EVALUATION

OF

COMMUNITY HEALTH EDUCATION PCV PERFORMANCE

IN

CCCD HEALTH EDUCATIION ACTIVITIES

IN

TOGO

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EXECUTIVE SUMMARY

The Peace Corps Togo Community Health Education Program, having placed its first Volunteers in the field in October 1985, is providing sound technical assistance to the National Health Education Service which in turn should be better able to develop and implement the CCCD health education and promotion component. This component has not evolved as rapidly as the rest of the CCCD Project in Togo. However, with assistance from the two Volunteer Specialists working at the central level and the two Volunteer Generalists at the peripheral level, health education activities are beginning to gain momentum and importance. An overall health education strategy and intervention plan is being developed by the Volunteer Specialists to accompany the three CCCD medical interventions. UNICEF has already expressed its support for this plan and is committing child survival monies for the plan's implementation over the next three years. The Peace Corps has the unique opportunity not only to expand the work of its Community Health Education Volunteers beyond the scope of CCCD, but also to institutionalize interventions and strategies through the National Health Education Service. To make such a contribution, the Peace Corps and the Ministry of Health should:

1. Request a renewal of the PASA with USAID to ensure the continued development of the CCCD health education component.

2. Assess the scope and character of other donor participation in CCCD type activities so that dependency on a single funding source is reduced.

3. Recruit and employ a seasoned Associate Peace Corps

Director for Health and Education with experience in health education program planning.

4. Request short-term technical assistance for the Volunteer Specialists in health education monitoring and evaluation, and in mass media intervention design.

5. Support and increase the effectiveness of the Volunteer Specialists by having them present reports periodically to the CCCD Coordinating Committee members for their advice and sanction.

6. Establish clear communication lines from the Volunteer Specialists to the Peace Corps Health Sector Manager in the Office of Training and Program Support (Washington), the CDC Health Education Specialist in the International Health Program Office (Atlanta), and the USAID CCCD Project Manager (Washington).

7. Collect baseline data for future comparisons of input, outcome, and impact indicators to measure the efficacy of the health education component.

8. Conduct confirmatory KAP surveys to diagnose existing behaviors and beliefs in order to set clear behavioral objectives and to develop relevant health education activities.

9. Develop more community organizing type of health education activities for PCVs at the peripheral level to complement the mass media and interpersonal communication channels being developed.

10. Require all PCVs and HECs to conduct KAP surveys and community diagnosis in their prefectures for CCCD health education baseline data.

INTRODUCTION

The Participating Agency Service Agreement (PASA) #698-0421 between USAID and the Peace Corps for the Combatting Childhood Communicable Diseases (CCCD) Project began October 1984 with a projected completion date of September 30, 1986. The expected outputs were:

1. To train 10 specialist Volunteers
2. To train 62 generalist Volunteers
3. To provide in-service training to 10 specialist Volunteers and 74 generalist Volunteers.

These Peace Corps Volunteers (PCV) were to be placed in the 12 African countries participating in the CCCD Project. Approximately $600,000 had been obligated to provide partial funding for the implementation of CCCD health education activities. The purpose of the PASA was two-fold. First, CCCD could focus greater attention on health education by increasing the amount of long-term technical assistance at the central level advisor role through the PCV Specialist. To be selected these individuals would need to possess an MPH degree or equivalent. The second purpose of the PASA was to enhance the CCCD health education component at the peripheral levels by providing on-the-job training for PCV Generalists working in the field. These individuals would need to possess a B.A. degree or equivalent.

In June 1985 the first group of PCVs to work with the CCCD Project in Togo arrived for pre-service training. Upon successful completion of 15 weeks of training, they were sworn-in as Community Health Education PCVs assigned to the National Health Education Service (SNES) of the Ministry of Health and

Social Welfare. They were not assigned specifically to the CCCD Project because a cooperative agreement between the USAID Mission and the Peace Corps in Togo was not reached. Consequently, these PCVs do not officially receive technical or material support from the CCCD Project in Togo. They do, however, directly receive technical and financial assistance from the PASA to strengthen SNES's capacity to develop the CCCD health education component. As stated in the Peace Corps Trainee Assignment Criteria sheet for Togo's Community Health Education Program:

> You will be responsible to the director of the Division of Health Education. Your primary duty will be to work in conjunction with health and social welfare agents in educating and assisting communities to make changes in their lives to protect their health. In particular, you will address communicable disease and the importance of vaccination; oral rehydration; prevention of malaria and guinea worm, among others.
>
> .....(In addition to the above, as a Specialist) you will have special assignments leading to professional growth and development. You will: 1. participate in all meetings and contacts with the Division of Health Education officials, 2. assist in the co-ordination of activities between the Division of Health Education and the Peace Corps, 3. provide technical supervision to the other health educators, and 4. Assist the Associate Director in assessing and developing new programming possibilities.

