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9. ABSTRACT
The Maternal and Child Health (MCH) Extension Project was designed as a regional project to assist small "non-emphasis" African countries to improve and expand basic health services for mothers and children and to introduce child spacing as an essential part of these services. At the request of the A.I.D./Africa Bureau and the A.I.D./Office of Population, a two member team has evaluated the MCH Extension Project activities in The Gambia and Dahomey. The on-site review was conducted from May 18-31, 1975. This report is divided into the following sections: Summary Conclusions and Recommendations; Historical Background of the Project; Project Goal and Purposes; Findings in the Gambia; Findings in Dahomey, and Contractor Performance. The project goal and purposes were found to be appropriate in the light of the Gambia's and Dahomey's stated national health objectives and priorities and of A.I.D.'s health strategy for Africa. Health education, nutrition and child spacing have been recognized as essential MCH services. Simple low cost methods of adding these functions and improving services have been demonstrated in the pilot areas. In-service training has been provided for health workers in and outside the pilot areas. The potential exists in both countries for the extension of demonstrated improvements in MCH services. It was recommended that A.I.D. continue to support MCH activities in both Bambia and Dahomey and that a way be found to give more autonomy to continued project development so that project activities can proceed at their own pace in each country.

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REPORT OF AN EVALUATION OF THE MATERNAL AND CHILD HEALTH EXTENSION PROJECT IN THE GAMBIA AND DAHOMEY

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The project goal and purposes are appropriate in the light of The Gambia's and Dahomey's stated national health objectives and priorities and of AID's health strategy for Africa. The majority of Phase I targets are being or have been met and in many instances, surpassed. Health education, nutrition, and child spacing have been recognized as essential MCH services. Simple low cost methods of adding these functions and improving services have been demonstrated in the pilot areas. In-service training has been provided for health workers in and outside the pilot areas. Certain project design assumptions such as dividing the project into two phases have not proven valid. The potential for extension of demonstrated improvements in MCH/CS services exists in both countries. Recommendations include: (1) that AID continue to support MCH project activities in both Gambia and Dahomey; (2) that a way be found to give more autonomy to continued project development in each country so that project activities in each country can proceed at their own pace; and (3) that consideration be given to extending the life of the project so that Phase II is long enough to give meaningful support to agreed upon extension activities.

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REPORT OF AN EVALUATION OF THE MATERNAL AND CHILD HEALTH EXTENSION PROJECT IN THE GAMBIA AND DAHOMEY

INTRODUCTION

The Maternal and Child Health Extension Project (932-11-580-358) was designed as a regional project to assist small "non-emphasis" African countries to improve and expand basic health services for mothers and children and to introduce child spacing as an essential part of these services. The life of the project was anticipated to be five years, with a two-year demonstration phase to be followed by a three-year expansion phase. The project was approved by the Agency for International Development (AID) in June 1971 and funded under Title X. The University of California at Santa Cruz (UCSC) was selected as the contractor to implement the project in The Gambia, Dahomey, and Lesotho, and field activities began in March 1972.

At the end of the two-year demonstration period AID participated with the contractor in an on-site evaluation and a proposal for Phase II was drafted. Although no AID action has been taken on this proposal, funding and project activities have continued to the present time. Because of AID's recent restriction on the use of Title X funds, further support for the health component of the project must come from general technical assistance funds. Since the project has not had a full-scale AID evaluation, and because several questions have been raised about the rate of progress and the potential for expansion in The Gambia and Dahomey, the AID/Africa Bureau determined that a special external evaluation should be carried out in these two countries before any decision is taken on future funding. The purposes of the evaluation were to reassess the validity of project goal and purposes in each country, to assess performance and progress in Phase I and the potential for extending project activities to other areas of each country as planned for in Phase II, and to recommend future courses of action.

At the request of the AID/Africa Bureau and the AID/Office of Population, the evaluation of MCH Extension Project activities in The Gambia and Dahomey was performed by a two member team: Walker Williams, Health Education Specialist, HEW, and Elizabeth Hilborn, Public Health Consultant, American Public Health Association. The on-site review of the project was conducted during the period May 18 through 31, 1975.

The evaluation study and field work entailed a review of documentation available at AID/W and in the field, intensive discussions with the U.S., Gambian and Dahomean staffs engaged in the project and with senior health officials in each country, observation of on-going project activities. In addition, interviews were held with representatives of the United Nations Development Program, the World Health Organization, Catholic Relief Society and National Family Planning Association as well as with U.S. Embassy/AID officials in each country. The UCSC Campus Coordinator for the project accompanied the team throughout the field visit.

The team wishes to express sincere appreciation to all who assisted with the study and gave so generously of their time and interest. Particular thanks go to the project staff, both African and American, for all their kindnesses and for their frank and thoughtful discussions of project accomplishments and problems.

The terms of reference for the study are attached to the report as Appendix A.

I. SUMMARY CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

1. The project goal and purposes are appropriate in the light of both The Gambia's and Dahomey's stated national health objectives and priorities and of AID's health strategy for Africa. The contractor's work plan targets seem in complete agreement with project goal and purposes.

2. The majority of Phase I targets are being or have been met and in many instances, surpassed. Health education, nutrition, and child spacing have been recognized as essential MCH services. Simple low cost methods of adding these functions and improving services have been demonstrated in the pilot areas. The role of existing health workers has been expanded and, in The Gambia, volunteers are being used effectively. In both countries, in-service training has been provided for health workers in and outside the pilot area, and certain project initiated activities are being introduced in other areas of each country. Successful project activities have resulted in more people being reached by pilot area health services.

3. Although the arbitrary division of the project into two separate phases has been proven unrealistic, it seems to be serving as a lever to promote movement from pilot activities to wider application of successfully demonstrated technics and services.

4. The advantages of the project's regional nature have not proven as great as anticipated, due to the long distances between countries and the dissimilarities in program implementation needs and possibilities. It was unrealistic and almost impossible for a regional staff of two to provide coordination, team leadership, country program direction, medical technical services, and administrative support services to the three widely separated and vastly different countries which made up the region.

5. Certain other project design assumptions have not proven valid. Demonstration activities could not begin immediately in the pilot areas. They had to be preceded by a long period of community study, project interpretation, role defining, and development of mutual trust. Even minor changes could not be introduced in the pilot centers without involving top level decisions. Collaboration between the project and other donors (specifically WHO)

has not been actively promoted by the governments. Governments and Ministry officials have not been stable enough to avoid fluctuations in degree of project understanding and support, and AID has not acted on revised program and budget proposals. All these have slowed down the rate of progress, but in some cases they have made progress sounder and more lasting.

6. The Phase II plans submitted a year ago are realistic and appropriate to both the countries' and AID's health program goals. Developed in close collaboration with the two governments, they have served to guide project activities during the past year. The long delay in their official approval by both AID and the participating countries have slowed the tempo of progress toward predicted end-of-project achievement, and modifications will be needed in work plan targets and/or time for their accomplishment. In the past year, government and personnel changes in Dahomey necessitate considerable re-planning in that country.

