

CLASSIFICATION PROJECT EVALUATION SUMMARY (PES) - PART I

Report Form 11447

1. PROJECT TITLE Congo Primary Health Care		2. PROJECT NUMBER 698-0410.39	3. MISSION, AID W OFFICE USAID/Zaire
		4. EVALUATION NUMBER (Number assigned and retained by the reporting activity, Country of AID W A, and Project or Contract Year, Serial No., beginning with "A" for AID W A) 83-16	
		<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	

5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION	
A. First STEAC or Equipment FY 82	B. Final Operation Expected FY 82	C. Final Input Delivery FY 84		A. Total \$ 701,000	From (month/year) June 1982
			E. U.S. \$ 500,000	8. DATE OF REPORT September 1983	

B. ACTION DECISIONS APPROVED BY MISSION OR AID W OFFICE DIRECTOR

A. List decisions and/or unresolved issues (note those items needing further study. (NOTE: Mission decisions which require AID W or regional office action should specify type of document, e.g., program, SPAH, PID, which will present detailed report.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
<p>1. The request for a six month extension of the project should be granted, provided that:</p> <p>(a) CARE/Congo reassesses the project inputs, outputs, and timetable, and advises USAID of whatever project redesign efforts it plans to make.</p> <p>(b) USAID approves these efforts.</p> <p>2. Immunization targets for the 24th month should be revised as follows:</p> <ul style="list-style-type: none"> - 10% for tetanus toxoid as opposed to 90% - 50% for measles as opposed to 80% - 50% for ECG as opposed to 90% - 30% for DTP/polio as opposed to 70% <p>3. If an extension is approved, a final evaluation of the project should take place in January 1985.</p>		

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT	
<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)	A. <input type="checkbox"/> Continue Project Without Change	
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PID/T		B. <input checked="" type="checkbox"/> Change Project Design and/or	
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PID/C	<input type="checkbox"/> Other (Specify)	<input checked="" type="checkbox"/> Change Implementation Plan	
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PID/P		C. <input type="checkbox"/> Discontinue Project	

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER BANNER'S PARTICIPANTS (AS APPROPRIATE (Names and Titles))		12. Mission AID W Office Director Approval	
Derek S. Singer, General Development Officer, USAID		Signature <i>[Signature]</i>	
David Bassett, CDC/Brazzaville		Typed Name Arthur S. Lezin, Acting Director	
Christie Collins, Congo USAID Liaison		Date 10/20/83	

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1. SUMMARY

Current Project Situation

The project was signed by AID in June 1982. The Government of the Congo (GPRC) signed the project in October 1982. CARE delayed recruitment of a project advisor until the GPRC had signed the project. CARE completed recruitment of a project advisor in early December 1982.

The project advisor arrived in Congo to assume his responsibilities in late December 1982. There is therefore a 6-month difference between the official (June 1982) and functional (December 1982) beginning of the project. This difference is a source of concern to the CARE organization because if the project terminates in June 1984, project implementation will have lasted only 18 months. It will be difficult to achieve project output targets in that period of time.

This difference in the perceived starting date of the project also created some problems for the evaluation team. An assessment of project progress results in a different interpretation if the project is considered to be in its 9th month of implementation rather than its 15th month. A 6-month extension of the project is necessary if CARE is to have a full 24 months to implement the project.

Project implementation activities up to August 1983, have been spent primarily on laying the groundwork for Primary Health Care (PHC) activities. These groundwork activities are essential if a viable PHC system is to be developed. The performance of these activities has required visits to government and health officials and to health facilities in the district. It has especially required visits to villages in the district for discussions with village leaders. It has been necessary for project staff to meet with all these people in order to explain what PHC will mean to them, both in terms of benefits and in terms of their responsibilities. While these activities have been necessary, indeed essential, they have also been time consuming.

In addition to this fundamental process of establishing a foundation for development of a PHC system, project implementation has included the following:

- other types of health education
- the development of health education materials
- one training course
- one sensitization seminar for district and government officials
- the development of training materials
- guidance in the formation of village health committee (VHC's)
- guidance in the selection of village health workers (VHW's) by the VHC's
- development of baseline health data
- implementation of systems for collection of health data
- creation of a PHC newsletter

A lot has been accomplished since December 1982.