In Togo presently there are two PCV Specialists, one with an MPH in health education and one with an MA in adult education, assigned to the SNES central office in Lome. Four PCV Generalists had been trained to work at the prefecture level. However, the two assigned to Sokode and Tchamba had terminated early for personal reasons. Of the remaining two PCV Generalists one is in Bassar and the other is in Atakpame. They are under the direct supervision of the Chief Medical Officer for the prefecture and their counterpart is the newly created cadre of

Health Education Coordinator (HEC). Twenty-one HECs have been named; one for each prefecture. The director of SNES is requesting the Peace Corps to recruit and train enough PCV Generalists so that the 21 HECs will have counterparts by the end of three years.

In support of this initiative to decentralize and extend health education services generated from the CCCD Project, PASA funds have been used in Togo to conduct the following:

1. In-service training (IST) for school health education PCVs and Ministry of Education personnel in May 1985.

2. Pre-service training (PST) for two Specialist and three Generalist Community Health Education PCVs in June-August 1985.

3. Training of Trainers Workshop for SNES central level personnel in January 1986.

4. Visual Aids Workshop for HECs and PCVs at the prefecture level in February 1986.

5. Evaluation of the Community Health Education Program in March 1986.

6. Travel for one PCV Specialist to attend the CCCD Consultative Meeting in Brazzaville in March 1986.

7. Program Planning Workshop for HECs and PCVs at the prefecture level is scheduled for 1986.

8. Supervision Workshop for HECs and PCVs at the prefecture level is scheduled for 1986.

I. THE EVALUATION: PURPOSE AND OBJECTIVES

In March 1986 an external team of evaluators was assembled to conduct the fifth annual evaluation of the overall CCCD Project. The 1986 evaluation was to place particular emphasis on the health education, health information system, operations research, and management components of CCCD. 1986 also coincided with the year for completing the PASA between the Peace Corps and USAID. Thus, the Peace Corps requested that an external evaluator, supported with PASA funds, join the evaluation team in Togo to assess PCV performance so that an informed decision could be made with regard to the future relationship between the Peace Corps and CCCD. Togo was selected as the field site because the program most closely fit the intended model described in the PASA.

USAID accepted the request from the Peace Corps and the technical evaluator participated with the external evaluation team in briefings with USAID in Washington and with CDC in Atlanta prior to leaving for Togo. The Peace Corps evaluator provided two additional days of work beyond the four days with the fully asssembled team in Togo.

The objective for the overall evaluation was to evaluate the accomplishments of the CCCD project, compare the accomplishments with the objectives stated in the project paper, project description and bilateral project agreements; identify problems which may have impeded project implementation and make recommendation for their amelioration. Specifically, the team was to implement an evaluation of operations research, health

information systems, health education, and management aspects of the CCCD project.

The objective for the Peace Corps evaluation was to conduct an evaluation of Community Health Education Volunteer performance in CCCD health education activities in Togo at the national and village levels. The technical evaluator was to join other project evaluators (as designated by the USAID Project Officer for CCCD) in the conduct of the external evaluation of the CCCD project in Togo.

II. THE EVALUATION DESIGN

To evaluate PCV performance in the CCCD Project, one needs to know what they are expected to accomplish within the health education component, and compare that against what they have actually accomplished. Therefore, it is equally important to the evaluation to know what are the health education component's goals, objectives, and activities and how they fit together. In each CCCD country the interventions are different, therefore, the health education components will differ as well.

To understand Togo's health education component a substantial volume of project documents were reviewed. Program details were examined with the principal U.S. based CDC and Peace Corps staff responsible for CCCD health education aspects. The diagram on the following page depicts how the health education component parts are supposed to fit together in general, and what they are for Togo in particular.

The diagram reveals that the health education activities being implemented use a mix of methods and communication channels, but appear to be heavily focused on health personnel. Moreover, the diagram indicates that these health education activities are being implemented in the absence of behavioral objectives. This lack of identified behaviors targetted for change would make it very difficult to conduct an evaluation, and particularly for assessing health education impact. However, the picture presented by the diagram may simply reflect incomplete information from the document review and interviews conducted prior to the field visit in Togo. Thus, an initial task for the evaluation upon arrival in Togo would be to fill-in as much of

CCCD HEALTH EDUCATION & PROMOTION GOAL

Promote maximum utilization of EPI, CDD, and malaria control services at health facilities by mothers or caretakers of children 0-4 years of age.