7. Government commitment to project purposes exists in both countries. This is particularly true at the technical level where project stimulated activities are increasingly initiated and carried out by national counterpart personnel. In both countries the project seems to have been integrated and accepted as the governments' own program. Both governments have absorbed logistic and operating costs of project activities as envisioned in the original agreement.

8. The potential for extension of demonstrated improvements in MCH/CS services exists in both countries, despite the fact that neither country can expect to have substantial increases in personnel or operating funds in the next few years. During this evaluation it was not possible to confirm details of the expansion plan with top Ministry of Health officials. In The Gambia the Minister and Chief Medical Officer were out of the country, and in Dahomey the newly appointed health officials were just beginning to study the expansion proposal as presented by their own Dahomean colleagues. However, the on-going and planned training programs to increase the skills of existing staff country-wide and the official approval given to new records, clinic procedures, child spacing and health education activities cannot help but result in improved services to a much greater proportion of the population. One health official said, "It would be better if you hadn't come at all than to phase out now when we are just getting started."

9. Contractor performance has been at a high level as evidenced by the excellent caliber of field staff, demonstrated commitment to project purposes, unusually good relationships developed with national personnel in both countries, innovative use of graduate students and locally recruited technical assistants, and sound program modifications based on continuing critical self-analysis. The University has provided good administrative and training backstopping services and programs. Two areas which need strengthening are the development of an overall evaluation design and provision of more consistent technical backstopping.

10. An adequate design for impact evaluation of the project has not been developed. Substantial measurable change in health status of total populations requires a very long period of time when project inputs and change agents are limited to demonstration and training for quality changes in existing services and resources. However, realistic expected changes in the health delivery systems are being identified, and small studies of health center users are providing a baseline against which it would appear that selected but significant measurements of project impact can be made. Evaluators are in agreement with the Field Coordinator's statement, "We are basically charged with instilling a broad philosophy of public health into a system where it is to a greater or lesser degree an alien idea. Success of this intangible process may be program elements which are measurable as achievements but which may not be nearly so significant as the change in underlying philosophy which permitted them to occur."

B. RECOMMENDATIONS

1. That AID continue to support MCH project activities in both Gambia and Dahomey. No change is needed in the basic conceptual framework of the present project which is still sound and relevant to both countries' needs and possibilities, as well as to AID's health program goals for Africa.

2. That the Phase II proposal, as submitted by the contractor last year and with modifications agreed upon AID, UCSC, and the participating countries, be used as the basis for further negotiations and program development.

3. That the "region" be limited to two countries, The Gambia and Dahomey, and that each country share half of the time of the project's regional staff. This recommendation

is made with the understanding that the MCH Extension activity in Lesotho may become a bilateral project.

4. That a way be found to give more autonomy to continued project development in each country so that project activities in each country can proceed at their own pace. For example, Phase II approval in The Gambia should not be held up while re-planning is going on in Dahomey.

5. That consideration be given to extending the life of the project (at least one additional year) so that Phase II is long enough to give meaningful support to agreed upon extension activities.

6. That within the next project year AID work with the contractor to develop a realistic and mutually acceptable design for end-of-project evaluation which measures accomplishments against projected activity targets and, insofar as possible, assesses project impact on individual health status and country health delivery systems. Care must be taken that the measurements selected are feasible within the operational, non-research nature of this project.

7. That AID move quickly (even before PROP revision is completed) to assure both countries and the contractor of continuing support and to approve filling of field staff vacancies. Unless this can be done, much of the momentum which has been generated in each country risks being lost.

II. HISTORICAL BACKGROUND OF THE PROJECT

A. REGIONAL PERSPECTIVE

"On a continent where there is little pressure of population on the land, where primitive subsistance farming requires many hands, and where 50% of the children die before they reach the age of 5 there is only limited and spotty support for programs which would control or reduce population growth. However, there is widespread concern about the high death rate of mothers and children, and most government health plans give high priority to the development of maternal and child health services."

"The health infrastructure of each country provides at least minimal hospital and public health service to all the major centers of population and each has a beginning network of health centers and dispensaries radiating out from these centers into the rural areas. There is wide variation in the extent of coverage but in every country large numbers of rural people have no health care except that given by indigenous healers and untrained traditional midwives. Health services that do exist in the most remote centers are almost entirely limited to the care of the sick, personnel are inadequately trained and unsupervised, and medications and equipment are continually in short supply." (PROP, June 1971)

Because of these general similarities and the fact that The Gambia, Dahomey and Lesotho appeared to be more nearly at the same stage of MCH/FP service development than the other potential participating countries, they were combined as a "region" for project purposes. In retrospect, the regional nature of the project was undoubtedly dictated more by AID policy at the time than by a determination that regionalization would contribute substantially to project success. Experience has shown that they were too widely separated geographically and too dissimilar in language, customs, bureaucratic policy and infrastructure, tempo and readiness for change to become a workable region.

B. THE MCH/EXT PROJECT

The project was designed to provide one dimension to AID's total population input in Africa in that it approaches the problem at the level of direct services to people. It introduces the concept of family planning as a health service and searches for ways to motivate people to want to space their children. At the same time, it develops feasible ways to extend the local health services through which family planning services can be given.

The project addresses the following problems: the high level of preventable illness and death of African mothers and children; large numbers of people unreached by present health services which are largely curative and provided by small numbers of inadequately trained health workers; cultural and traditional beliefs and practices which militate against changed health behavior; political and social objection to family planning; and limited administrative and financial resources, both present and projected, for health service development.

The plan of action was to study and demonstrate, in several settings (rural and urban, traditional and transitional) that the role of existing local health workers can be expanded to include giving MCH/FP services which will affect the health of mothers and babies. Emphasis was to be placed on services which could be provided without necessitating substantial increases in drugs or other recurrent costs and on health education activities which would motivate people to change their own health behavior. The concept of family planning was to be introduced as a preventative health measure. Overall increase in cost to host governments would be extremely modest and would not inhibit pilot area activities from being replicated elsewhere in the country or other African nations.

Project implementation was to be in two phases. During Phase I the project would assist selected African countries to initiate or improve MCH services in defined pilot areas. In Phase II the project would assist the participating countries to replicate successful pilot zone activities in other areas and to integrate appropriate pilot activities in the total government health service system.

The original project design anticipated project activities to be initiated in six countries, with the proviso that it might be necessary to engage more than one contractor. Eventually, AID contracted with the University of California/Santa Cruz to implement project activities in The Gambia, Dahomey, Lesotho and with the Organization for Rehabilitation through Training to carry out similar activities in Niger and two other countries to be selected later. For reasons outside the purview of this study, the ORT contract and the Niger activity were phased out after the second year.

