnel and Training
Resource Personnel		
Mr. Michael Campbell	AMREF	Medical Supplies
Mr. Hillard Davis	MSCI	Health Information
Dr. Fred Katz*	WHO	Evaluation
Mr. Gary E. Leinen	USAID	Public Health Officer
Dr. Markarian	MSCI	Training Specialist
Mr. Dan Marwa	AMREF	Health Information
Dr. Mary Ann Micka*	USAID	Chief, Health Division
Dr. Joseph S. Nyanzi	AMREF	Health Planning, Administration.
Ms. Arlene O'Reilly*	USAID	Evaluation Specialist
Dr. Jerry Weaver	USAID	Social Science Analyst
Mr. B.R. Wisnéiwsky	MSCI	Logistics
GOS Representatives		
Dr. Mohamed El Mahdi Balla	MOH	Health Statistics & Research
Dr. Parmena Marial	RMOH (Juba)	PHCP Director
Dr. Eisa Abu Bakr Mohed	MOH	Malaria/Community Physician
Dr. Mohamed A. Musbah	MOH	PHCP-MPH
Dr. Mark Taban	RMOH (Juba)	PHCP-Medical Supplies

*Advisors to team

AMREF - African Medical & Research Foundation
APHA - American Public Health Association
MSCI - Medical Services Consultants, Inc.
MOH - Ministry of Health
RMOH - Regional Ministry of Health
UNICEF- United Nations Children's Fund
USAID - United States Agency for International Development
WHO - World Health Organization

PROJECT DESIGN SUMMARY

LOGICAL FRAMEWORK

Life of Project:
From FY 78 to FY 83
Total U.S. Funding $3,700,000
Date Prepared: June8,1981

Project Title & Number: SOUTHERN PRIMARY HEALTH CARE (OPG) 650-0019

NARRATIVE SUMMARY	OBJECTIVELY VERFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
Program or Sector Goal: The broader objective to which this project contributes: To improve significantly the health status of the rural poor.	Measures of Goal Achievement: 1. Decreased morbidity. 2. Decreased mortality	Percentage reduction projections will be made after baseline studies are completed and information system is established.	Assumptions for achieving goal target: 1. Donors maintain present levels of commitment to Primary Health Care Program. 2. Government continues its commitments to the National Health Plan.
Project Purpose: To strengthen the delivery of Primary Health Care Service to the rural population of Southern Sudan with special emphasis on community participation.	Conditions that will indicate purpose has been achieved: End of project status. 1. Village elders participate in the selection of virtually all Community Health Workers (CHW's). 2. High percentage (60%) of Primary Health Care Units (PHCU's) constructed through self-help. 3. Health component/subcommittee of Village Development Committee (VDC) strengthened/formed to function in support of CHW activities in 75% of villages with PHCU's. 4. An adequate supply of drugs on hand in 75% of PHCU's. 5. Preventive/promotive health measures being practiced by villagers, such as using safe water, better methods of vector control and better system of refuse & excreta disposal.	1. RMOH & provincial records; sampling, on site evaluation. 2. RMOH & provincial records; sampling, on-site evaluations. 3. Monthly CHW reports; provincial records. 4. Monthly CHW reports;sampling on-site evaluations. 5. Monthly CHW reports; sampling, on-site evaluations.	Assumption for achieving purpose: 1. That villagers & RGOS support community based PHC concept and participate in program. 2. That adequate administration/support is provided at Provincial level. 3. All weather roads to provincial capitals are completed as scheduled. 4. Educational system will provide adequate qualified candidates for training as CHW's. 5. That CHW's will have basic wherewithal to provide PHC services. 6. That the GOS will provide the necessary funding and transportation to assure an adequate drug supply.

Attachment A

Project Outputs:	Magnitude of Outputs:		Assumptions for achieving outputs:
1. Two CHW Training Schools operational.	1. 20 CHW's trained annually at Lirya and at Akot in FY 82 and 83.	1. AMRF/RMOH records; site visits.	1. Commitment to provide PHC services to population remains a high priority with RMOH.
2. Two dispensarries affiliated with CHW Schools providing practical training.	2. Each CHW receives one week of training at Lirya and Akot dispensaries in FY 82 and 83.	2. AMRF/RMOH records; site visits.	2. PHC Department in RMOH is fully staffed.
3. Self-Help construction in Primary Health Care Program.	3. Five PHC units in FY 82 and five in FY 83.	3. AMRF/RMOH records; site visits.	3. Cooperation continues between Non-Govt Organizations and RMOH on PHCP activities.
4. A functioning PHC complex at both Lirya and Akot consisting of a training dispensary and 5 PHC units.	4. Medical staff & CHW trainees participating in monthly discussion sessions by October, 1982.	4. CHW interviews; complex records of sessions held.	4. Staff of CHW training dispensaries capable & committed to concepts of PHCP.
5. Training program developed for sanitary overseers.	5. Curriculum revised and tested by September 1983.	5. Visit school.	5. Villages respond to self-help constructive incentives.
6. Primary Health Care personnel retrained.	6. CHW's 390; Nurses 300; sanitary Overseers 100; others 110; (300 annually beginning FY 1981.)	6. RMOH/provincial records.	6. Provincial authorities give high priority to implementing the Primary Health Care Program in cooperation with the RMOH.
7. Improved data collection and reporting system for PHCP.	7. RMOH, through Provincial Hdqs., receiving monthly reports from PHCU's & supervising dispensaries * by 9/83.	7. RMOH/Provincial records.	7. Petrol is available to facilitate PHCP activities.
8. Trained and/or retrained PHCP data collection personnel.	8. 45 Statistical clerks; 160 CHWs; 150 MAs by 9/83.	8. RMOH/Provincial records.	8. RMOH maintains and operates commodities for purposes intended by the project.
9. Provincial baseline & follow-up surveys.	9. Three baseline and 1 followup survey submitted to and accepted by RMOH by 6/83.	9. AMREF records.	9. Cooperation between MOH and RMOH continues in areas of data collection, information sharing and logistics.
10. Trained and retrained medical supply/logistics personnel.	10. Seven storekeepers and seven assistant storekeepers for PHCP by 9/83.	10. RMOH/provincial records; site visits.	10. Paper, registration and reporting forms are available to CHW's.
11. Upgraded drug & supply distribution system.	11. 75% PHC Units receiving drugs and supplies on a regular basis by 9/83.	11. RMOH/provincial records; site visits.	11. Drugs/supplies are available from the Central Medical Stores (CMS) in Khartoum.
12. Upgraded reporting & accountability system for drugs.	12. Provincial Hdqs., receiving monthly reports from 60% PHCU's and dispensaries by 9/83.	12. Provincial records.	12. Transportation for supplies from CMS to the Southern Region is available at a reasonable cost.

Attachment A

13. Trained RMOH counterpart personnel.	13. One MPH; MS in statistics; two rural health training; one clerical; one stastistical; one logistics by 6/83.	13. RMOH records sitevisits	13. Returned participants will be utilized in the PHC program.
14. 34 Trained clerical staff at regional and provincial health offices.	14. FY 81: RMOH 9, E.Equatoria 5, W.Equatoria 8; and FY 82: Bahr El-Ghazal 6, and Upper Nile 6.	14. RMOH/Provincial records and site visits.	
15. CHW manual revised and published.	15. 700 manuals distributed to schools, CHW's and MA's by 9/83. * Estimated 500 functioning PHCUs 100 dispensaries by 9/30/83.	15. Interview CHW's & visit training schools.	

Inputs:	Implementation Target (Type and Quantity) ($000) OPG	Amendments	Total		Assumptions for providing inputs:
AID:					
1. Technical Assistance (384 PM).	$ 651	275	926	1. Budgets and records of the RMOH, AMREF and other donors.	1. That the numbers of health persom personnel and facilities are called for in the six-year Primary Health Care Program for the Southern Region are met.
2. Training	264	16	280		2. That qualified people will be nominated for both in-service and participant training.
3. Commodities	557	59	616		3. That RMOH adequately furnishes, staffs and operates two CHW training schools and two training dispensaries constructed under project.
4. Construction	1,032	45	1097		
5. Other Direct/Indirect Costs	682	85	767		
Subtotal	3,186	500	3,686		
Other Donors:	242	71	313		
GOS:	316		1,316		
Project Total	4,744		5,315		

Attachment A

Progress Review Worksheet
PROJECT OUTPUTS - PROGRESS TO DATE

Evaluation for Period 4/81 to 3/82

A. QUANTITATIVE INDICATORS FOR MAJOR OUTPUTS		TARGETS (Percentage/Rate/Amount)					
		CUMULATIVE PRIOR FY	CURRENT FY 82 TO DATE 1/2	CURRENT FY 82 TO END 1/2	FY 83	FY ___	END OF PROJECT 6/30/83
1. Primary Health Care units constructed by self-help	PLANNED	0	0	5	5		10
	ACTUAL PERFORMANCE	0	0				
	REPLANNED			0	10		10
2. Medical staff &CHW trainees participating in monthly discussions at meeting of PHC completes at Lirya & Akot	PLANNED	0	0	0	24		24
	ACTUAL PERFORMANCE	0	0				
	REPLANNED			3	18		21
3 Curriculum revised and tested for sanitary overseers training program.	PLANNED	50%	10%	15%	25%		100%
	ACTUAL PERFORMANCE	25%	25%				
	REPLANNED			20%	30%		100%
4. PHC personnel retrained: 390 CHWs; 350 MAs; nurses 300; sanitary overseers 100; others 110.	PLANNED	650	150	150	300		1250
	ACTUAL PERFORMANCE	844					
	REPLANNED						1250

B. QUALITATIVE INDICATORS FOR MAJOR OUTPUTS

1. CHW graduates of new training schools (20 each at Lirya and Akot).

Comment:
Planned: 40 CHW graduates by 9/82; 80 graduates by 6/83.