Facilitate adoption of certain behaviors in home/community relative to episodes of diarrhea and fever in children 0-4 years. Emphasis is on early treatment behaviors, then on primary prevention.

↑

TOGO CCCD HEALTH EDUCATION & PROMOTION GOAL

Promote reduction in mortality and morbidity among children between 0-5 years due to EPI diseases, diarrheal diseases, and malaria by adoption of behavior favorable to the effective utilization of CCCD Project services and by taking the correct measures to treat the first signs of diarrhea and fever.

↑

HEALTH EDUCATION ACTIVITIES Mass Media / C.O. / Inter-personal Comm.	EPI BEHAVIORAL OBJECTIVES	CDD BEHAVIORAL OBJECTIVES	MALARIA BEHAVIORAL OBJECTIVES
	Benef'cies	Benef'cies	Benef'cies
7 posters for clinics 2 decals for personnel Training of SNES Personnel Training of Health Agents	Health Personnel	Health Personnel	Health Personnel

the missing information as possible as well as to verify the information collected. The result should yield the overall picture of the programming intent, which should form the basis for the evaluation.

A. INPUT, COVERAGE, AND IMPACT

In the September 1985 document for guidelines and management of health education/promotion in the CCCD Project, it is stated that evaluation of the health education component should occur at a minimum at three levels. The first level is that of INPUT to measure the extent to which the resources needed for planning and implementation are available and being used. For example, have the necessary KAP data been collected as part of a community diagnosis? Have printed educational materials been distributed to health personnel in the clinics? Thus, if the "input" is not adequate, then it is most likely that the health education objectives will not be achieved because the "availability" of health education activities is not sufficient.

The second level of evaluation is that of COVERAGE which is meant to measure the extent to which the target population(s) is actually being reached by the health education component. That is, what percentage of the intended beneficiaries is receiving health education services and messages, and participating in health education activities? If the input is adequate but the "coverage" is insufficient, then it is most likely that the health education objectives will not be achieved because not enough people are being "exposed" to the health education component.

The third level of evaluation is that of IMPACT which is supposed to measure the extent of behavioral change in the target population(s). For example, what percentage of mothers report giving sugar and salt solutions to their infants at the first sign of diarrhea? How many health agents report counselling mothers to prepare and administer the ORS packet to their infants at the first sign of diarrhea? Thus, if the input and coverage are sufficient but the "impact" is inadequate, then it is most likely that the health education objectives will not be attained because the health personnel and the mothers are not adopting the behaviors desired by the health education component.

For each participating CCCD country the specifics of the health education component will vary according to sociocultural and biophysical parameters found within each country. These specifics should be apparent in the evaluation indicators used to measure the degree of input, coverage, and impact. Nonetheless, among all participating CCCD countries there should be a commonality across their health education components which had been developed by the CDC Health Education Specialist. The following evaluation indicators have been derived from the September 1985 document on guidelines and management of health education/promotion in the CCCD Project:

EVALUATION INDICATORS

INPUT INDICATORS

1. Collection of KAP data for baseline and for adaptation of health education activities

2. Training and retraining of personnel at National Health Education Unit

3. Print and recorded materials prepared for pretesting, revision, final production, and distribution

4. Central level CCCD Coordinating Committee decide priority directions

5. Health Education working group prepare strategy and implementation plan

6. Training and retraining of health personnel

7. Mix of mass media, interpersonal communication, and community organizing activities

COVERAGE INDICATORS

1. % of intended beneficiaries reached by health education activities

2. % of health personnel reached by training

IMPACT INDICATORS

1. Extent to which behavioral objectives achieved among targetted beneficiaries

2. Extent to which behavioral objectives achieved among targetted health personnel

B. DATA COLLECTION

As discussed earlier, much of the data to measure input can be collected by document review. For Togo documents were made available to the evaluator from PC/Washington, CDC/Atlanta, and USAID/Washington. It was not until her arrival in Lome that she received the informative documents attached as appendices to this report. These reports, memorandums, and survey questionnaires written in Togo contained valuable data for determining the degree of input because they predominantly came from the Community Health Education PCVs. Why these documents were not available in the U.S. to the evaluators is not clear because no one in Togo appeared to know who should have been responsible for sending copies back to the U.S.