The UCSC contract was signed in June 1971, and by the following March all contract staff were in the field. Two public health nurses were assigned to The Gambia, one public

health nurse and a nurse-midwife to Dahomey, and a public health nurse and a health educator to Lesotho. A public health obstetrician and an administrative officer were based in Dahomey and expected to divide their time equally between the three countries.

C. CHRONOLOGICAL HISTORY OF UCSC PROJECT ACTIVITY

August 1970	- Preliminary project proposal approved.
November 1970	- AID/W field visit to seven countries to explore interest in proposed MCH/CS project concept and possible activities.
December 1970-January 1971	- UCSC selected as potential contractor.
March - April 1971	- UCSC project design visit in three countries - The Gambia, Dahomey and Lesotho.
June 1971	- PROP developed and approved by AID/W (on basis of UCSC field study report).
June 1971	- Contract signed by AID/UCSC.
September 1971	- UCSC work plan submitted to AID/W (including modified PPBS records and evaluation design).
October 1971-February 1971	- Letters of Agreement signed (UCSC/Participating Country) specifying Phase I Plan of Action in each country.
December 1971	- Two UCSC staff members attended AID/W Program Evaluation Seminar.
November-December 1971	- Dahomey - based staff in language training.
January 1972	- All field recruited and participating in six-weeks orientation at UCSC.
March 1972	- All field staff on-site in The Gambia, Dahomey and Lesotho.

March 1972 to present	- Seven semiannual progress reports have been submitted to AID/W.
December 1972	- First annual review of project status by UCSC campus and field staff with national counterparts. (Reports submitted to AID/W in Third Semiannual Report.)
December 1972	- PPBS records and evaluation plan assessed as unsatisfactory and abandoned with AID/W concurrence.
January-February 1974	- On-site Evaluation Conference by Participating Country representatives UCSC, and AID/W (Report submitted to AID/W as Fifth Semiannual Report).
March 1974	- Contractor Proposal for Phase II submitted to AID/W (including revised log frame and work plans for each country and a proposal to initiate project activities in Swaziland).
August 1974	- External evaluation visit by UCSC consultant (Report submitted to AID/W in Seventh Semiannual Report).
Summer 1974	- Revised PROP prepared by AID/W (based on contractor proposal). NO ACTION TAKEN TO DATE.
April-May 1975	- On-site evaluation by AID/W.

III. PROJECT GOAL AND PURPOSES

"The goal toward which this project is addressed as the improvement of the quality of life of African mothers and children through the reduction of preventable maternal and child morbidity and mortality and the acceptance of child spacing as an essential health service..." Its purposes are 1) "to find and demonstrate simple but effective ways to improve MCH services," 2) "to promote awareness and acceptance of the values of child spacing," 3) "to initiate appropriate child spacing services without necessitating the political development of a national policy on population matters," and 4) "to extend these MCH/child spacing services to previously unreached population groups without necessitating substantial increases in facilities, personnel or operating costs..." "The expected end of project status is the establishment of basic MCH services which emphasize prevention of illness and death, include child spacing, and which are being provided to previously unreached populations." (PROP, June 1971)

In the opinion of the evaluators, the project goal and purposes are appropriate in the light of stated national health objectives and priorities in both The Gambia and Dahomey (see detailed reports of each country). They are in line with specific needs and recommendations as identified in the CWR, DAP Review: "reorientation of national health programs toward preventive services (including nutrition and MCH) for the rural majority" and "design programs to retrain and upgrade those now in health services and for extension of these services to rural areas." (CWR, DAP Review, AID-90, May 13, 1975.)

To further assess its appropriateness to AID's policy, the project has been measured against the criteria for evaluation of proposed projects as defined in AID's Health Strategy for Africa. (Health in Africa, AFR/DS, January 1975.)

1.	Will the proposed project provide health services to population groups not now being reached with such services?	1.	Yes - stated purpose.
2.	Is project feasible in terms of host country projected resources?	2.	Yes - stated purpose.
3.	Is there evidence of host country commitment to project goals and objectives?	3.	Yes - commitments to date have been kept.

4.	Is project likely to have measurable impact on health status of population? On economic status?	4.	a. Yes. b. Only indirectly.
5.	Does project incorporate areas of AID priority concern, i.e., nutrition, family planning, rural populations, preventive health services, environmental health, and health education?	5.	Yes - all.
6.	Does project contribute to development of management and skills within host government infrastructure?	6.	Yes - at program planning and supervisory levels.
7.	Does project provide for development of (a) appropriate manpower to deliver primary health services, and (b) for necessary supervisory skills and services?	7.	a. Yes - training is the largest component. b. Yes.
8.	Is project (a) based on systematic analysis of the health sector and (b) is provision made for suitable evaluation and data feedback?	8.	a. Analysis made of MCH needs and services. b. Yes.
9.	Is project emphasis on preventive vs. curative health services?	9.	Yes - stated purpose.
10.	Is design for provision of services appropriate to needs and resources of host country...?	10.	Yes - stated purpose.

IV. FINDINGS IN THE GAMBIA

A. OVERVIEW

The Gambia is a seven to twenty mile wide strip of land extending for 200 miles along both sides of the Gambia River. Of its population of 357,000, more than 300,000 live in small rural villages. The annual per capita income is about $90. The annual population growth rate is estimated at between 1.7% and 2.2% and the average life expectancy is 43 years. The high infant and child mortality rate is attributed to malaria and other parasitic and infectious diseases, the diarrhea/pneumonia complex and malnutrition. There are two government general hospitals in the country, nine rural health centers, some 40 to 50 rural dispensaries, 10 or 11 practicing physicians, and about 200 nurses, midwives and dressers.

The project pilot area in the Lower River Division serves about 60,000 rural people, with a health center containing 11 hospital beds in Mansa Konko and seven satellite dispensaries. The health center staff (which includes one nursing sister, two nurse-midwives, a dispenser, a health inspector, a leprosy officer, and eight auxiliaries) make regular treks to provide services at the dispensaries, each of which has a resident dresser. Before inception of the project, the services given were largely curative. Unlike some other African countries, it would appear that Gambian health center personnel are working at full capacity, and new services can be added only by adding staff, using volunteers, or substituting new tasks for old ones. One U.S. technician lives in Mansa Konko and works as the counterpart of the Health Center sister. They share responsibility for demonstrating and testing new or improved MCH/FP services and also for developing the pilot area as the national rural field training center. The second technician and her counterpart are based in the Ministry of Health and make regular supervisory training visits to the pilot area as well as participate in national planning, health training programs and on-going extension of health education services to other population groups.