Actual: The school at Lirya was completed and accepted by RMOH 16 Oct. 1981. During 2nd qtr, FY 82 a special tutor training course was held at Lirya for approximately 3 months - 20 medical assistants (MA) and sanitary overseers (50). The school at Akot has not been completed.

Replanned: CHW training at Lirya to begin 6/82
(In view of 89% coverage by CHW's in the Equatoria Provinces, the use of the school at Lirya for CHW training should be reassessed).
Akot - school completion expected 4th qtr, FY 82 with 20 CHW graduates expected in FY 83. Therefore, maximum number of graduates would be 40.

2. CHWs receive one week of training at dispensaries at Lirya and Akot.

Comment:
Planned: 40 by 9/82; 40 by 6/83.
Actual: One dispensary completed but not yet in use for training because CHW's not yet in training

Replanned: 40 by 6/83.

3. 75% of PHC units receiving drugs and supplies on a regular basis (estimated 500 PHC units at end of project).

Comment:
Planned: 72 Units by FY 81 (25% of goal); 199 by FY 82 (60% of goal); 375 by 6/83 (100% of goal)
Actual: Many non-government agencies supply the PHC units with drugs and supplies but the actual number is unknown. An assessment is in progress to collect baseline data.
Replanned: 62/333 units by end of FY 82 (25% of goal) 188/500 units by 6/83 (50% of goal).

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Southern Primary Health Care, 650-0019

Progress Review Worksheet

PROJECT OUTPUTS-PROGRESS TO DATE

Evaluation for Period 4/81 to 3/82

A. QUANTITATIVE INDICATORS FOR MAJOR OUTPUTS		TARGETS (Percentage/Rate/Amount)					
		CUMULATIVE PRIOR FY	CURRENT FY 82 TO DATE 1/2	CURRENT FY 82 TO END 1/2	FY 83	FY ___	END OF PROJECT ~~6/30/83~~
7. RMOH through Provincial Hdqs. receiving monthly reports from 60% of PHCUs and the supervising dispensaries. 1/	PLANNED	8%	12%	20%	60%		100%
	ACTUAL PERFORMANCE	15%	17%				
	REPLANNED			38%	30%		100%
8. 355 PHC Data Collection personnel trained or retrained.	PLANNED	85	45	100	125		355
	ACTUAL PERFORMANCE	30	63				
	REPLANNED			100	162		355
9. Three Baseline and one Follow-up Survey submitted to and accepted by RMOH.	PLANNED	3	0	0	1		4
	ACTUAL PERFORMANCE	2	.25				
	REPLANNED			.75	1		4
10. 7 storekeepers and 7 assistant storekeepers trained or retrained.	PLANNED	0	3	4	7		14 trained & retrained
	ACTUAL PERFORMANCE	7	3				
	REPLANNED			8	10		28
12. Provincial Hdqs. receiving monthly reports from 60% of PHCUs and dispensaries.	PLANNED	28%	16%	16%	40%		100%
	ACTUAL PERFORMANCE	3%	1%				
	REPLANNED			31%	65%		100%
13. One MPH; one MS in statistics; two rural health training; one clerical; one statistical; one logistics.	PLANNED	4	0	0	4		8
	ACTUAL PERFORMANCE	4.25	0				
	REPLANNED			0	2.75		7
14. 34 clerical staff trained: in FY 81 - RMOH 9, East Equatoria 5, W. Equatoria 8; and FY 82 - Upper Nile 6 and Bahr El Gazal 6.	PLANNED	28	6	0	0		34
	ACTUAL PERFORMANCE	19	0				
	REPLANNED			0	6		25
15. CHW Manuals distributed to schools, CHWs and MAs(700).	PLANNED	70%	7%	8%	15%		100%
	ACTUAL PERFORMANCE	40%	10%				
	REPLANNED			20%	30%		100%

1/ Estimated 500 PHC units by 6/30/83.

Southern Primary Health Care 650-0019

Progress Review Worksheet

Evaluation for Period: 4/81 to 3/82

PROGRESS TOWARD CONDITIONS EXPECTED AT END OF PROJECT

A. CONDITIONS EXPECTED TO EXIST AT THE END OF THE PROJECT	B. METHOD (OR MEASUREMENT) OF VERIFYING CONDITIONS AT END OF THE PROJECT	C. PROGRESS AS SHOWN BY MEASUREMENT VERIFICATION *
1. Village elders participate in the selection of virtually all Community Health Workers (CHW).	RMOH and Provincial records; sampling, on-site evaluations.	All CHW's selected by one or more village elders.
2. High percentage (60%) of PHC Units constructed through self-help.	RMOH and provincial records; sampling, on-site evaluations.	Six of twelve PHC units (50%) constructed through self-help.
3. Health component/subcommittee of village Development Committee (VDC) strengthened/formed to function in support of CHW activities in 75% of villages with PHCU's.	Monthly CHW reports; provincial records.	Eleven of twelve villages had VDC and discussed health issues. Six contributed significantly to upkeep of PHC unit (50%) four provided administrative supervision of CHW (33%).
4. An adequate supply of drugs on hand in 75% PHCUs.	Monthly CHW reports; sampling, on-site evaluations.	Of 49 PHC units on which provincial authorities reported, 15 (35%) had druges supplied regularly by non-governmental organizations.
5. Preventive/promotive health measures being practiced by villagers, such as using safe water better methods of vector control, and better system of refuse and excreta disposal.	Monthly CHW reports; sampling, on-site evaluations.	In three of four villages preventive/promative knowledge demonstrated by villages but little practive of preventive measures. In nine other villages no records were kept of CHW promotive activities.

* Data base: 12 PHC units and 13 CHW's visited during evaluations of 3/81 and 3/82. Records and data base at regional and provincial level still tooo meager to conduct a review.

Attachment C

Attachment D

OBSERVATIONS ON THE IMPLEMENTATION OF THE PHCP SOUTHERN REGION, SUDAN

Dayl Suzanne Donaldson
MOH/AID/UNICEF/WHO Evaluation
24-31 March 1982

OBSERVATIONS ON THE IMPLEMENTATION OF THE PHCP
SOUTHERN REGION, SUDAN

PHCP Drugs, Supplies, and Instruments Distribution

The information below was obtained during a visit to the PHCP Regional Store in Juba.

Sources of PHCP Drugs, Supplies and Instruments

In the PHCP store, Juba, all PHCP drugs, equipment and instruments are supplied by UNICEF (via Mombasa and Nairobi). No drugs are provided to dispensaries or PHCUs from the Regional Medical Store. Some drugs may go directly to the Provinces from the Central Medical Store in Khartoum. The NGOs in the South have separate stores for the drugs which they supply to the PHCP.

Distribution of PHCP Drugs, etc.

In the Southern Region, PHCP drugs, etc., are distributed 1) directly to CHWs who come to the store, 2) via NGOs doing PHCP supervision, 3) to A. Commissioners for Health (ACH) who use contracted vehicles, or 4) via UNICEF trucks. The PCHI in the Provinces distributes the drugs to dispensaries and PHCUs.

Development of the Drug, Supplies and Instruments Lists

Since the "Green Book," the list of drugs, instruments and equipment supplied to PHCP facilities has been modified as a result of consultation between PHCP staff and UNICEF. UNICEF's input is in the form of "kits." The author does not know if the NGOs supply kits or fill the requisitions of the units they supervise. It is unknown what analysis preceded the development of the SE drug lists and if the drugs supplied are adequate.

Regional PHCP Store, Juba

The regional PHCP store in Juba is located in one of several warehouses of the Regional Medical Store. The stocks are neatly ordered and the warehouse appears to have adequate space for the items currently

stocked. Since the PHCP store had just recently been moved to this building, the staff was unable to report whether the building was watertight during the rainy season. On the porch of the warehouse was a large pile of half-opened cartons with a variety of medical supplies visible. The PHCP store staff reported that these were reject cartons from the Regional Medical Store which could be used by the PHCP if such items were needed. The author would be unable to find particular items from these disorganized boxes. Refrigerators in the store were not in operation but merely stored to be moved to unspecified medical facilities.