Most of these documents were brought to the evaluator's attention during the interviews she conducted in Togo. The data being collected was used to complete the diagram described earlier and to measure input. The following individuals were interviewed:

Joe Naimoli, PCV Specialist, Lome

Gail Naimoli, PCV Specialist, Lome

Marc Dagbovi, APCD Health, Lome

Susan Woolf, Rural Water Project, Lome

Holly Stevens, PCV Generalist, Atakpame

Mme. Gassihoun, Health Education Coordinator, Atakpame

Dr. Komlan Siamevi, SNES Director, Lome

Kevin Murphy, CCCD Technical Officer, Lome

Peter Delahaye, UNICEF Representative, Lome

William Piatt, PC Director, Lome

The interview format was conversational. Eleven questions were used to guide the conversation's content, but not in any particular order. From the list of individuals interviewed, one can see that a wide range of expertise and affiliation with the CCCD health education component was represented. Consequently, different respondents were more knowledgeable about specific questions than other respondents. This diversity was also reflected by the length of the interview itself which ranged from one hour to eight hours spread over five days.

The 11 questions do not inquire beyond the CCCD Project so that the interview can focus on the details of the health education component. It also allows the evaluator to compare responses across individuals to check the reliability of the data. For example, if the interviews reveal little repetition of malaria control behaviors targetted for change among health personnel and mothers, then one could conclude that behavioral objectives have not been established for the health education component of malaria control. If such a pattern persists in the responses to other interview questions, then one could conclude that a health education plan for the CCCD Project does not exist. This was one of the findings from the interviews conducted in Togo. However, an overall health education strategy and plan is being developed correctly. Greater discussion of this can be found in Chapter III A.

The interview guideline follows:

INTERVIEW GUIDELINE

Show or read aloud the CCCD health education and promotion goal for your country. Then ask the following questions:

1. Given this health education and promotion goal for the CCCD Project, what behaviors among intended beneficiaries are targetted for change with respect to:
   EPI

   CDD

   Malaria Control

2. What behaviors among health personnel are targetted for change with respect to:
   EPI

   CDD

   Malaria Control

3. What additional behavioral objectives are included in the health education component of the CCCD Project?

4. To achieve these desired behavior changes what has been the content, methodology, and schedule of training and retraining for health personnel:
   at the National Health Education Unit

   in the field

5. What is the next year's training plan for health personnel:
   at the National Health Education Unit

   in the field

6. To bring about and maintain these desired behavior changes, what have been the specific health education and promotion activities implemented through:
   Mass Media

   Community Organizing

   Interpersonal Communication

7. What health education and promotion activities are planned for next year through:
   Mass Media

   Community Organizing

   Interpersonal Communication

8. What print and recorded materials have been prepared for:
   Pretesting

   Revision

   Final Production

9. To what extent has the central CCCD Coordinating Committee determined priority directions for health education?

10. To what extent has an overall health education strategy and implementation plan been developed by a Health Education and Promotion working group?

11. To what extent has KAP data been collected for:
   baseline

   adaptation of activities

To collect information on coverage and impact, secondary data analysis will be the predominant method. Quantitative data will be used mostly since percentages of target populations reached or who have adopted certain behaviors will serve as indicators. Analysis of data from CCCD studies such as the Mortality and Utilization of Health Services (MUHS) survey can serve as baseline for many of the indicators in the Plateaux and Maritime Regions. The MUHS questionnaire is attached in the Appendix. Data can also be gathered from clinic records and participant lists from training reports to calculate the number of people reached by health education services and messages.

The collection of original data is not within the realm of possibility for this particular evaluation given the constraints of time and available resources. It is, however, recommended that enough flexibility be built into future evaluations so that some original data collection can take place to fill-in possible gaps in information.

C. DATA ANALYSIS

Input Analysis

The input indicators are to be used to assess the degree to which a health education and promotion component is alive and functioning within the CCCD Project. That is, input indicators are measures of specific performance criteria, not of adequacy or effectiveness criteria. Thus, the items covered in the interview guideline are intended to be partial measures of performance. Additional measures of performance using the same input indicators should come from a review of documents such as CCCD Technical Officers Monthly Reports, MOH training plans and reports, annual CCCD country evaluation reports, Peace Corps training reports, and CCCD Health Education Specialist trip reports. The data gathered from the interviews and the document review will of course be qualitative.

The analysis of this performance data is, therefore, non-quantitative. The analysis plan is to categorize the data by the type of health education activity (mass media, community organizing, or interpersonal communication), by the type of behavioral objective (EPI, CDD, malaria control), and by target population (beneficiaries, health personnel). By using the following grid to display the data, one should be able to determine visually where there is an over or under emphasis in the type of input.