B. NATIONAL HEALTH GOALS AND PRIORITIES

The evaluators were told that the Ministry of Economic Planning is giving highest priority to rural development. The national health plan, now in a draft stage, is reported to place high priority on extending and improving basic health services in rural areas, with emphasis on MCH. It

projects the building or upgrading of five to six rural health centers per year as well as expanding the one existing provincial hospital and building a small community hospital in an unserved area. High on the list of health personnel development priorities is the training program for existing auxiliary personnel with which the project is assisting. With the support of both the Ministries of Planning and Health, a national policy to accept family planning as an essential part of MCH services will be considered by the Parliament this year.

C. PROJECT INITIATION

There are a number of reasons why the project got off to a slow start in The Gambia. This was the only country where the Government/UCSC agreement was required to have approval at a higher level of government than the Ministry of Health. The agreement was not ratified by the Cabinet until project personnel had been in the country several months. Key Ministry of Health personnel changes took place in the interval between design and negotiation of the project and arrival of project staff and new officials did not automatically assume the commitments of their predecessors. It was necessary to reinterpret project purposes and goals, re-plan activities, gain new commitments and tool up for implementation. For example, the government had agreed, during the feasibility study, to provide housing for a U.S. technician in the pilot area (which is a two and one-half to three hour drive over rough roads from Banjul). This commitment had to be accepted by new health officials, money allocated and a house constructed and furnished. It was one and one-half years before full-time work could begin in the pilot area. In addition, there was lack of understanding and acceptance of the administrative and planning authority of The Gambia based technicians, and local officials were unwilling to make decisions or take action except during the sporadic visits of the field coordinator. A basic misunderstanding, by both UCSC and GOG, about the desired long-term functions of the Ministry of Health based technician and her counterpart was not completely resolved until toward the end of the second project year.

It is to the credit of project staff that this long waiting time was constructively used. In addition to their own orientation and study of the country's health problems and services, they designed and conducted a rural health survey, reinforced the MCH/FP content in the two health training institutions and in training programs for agricultural workers and youth groups, established informal relationships with other donors, and initiated selected project related activities in Banjul as well as in the pilot area.

D. PERFORMANCE AND ACCOMPLISHMENTS

Progress is reported and discussed in relation to each of the tasks identified in the PROP and in the GOG/UCSC agreement.

Task No. 1: Collect demographic, health status, and KAP baseline date.

Progress: A rural health survey was carried out during the first project year and results were tabulated and analyzed at UCSC. The GOG was deeply interested in this activity and at their request, the area covered was greater than the pilot area, the questionnaire too elaborate and the sample far too large (more than 10% of the total population) in light of the time and resources available under the project. Though the study produced a mass of information which has been useful in guiding project activity development, it does not provide an accurate baseline for project impact evaluation. Recognizing this, the staff has initiated a series of small health center-user studies which give promise of producing effective baseline information.

Task No. 2: Study and improve existing services.

Progress:

1. Group patient teaching is being done by a Gambian nurse midwife and auxiliaries in the pilot health center and satellite dispensaries and has already been extended to matters in the referral hospital in Banjul and to a second health center. Content includes nutrition, family hygiene, first aid, child care and child spacing. Mothers who can extend this teaching to small villages have been identified. Approximately 200 mothers attend health teaching sessions each month.

2. New clinic records, safer techniques and new simple equipment have been introduced and are being effectively used.

3. Health problems which has been ignored are being identified and preventive or treatment measures taken through use of the Ilesha growth chart and nutrition teaching, taking of antepartum and delivery histories to detect risks, initiation of post partum services, testing expectant mothers for syphilis and treating as indicated, and initiation of other simply laboratory services.

4. Child spacing motivation and limited family planning services are now being given as government services -- they were previously done only by Family Planning Association (FPA) workers.

5. A referral and reporting system has been developed between the health center and referral hospital and transportation is provided to high risk mothers.

6. The health inspector and his students are including MCH/FP in their talks with village groups (average four meetings, 250 people per month).

Task No. 3: Provide short-term on-the-job training for pilot area personnel.

Progress: 1. Regular biweekly training sessions are being held for pilot health center staff and volunteers.

2. MCH/FP training has been provided to pilot area child care supervisors and volunteers.

3. Informal on-the-job training is given during the course of mobile team visits to dispensaries.

4. Additional planned training awaits assignment of another nurse-midwife to the health center staff. This was recommended by the project, approved by the Ministry of Health, but has not yet been implemented.

Task No. 4: Recruit, train, and use volunteers.

Progress: 1. Seven high school and post high school volunteers have been recruited, given on-the-job training and are working regularly in the MCH clinics at the health center.

2. Two traditional birth attendants are working as volunteers.

3. Follow-up is planned to recruit and motivate selected mothers to be health teachers in their own villages.

Task No. 5: Develop regular method of supervision of pilot health center.

Progress: Now the Banjul based project technician and her counterpart are visiting the health center weekly for participating supervision. The plan is for the counterpart's role to expand to MCH coordinator and supervisor of all health centers, but this has not been formalized by the Ministry of Health.

Task No. 6: Develop an overall plan for regular re-training of all health personnel.

Progress:

1. The auxiliary nurse training program, in the final stages of development and scheduled to begin October 1, provides for retraining of all auxiliaries now in government service.

2. The pilot area is to be used for rural field training and re-training of all health personnel. It is now being used for field experience for basic nursing and health inspector students from Banjul and for nursing students from Senegal.

Task No. 7: Develop appropriate health education technics and materials.

Progress:

1. Early didactic training efforts have not been very successful in changing behavior of trainees.

2. Present programs focus on demonstration and participation as the most effective teaching technics, with locally available materials as teaching aids. Examples are the home cooking demonstrations at village dispensaries, kitchen gardens at the Health Center and at Banjul Hospital, and the training kitchen planned for the pilot area.

3. Use has been made of posters and other audio-visual aids from other sources, but no attempt has been made to produce these within the project.

4. A manual of health education lessons for parents is being developed on the basis of present pilot area and hospital health teaching experience.

Task No. 8: Participate in development of health records and demographic data collection systems as needed.

Progress: New prenatal, postpartum, and delivery records have been developed, tested, and are in use in the pilot area; and service statistics are being collected.

Task No. 9: Work with Ministry of Health to improve supply dispersal system to outlying areas.

Progress: Record and dispersal of all project supplies has been completely integrated into the government system.

Task No. 10: Participate in training programs and professional conferences of all levels of health and health related personnel and provide MCH/FP training as requested.

Progress:

1. Project staff participated in nursing school curriculum revision to include family planning and regularly teach MCH/FP content in the health inspector's school.

2. Recently they assisted with an EEC/FAO workshop seminar on Improvement of the Quality of Life of Village Mothers. Part of the seminar took place in the pilot area.

3. With consultants from UCSC, the project gave a two-week "Training of Trainers" course for 16 senior health personnel from a variety of agencies and services.

4. One hundred and fourteen individuals have had some level of technical training under project auspices.

Task No. 11: Develop a method for technical evaluation of pilot activities and assess project effectiveness concurrently and at the end of two years.