PHCP Inventory System

The PHCP Storekeeper reported that UNICEF takes the inventory on a monthly basis. Only UNICEF supply lists were found at the store, not records of the UNICEF inventories.

The PHCP store's inventory system consists of a set of cards. Each card represented an item in the inventory, e.g., the entire PHCU kit (5 boxes); each box in the UNICEF kits or individual items from opened cartons of the kits. Unfortunately, the information on these cards had not been sufficiently well recorded to allow for assessment of the materials which had been distributed the prior year. This is partly because the actual content of the UNICEF kits has changed and partly because of poor recordkeeping. The storekeeper could not easily explain anomalous information on the cards, nor identify certain cards with particular boxes or items.

Movement of Stocks from the PHCP Store

Several UNICEF kits from 1 to 2 years ago were in the PHCP store. The storekeeper stated that these would be the first to go to the Provinces even though they contained outdated or spoiled items (e.g., Lidocaine) or items which PHCP workers were not trained to use. It was stated that a letter is sent with these kits to the ACH or PHCI, instructing him to remove the inappropriate items.

Recommendations

1. The AMREF staff position for logistics should be staffed on a full time basis. The progress performance of the staff person with respect to a plan for drug distribution in the South should be monitored biannually by AMREF and USAID.

2. The Storekeeper's skills with respect to taking the inventory and maintaining these records should be strengthened to the point where an AMREF seconded staff person is not required. Job descriptions and on-the-job training plans for those involved in the Regional PHCP store should be developed, implemented, and the progress of the Sudanese staff quarterly assessed, so that it is possible to determine when seconded staff are no longer required.

3. The drugs "needed" to supply PHCUs and dispensaries should be determined by studies such as the one recently done by the GMT or by requesting that units which have received known quantities of drugs be inventoried to estimate the average quantity of drugs used in a year. To the extent possible, these studies should assess the size and illness pattern of the population which use the facilities studied, since these factors affect the quantities of drugs required.

4. Since even the simple "kit" system is not correctly managed at this time, careful consideration should be given to bringing in drugs in other than kit form (e.g., bulk form to be repackaged). If drugs are not in kits, a plan to distribute them should be developed and its implementation carefully monitored by AMREF and AID.

5. Short studies should be done of ways to minimize the transportation costs of drug distribution to dispensaries and PHCUs.

6. Collaboration between the GOS, RMOH/PHCP, AMREF, UNICEF and NGOs to rationalize drug distribution in the South should be strengthened.

Issues

1. At the present time, GOS/PHCP drugs (if there are any) come to the South via Port Sudan and Khartoum. However, UNICEF and NGO PHCP drugs come to the South via Mombasa and Nairobi. Consideration should be given to: a) whether AID funded drugs for the PHCP in the South should be distributed from Khartoum or from Juba (via Kenya) and b) whether AID funded technical assistance in the area of logistics should be directed to improve the Kenya or Sudan supply line. This issue will require a policy determination by the GOS as to whether it will provide foreign exchange to the regional medical stores to procure drugs in the most straightforward and least costly (both from perspectives of time and money) fashion, or if the current organization of distribution by the government will continue to be through Khartoum.

2. Should AID fund the construction of PHCP warehouses in the South when it is unlikely that the GOS will have foreign exchange to purchase pharmaceuticals for the PHCP?

Health Information System

Observations

RMOH/SW Level. Tables with data from 1979 and 1980 for the Annual Report of the RMOH were reviewed. A comparison of a table summarizing data on the top ten causes of illness in the two years showed several critical errors of analysis and recording. The causes of illness were represented as percents of the total number of illnesses reported. However, different numbers of illnesses were recorded for each year, thus affecting the percentages observed. Further, data from 1980 was recorded as that for 1979 and vice versa. Documentation of the fact that different numbers of facilities and months of the year were used for each year was not made on the table. Thus, for example, the analysis that malaria had decreased as a cause of illness between the two years was totally fallacious.

The statistical officer with whom this was discussed was able to understand these problems but had not discovered them himself.

PHCP Level. The PHCP files were not organized in such a way as to easily abstract information on numbers of facilities, workers trained, etc. Rather, these numbers are contained in correspondence files which are laborious to wade through. The existance of an annual report containing some tabulated information was not brought to the attention of the author by the Sudanese information officer, rather it was found when the correspondence files were scanned.

The Sudanese PHCP information officer is not qualified for the AMREF training component of the grant. Nor did the officer appear to be particularly effective with respect to compiling information requested by the author.

The proposed PHCP information system does not ask explicitly for the number of persons who utilize the facility monthly. Rather, notation is required of new and old "cases" on the basis of a primary diagnosis, and it is not clear that the number of cases would be equivalent to the number of visits per month.

Recommendations

1. The analytic and management skills of personnel in the RMOH and PHCP should be strengthened. Given the importance of reliable information to planning and evaluation, it is recommended that the training funds remaining in the AMREF grant be used to train someone in the RMOH in place of the information officer of the PHCP. The question of whether the PHCP or RMOH is in more need of this person after training requires further consideration. Nonetheless, it would be a shame not to utilize the AMREF funds to help in this critical area.

2. The proposed PHCP information system should be modified so that all principle diagnoses of patients are recorded (either new or old) and the monthly sum of the number of patients seen is recorded on a separate line. A simple guide for correct use of the forms should be developed--the guide written by the PHCP information officer is interesting but inadequate as an instructional tool.

3. The filing system of the PHCP and RMOH should be improved so that information relevant for planning and evaluation is available in an annual report. Filing cabinets and improvements in the office space of the PHCP would facilitate improvement of the order and efficiency of the information system and the program. A minimum set of tables to be filled in annually should be developed.

4. With respect to the National Health Information System, it does not seem appropriate to introduce the new system in a 6 month period without evaluating what unanticipated problems develop which were not dealt with in the first field test of the forms. Is is recommended that the information system initially be introduced on a region by region basis or in one district of every region followed by a review and modification before introduction into other areas. This recommendation is intended to counter the contractual requirements and deadlines which would push for national introduction without any further field review.

Construction of Training Facilities, Southern Region, Sudan

Observations

Neither of the new CHWTS at Lirya or Akot were visited. However, they were reported to be 95 percent complete. The USAID engineering

evaluation of the Lirya construction found,

> "the construction of all buildings in the dispensary area . . . to be substandard and, although allowances are made for local practices and workmanship, certain elements of the construction program are considered to be unacceptable." (J. Smith letter, May 20, 1981)

Neither the contractor nor USAID had visited the construction site prior to the May evaluation. Steps to rectify the problems found were undertaken and the Lirya building has been presented to the RMOH. However, the recurring costs of maintaining a building which was not properly constructed will be higher than would otherwise be the case.

The principal of the Lirya School stated that the school may only train one more class of students because of the lack of funds for contracting for food to be delivered to the school and because the Eastern Equatoria Province is thought to have enough CHWs. Thus, due to construction delays, the school may be used to train only one batch of students. The Principal was not clear about what the school's staff would be used for after training this last batch. The director of the regional PHCP said the facility would be used for refresher courses.

Finally, the March 1980 evaluation of the project raised the question of whether unused buildings from an AID-funded technical school project in Lirya could have been renovated for the CHWTS. The Ministry of Education has been reported to have been using these buildings although it has not renovated them. Hopefully the new CHWTS will not become another AID-funded "white elephant" in Lirya.

Recommendations

1. A different contractor or contracting arrangement should be undertaken for new AID-funded construction so long delays, which could be avoided, do not occur.

2. Construction of facilities should be very carefully considered, since the RGOS does not have sufficient funds for the recurrent costs of its present capital stock. For example, PHCP training facilities could be created by renovating existing buildings, e.g., a conference room at the district hospital, instead of constructing a new facility. This approach would have the additional advantage of strengthening the referral system between different levels of the health care system by having PHCP workers meet hospital staff. The drawback to this approach is that it would tend to strengthen the curative side of the PHCP; however, since this aspect is in most demand from the communities, perhaps it should be recognized that CHWs are part of a curative system and other measures taken to promote prevention. The construction of new warehouses versus renovation of available space should also be considered.

3. Use of imported construction materials should be minimized because of the lack of foreign exchange available for purchasing materials for their repair or replacement.

Vehicles

Observations

The 24 project vehicles given to the GOS were all reported to be operational and only one in marginal condition. A year ago when AMREF found that the vehicles were non-operational, they imported spare parts and hired personnel for maintenance of the vehicles. The current estimated cost of operating the vehicles is US$1.00/mile (1/3 depreciation, 1/3 parts, 1/3 petrol). Since the vehicles average from 500 to 1,000 miles per month, the total annual recurrent cost of the vehicles at 750 miles per month is US$216,000. At the present time, the GOS is only responsible for purchasing petrol, not for supplying spare parts.