	BENEFICIARIES			HEALTH PERSONNEL		
	EPI	CDD	MALARIA	EPI	CDD	MALARIA
MASS MEDIA						
COMMUNITY ORGANIZING						
INTERPER-SONA COMMUNICA-TION						

For example, during the first year one might expect to see more input targetted at health personnel than at beneficiaries. However, if the type of health education activity used is predominantly interpersonal communication, i.e., training , then the mass media and community organizing boxes would be nearly empty of indicators. Such a finding would suggest that support and follow-up to health personnel training are weak. Additionally, if there are very few indicators in the boxes under the beneficiairies category, then this may suggest that there is not enough linkage between health personnel training and service delivery.

Coverage Analysis

While an analysis of input indicators may show that the health education component is functioning and balanced in emphasis, one also needs to know if the targetted population is indeed being reached by the activities. Thus, the coverage indicators are to be used to assess the degree to which intended beneficiaries or health personnel are indeed exposed to health

education services and training. Unlike the qualitative data for performance, measures of coverage will be quantitative, i.e., numerical percentages of population reached by CCCD health education component. The number of people exposed to specific activities should be available from CCCD Project records such as lists of participants attending training workshops, and clinic records. However, in some instances original data will need to be collected to arrive at a reliable estimate. For example, a survey of a small random sample of villagers may be conducted to determine the percentage of people who listened to a radio show on EPI. Ideally, this kind of data should be kept by CCCD staff as part of its monitoring system to be tracked over time. Thus, as the Project progresses over time, the percentages of people reached should increase with time.

The same grid used to analyze the input indicators can be used to calculate the numerators of the proportions. That is, the number of people reached can be categorized by type of health education activity, type of behavioral objective, and type of target population. Row and column totals can also be used when less specificity is needed.

Impact Analysis

Assuming that the CCCD health education component performed its tasks and reached its intended audiences, the next step would be to see if it was effective. The extent to which behavior changes are achieved will serve as measures of a health education

impact. It is then assumed that this impact will contribute toward the achievement of the CCCD health education and promotion goal.

To measure the extent to which the desired changes in behavior occurred, one should use the results from the initial KAP survey as baseline data to be compared with findings from later surveys. While a random sample of villages is recommended but not mandatory, the villages surveyed should include those in which CCCD Volunteers have and have not worked so that comparisons can be made between "exposed" and "unexposed" groups. The exposure, of course, is to CCCD health education activities implemented by Peace Corps Volunteers. And if these health education activities are effective, one should expect to see higher rates of behavior change among the "exposed" population. Thus, to examine the degree to which the CCCD health education component had an impact, ratio measures can be calculated from the following data layout. The quantity ad/bc should be greater

NUMBER OF SUBJECTS, BY EXPOSURE CATEGORY AND BEHAVIOR CHANGE STATUS

Behavior Change Status	Exposure Category	
	Exposed to Health Education	Not Exposed to Health Education
Change	a	b
No Change	c	d

than 1.00, if health education activities made an impact on behavior change.

III. MAJOR FINDINGS AND CONCLUSIONS

The CCCD Project was officially begun in Togo on April 1983. The health education needs assessment and proposed plan of action for Togo was conducted in May 1984. In June 1985 the first groups of Community Health Education PCVs arrived for training in Togo. On October 1985 the PCV Specialists were officially assigned to the SNES central office and the PCV Generalists joined their respective posts in the periphery. In the words of the Director of SNES: "We are two years behind the rest of the CCCD Project."

The health education component is indeed behind and strongly pressured by the MOH and USAID to catch up. All the documents reviewed and all the individuals interviewed repeated this observation. The openness with which the observation is made appears to come from newly found confidence in the ability to catch up. The source of this confidence is the presence of two health education specialists who arrived five months ago as PCVs assigned to SNES. Joe and Gail Naimoli were described by Dr. Siamevi, the Director of SNES, as his "third lung." The recently retired APCD for Health, Marc Dagbovi, regretted leaving the Peace Corps at this time because he could learn so much from them. While under a personal services contract until the Peace Corps hires his replacement, Dagbovi and Joe are running the program together. The CCCD Technical Officer, Kevin Murphy, very candidly remarked that were it not for the Peace Corps there would be no health education component.

Consequently, the Naimolis are over-worked because they are in high demand by people within and outside of CCCD. Before

their arrival in Togo, no one in the country, including the Director of SNES, had any degree training in health education. Thus, until now no one in Togo actually could envision or articulate what the overall health education component for CCCD should look like. The "big picture" of health education still does not exist, but it is quickly emerging. The evaluation findings reflect, therefore, the evolving nature of the health education component and the PCVs performance within it.