Progress: Concurrent assessment of individual project problems and programs and a search for reasons for successes and failures has been thoughtfully and regularly carried out and has resulted in constructive changes in technics and operating methodologies. The two year evaluation was this type of an assessment rather than a pre-designed objective measurement of achievements against targets. A design has not yet been developed for end-of-project evaluation.

E. PARTICIPANT TRAINING

Two nurse-midwives have completed and a third is currently participating in family planning training as project participants. One of these returned nurses is now the nursing sister in charge of the pilot zone health center and the other will work as a Family Planning Association supervisor in a rural area. Both are having follow-up training in family planning technics under the supervision of local obstetricians. The other project counterpart nurse is just completing nine months U.S. training in public health nursing and family planning.

Training plans are being made for other senior nurses who will be posted to other rural health centers.

F. OTHER INDICATORS OF PROJECT IMPACT

A number of government initiatives which have been stimulated by the project would seem to be additional indicators of project impact. Some of these are:

1. Family planning has been accepted as a government agency function. The FPA introduced FP in The Gambia and eventually, was allowed to operate in government facilities. Now, in the pilot area, government employees are beginning to give services on government time with government supplies. And a national FP policy is being presented to Parliament this summer. The Acting Chief Medical Officer told the evaluators "the UCSC project has saved family planning in The Gambia by demonstrating that it must be an integral part of MCH rather than a free standing program."

2. Originally the Ministry of Health insisted that project vehicles be identified with the lettering "University of California Maternal and Child Health/Child Spacing Project"; presumably to protect themselves if the project failed or was publicly criticized. Now the Ministry has changed the vehicle identification and it reads "Ministry of Health MCH/FP Project".

3. After the need and technics for laboratory services to find high risk mothers and children were demonstrated in the pilot area, the local government provided a man and his salary, he is being trained in the government laboratory, is working part time in the pilot area and will be assigned there full time when his training is completed. With WHO assistance, the GOG is now setting up a regular training course for laboratory assistants with the goal of providing the same service in all health centers.

4. More than a year ago the GOG asked project personnel to plan and conduct an auxiliary training program. They succeeded in getting recognition that official coordinated planning was needed and now an official planning committee is chaired by the Director of Nursing and Midwifery Training. The Committee includes representatives from the School of Public Health, the Ministry's Division of Medical Services and Health Planning Committee, and WHO as well as project personnel.

5. Success of nutrition teaching to a group of mothers who are volunteer day nursery workers in the pilot area prompted the Community Development Director to request similar training for day nursery supervisors. This training is being given at two health centers with a plan to extend to other areas.

6. The Chief Matron told evaluators that for the first time officials have recognized the value and have released senior nursing staff to participate in specialized in-country refresher training provided under the project.

G. COORDINATION WITH OTHER DONORS

Project technicians have established good relationships with personnel of other donor and nongovernment agencies. They work particularly closely with CRS and FPA and have actively sought ways to encourage these and other agencies to participate in project activities. The GOG has obtained supplies and commodities for pilot activities from both UNICEF and CRS, and U.S. selfhelp funds have been used for health center and dispensary renovations. With project initiative, the FPA and Ministry of Health are meeting regularly to coordinate family planning activities. Project staff have participated in an Inter-Ministerial Group on Family Planning, the Pre-school Committee of CRS, the EEC/FAO Rural Seminar in planning for a British supported management project in the Ministry of Health, and they have been told that they will be co-opted when a health planning subcommittee on MCH is established. WHO has just begun operations in The Gambia ans is planning for a Basic Health Services Project. The WHO Representative assured evaluators of his willingness to collaborate with the project.

H. GOVERNMENT SUPPORT AND COMMITMENT

The government has lived up to nearly all its commitments as defined in the Agreement and in several instances, has far exceeded them. They have provided counterparts, participants,

facilities, personnel and operating costs in the pilot zone, supplies and equipment from CRS and UNICEF, and the Chief Medical Officer, himself, has served as the focal point for project administration. In addition, the government provides office space in the Ministry of Health, housing for one U.S. technician, and, in the past year, has taken over the salaries of drivers and secretary, postage and office supplies, vehicle maintenance and operating costs, and the handling of all project equipment.

Because both the Minister of Health and the Chief Medical Officer were attending the World Health Assembly meeting in Geneva during the study visit, evaluators were not able to get official commitment of the level of continuing support. It would be useful to schedule an AID/W visit by the Chief Medical Officer this summer or early fall when he plans to spend some time at UCSC. A good time for this visit would be in conjunction with the International Health Conference scheduled in Washington in October 1975.

The Acting CMO and other Ministry officials were warmly supportive of the project and expressed their concern that it continue. In a letter to the evaluators the U.S. Charge d'Affaires commented, "To date the project has succeeded in moving the GOG from a position of opposition, first to tacit acceptance and now to one of understanding and active support for the goals of the project -- the change has been fundamental and, given at least the time originally projected, should become irreversible."

Health budget and personnel resources in The Gambia are minimal and cannot be expected to increase substantially. The Ministry of Health gets only five percent of the national budget and there was no evidence that this proportion would change. However, the proposed Phase II activities seem realistic and require very little increase in either personnel or budget beyond what is already being planned for. Full achievement of the proposed project program may depend on the extent to which the hospital expansion absorbs funds and personnel planned for other rural health services. Discussion with the Chief Medical Officer could probably clarify this point.

V. FINDINGS IN DAHOMEY

A. OVERVIEW

Dahomey, with a population of 2.8 million and an area slightly smaller than Pennsylvania, is one of the most densely populated countries in franceophone west Africa. About 90% of the people live in the rural sector, and the population growth rate is estimated at 2.8%. Life expectancy is 37 years and the infant mortality rate is reported as 110. As in The Gambia, major causes of infant and child deaths are malaria and other parasitic and infectious disease, the diarrhea/pneumonia complex and malnutrition. There are less than one physician and four nurses for every 20,000 people. The average annual income is $80. and government expenditures for health are just under $2. per capita. The health infrastructure includes general hospitals and "maternities," a network of 200 dispensaries providing curative and some antepartum care, one urban and six rural MCH centers, and mobile endemic disease teams. In addition, there are 11 social centers providing well child care as well as social services.

In Dahomey, health officials wanted the project to work with the population in transition from rural areas and traditional behavior to the urban area and the modern world. Pilot areas were located in the Akpakpa quarter of Cotonou, a transitional suburban area of 30,000 people living in small village clusters, and at the Central MCH Center and Maternity Hospital where sick children and complicated maternity patients from Akpakpa are served. Health facilities in Akpakpa include a social center, three satellite village centers and a dispensary. One U.S. PH nurse-midwife technician has worked in Akpakpa with the director and midwife of the social center as her counterpart; and the other U.S. PH nurse worked in the Cotonou MCH Center where a senior midwife was assigned as her counterpart.