Given the RMOH's difficulty in obtaining foreign exchange with which to purchase petrol, AMREF has assisted by selling AMREF imported petrol to the RMOH in exchange for Sudanese currency. AMREF then uses the Sudanese currency to support its operations in Juba. From the objective of discouraging dependancy, this exchange is preferable to giving the RMOH petrol to fill their chronic and crisis needs.

Recommendations

1. Improvement of the vehicle maintenance skills of the Sudanese responsible for the PHCP vehicles is recommended. (Though "slots" have been open in the courses offered by the Northern Project, these are too few in number and--since the teaching is in Arabic--inappropriate for the Southern staff.) AMREF should also be encouraged to think innovatively and develop a system whereby the maintenance and supply for PHCP/RMOH vehicles could be institutionalized.

Status of Counterpart Training

Observations

As noted above, neither the Sudanese regional PHCP store staff nor the survey and evaluation officer currently have a functioning logistics or information system which they can learn/master and thus will not be fully able to manage these systems at the end of the project.

The training counterparts were not met and so determination of their ability to carry on the program without AMREF assistance is not known.

Recommendations

1. Job descriptions and a learning plan should be developed for each PHCP or RMOH staff who is a counterpart to an AMREF seconded staff. Periodic assessments can then be made of the progress of the counterpart and the success of the seconded staff in training of the counterpart. These assessments would also ensure earlier identification of inappropriately trained or experienced counterpart or seconded staff, and would provide a more rational basis for withdrawal of AMREF seconded staff than the ending of the project.

PROJECT EVALUATION SUMMARY (PES) - Part II

Implementation of Primary Health Care in Selected Provinces of Sudan

13. Summary

The Evaluation, undertaken by an evaluation team sponsored by the Ministry of Health (MOH) Sudan, WHO, UNICEF and USAID, addressed the question of progress being made in the implementation of Sudan's Primary Health Care Program (PHCP) in four provinces selected for detailed study.

PHCP is described as a community-based health service that reaches beyond the health center and dispensary to rural and nomadic populations with promotive/preventive health activities and curative services at community level. It relies upon community participation and self-help. The MOH design called for one community health worker (CHW) based in a Primary Health Care Unit (PHCU) for each 4,000 population.

Implementation of PHCP is proceeding along the general lines propounded in the national health plan of 1975. PHCP was planned in an exemplary manner, although the action plan is not specific in regard to the phased implementation of its components. Accomplishments were scheduled for completion in 1984 but new plans with a smaller CHW/population ratio (1/1000) are projectd for 1990.

Although considerable success has been achieved, with 2,800 PHCUs having been established during the past 5 years, implementation has been impeded by considerable financial and technical constraints. The PHCP receives strong support within the MOH, has had close to $50,000,000 of international assistance committed up through 1980/81, and is a program well-accepted and actively supported by the rural and nomadic populations it reaches. An estimated 75% of the targeted population is already being reached based on the 1/4,000 ratio or 19% according to the MOH's revised ratio of 1 CHW/1000 population. Of the eight components of a PHC system as defined at Alma-Ata in 1978 the evaluation team identified only one component being offered routinely at the village level, i.e. treatment for common diseases and injuries.

14. Evaluation Methodology

The evaluation was carried out by a 10-member multidisciplinary team working with MOH program implementors and project personnel. The study focused on the work and activities of front-line health workers serving rural and nomadic populations in four selected provinces and on progress being made in strengthening the supportive infrastructure. Analysis of recurrent cost factor implications of the AID-supported PHC projects in the North and in the South of the Sudan were included.

Field teams visited the provinces of Bahr el Ghazal, Kassala, North Kordofan and Upper Nile to observe PHC activities and collect data through guided interviews. Data were then assembled and analysed by functional groups made up of team members who assessed the significance of the field findings, related them to the National PHCP, and formulated sets of recommendations. The evaluation concerns elements only of the PHCP, addresses qualitative as well as quantitative accomplishments and employs the critical instant techniques of evaluation.

15. External Factors

Although MOH places high priority upon the donor agency contributions have been significant, socio-political, economic and technical constraints have had an impact upon the program. These include the decision to decentralize the governmental apparatus to regional level, stringent financial limitations especially for foreign currency exchange, weaknesses within the managerial-supervisiory component of the MOH supporting infrastructure, including brain-drain to neighboring countries, maldistribution of medical and health personnel and problems of transport, communication and commodities. Drugs at PHCU level are in particularly short supply.

16. Inputs

In addition to MOH inputs, bilateral, multilateral and non-governmental commitments to PHC in Sudan have approached $50 million, including vehicles, construction of facilities, drugs and other commodities, technical assistance and training. Donor support in North Sudan tends to follow MOH guidelines for program implementation; in the South the trend has been toward assigning donors responsibility for health service delivery for a given geographic area.

Project 650-0011 has provided $5.0 million for three long term technical advisors, long term and short term U.S. training, in-country and third country short term training, vehicles medical equipment and supplies, drugs, data forms and construction of phase I dispensaries. Construction and drugs/equipment have been delayed significantly by circumstances beyond the control of the contractor, Medical Services Consultants, Inc. (MSCI). These delays interfere with achieving project outputs. An extension of the Project Assistance Completion Date (PACD) from 6/30/82 to 6/30/84 was requested 3/8/82. If granted,* the extension of the PACD will allow sufficient time for completion of the inputs.

In addition, the amount of funds available in the contractors budget for drugs/equipment and for printing of the PHCP data forms is inadequate. A PIO/T was executed 3/10/82 requesting revision of the contract budget within the present total, to adequately fund these inputs. Extenstion of the long-term technical assistance was also requested through 3/31/83 at no additional funding.

Project 650-0019 has provided $3.7 million for seven long term advisors, long term U.S. training, short term third country and in-country training, vehicles, bicycles and construction of training schools and dispensaries. Construction, community development activities and long term training of counterparts have been delayed significantly because of circumstances beyond the control of the OPG grantee, African Medical Research Foundation (AMREF). These delays have interfered with achieving project outputs. The progress toward the related outputs will be reviewed in six months to determine which inputs/outputs need to be carried over to the Rural Health Support Project (RHSP).

The cost of fuel has escalated so much that the project may need to phase out long term technical advisors prior to 6/30/82 to stay within the amount of the grant. The status will be reviewed in six months.

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* PACD extension granted March 29,1982.

17. Outputs

MOH achievement targets are not broken down by year, but PHCUs are being established as new CHW trainees are graduated. 2,800 CHWs are already employed in community-based PHCUs. The evaluation report addresses selected qualitative aspects of PHC worker activities in terms of preventive-promotive health activities (low to absent) compared to curative, supporting structures in manpower development, supervision (weak), logistics, health information system components, recurrent cost factors. Construction of new facilities by villagers at the community level is proceding well; construction of donor-assisted dispensary facilities is behind schedule. Logistics support for PHC is weak; drug supplies are low with virtually no anti-malarials available at any level of MOH. New lists of essential drugs for PHC have been developed recently and accepted by MOH.

Project 650-0011: Actual progress measured against the logframe, Revised 9/80 (Attachment I to PES Part I, 650-0011) is tabulated on the "Progress Review Worksheet, Project Outputs - Progress to Date" included as Attachment II to PES - Part I for this project. As component parts of several outputs, needs assessments for baseline data in the areas of health information and logistic systems have been completed for only four of twelves provinces. These needs assessments will be completed through the use of short term technical assistance.

Completion and provisioning of phase I dispensaries have been markedly delayed primarily because of lack of continuity among USAID management and technical personnel as well as changes in personnel and procedures by GOS. The requested change in the PACD as discussed above should allow for completion of these outputs.

Project 650-0019: Actual progress measured against the Logframe, Revised 3/81 (Attachment A to PES Part I, 650-0019) is tabulated on the "Progress Review Worksheet, Project Outputs - Progress to Date" included as Attachment B to PES - Part I for this project. Outputs for any project in the South are severely constrained by the difficulties in logistical support for project activities and by the lack of adequate administrative and technical infrastructures. Turnovers in AMREF personnel have resulted in a 108 person months shortfall in planned technical assistance, 62% of which involves the community development, health information and logistic officers. Hence the delays in outputs 1-4, 7-12. Two Regional MOH counterparts have yet to be selected; hence the delay in output 13. Output 14 has been delayed and revised downward due to the completion of service of the CUSO volunteer providing the training. Printing for output 15 was delayed by one year. Construction has been delayed by various environmental and political realities.

18. Purpose

The purpose and design of the PHCP as developed by MOH in 1975 remains valid: to achieve maximal coverage of the rural population as the community level by 1984. The term "coverage", originally based on 1 CHW/4,000 selected population and 1 CHW/1,5000 nomadic population is being revised by MOH to 1/1000 for future planning cycles. The evaluation team underscores the problems in developing a realistic definition.