A. HEALTH EDUCATION STRATEGIES AND INTERVENTIONS

From examining the input indicators the technical aspects of the health education component in Togo has been developing unevenly. Prior to the arrival of Community Health Education PCVs, the CCCD health education strategy focused almost exclusively on developing interpersonal communication activities that are clinic based. These would include health talks, demonstrations, individual consultation, and home visits to be conducted by health personnel. Consequently, the health education training emphasis and the type of materials developed concentrated on increasing the ability of health personnel to deliver clinic based health education services. For example, print materials consisted of three posters on malaria control, two posters on ORT, two posters on vaccinations, and two adhesive backed decals on vaccinations. The intended use for all these materials was to post them on the clinic walls to educate the health personnel, who then in turn would use the same materials to educate their clients. The objective was to increase utilization of and compliance with CCCD services.

SNES had already organized 10 days of training for central level staff on the CCCD interventions. An in-service training program in health education for approximately 10000 Togolese frontline health personnel had been elaborated. Some 20-25 workshops, inviting 50 participants respectively to attend for three days, have been planned.

However, no mass media or community organizing strategies had been developed to complement the clinic based educational materials and the in-service training on interpersonal communication. Moreover, no KAP data had been collected among health personnel or their clients for adapting the materials and training. Neither a central level CCCD Coordinating Committee nor a Health Education Working Group existed to correct such oversights.

When the first PCVs officially began working with the CCCD Project through SNES in October 1985, they provided additional input to the existing health education activities and for filling in some of the gaps in the health education component. Their experience in materials development did not arrive in time, however. The posters and decals were in final production by the time of the PCVs assignment to SNES. They were only able to pretest on a very limited basis the poster on the vaccination calendar and to do minimal touch-ups on the other posters. Dr. Siamevi has asked the Naimolis to add visuals for the text of three brochures on the three CCCD interventions that SNES is developing. They are also developing "aides-memoires" to help health personnel learn the CCCD technical information during in-service training workshops sponsored by SNES. By working closely

with the SNES artist, the Naimolis are training her to go through all of the steps in developing print materials (conceptualizing, visualizing, pretesting, revision, final production, and distribution). In terms of recorded materials, they have requested sound equipment from UNICEF so that SNES can record its own radio shows and radio spots on a tape to be given to the radio station for broadcast. However, the SNES staff need technical assistance in conducting a marketing research survey of listeners not only for adapting content, but also for finding out WHO listens WHEN.

The Naimolis have just concluded a visual aid training workshop for HECs and PCVs in Lama Kara from February 25-28 1985. The objective was to decentralize the development of health education materials to the peripheral level by training personnel to design, pretest, and produce visual aids that are appropriate for their own clients. A major product from this workshop was three flannelographs to accompany health talks on malaria, ORT, and immunizations.

Community organizing activities have begun with the placement of PCVs at the peripheral level to work with HECs. In the prefecture of Bassar the PCV and her counterpart have prepared a KAP survey in 10 neighborhoods in the town of Bassar on malaria, diarrhea, and infectious childhood diseases (See Appendix for the questionnaire). The results will serve as a basis for a major public health intervention in the 10 neighborhoods. Bassar's Medecin-Chef has expressed a desire to extend this survey to all areas of the prefecture. When completed, the Bassar KAP will be the only data specifically

collected in Togo for adapting CCCD health education activities. The information should also prove to be valuable baseline data for subsequent evaluations of CCCD.

There is only one other PCV in the Commur v Health Education Program. Thus, the strength of health educat. at the peripheral level is very limited at this point. While the 21 HECs have already been designated, it will not be until 1988 when each one will have a PCV counterpart. The Peace Corps is in the process of phasing out the math-science teaching program as it gradually increases the number of PCVs in the community health education program.

It is, therefore, premature to try to assess the performance of volunteers in community organizing. However, this is not to say that a community organizing strategy for the CCCD health education component should not be thought out before more PCVs arrive. It appears that the community based experience of the PCV in Bassar is worth documenting as a pilot of what the strategy could be for future PCVs assigned to the peripheral level.

The newly formed health education working group could monitor the Bassar experience since this group is in the process of finalizing a 1986 Action Plan for SNES. This group is made up of Dr. Siamevi, Joe and Gail Naimoli, and the UNICEF representative. This Action Plan includes but is not limited to CCCD for it addresses the five major health programs for Togo, i.e., EPI, ORT, malaria control, guinea worm, and school

pharmacies. The outline for the more detailed SNES Work Plan is found in the Appendix.