The fact that MCH services are fragmented between health and social services has presented problems, and the project has worked in both areas with the goal of influencing integration, at least at the local level.

B. NATIONAL HEALTH GOALS AND PRIORITIES

The new government is reported to be putting great emphasis on rural development. However, the evaluators were not able to learn of existence of an operational development plan nor of the priority which is being given to health aspects of rural development.

Health planning has been going on for some time in the Ministry of Health, under the direction of a Chief of Studies and Planning and with assistance of WHO. Several Ministry officials stated that highest priority is being given to preventive and rural health services. This would seem to be born out by the existence of the WHO Basic Health Services Project with its demonstration zone, the training of itinerant workers and home visitors, and a recent major change in Ministry organization which provides for decentralization and coordination of all health services at the district level.

Although Dahomey has no official population policy, family planning services are given at the MCH Center in Cotonou and the government has permitted some 30 of its senior health staff to go out of the country for family planning training, presumably with the goal of expanding family planning services throughout the country.

C. PERFORMANCE AND ACCOMPLISHMENTS

Progress is reported and discussed in relation to each of the tasks identified in the PROP and in the GOG/UCSC Agreement.

Task No. 1: Collect demographic, health status and KAP baseline data.

Progress: 1. In Akpakpa a health survey was conducted to develop a profile of basic health practices, customs and awareness. Two hundred families in 10 villages were interviewed by nursing and medical students. Results of the survey have been used in program development and as a basis of comparison for evaluation purposes. More recently, a study was done of mothers using newly established services in a village in the Akpakpa area.

2. Two types of baseline data were initially collected at the MCH Center and the Maternity Hospital, one on personnel and their utilization and the other on preventive health services. Later, a survey of 600 women was conducted to obtain information on the extent to which preventive services are known and used by MCH Center clients.

Task No. 2: Study and improve existing services.

Progress: 1. At the MCH Center group patient teaching is done by Dahomean staff four times a week, reaching approximately 500 mothers per week. In the year since this health education

program was initiated, family planning acceptors have doubled and there has been a 60% increase in parents who buy vaccines and have their children immunized.

2. A new program of well baby supervision has resulted in identification and special care of referral for babies at risk. A special clinic for women in thier first pregnancy has been established, and home visiting to mothers with problems is beginning.

3. New family planning records developed and in use have not only resulted in better service to the patients but provide a basis for follow-up and evaluation.

4. The patient teaching and well baby supervision services have been replicated in three dispensaries in the Cotonou area. U.S. self-help funds were used to enlarge the dispensaries to provide space for these services.

5. In the Akpakpa Social Center, antepartum and post partum care has been added, high risk mothers and babies are being identified by new evaluation and laboratory technics, the well baby weighing and nutrition teaching program has been established regular group health teaching is being done, high risk mothers and other interested patients are being referred for family planning services. There has been a 300% increase in children being brought for health supervision since prenatal services were added. The number of children brought for immunization has doubled since the health teaching program began.

6. A midwife was added to the social center staff and new MCH/FP services have been established in a village center. In the first nine months, 146 pregnant women from five nearby villages were registered and given care. Child health supervision and health education activities are being carried out and 25 to 30 home visits to families with problems are made each month. Plans are underway to establish these same services in a second village center in the next few months.

7. Evidence of the effectiveness of the new services being offered is the fact that almost as many expectant mothers are coming to the social center and its village satellite center (where there is one midwife) for care as are going to the nearby dispensary where there is a staff of five midwives. A cost analysis of these new services has been made and reported to the Ministry of Health.

Task No. 3: Provide short-term on-the-job training for pilot area personnel.

Progress: 1. At the MCH Center, two-week training in health education methods has been given to 125 health workers from the MCH Center, the Maternity Hospital, six outlying dispensaries, and the military camp. More recently, a longer course was given to senior personnel from these and other health facilities in the area. Follow-up indicates that trainees are using what they learned. Instructors were Dahomeans who had previously been given training as trainers.

2. All personnel at the social center had two weeks training and practical follow-up in each of the following areas: well child supervision nutrition, health education, identifying high risks, need family planning. Even the project drivers have had training and now they locate clinic records, give out vitamins, and discuss family planning with the fathers.

Task No. 4: Recruit, train, and use volunteers.

Progress: Traditional birth attendants in the pilot area have been identified and training is planned.

Task No. 5: Develop regular method of supervision of pilot health center.

Progress: The directrice of the social center is now supervising the satellite centers, and the health education coordinator at the MCH Center is supervising health education services there and in the three dispensaries to which certain project activities have been extended. The plan is that she will be based in the Ministry of Health and will supervise MCH/Health Education Activities in all centers.

Task No. 6: Develop an overall plan for regular re-training of all health personnel.

Progress: Health education training, as developed by the project, has been shared with WHO staff who are responsible for continuing education. It is also being incorporated into the first year curriculum for student nurses and midwives.

Task No. 7: Develop appropriate health education technics and materials.

Progress: With the help of UCSC graduate student, the project developed, tested, and reproduced a packet of visual aids which are being effectively used in all the patient teaching programs. This was very time consuming and project staff are questioning the cost-benefit of continuing to produce original A-V materials. Other health education methods and materials (particularly, demonstrations using locally available materials) are being tested with each new group of trainees. With community participation, a demonstration "health education house" and latrines were built and are in use in the pilot area.

Task No. 8: Participate in development of health records and demographic data collection systems as needed.

Progress: New family health, antepartum, post partum, delivery, referral, family planning, nutrition, and clinic service records have been developed, tested, and are being used in the pilot area. They have resulted in improved services and are producing data which will be useful for further program development and evaluation. Yet to be determined is whether or not the added time and expense will prohibit them from being generally adopted.

Task No. 9: Work with the Ministry of Health to improve supply dispersal system to outlying areas.

Progress: To date, activity has been limited to integrating management and dispersal of project supplies and equipment into the existing government system.

Task No. 10: Participate in training programs and professional conferences of all levels of health and health related personnel and provide MCH/CS training as requested.

Progress: The project has been asked to assist with theoretical and practical field training in family planning for medical, midwifery, and nursing students and this will undoubtedly be possible if and when the project is fully staffed and FP services are expanded. Project staff have participated (as MCH/FP experts) in a variety of professional and community meetings.

Task No. 11: Develop a method for technical evaluation of pilot activities and assess project effectiveness concurrently and at the end of two years.

Progress: At regular intervals since the inception of the project, U.S. technicians and their counterparts have measured progress against activity targets and analyzed strengths and weaknesses in project development. Purpose of these evaluations has been not so much to report stewardship as to find ways to improve operations; and they have tended to concentrate more on problems than successes. Project impact has been measured by extended utilization of services and changed behavior. Staff has agreed to develop an overall end-of-project evaluation design as soon as a Phase II work plan is agreed upon.