Progress in Relation to Design

Given that substantial accomplishments have been made in project implementation, it is fact that a number of these accomplishments are not called for in the project design. This is especially true of the groundwork activities that are an indispensable prerequisite to the development of a PHC system. A lot of time and effort has necessarily been expended on these groundwork activities. These activities are perhaps assumed, but are certainly not specifically included in the project design. This is a fundamental shortcoming in the project paper. In terms of the evaluation this means that if the evaluators relate project progress only to the project design, the project implementors do not receive credit for the considerable amount of essential and difficult work that has been done on groundwork activities.

The project paper seems to assume the performance of groundwork activities without allotting project time for them. This shortcoming is underscored by the fact that the project design envisions project impact on certain aspects of Mossendjo District's health status by the end of its 2 years. This would perhaps be possible in a 2-year period after the completion of groundwork activities, but it is certainly not possible in a 2-year period

that includes the groundwork activities.

The project advisor discovered this fundamental shortcoming in the project design when he assumed his responsibilities. His response was to redesign the project so that it more accurately reflected what had to be done. The evaluation team understands the reasons for this action. The evaluation team also feels that the project advisor's revised design is more realistic than the original. The evaluation team wishes to note, however, that rather than unilaterally revising the project design, the project advisor could have taken his concerns to MID. He could then have worked with them to determine the best method of modifying the project design to make it conform to the realities of project implementation.

Prospects of Achieving Purpose and Goal

The project goal established standards to be achieved by 1988. It is difficult at this stage of project implementation to make knowledgeable predictions concerning the likelihood of achieving this goal. The evaluation team does think that project implementation is proceeding well, but it will be another year or two before substantive predictions can be made concerning the prospects for goal achievement.

The project purpose is regrettably stated in terms too "soft" to provide much guidance. At the end of the project it will certainly be possible to say that the project purpose has been achieved, but given the "softness" of the stated purpose, this will not be very meaningful.

Major Problems

1. Project Paper. Two major shortcomings in the project paper put those responsible for implementing the project at a distinct disadvantage. One is the vague nature of the stated project purpose. The second is the lack of recognition for groundwork activities that must be carried out before PHC activities can be implemented.

2. Unrealistic Expectations. This relates to the project paper's lack of recognition for the time required to carry out groundwork activities. The project paper anticipates the creation of high levels of health services and even significant impact on some aspects of health status in Mossendjo District by the end of the project's 2 years. Since groundwork activities will require the preponderance of implementation energies during the first year of the project, such expectations are entirely unrealistic.

2. EVALUATION METHODOLOGY

Reason for Evaluation

The basic reason for the evaluation was to measure project progress. By the reckoning of AID, evaluation of the 24-month project was carried out during its 15th month of implementation (June 1982, to August 1983). AID is concerned that project implementation may be lagging behind schedule.

A second reason was to review the project design. AID is aware that the project advisor has made some unilateral revisions in the project design. AID would like to know if these changes are necessary, and if so, if they are reasonable.

A third reason was to have an assessment of the advisability of a project extension. Twenty-four months is not a long time for a project of this nature. Since project implementation did not commence until the seventh month of the project, AID would like to know if a project extension is warranted.

A final reason for the evaluation of the project was to have an advance assessment of the possible usefulness/need for AID-funded follow-on activities.

Description of Methods Used for the Evaluation

The method used for this evaluation was an informal review of project progress through visits, discussions, and review of relevant reports and literature. The evaluation team spent two and one half days in Mossendjo District. During this time, visits were made to key officials in Mossendjo Town and to many of the villages in the district. Project staff, CARE staff, health facility staff, village health committee officials, and selected village health workers were met and asked questions. Officials responsible for health activities in other areas of Niari Region were also contacted. These included the project advisor for the West German PHC project, which covers the remaining districts of Niari Region.

In addition, many project and project-related documents were reviewed by the evaluators.

Through these efforts the evaluation team was able to acquire considerable knowledge about the project in both theory and practice, and was able to examine the differences between theory and practice that were observed.