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of coverage. Based upon the 1/4000 ratio an estimated 56% of the targeted population is already being reached with the establishment of 2,800 PHCU's during the last 5 years. Based upon the 1/1000 ratio the coverage is estimated at 14%.

The PHCP receives strong support within the MOH, has had about $50 million of international assistance committed through 1980/81. It is a program well-accepted and actively supported by the rural and nomadic population it reaches. However, implementation has been sharply constrained by financial and technical resources.

As the program has evolved over time, some elements have outstripped others in implementation. Restructuring of the MOH's efforts would seem to be in order to achieve a more favorable balance between preventive/promotive activities (now largely neglected) and curative (being emphasized). The original design was appropriate but lacked strength in the MCH component. The five year USAID-sponsored Rural Health Service Project will address the latter issue.

Project 650-0011 Purpose: To accelerate, expand and strengthen the capability of the Government of the Sudan (GOS) to deliver PHC services to the rural areas of Northern Sudan, especially to Kordofan Region and to provinces with nomadic population, by June 30, 1982.

Progress toward conditions expected to exist at the end of the project (EOPS) is tabulated on the "EOPS Progress Review Worksheet", attachment III to the PES Part I for this project. There is evidence of some progress in six of nine EOPS, (3-6, 8-9). It is expected that progress will continue slowly even after the end of the project because the PHCP is continuing. Inputs/outputs leading to achievement of EOPS I have been delayed. Thus, achievement of this EOPS will not be accomplished during the life of the project. Work toward this EOPS will be carried on under RHSP. A major factor preventing progress toward EOPS 2 and 7 is the lack of foreign currency with which to buy drugs and petrol. Work towards these EOPS will continue under the RHSP.

Project 650-0019 Purpose: To strengthen the delivery of the PHC services to the rural population of Southern Sudan with special emphasis on community participation.

Progress toward the EOPS is tabulated in the "EOPS Progress Review Worksheet", Attachment C to the PES - Part I for this project. There is considerable progress toward three of five EOPS (1-3) and there will continue to be progress under the RHSP. Some progress toward EOPS 4 has been noted; however the lack of foreign currency interfers with achieving an adequate drug supply. Work on this EOPS will continue under the RHSP. Progress toward EOPS 5 has been minimal since the behaviorial change of putting into practice newly acquired knowledge takes 5-10 years to become evident. Work toward this change will continue under the RHSP.

19. Goal/Subgoal

Project 650-0000 Sector Goal: Reduce the incidence of the most prevalent diseases and other health problems that are deterimental to the overall development of the Sudanese. Measures of achievement of the sector goal are related to the

objectives of the eight national health programs of which Primary Health Care Services is one program. The objective is achievement of maximum coverage of PHC services throughout the country:1 CHW/4000 settled population and 1 CHW/1500 nomadic population. Progress toward this objective are described above in 18. Project 650-0011 one of many activities contributing to the PHCP and to the achievement of coverage at a 1/4000 ratio.

Project 650-0019 Sector Goal: To improve significantly the health status of the rural poor. It is too early and the health information system is too weak to detect a decreased morbidity and mortality that would be expected when the goal is achieved.

20. Beneficiaries

The population to be reached by the PHCP is estimated at 16.6 million rural, semisettled and nomadic people. Urban and periurban populations, served by the MOH hospitals, dispensaries and health centers, are not included in these figures. Reductions in mortality, morbidity or infant mortality rates have not been demonstrated, nor should measurable changes be anticipated in the near future.

21. Unplanned Effects

Unplanned effects include 1) an asymmetrical growth of two components of the PHCP with emphasis being given to curative medicine as contrasted with the balanced, community-based health service that was originally contemplated, which gave equal weight to the health promotive/preventive component, 2) the original design called for an umbrella-type administrative structure under which PHC would encompass such other peripheral activities as MCH, EPI, malaria, TB control. Instead, the PHCP has assumed the characteristics of a "vertical health program" at regional, district and local levels, 3) originally conceived as an unsalaried village volunteer, the CHW now receives a salary from government, is technically supervised by MOH, receives his drugs and supplies from outside his village. It is possible that community members are beginning to view the CHW as a health provider representing government rather than as an indigenous member of the community who promotes healthful conditions.

22. Lessons Learned

The Evaluation Team, in its report, identifies a series of recommendations which might be incorporated in future plans to develop and expand Sudan's PHCP and which might, also, serve as a checklist for consideration by PHC implementers in other developing countries.

23. Special Comments or Remarks.

In developing a Scope of Work that would meet the common evaluative requirements of for such disparate agencies as MOH, WHO, AID and UNICEF the specific objectives of a field evaluation of the two AID-assisted PHCPs had to be forgone. Instead, data were collected by the Joint Evaluation Team that can contribute as background information to a subsequent AID prepared PES. Emphasis was thus shifted away from an EOPs evaluation that would have addressed an issue of primary concern to AID toward the broader goal of describing the status of implementaiton, identifying problems and offering recommendations that could assist all four agencies in future planning and implementation activities.

Suggestions are offered for consideration by USAID/Sudan, based on field observations and discussions with health authorities at all levels, that bear upon the implementation of the Rural Health Support Project (RHSP) over the up-coming 5 years:

1. Problems of logistics and supply are unlikely to be resolved before the Northern and Southern Primary Health Care projects technical assistance terminates in March/June 1983. The RHSP has planned for logistic support through short-term technical advisors over a 1-2 year period. However, a full-time logistics expert for at least the first two years of the RHSP is recommended, with the funding requirements, if any, taken from construction fund allocations, to assist in resolving the acute logistic problems.

2. Two long-term MCH advisors are included in the RHSP proposal. In recruiting candidates for these positions, emphasis should be placed upon her/his future role as an implementor, at regional and district level, of MCH activities, rather than as an MCH planner and originator of ideas at the central level. Simple, practical and realistic quidelines for making an MCH input already are known to, and accepted by, the MOH. Implementation of such activities in training curricula, in PHC community-based work and in supervisory and managerial functions from regional health offices to the periphery suggest the desirability of a practical worker skilled in working at peripheral rather than an "idea-generator" at the central level. The latter function could be performed by a short-term MCH/FP advisor if needed.

3. Regional Coordinator, long-term, to be stationed in Darfur; Kordofan and the South, should be selected on the basis of managerial and adminstrative skills (and a strong physical constitution) as well as upon their professional or educational backgrounds. To the regional coordinators will fall the tasks of unsnarling log jams in logistics and supplies and working with MOH administrations and supervisors. While technical skills will be important, managerial skills will dominate, and recruitment efforts should be addressed to individuals with adminstrative/managerial/training experience in countries such as Sudan.

4. Health Information Systems (HIS) advisory services requirements cannot be foressen at this time. The HIS is currently under review by MOH, UNICEF and WHO; issues are not yet resolved and important decisions remain to be reached. Whether HIS advisor should serve on a long-term basis for the RHSP is not yet clear.

5. The "needs assessment team" that the RHSP contractor for the North has proposed, should include a health planner, an administrative-managerial officer and an LDC-experienced logistics expert.

RECOMMENDATIONS FOR IMPROVING IMPLEMENTATION OF A PRIMARY HEALTH CARE SYSTEM IN THE SUDAN

The following recommendations are based upon the findings of the evaluation team which are reported in a separate evaluation report. The recommendations are grouped under the following headings:

A. Health Personnel and Training

B. Management

C. Logistics and Supplies

D. Health Information System

E. Reducing Costs of PHC

F. Increasing Revenues of PHC

G. Coverage, Availability, Accessibility and Community Participation.

A. HEALTH PERSONNEL AND TRAINING

1. Currently there is a shortage of all PHC providers. Manpower training needs assessment should be undertaken on a regional and provincial basis to identify number and category of shortfalls based on actual health needs, population characteristics, and training resources.

2. Regional health officials, in collaboration with the MOH Department of Statistics should obtain demographic data for the district and village levels in preparation for the formulation of a health manpower development plan.

3. Departments for health manpower development should be established at regional/provincial levels.

4. All PHC workers, including medical assistants (MA), CHW's, village midwives (VMWs), sanitary overseers (SOs) and assistant SOs, should become more involved in preventive and promotive health activities. In addition, they should assume a leadership role in organizing community activities directed at improving local health conditions. These health workers must be trained specifically for these activities.

5. Central MOH authorities should establish a means for and guidelines for a review and revision of task oriented job descriptions for all categories of PHC personnel. Regional authorities should utilize such guidelines in developing job descriptions relevant to their local situations. These job descriptions should be used by trainers to assist in curriculum revisions and by supervisors as a managerial tool.

6. Training programs for all categories of primary health workers should be modified, in accordance with the new job descriptions, incorporating the following items and tutors should be retrained accordingly:

a) emphasis on prevention of disease and promotion of health, e.g., child care, child spacing, sanitation rather than on curative services.

b) emphasis on task-oriented problem solving training activities, e.g., conducting health surveys, improving sanitation, motivating the community about health problems, rather than on theory and disease processes.

c) emphasis on community-based training within the villages rather than on curative training now being done in dispensaries and hospitals.

d) emphasis on the techniques of transmitting health information to the illiterate population.