In December 1985 the central level CCCD Coordinating Committee was mandated officially by the Minister of Health to meet. Needless to say, this Committee has not yet provided the priority directions needed for developing the health education component. Joe Naimoli will be accompanying two members of this Committee to the CCCD Consultative Meeting in Brazzaville in March 1986. The PASA paid his expenses so that he could assist the Togo delegation in making their presentation of the health education component.

In sum, the health education strategies and interventions for Togo are essentially being planned now. The contribution of the PCVs to this planning has been an important one because they are involved with nearly every aspect. It is in the area of mass media that PCV expertise does not exist to help SNES develop this strategy.

While it is too early to measure coverage and impact of PCV performance, it is not too early to collect baseline data and to begin monitoring progress. The Health Education Working Group and the central level CCCD Coordinating Committee are two places where thought to measuring coverage and impact should be given. Data needs to be collected on the number of people reached by health education activities conducted by PCVs as well as on the number of people who have adopted desired behaviors. There is presently no mechanism in place for gathering and analyzing this type of information.

B. STAFF DEVELOPMENT AND TRAINING

As mentioned earlier, SNES plans to provide in-service training for 1000 frontline health personnel during 1986. These 20-25 three day workshops were to be conducted by the staff at SNES. This ambitious training plan was drawn-up by Dr. Siamevi before the PCVs began their work.

Faced with too many trainees and not enough trainers, the Naimolis requested and received UNICEF funding to conduct Training of Trainers (TOT) workshops for SNES staff, HECs, and PCVs in the Maritime, Central, Kara, Savanes and Plateaux Regions. The objective is to form training teams for each region and to form a training coordinating team within SNES. The Naimolis have recently completed the revisions on a manual for trainers and a training curriculum for health personnel. The manual for health personnel includes technical information, memory aids, and practical materials, while the trainer's manual consists of a variety of experiential learning activities for adults and suggestions for facilitating these practical experiences. The curriculum will continue to undergo further revision as the training program extends northward.

The Naimolis also requested and received PASA funds to conduct a series of three workshops for HECs and PCVs on visual aids, planning, and coordination/supervision. They have already completed the visual aids workshop in February and have been requested by the Rural Water and Sanitation Project to conduct it for their agents. The other two workshops will be completed before the end of this fiscal year.

In sum, the 20-25 CCCD sponsored workshops will become an integral part of a larger staff development plan. That is, instead of providing "shot gun" training in which everyone will get a little bit of exposure, SNES will now have a cadre of trainers who will also be able to provide support and supervision to frontline health personnel after training. This is a direct result of the contribution made by the Naimolis.

In terms of measuring coverage and impact of training, it is still too early with only one workshop completed thus far. However, it is not too early for a monitoring system to be in place for gathering the information needed. The Naimolis and Dr. Siamevi realize that they have not given enough attention to evaluation because they have been so preoccupied with soliciting resources to train enough personnel to implement health education activities. At this point it is difficult to see where they will find the time to design and implement a monitoring system, given their ambitious training program for 1986.

C. ORGANIZATIONAL DEVELOPMENT

Dr. Siamevi had begun putting into place a decentralized system of health education long before the Community Health Education PCVs arrived. Regional satellite offices had already been established in Kara and Dapaong. Two additional ones are slated next year for Atakpame and Sokode.

The Naimolis have been working with Dr. Siamevi and his staff on designing the details of the decentralized system (See page 2 of Appendix D for a sketch of the system). Moreover, they have been helping the staff to analyze the practical implications

of such an approach upon those expected to implement it. Eventually, the HECs and PCVs at the prefectural and regional levels will also become involved in reviewing the system.

This decision to decentralize to all prefectures by 1989 is intended to extend the outreach capabilities of SNES, which is presently very limited in personnel and funds. UNICEF is prepared to equip the regional offices with whatever is necessary through its child survival monies. The Peace Corps is prepared to provide PCV counterparts for all HECs. However, what is unclear is the role that these HECs and PCVs will play in CCCD at the regional and prefectural levels. It is also not clear how the central SNES staff will be expected to provide support to them. These are issues that the CCCD Coordinating Committee may want to consider for deciding on priority directions.