D. PARTICIPANT TRAINING

Two key physicians, two pilot area midwives, and six other midwives have had, or are having, special MCH/FP training in the U.S. Staff report a marked increase in project activity since return of the pilot area trainees. The other trainees are expected to initiate new MCH/FP services in at least four other districts.

E. COORDINATION WITH OTHER DONORS

Staff has made a valiant effort to coordinate project activities with those of the WHO Basic Health Services Project. At the technical level, exchange has been good, but the extent of administrative and planning level coordination has varied with changes in WHO personnel. The present WHO representative received the evaluators only briefly and indicated his willingness to work with project personnel when the government takes the initiative in bringing this about. Project staff has successfully collaborated with staff of other agencies - the CRS, FAC, CIDA, UNICEF, Peace Corps, church missions,

and the FPA. The UNDP has almost no health input in Dahomey (WHO works quite independently), but it is interesting to note that even without a development plan, UNDP aid to Dahomey is increasing. A five million dollar grant was made this past six months for personnel and petrol costs.

F. GOVERNMENT SUPPORT AND COMMITMENT

Since its independence in 1960, Dahomey has had 10 different military and civilian governments. The present government's preoccupation with establishing itself firmly, and the many recent policy and personnel changes at all levels, make it difficult to assess potential commitment for this or any other project. At the Ministry of Health, the focal point for project planning and administration has changed several times. Now, it is through the Directors of Preventive Medicine and Social Affairs to the Permanent Secretary. Project staff seem to have free access and good relations with these decision makers. All three of them expressed to the evaluators their support for the project and their desire to see it continue. The Permanent Secretary said priority was to be given to extending preventive services to the rural areas and he wished to use personnel trained at UCSC and simple and replicable equipment furnished by the project. Last year's Phase II planning was done with a different group of officials and re-planning had been postponed, but the Permanent Secretary assured the team that it would be held the following week.

The government has kept the commitments made in the Phase I agreement and, in several instances, has surpassed them. Counterparts were assigned, pilot area services and personnel made available, and staff were released for participant training. In addition, they have taken over the salaries for two counterparts, and two drivers, supplemental salaries for two additional counterparts, and a portion of vehicle maintenance costs. They have established a central health education office and plan to provide the project with office space there. They are working with project staff now on plans to integrate project vehicles and supplies and equipment into government transport and storage and dispersal systems.

Commitment to project purposes and program has increased markedly at the technical level. Project counterparts and their immediate supervisors are enthusiastically assuming leadership in the carrying out of on-going programs, initiating additional innovations and, most importantly, in negotiating with top officials for project continuation and expansion. The Professor of OB/GYN at the Medical School and Director of the Nursing and Midwifery School is also strongly supportive.

It is with the hope that government commitment will continue at the same level as in the past and with the sincere reconviction that substantial further accomplishment can be achieved at the service and training levels that the evaluators recommend continued AID support for the project in Dahomey.

VI. CONTRACTOR PERFORMANCE

A. PROJECT STAFF

The contractor has been able to recruit field staff who are both technically and personally well-qualified. Almost all of them have had previous overseas experience. They adjusted well and quickly to field situations and, without exception, have performed with total dedication to project purposes. They have worked willingly and effectively at both the grass roots and the policy levels. All personnel assigned to Dahomey had or have acquired a good working knowledge of the French language.

When the University was not able immediately to replace a French speaking technician who had completed her tour, a similarly qualified nurse was located in Dahomey (wife of a Peace Corps staff member) and employed on a temporary basis so there was no gap in service. An ex-Peace Corps staff health education specialist, also recruited in Dahomey, was employed as a three months consultant to carry out a special training program. Three UCSC graduate students spent a total of 13 months in the field, to assist with coding and analyzing survey findings and with the production of visual aids. Replacements for the current staff vacancies (Field Coordinator and PH Nurse) have been recruited and are in Santa Cruz awaiting AID clearance to go to the field.

B. UCSC BACKSTOPPING

The administrative backstopping from UCSC seems to have been adequate and efficient despite the inevitable communications problems between field and home base. This was one of the first contract countries where there was no backstopping AID Mission and all housing, financial, and logistics problems of installing and maintaining staff in the field were the responsibility of the contractor. Good relationships were established with the Embassies and there seems to have been a minimum of problems. Since that time, the Campus Coordinator and his assistant have each made one administrative field visit to all three countries, in addition to participating in the field conference in 1972 and the field evaluation conference in 1974. University business and administrative services have apparently been adequate for project needs.

Health resources of the University of California Medical Nursing and Public Health Schools and local community health agencies have supplemented the community development and training resources available in the UCSC Extension Division where the project is based. Training consultants have been

effectively used in the field to assist with the three country field conference and to conduct training of trainers. Health consultants have been used for field evaluation on two occasions and, more regularly, to advise Santa Cruz staff on program development and to participate in staff and participant training programs at UCSC. Project staff are just beginning to identify needs for more consistent specialized technical consultation in the field.

C. REPORTS AND EVALUATION

Detailed semiannual reports are prepared at UCSC from field staff monthly reports. (If they were prepared in the field, it might be possible to condense them without losing substance.) These and a number of other special reports have been submitted regularly to AID/W. When the Embassies and Regional AID officers complained that project reports were not reaching them, the contractor began making direct distribution. The U.S. officials in both countries expressed appreciation for the close liaison which the project has maintained.

Three evaluation reports have been submitted to AID/W: the report of the field evaluation conference in January 1974, the August 1974 report of Dr. Gold, consultant evaluator, and a critical account of Phase I by the Field Coordinator. All three are informative, useful documents, but none follows the current AID/W evaluation pattern. It would be useful if AID would work with the contractor to develop an end-of-project evaluation design which would fully meet AID requirements.

D. STAFF TRAINING

The six-week orientation for the original field staff was carefully planned and executed by the campus staff and their Technical Advisory Committee. In retrospect, it seemed almost too comprehensive for new staff who had not first-hand knowledge of the field situations. Subsequent staff have had part of their orientation in the field. Other in-service training for staff has included supplemental clinical and community development training and training for trainers.

E. PARTICIPANT TRAINING

When the contractor was not able to find suitable ongoing training in family planning for project participants, a special family planning practitioner course for international students was organized at UCSC. Four eight-week cycles of training have been offered, one in English and three in French. The courses were open to other AID-assisted countries and there have been students from Senegal, Tunisia, Niger, Togo, Cameroon, Rwanda, Mauritius, Madagasgar, Dominica and India, as well as from the three project countries.

Additional training, for periods of from one week to nine months, was designed to meet specific needs of individual participants. Returned participants and health officials in both countries were enthusiastic about UCSC training and its demonstrated value to their health services.