The evaluation team consisted of David C. Basset, Regional Liaison Officer for AID's Regional CCCD project, and Christy Collins, AID Liaison Officer. Both Mr. Bassett and Ms. Collins are based in Brazzaville. The evaluation team was ably assisted by Mr. Dale Huntington of the CARE nutrition project, and by Mr. Cyril Pervilhac, the CARE PHC project advisor.

The evaluation team's field itinerary is presented in Annex 3. A list of documents reviewed is presented in Annex 1.

3. EXTERNAL FACTORS

Major Changes in Project Setting Impacting on Project.

Two factors are worthy of mention here although they perhaps do not represent major changes.

1. The CARE/AID Smallholder Agriculture Project (PAPAN) operates in the same area as the PHC project. The agricultural project includes high profile, village level construction aspects. The initial village-level expectation vis-à-vis the PHC project was that this same type of activity (construction of dispensaries, for example) would be part of the PHC project. Such false village-level expectations complicated the already difficult task of carrying out PHC groundwork activities. In addition, the PHC process of securing the volunteer services of VHM's was made more difficult to implement by the PAPAN practice of paying warehouse managers and some construction workers for short terms of service.

Implementation of PAPAN began in January 1982. When the PHC project began implementation, project personnel visiting villages found it necessary to spend time convincing the villagers to undertake PHC activities without the incentives that had been provided by PAPAN. This slowed the progress of groundwork activities.

2. A change in the project setting that will likely have a positive influence of the project is the unanticipated establishment of sister PHC projects. The West German Government has initiated a large PHC project which will endure for 5 years. It began in February 1983. The project advisor for this project is very cooperative. The prospects for mutually beneficial collaboration between the West German project and the CARE/AID project are excellent.

A second sister PHC project is a Protestant Mission project which is being established within Mossendjo District. This is a small project, covering only the catchment area of the Mission's rural health facility at Madouma. There is every indication that the person in charge of this project will be willing to work closely with the CARE project, which should make the work easier for everyone.

Continuing Validity of Project Assumptions.

Three assumptions inherent in the project paper, but not specifically discussed in it, are invalid and give rise to unreasonable expectations for project implementation.

The first of these is the apparent assumption that the basic groundwork activities that are a prerequisite for the establishment of a viable PHC system are either already completed or can be completed practically overnight.

The second is the apparent assumption that the baseline data and data collection systems necessary for the measurement of project accomplishments were either in existence or could be developed during the first few weeks of project implementation.

The third apparent assumption is related to the second. This is that the project will be able to demonstrate a measurable impact on the health status of the district within a 24-month period. Only under extraordinary circumstances could this happen, even if a well-established health infrastructure, complete with baseline data and useful data collection system were already in place. For a project that must first concentrate on groundwork activities, including the development of baseline data and a data collection system, a measurable impact on the health status in Mossendjo District in a 24-month period is impossible.

4. INPUTS

Problems with Inputs

The problems that have occurred with respect to project inputs have been relatively minor, but several are worthy of mention:

1. The project advisor was not assigned to the project until 6 months after the project was signed by AID. As already discussed, this delay was due in part to the delayed signing of the project by the GPRC. This delay in assigning the project advisor means that the project was 6 months behind schedule when implementation began. This has repercussions for the project's progress and pace.
2. There was also a delay in the GPRC assignment of project personnel and in its contributions of financial support to the project. A project director was assigned by the government in December 1982. The remaining government personnel were assigned in August 1983. The cash contribution to the project by the GPRC has not yet been made.

The delay in assignment of personnel occurred because it was necessary to wait for the end of the school year so that personnel could be selected from newly graduated health personnel. The GPRC appears to have provided for its financial contribution to be made at the beginning of its 1984 fiscal year (January 1984).

3. The GPRC in-kind contribution of buildings included buildings in a state of serious disrepair. Time and expense are required to put them in order.

5. OUTPUTS

Progress Against Projected Output Targets.

The output targets with which this evaluation is concerned can be found in the project paper on pages 6 and 7 under the headings Intermediate Goals and Project Activity Targets for Year 1. It is assumed that the Health Objectives and Indicators listed on pages 4, 5, and 6, relate back to the Final Goal on page 4. These objectives concern outputs which are not likely to be realized before the year specified in the final goal, which is 1988.