7. Training centers should place emphasis on the mobilization of trainees themselves for making improvements in the training center facilities and their environs (including nearby villages). Trainees could, for example, become more self-supportive and gain useful experience through the establishment of vegetable gardens, raising poultry and/or livestock, and undertaking maintenance and repairs of the training center itself.

8. All MCH workers, after a revision of their training programs, should assume responsiblity for child care and child spacing, in addition to their work with mothers in maternity care. Implementation plans should be developed for the regional and provincial levels at least.

9. The role of the TBA in the community as a service provider needs to be reviewed and upgraded. An evaluation of the TBA training in Southern Kordofan and the South should be conducted and training revised appropriately. Adequate supplies are needed to improve the services rendered to the community by the TBA.

10. All CHW's, MAs, supervisors and tutors should receive training in the maternal and child health implications of child-spacing and in techniques to impart this information to the members of the community.

11. Criteria and mechanisms should be developed for selecting CHW candidates who are capable and have strong leadership characteristics. Educational requirements should be weighed in a flexible and pragmatic manner to encourage recruitment of such candidates.

12. Working within the context of prevailing cultural norms and traditions, every effort should be made to increase the recruitment and training of women as CHWs.

13. Tutors for CHWs should be drawn from the ranks of experienced public health officers (PHO) and health visitors (HV) in order to provide a multidisciplinary teaching team rather than selection of experienced medical assistants only. For areas of the curriculum where special skills are required e.g. health information and statistics, the use of statistical technicians as part-time tutors should be encouraged. One approach to the problem of excess tutors which would then result is to involve tutors half time in supervision.

14. Teaching materials and manuals in Arabic for use in the North and the South should be developed for MA's, VMW's, PHO, SO, HV and assistant HV if they do not now exist.

15. Training of all tutors in systematic course design, teaching methodology, etc., should be conducted, possibly through the Education Development Center.

16. Refresher courses for all categories of health workers, including medical officers; should be reviewed and revised to include practical training in community-based health promotive activities. A systematic planning schedule for such refresher courses should be developed at the district level with MOH providing appropriate resources. Refresher courses should be evaluated for their impact on knowledge, attitudes, and practice.

17. Participant training for senior health officials should be task-oriented and adjusted to the job discription of the officials. For many, a one-month course relevant to the conditions of Sudan would be adequate to cover organization, management, planning, allocation of resources and utilization of health information for management decisions.

B. MANAGEMENT

1. MOH should play a more active role in setting criteria for a standardized organizational structure and in providing regional officials with guidelines for planning and implementing the PHC system. The criteria and guidelines should be developed with the purpose of achieving national goals and should be governed by the functions necessary to address the major health problems.

2. To avoid duplication and to maximize resources, central coordination of PHC donor agencies' contributions, present and proposed, should be clearly established within the MOH based upon an upward flow of information about program implementation and program needs at regional level. The present system appears to be fragmented among International Health, Health Planning and Rural Health. Standardization of drugs among the various donors should be included in this mechanism.

3. Establish effective two-way communication between the regions and the Central MOH in the planning of PHC delivery systems. The establishment of regional planning departments would facilitate such communication.

4. The planning activities of regional and district councils should be supported by technically competent advisors, such as community physicians, and by the training of district and regional personnel.

5. Budgets for PHC should be established at all administrative levels. These PHC budgets should support community health development activities re: water, environmental sanitation,nutrition, maternal and child care, etc.

6. Training in management for regional and district personnel is needed to promote and to establish more effective and efficient feedback and control mechanisms within districts and between the regional and district councils and health personnel.

7. The structure of the health services below the Deputy Director/Assistant Commissioner level should be reviewed and revised to enable the implementation of PHC and the integration of PHC activities and to minimize the vertical organizational pattern which is prominant. This would, inter alia, improve supervision and logistical support of frontline workers.

8. Strengthen field supervision of CHW's and PHCU's by training supervisors and by improving transport arrangements to PHCU's, supplemented where necessary by periodic supervisory meetings of CHW's at a more central point when they come to collect salaries and drug supplies. Tutors should become involved in supervision to establish a feedback mechanism for improving training of CHW's. The concept of supportive supervision and the techniques of supervision should be introduced in the initial training of all health workers.

9. Where the PHC "complex" model is being implemented, the activities should be reviewed to ascertain lessons of experience that could lead to more effective implementation elsewhere. Where the PHC "complex" model is not being implemented, a study should be conducted to determine why it has not been implemented.

10. A leader of the health team at the village level should be selected by each village council. This individual would then be responsible for coordinating the activities of health personnel and should provide technical guidance on health matters to the village council.

11. The PHC system should integrate the activities of bilharzia, leprosy, malaria, onchocerciasis and sleeping sickness at the village level.

12. There is a need for an assessment of the career mobility open to CHW's and health statistical personnel with specific attention given to the opportunities for further training and career advancement.

13. A system for the assignment of health workers should be developed based upon information collected for the manpower needs assessment and the manpower development plan.

14. A director of PHC services (all 8 components) should be appointed at regional and provincial levels. Deputies/assistants for Health Manpower Development and MCH/Child Spacing should also be named.

C. LOGISTICS AND SUPPLIES

1. Standardization of drug kit contents for a 3 month supply should be undertaken for all units. To cater for local conditions, however, it may be necessary to vary the contents and have more than one type of 'kit'. (See section E.6).

2. Local pharmaceutical manufacturing should be encouraged to produce the drugs for the 'kits' and to undertake the packing. (See section E.7 & 8).

3. The lists of equipment and instruments for PHCU's and dispensaries should be reviewed and standardized for all units of the PHC system.

4. A reserve supply of consumable items which form a part of the standard kits e.g., syringes, needles, suturesm catheters, etc., should be held in stock at regional and district level stores.

5. Existing buildings for medical stores should be up-graded, cleaned and properly arranged. Shelving should be provided.

6. The building program for new stores should take account of the total needs for the region and allow for future expansion.

7. Training of storekeepers should be in line with the national system for medical storekeeping but with consideration for the language difference in the North and South.

a. training program should be undertaken to upgrade the performance of storekeepers, especially in inventory control, record keeping, ordering. Evaluation of the storekeepers courses offered at the Management Development Center and the Central Medical Stores should be undertaken as a first step.

8. PHC vehicles:

a. Existing facilities for the repair of vehicles should be made more effective to maintain the operational capability of all government vehicles.

b. Greater control of the use of PHC vehicles by the keeping of meaningful log book records should be started and inspection by donor agencies should be encouraged. (See section E. 3&4.)

c. Additional appropriate and alternative means of transport is needed for supervision and commodity delivery. Encouragement should be given to the use of animals, bicycles, water transport and other cost-effective forms of transport. (See section E.5.)

d. The appointment of regional and provincial supervisors for transportation/communication systems would facilitate (b) and (c) above.

9. The possibility of greater utilization of river transport should be investigated, particularly for the movement of drugs and supplies to the South.

D. HEALTH INFORMATION SYSTEM

1. The Health Information System relating to PHC should be based on standard forms and procedures throughout Sudan and should be developed to provide a practical and regular reporting system.

a. In the event that the present system, which is just being implemented proves unsatisfactory, it should be reassessed; a shortened and simplified monthly reporting form should be considered to include information on the following items only:

1. Number of persons in attendance (children, adult males, adult females).

2. Number of new cases (by diagnosis)

3. Number of Births (born alive, born dead)

4. Number of Deaths (Under 1 year, 1-4 years, other).

2. Supervision should be enhanced by defining precise managerial functions at each level; providing instructions on the flow of activities and a timetable of the processing stages with clear guidance on when and how to take action if delays occur.

3. Consideration should be given to the need for continuing technical and financial assistance to the Department of Health Statistics, MOH to assist in the training and organizing of district and regional offices of statistics.

4. A needs assessment should be conducted to determine the appropriateness of electronic data processing facilities at the Ministry of Health, but not at the regional level at this time. There is a need to facilitate the processing of data and its publication, as well as feed-back to the field.

5. All units operating within the system should be provided with adequate supplies and equipment including registers, worksheets, report forms, carbon paper and files. Statistical units at hospitals, district and regional offices should be supplied with adequate storage facilities for their records and adding machines or calculators.

6. The role of the CHW's and MA's in the issuance of birth and death certificates should be reviewed by the MOH and the Ministry of Finance and Economic Planning Dept. of Statistics as the present system causes confusion which adversely affects Birth and Death Registration.

7. There should be a review of the training and re-training needs at all levels of the health information system, e.g. the frontline recorders (MA's and CHWs) re: precise instructions for completing forms and use of the data to identify health problems in their areas; statistical personnel re: completion of new forms; health managers re: importance of the system and its managerial needs.