REPORT OF AN EVALUATION OF THE MATERNAL AND CHILD HEALTH EXTENSION PROJECT IN THE GAMBIA AND DAHOMEY

APPENDICES

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APPENDIX A

Evaluation of MCH Extension in Gambia and Dahomey

FRAME OF REFERENCE

I. Scope of Evaluation Services

The special external evaluation of the project is to be performed by a two-member team composed of one public health specialist as an APHA consultancy and one health education specialist provided under RASA arrangement with the HEW Office of International Health (OIH). The team will depart in mid-May spending about two weeks in the field, one week each in Gambia and Dahomey, and returning to Washington in early June. Jim Franks, the contractor representing UCSC, will be present in the field to brief and assist the team on each country visit. Prior to the team's departure from Washington, AFR/W and PHA/POP will also hold a briefing session to present the description, background and current status of the project.

The team should, if practical, present USAID/Embassy and appropriate government officials with a brief summary of major findings and conclusions prior to departure from each post, Banjul and Cotonou. The final evaluation report should be presented to AID/W no later than July 11, 1975 unless there is prior AID/W approval for further delay. Two half-day de-briefing sessions are to be scheduled in AID/W, one upon return of both team members to U.S. and one upon submission of the final evaluation report.

AID/W Liaison Officers for this evaluation study will be Jean Pinder of AFR/DS and Irving Licht of AFR/DP. In addition to PROPs, Pro Ags and related background materials on this subject project, the team will be furnished sample evaluation reports on other projects as guidance on AID's evaluation system.

II. General Scope of Work

Reassess project goal and purposes in each country separately in the light of each country's national health objectives and priorities. Examine the relationship of this project to other donor programs and the potential for duplicating project activities in other areas of each country (as planned for Phase II).

III. Specific Tasks and Issues

A. Performance and Progress in Phase I

1. Determine whether Phase I has been completed in line with anticipated targets and schedules.

2. Examine contractor's work plan and determine whether work plan is being carried out, using contractor's targets. If not, what are problems and issues?

3. Examine relationships between contractor's work plan targets, program objectives and project purpose and goals. (a) Can hypothese and assumptions be confirmed? (b) Is there progress toward objectives? (c) How can progress toward objectives be measured?

4. Assess administrative experience in running three country projects. What are transferable experiences? What are inter-country coordination achieved?

B. Government Support

1. Are counterparts available?

2. Does Government plan to expand services?

3. Does Government have resources to expand services?

   a) Health personnel or potential

   b) Financial resources

C. Project and Contractor Evaluation

1. Has evaluation data as envisaged in the PROP and contract been produced?

2. Has contractor performed a satisfactory evaluation as a basis for Phase II? What additional studies or data, if any, are needed to validate Phase I results? Are there any to make them adaptable to wider application?

D. Recommendations for Future Courses of Action

Should Phase II proceed? (a) If so, on what basis? (b) If not, what recommendations are made?

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APPENDIX B

CONTACTS IN THE GAMBIA

Mr. Haddy Fye, Perm. Secy., Ministry of Health and Labor, and Chairman, Health Planning Committee

Dr. E.M. Samba, Acting Chief Medical Officer, Health Planning Committee, and Medical Supt'D. of Royal Victoria Hospital

Dr. Fred Oldfield, Pathologist and Secy. Health Planning Committee

Dr. Perera, Medical Officer of Health

Dr. Angela Fuller, Chief of Pediatrics and MCH

Dr. Hassan, Chief, OB/GYN, Royal Victoria Hospital

Mrs. Annie Lusack, Matron, Royal Victoria Hospital

Mrs. Abagail Joiner, Nurse, Midwife, and Project Counterpart

Mrs. Rachel Palmer, Director, Nursing and Midwifery School

Dr. George Palmer, President, Gambia Family Planning Association

Mr. Taylor Thomas, Executive Secretary, Gambia Family Planning Association

Ms. Gertrude Eastwood, Nutritionist, Catholic Relief Soc.

Dr. N.B. Akim, WHO, P.H. Advisor

Mr. James Mc Farland, Charge D'Affaires, U.S. Embassy

Ms. Anne Richter, P.H. Nurse, UCSC

Ms. Ione Armstrong, P.H. Nurse, UCSC

Mr. James Franks, Campus Coordinator, UCSC

Ms. Karen Mounday, Campus Secretary, UCSC

CONTACTS IN DAHOMEY

Professor Yord, Perm. Secy., Ministry of Health

Dr. Codja, Director of Preventive Health Services, Ministry of Health

Mme. Ahoyo, Director of Social Affairs, Ministry of Health

Dr. Veronica Lawson, Director of MCH Center, Ministry of Health

Mr. M. Adjovi, Director of Health Education Section, Ministry of Health

Mme. Constance Facia, Director of Akpakpa Social Center

Mme. Sitha Hodonou, Midwife at Akpakpa Social Center

Mme. Lucie Overndo, Midwife and Health Education Instructor, MCH Center

Mme. , F.P. Midwife, MCH Center

Mme. Catherine Totah, Midwife, Maternity Hospital

Fifteen Health Education Trainees

Dr. Alihounou, Prof. OB/GYN and Director Nursing and Midwifery School

Mr. Blanch, Soler, UNDP Representative

Mr. Herbert Behrstock, UNDP

Dr. F.A. Silou, WHO Representative

Father Bessan, Director, Catholic Relief Society Project

Ambassador Engle, U.S. Embassy

Mr. Martin L. Cheshes, D.C.M., U.S. Embassy

Mr. Steve Singer, USAID/Cotonou

Mr. Johnson, USAID/Niamey

Miss Susan Nalder, P.H. Nurse - Midwife, UCSC

Miss Anne Marie Tinembart, P.H. Nurse - Midwife, UCSC

Mr. Alan Alemian, P.H. Administrator, UCSC

Mrs. Betty Pasela, P.H. Nurse, UCSC

Miss Geni Eng, Health Education Consultant, UCSC

Mr. Franks and Mrs. Mounday, UCSC

PLACES VISITED:

Akpakpa Social Center - for graduation of H.Ed. Trainees

MCH Center - observed parent education in F.P.

Three dispensaries

APPENDIX C

PERTINENT PROJECT DOCUMENTATION

(Which Should be Available in AID/W)

Original Project Proposal and Amendments

AID/UCSC Contract

Letters of Agreement with Participating Countries

UCSC Work Plan

Seven Semiannual Reports

Contractor Proposal for Phase II - March 1974

Draft PROP Revision for Phase II

Evaluation Material:

- Field Evaluation Conference Report - Fifth Semiannual Report, July - December 1973
- Consultant Evaluation Report - Seventh Semiannual Report, July - December 1974
- A Critical Account of Phase I - special report of Field Coordinator
- Report and analysis of individual country activities - by field technicians and their counterparts
- End-of-Tour Reports of Field Technicians

Compiled in special summary report submitted in Spring of 1974