Intermediate Goals

1. Ninety-nine trained VHW's in 25 villages and 8 urban arrondissements in Mossendjo District by the 24th project month.
2. An MCH center providing referral services for the inhabitants of Mossendjo District by the 12th project month.
3. Basic medications (list provided) available in the villages and health posts by the 18th project month.
4. All children under 5 years of age included in a well-child care program by the 24th project month.
5. Immunization of:
 - 90% of childbearing women with tetanus toxoid
 - 80% of children under 3 with measles vaccine
 - 90% of children under 1 with BCG vaccine
 - 70% of children under 1 with at least 2 doses each of DTP and polio vaccinesby the 24th project month.
6. Fifty percent decrease in the incidence of measles, gastro-enteritis, malnutrition, malaria and intestinal parasites among children under 5 and pregnant women of the target population by the 24th project month.

Progress Toward Intermediate Goals.

1. As of August 1983, there are no trained VHW's.
Reason for Shortfall. Since the target does not require 99 trained VHW's until the end of the 24th project month, there is technically no shortfall at the present time. Several points are worth mentioning with regard to this target, however.

The first is that the project advisor feels that one VHW for 500 people is the ideal to be pursued. Based on the population concentration of the towns and villages of Mossendjo District, this works out to a total of 74 VHW's to be trained, instead of 99.

The second point is that 31 VHC's have been formed and most have already selected their VHW's. Training of VHW's is scheduled to begin in October 1983. By the end of December 1983, it is expected that there will be 40 trained VHW's.

A third point to be added is that it was necessary to work with the formation of VHC's before the further steps of selecting VHW's and training them could be considered.

2. The MCH center will probably not be open until January 1984.
Reason for Shortfall. The building given by the GPRC for the MCH center is in extremely bad repair. Much construction work remains to be done before the facility will be physically ready. There have been a number of construction delays, the most significant of which is related to the June 1983 resignation of the CARE construction supervisor.

It should be pointed out that the GPRC has already made personnel available to staff the facility. They can begin work whenever the facility is ready.

3. There should be no problem in achieving this target. The only problem to be overcome to meet this target is to find a reliable means to assure the smooth replenishment of stocks once the system is established.

4. Since the MCH center is not yet open, the number of children under 5 attending a well-child care program is no different than when the project began; which is to say, very small.

Reason for Shortfall. Obviously, the delay in establishing the MCH center has meant a delay in progress toward the achievement of this target. It must be pointed out, however, that the target of all children to be included in a well-child program by the 24th project month is patently unreasonable. This will probably never happen, and it certainly won't happen by the 24th project month. A more realistic target for the 24th project month would be 25% of children under 5 by the 24th project month, with the percent to continue increasing during subsequent years. Even a 25% target is ambitious.

5. Immunizations began in August 1983, in Mossendjo Town. Additional personnel have been trained. These personnel will be able to perform immunizations in rural health facilities when immunization activities are extended. There is no plan to have VHW's perform immunizations.

Reason for Shortfall. Since the target immunization levels are not called for until the 24th project month, there is no shortfall at the present time. The evaluation team feels compelled to advise, however, that future evaluators need to be prepared for a shortfall at the end of the 24th project month.

The target percentages are unreasonably high. One would hope for this level of coverage 5 years from now, but it certainly will not occur by the 24th project month. Project implementation has rightly concentrated its initial efforts on groundwork activities. It is only in the project's 15th month that immunizations were begun. The project will be doing well to make immunizations available at all health facilities by the 24th project month. Attainment of significant coverage levels will not come until a year or two after the 24th project month.

Coverage targets should be revised. The evaluation team proposes the following:

- 10% for tetanus toxoid.

Of the approximately 6000 women of child-bearing age in Mossendjo District, some 1200 give birth each year. Of these births, approximately 600 take place at Mossendjo Hospital. Thus some 10% of the districts's child-bearing age women give birth at Mossendjo Hospital each year.