8. Senior statistical clerks should be trained to teach the CHW's, MA's and Nurses about the Health Information System and its importance to the PHCP.

E. REDUCING COSTS OF PHC

1. In view of the Government of Sudan's difficulty in meeting the recurrent cost of the PHCP, donors should attempt to minimize the recurrent cost burden which their projects might impose, e.g. the construction specifications for dispensaries, training schools and other PHC facilities should minimize recurrent costs of building maintenance and repair (particularly the foreign exchange component.)

2. For supervisory purposes, the PHC system should use a single type of vehicle, robust and with high mileage per gallon. Standardization of the make used will permit economies in the area of spare parts. Donors should provide only the standardized vehicle, even when this is not manufactured by the donor itself.

3. A new system of incentives should be considered for the drivers of PHC vehicles, instituting rewards or sanctions which will encourage careful use and maintenance of the vehicles.

4. For the transportation of heavy loads (e.g. drug distribution), the PHCP should consider using private contractors rather than maintaining a fleet of government vehicles.

5. To reduce losses of drugs in the distribution system, drugs should be acquired and distributed in the form of prepackaged kits.

6. The system of tariffs and exchange controls should be rationalized, at least as regards the treatment of certain imported raw materials whose present artificially high tariff inhibits the development of a local pharmaceuticals industry.

7. Familiarity with traditional health practices, such as the use of herbs as medicinal agents, should be introduced into the CHW training to augment the limited drug resources.

8. In view of the limited amount of foreign exchange available for drugs, it is important that the funds be spent on those items with the greatest effectivenesss (in terms of contributing to the health of the majority) in relation to the cost.

F. INCREASING REVENUES OF PHC

1. Recipient contributions in dispensaries and PHCUs, perhaps tied to the dispensing of drugs, should be encouraged. The funds in question should be utilized for PHC activities with the community taking the lead role in regulating and managing the use of the funds.

2. The establishment of charitable endowments in support of PHCUs and dispensaries should be officially encouraged.

3. A study of the relative cost-effectiveness of the PHC system and hospital based treatment system as it presently exists should be undertaken to determine whether a reallocation of resources in favor of PHC would raise the productivity of the health care system as a whole.

G. COVERAGE, AVAILABILITY, ACCESSIBILITY AND COMMUNITY PARTICIPATION

1. During the next six year plan, priority should be given to improving the quality of services provided and to enlarging the scope of PHC services to all eight components provided routinely at the village level.

2. Targets set for further extension of the coverage of rural populations by PHC should be closely matched with resource availability, as projected by regional health authorities and the Central MOH and with local population densities.

3. The formal and informal institutions at village and district level should be utilized as fully as possible in extending knowledge of, and soliciting community support for, the PHC approach. Orientation of members of Regional Executive Councils and District Councils should be undertaken by regional health officials to familiarize them with the PHC approach. At the local level, village councils should receive similar orientation and training by CHW's.

4. The establishment of workshops should be considered for the training of personnel from district.regional/central levels in health planning, management and supervision in relation to the PHC approach. It should then be possible to assist local authorities identifing their health problems priority needs, local resources and requirements in order to develop a realistic health plan and to promote a more effective and efficient feed-back and control mechanism.

5. Every effort should be made to stimulate increased community participation, particularly in the form of PHCU construction and maintenance, community instituted health promotive, disease preventive activities and administrative support for the CHW, i.e. use of recipient contributions/local taxes to purchase supplies and pharmaceuticals for use at the local level.

UNCLASSIFIED
CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) — PART I

Report Symbol U-447

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
Northern Primary Health Care	650-0011	USAID/Sudan

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) 650-82-03

☐ REGULAR EVALUATION ☒ Part of a SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY 78	B. Final Obligation Expected FY 79	C. Final Input Delivery * FY 82	A. Total $ 22,979,000 B. U.S. $ 5,863,000	From (month/yr.) October, 1980 To (month/yr.) March, 1982 Date of Evaluation Review April 10, 1982

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
1. Extend PACD to 6/30/84, r Requested	AID/W Micka	4/30/82 3/ 8/82
2. Execute PIO/T to extend contract through March 31, 1983 and to revise budget.	Micka	3/10/82
3. Conduct knowledge, appitude and practice evaluation of refresher and orientation courses in Darfur and/or Kordofan Regions.	Markarian/ Musbah	1/83
4. Initiate training workshops for regional provincial and district level personnel re: planning and management of primary health care (PHC) services.	Markarian/ Baradi	3/83
5. Review recommendations of evaluation entitled "Implementation of Primary Health Care in Selected Provinces of Sudan" in relation to implementation planning for Rural Health Support Project.	Kabbashi/ Micka	10/82
6. Complete logistics needs assessments in 8 provinces and complete reassessment in 4 provinces.	Wisniewsky	3/83
7. Develop curriculum for training of storekeepers emphasizing on-the-job practicum of organizing and maintaining medical stores.	Wisniewsky/ El Rasheed	7/83
8. Complete health information needs assessments in 7 provinces and complete reassessment in 5 provinces.	Davis	3/81
9. Develop implementation plan for new PHC health information system.	Davis/Khari	6/82

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☒ Financial Plan
- ☐ Logical Framework
- ☒ Project Agreement
- ☒ Implementation Plan e.g., CPI Network
- ☒ PIO/T
- ☐ PIO/C
- ☐ PIO/P
- ☒ Other (Specify) Contract
- ☐ Other (Specify)

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. ☐ Continue Project Without Change
- B. ☐ Change Project Design and/or ☒ Change Implementation Plan
- C. ☐ Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

Dr. Mary Ann Micka, Project Officer/USAID

Dr. Mohamed A. Musbah, Director PHCP/MOH

(see page 3 of PES Part I for list of evaluation team)

12. Mission/AID/W Office Director Approval

Signature

Typed Name: Arthur W. Mudge, USAID/DIR.

Date: 4/22/83

AID 1330-15 (3-78)

* On March 29, 1982, PACD extended to 6/30/84.

CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) — PART I

Report Symbol U-447

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
Southern Primary Health Care	650-0019	USAID/Sudan

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) 650-82-03

☐ REGULAR EVALUATION ☒ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES	6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY 78 B. Final Obligation Expected FY 81 C. Final Input Delivery FY 83	A. Total $ 5,315,000 B. U.S. $ 3,686,315	From (month/yr.) April, 1981 To (month/yr.) March, 1982 Date of Evaluation Review

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
1. Review rate of project expenditures in 6 months to determine whether project completion date should be 9/30/83 (AMREF - RMOH Agreement) or 6/30/83 (OPG Agreement). Take appropriate action to make both documents consistent.	Micka/Paton	10/82
2. Review progress toward outputs and purpose in 6 months to determine which ones need to be carried over into Rural Health Support Project.	Micka/Paton	10/82
3. Review health manpower training needs for E.&W. Equatoria Province to determine the appropriate use of the CHW Training School at Lirya.	Noel	10/82
4. Develop implementation plan for outputs 10-12. Submit to USAID and RMOH SW.	Campbell	6/82
5. Develop plan for continuing logistics technical assistance under Rural Health Support Project.	Micka/Paton	1/83
6. Conduct knowledge, apptitude and practice evaluation of refresher and orientation. Submit report to USAID and RMOHSW.	Asante	6/83
7. Review recommendations of evaluation entitled "Implementation of Primary Health Care in selected Province of Sudan in relation to implementation planning for RHS Project.	Parmena/Paton	10/82
8. Turn over training school and dispensary at Akot to RMOHSW.	AMREF	7/82

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☐ Financial Plan
- ☐ Logical Framework
- ☒ Project Agreement
- ☐ Implementation Plan e.g., CPI Network
- ☐ PIO/T
- ☐ PIO/C
- ☐ PIO/P
- ☐ Other (Specify) _____
- ☐ Other (Specify) _____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. ☐ Continue Project Without Change
- B. ☐ Change Project Design and/or ☒ Change Implementation Plan
- C. ☐ Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

Dr. Mary Ann Micka, Project Officer USAID
Dr. Parmena Marial, Director PHCP, RMOHSW
(see page 2 of PES - Part I for list of evaluation team)

12. Mission/AID/W Office Director Approval

Signature

Typed Name: Arthur W. Mudge, II USAID/DIR

Date: 4/22/83

AID 1330-15 (3-78)

Southern Primary Health Care 650-0019

Progress Review Worksheet

Evaluation for Period: 4/81 to 3/82

PROGRESS TOWARD CONDITIONS EXPECTED AT END OF PROJECT

A. CONDITIONS EXPECTED TO EXIST AT THE END OF THE PROJECT	B. METHOD (OR MEASUREMENT) OF VERIFYING CONDITIONS AT END OF THE PROJECT	C. PROGRESS AS SHOWN BY MEASUREMENT VERIFICATION *
1. Village elders participate in the selection of virtually all Community Health Workers (CHW).	RMOH and Provincial records; sampling, on-site evaluations.	All CHW's selected by one or more village elders.
2. High percentage (60%) of PHC Units constructed through self-help.	RMOH and provincial records; sampling, on-site evaluations.	Six of twelve PHC units (50%) constructed through self-help.
3. Health component/subcommittee of village Development Committee (VDC) strengthened/formed to function in support of CHW activities in 75% of villages with PHCU's.	Monthly CHW reports; provincial records.	Eleven of twelve villages had VDC and discussed health issues. Six contributed significantly to upkeep of PHC unit (50%) four provided administrative supervision of CHW (33%).
4. An adequate supply of drugs on hand in 75% PHCUs.	Monthly CHW reports; sampling, on-site evaluations.	Of 49 PHC units on which provincial authorities reported, 15 (35%) had druges supplied regularly by non-governmental organizations.
5. Preventive/promotive health measures being practiced by villagers, such as using safe water better methods of vector control, and better system of refuse and excreta disposal.	Monthly CHW reports; sampling, on-site evaluations.	In three of four villages preventive/promative knowledge demonstrated by villages but little practive of preventive measures. In nine other villages no records were kept of CHW promotive activities.