IV. PC/CDC/USAID COORDINATION OF CCCD HEALTH EDUCATION

From interviews with staff from the Peace Corps, CDC, and USAID in Togo, Washington, and Atlanta, there appears to be a coordination of information problem. That is, a reporting mechanism for communicating information among these various parties did not exist. While direct supervisors of people in the field received regular reports and correspondence, there was no inter-agency means to automatically send copies. In some cases there were internal problems of coordination. For example, the CCCD Technical Officer meets regularly with the SNES PCVs and writes a monthly report on the health education activities along with all other CCCD related events. This report is sent to his supervising office in Atlanta. However, neither the Health

Education Specialist in Atlanta nor the Peace Corps office in Washington receives a copy of the monthly reports. The same oversight happens with reports submitted by PCVs.

The consequence of this was that the Atlanta and Washington based staff were not up to date on the activities of the PCVs in SNES and the periphery. In essence, this meant that the staff were not up to date on the CCCD health education component in Togo. When the evaluation team arrived in Togo, the expectation was that very little was happening in health education. The contrary was found.

An additional problem of coordination was in the area of requesting technical assistance from CDC or from the Peace Corps PASA. The PCVs and the CCCD Technical Officer were wondering why the CDC Health Education Specialist had not come more often to provide technical assistance while the Health Education Specialist was wondering why they had not been requesting her assistance. The PCVs did not realize that PASA funds were available from Washington to support their activities until Peace Corps/Washington cabled them with suggestions. Yet, it was still not clear to them that they could request funding on their own initiative.

This type of misunderstanding tends to slow down the pace of programming. In Togo this can be particularly damaging because there is no one beside Joe Naimoli who has graduate degree training in health education. Thus, short term technical assistance would be especially important to complement his long term abilities. However, he is a newcomer to the field in Togo and is not aware of how to make requests for assistance.

Provisions need to be made for these gaps in the system for procuring resources and information.

V. OTHER DONORS IN PC COMMUNITY HEALTH EDUCATION

UNICEF has an established relationship with SNES and the Peace Corps through an earlier collaboration on guinea worm prevention and treatment through school health education. A PCV has been assigned to work on a teachers manual with SNES and the School Health Unit in the Ministry of Education.

UNICEF has extended this collaboration by funding the TOT workshops being designed and executed by the Naimolis for 1986. Most recently, UNICEF received US$2 million in child survival monies for Togo and has committed US$125,000 per year to health education for the next three years. SNES needs to elaborate a yearly work plan with UNICEF and the Peace Corps to decide how best to use the funds and the PCVs.

Given this support from UNICEF, the Peace Corps in Togo could continue developing the CCCD health education component without PASA funds since ORT, malaria control, and EPI are part of child survival strategies as well. However, collaboration with CCCD staff would be weakened since short and long term technical assistance would now come from another agency. With less control over who provides the technical assistance, CCCD would be less able to guide the evolution of the health education component, especially in the face of the SNES move to decentralize. By renewing the PASA with the Peace Corps, CCCD

will not risk altering the pace or the direction of the momentum generated by the Naimolis within SNES.

VI. RECOMMENDATIONS

Given the above findings and conclusions, the Peace Corps contribution to and involvement with the CCCD health education component is more than what was requested in the PASA. The PCV Specialists are doing more than their job descriptions require. Nonetheless, the health education component and the PCV performance can be improved. It is in this light that the following recommendations are made:

1. Request a renewal of the PASA with USAID to ensure the continued development of the CCCD health education component.

2. Assess the scope and character of other donor participation in CCCD type activities so that dependency on a single funding source is reduced.

3. Recruit and employ a seasoned Associate Peace Corps Director for Health and Education with experience in health education program planning.

4. Request short-term technical assistance for the Volunteer Specialists in health education monitoring and evaluation, and in mass media intervention design.

5. Support and increase the effectiveness of the Volunteer Specialists by having them present reports periodically to the CCCD Coordinating Committee members for their advice and sanction.

6. Establish clear communication lines from the Volunteer Specialists to the Peace Corps Health Sector Manager in the Office of Training and Program Support (Washington), the CDC

Health Education Specialist in the International Health Program Office (Atlanta), and the USAID CCCD Project Manager (Washington).

7. Collect baseline data for future comparisons of input, outcome, and impact indicators to measure the efficacy of the health education component.

8. Conduct confirmatory KAP surveys to diagnose existing behaviors and beliefs in order to set clear behavioral objectives and to develop relevant health education activities.

9. Develop more community organizing type of health education activities for PCVs at the peripheral level to complement the mass media and interpersonal communication channels being developed.

10. Require all PCVs and HECs to conduct KAP surveys and community diagnosis in their prefectures for CCCD health education baseline data.