* Data base: 12 PHC units and 13 CHW's visited during evaluations of 3/81 and 3/82. Records and data base at regional and provincial level still tooo meager to conduct a review.

Attachment C

Progress Review Worksheet
PROJECT OUTPUTS - PROGRESS TO DATE

Evaluation for Period 4/81 to 3/82

A. QUANTITATIVE INDICATORS FOR MAJOR OUTPUTS		TARGETS (Percentage/Rate/Amount)					
		CUMULATIVE PRIOR FY	CURRENT FY 82 TO DATE 1/2	CURRENT FY 82 TO END 1/2	FY 83	FY ___	END OF PROJECT 6/30/83
1. Primary Health Care units constructed by self-help	PLANNED	0	0	5	5		10
	ACTUAL PERFORMANCE	0	0				
	REPLANNED			0	10		10
2. Medical staff &CHW trainees participating in monthly discussions at meeting of PHC completes at Lirya & Akot	PLANNED	0	0	0	24		24
	ACTUAL PERFORMANCE	0	0				
	REPLANNED			3	18		21
3. Curriculum revised and tested for sanitary overseers training program.	PLANNED	50%	10%	15%	25%		100%
	ACTUAL PERFORMANCE	25%	25%				
	REPLANNED			20%	30%		100%
4. PHC personnel retrained: 390 CHWs; 350 MAs; nurses 300; sanitary overseers 100; others 110.	PLANNED	650	150	150	300		1250
	ACTUAL PERFORMANCE	844					
	REPLANNED						1250

B. QUALITATIVE INDICATORS FOR MAJOR OUTPUTS

1. CHW graduates of new training schools (20 each at Lirya and Akot).

Comment:
Planned: 40 CHW graduates by 9/82; 80 graduates by 6/83.

Actual: The school at Lirya was completed and accepted by RMOH 16 Oct. 1981. During 2nd qtr, FY 82 a special tutor training course was held at Lirya for approximately 3 months - 20 medical assistants (MA) and sanitary overseers (SO). The school at Akot has not been completed.

Replanned: CHW training at Lirya to begin 6/82
(In view of 89% coverage by CHW's in the Equatoria Provinces, the use of the school at Lirya for CHW training should be reassessed).
Akot - school completion expected 4th qtr, FY 82 with 20 CHW graduates expected in FY 83. Therefore, maximum number of graduates would be 40.

2. CHWs receive one week of training at dispensaries at Lirya and Akot.

Comment:
Planned: 40 by 9/82; 40 by 6/83.
Actual: One dispensary completed but not yet in use for training because CHW's not yet in training

Replanned: 40 by 6/83.

3. 75% of PHC units receiving drugs and supplies on a regular basis (estimated 500 PHC units at end of project).

Comment:
Planned: 72 Units by FY 81 (25% of goal); 199 by FY 82 (60% of goal); 375 by 6/83 (100% of goal)
Actual: Many non-government agencies supply the PHC units with drugs and supplies but the actual number is unknown. An assessment is in progress to collect baseline data.
Replanned: 62/333 units by end of FY 82 (25% of goal) 188/500 units by 6/83 (50% of goal).

MEMBERS OF THE EVALUATION TEAM AND RESOURCE PERSONNEL - 3 page

Outside Evaluations	Agency	Speciality
Dr. Robin Barlow	APHA	Recurrent Costs
Ms. Catherine Ada Beckley	UNICEF	Maternal Child Health
Dr. Helmy M. Bermawy	Consultant	Community Organization
Mr. A.G.T. Carter	UNICEF	Health Information Systems
Dr. A. Deria	WHO	Public Health Advisor
Ms. Dayl Donaldson	APHA	Recurrent Costs
Mr. Vic Evans	Consultant	Logistics and Supplies
Dr. Brooks Ryder	APHA	Team Leader
Dr. May Yacoob	Consultant	Health Management
Dr. Enaam Abou Youseff	Consultant	Personnel and Training

Resource Personnel		
Mr. Michael Campbell	AMREF	Medical Supplies
Mr. Hillard Davis	MSCI	Health Information
Dr. Fred Katz*	WHO	Evaluation
Mr. Gary E. Leinen	USAID	Public Health Officer
Dr. Markarian	MSCI	Training Specialist
Mr. Dan Marwa	AMREF	Health Information
Dr. Mary Ann Micka*	USAID	Chief, Health Division
Dr. Joseph S. Nyanzi	AMREF	Health Planning, Administration.
Ms. Arlene O'Reilly*	USAID	Evaluation Specialist
Dr. Jerry Weaver	USAID	Social Science Analyst
Mr. B.R. Wisneiwsky	MSCI	Logistics

GOS Representatives		
Dr. Mohamed El Mahdi Balla	MOH	Health Statistics & Research
Dr. Parmena Marial	RMOH (Juba)	PHCP Director
Dr. Eisa Abu Bakr Mohed	MOH	Malaria/Community Physician
Dr. Mohamed A. Musbah	MOH	PHCP-MPH
Dr. Mark Taban	RMOH (Juba)	PHCP-Medical Supplies

*Advisors to team

AMREF - African Medical & Research Foundation
APHA - American Public Health Association
MSCI - Medical Services Consultants, Inc.
MOH - Ministry of Health
RMOH - Regional Ministry of Health
UNICEF- United Nations Children's Fund
USAID - United States Agency for International Development
WHO - World Health Organization

Progress Review Worksheet
PROJECT OUTPUTS-PROGRESS TO DATE

Evaluation for Period 10/80 to 3/82

A. QUANTITATIVE INDICATORS FOR MAJOR OUTPUTS		TARGETS (Percentage/Rate/Amount)					
		CUMULATIVE PRIOR FY	CURRENT FY 82 1/2 TO DATE	CURRENT FY 82 1/2 TO END	FY 83*	FY 84*	END OF PROJECT*
5. Personnel from Central Medical Stores (CMS) complete observational training and return to positions by June 30, 1982.	PLANNED	2	2	0	-	-	4
	ACTUAL PERFORMANCE	0	0				
	REPLANNED			2	2	-	4
6. Senior drivers/mechanics complete 6 weeks in country training and return to positions by June 30, 1981.	PLANNED	14	0	0	-	-	14
	ACTUAL PERFORMANCE	14	7				
	REPLANNED			0	14	-	35
8. Nomad community health workers (CHW) provisioned with equipments, and instruments and a 2-month issue of drugs & supplies by December 31, 1981	PLANNED	300	0	300	-	-	600
	ACTUAL PERFORMANCE	0	0				
	REPLANNED			0	600	-	600
10. Provincial health personnel oriented to PHCP.	PLANNED	2060	500	1560	-	-	4120
	ACTUAL PERFORMANCE	1480 (UNICEF financing) 878	604				
	REPLANNED			875	283	-	1480 (UNICEF) 2640 Project outputs
11. CHW's receive continuing medical education by June 30, 1982	PLANNED	560	100	460	-	-	1120
	ACTUAL PERFORMANCE	562	157				
	REPLANNED			200	200	-	1120
12. MOH counterparts completed long-term training, MPH/equivalent degree, and returned to positions by 1/82.	PLANNED	0	2	0	-	-	2
	ACTUAL PERFORMANCE	0	2				
	REPLANNED			-	-	-	2
13. MOH community physicians completed 3-months short-term U.S. training and returned to former positions by June 30, 1982.	PLANNED	8	0	4	-	-	12
	ACTUAL PERFORMANCE	6	0				
	REPLANNED			6	0	-	12
14. Sr. Medical assistants tutors & other health personnel completed 3-months management training course in-country.	PLANNED	18	18	0	-	-	36
	ACTUAL PERFORMANCE	18	32				
	REPLANNED			0	54	-	104

* Assuming that PACD extended from 6/30/82 to 6/30/84 as requested.