It is only at the Mossendjo Hospital's pre-natal clinic that TT is presently given. For a target of 10% immunization with TT to be achieved, a combination of 600 women, coming either from those giving birth at the hospital or from child-bearing age women in the area who are not pregnant, would have to be immunized. This would be a major accomplishment by the end of the project's 24th month.

- 50% for measles

- 50% for BCG

- 30% for 2 doses of DPT and polio

6. It is not yet possible to measure a decrease in incidence of the diseases mentioned. The baseline data for measles, diarrheal disease and malaria have only just been established. Survey data for malnutrition is available as baseline data. There are no reliable baseline data on the incidence of intestinal parasites.

Reason for Shortfall. Again, there is technically not a shortfall at the present time, but the evaluation team advises that there will be by the 24th project month. A measurable project impact on disease incidence in a 24-month period would be an extraordinary achievement under the best of circumstances. If part of the 24-month period must be spend doing basic groundwork, including the development of baseline data and data collection systems, it is certain that it will not be possible to demonstrate a measurable impact on disease incidence by the end of the 24th month.

The baseline data for this project were not developed until after the 12th month of the project. It was an impressive accomplishment to develop the information so quickly.

A reasonably good disease surveillance system has been established. This system would provide data which in future years can be compared with the baseline data. There are no reliable disease data for pre-1982.

By the 24th month of the project, only a 12-month interval will exist between the time the baseline data were established and the end of the project. This is probably not a sufficient period of time for a measurable impact to be made on the health status of the target population.

Project Activity Targets for Year 1

1. Establishment of Rural Training Center at Mossendjo.
2. Development of VHW training curriculum, including education material and aids.
3. Development of in-service training mini-courses for:
 - Primary Health Care
 - Pre-natal Care
 - Treatment of diarrhea by oral rehydration
 - Malaria treatment
 - Nutritional surveillance
4. Completion of in-service training sessions for 15 health personnel.
5. Establishment of an MCH center under the auspices of the MOHSA at Mossendjo.
6. Installation of drug depot stocked with 3 months supply of medications for the district government dispensaries.
7. Develop health statistics and evaluation system.
8. Formation of VHC's including orientation of the committee presidents.
9. Completion of training of 16 VHW's with assumption of village responsibilities.
10. Eight village agglomerations covered by EPI vaccination services.

Progress Toward Project Activity Targets for Year 1

1. This center is established. The first PHC training (for EPI) took place at the center July 4-9, 1983. The next use of the facility is scheduled for September 5-10, for the training of VHW trainers.

2. A health education consultant arrived in April 1983. Health education materials are in the developmental stage. The first of these materials will be ready for use during the VHW training scheduled for October 1983.

3. It has been a project decision not to develop 5 separate and independent mini-courses. The health education consultant is responsible for developing a course on MCH services to be used during the re-cycling of chief health personnel from rural dispensaries. This course will include instruction on prenatal care. The course covering PHC, diarrhea, malaria and nutrition is scheduled to be given for the first time in September 1983. The course covering MCH services will be held for the first time in February 1984.

Reason for Shortfall. The project advisor recognizes that these courses are behind the original schedule. This was a calculated delay because it was felt that the needs for developing for the VHW's selecting VHW's and providing a supervisory mechanism for the VHW's, were higher priority for successful implementation of the project than was the development of the mini-courses. The evaluation team concurs in this judgement.

4. These courses will take place in September 1983, and February 1984. More than 15 personnel will be trained during these sessions.

Reason for Shortfall. The same comment given as reason for shortfall under 3, above, applies here.

5. Due to construction delays, the MCH center will probably not begin operation until January 1984. If a new construction director is not engaged by the end of August, further delays will result.

Reason for Shortfall. The building provided by the GPRC was in serious disrepair. CARE efforts to refurbish the building have been

plagued by construction delays. The most serious delay resulted from resignation of the CARE construction supervisor in June 1983.

6. The drug depot is to be established in the MCH facility. A list of 15 essential drugs has been developed that will be the guide for drug stockage. It is expected that the drug depot will be established two months after the MCH begins to function; i.e, March 1984, at the earliest.

Reason for Shortfall. Delay in establishment of MCH center.

7. A consultant epidemiologist was engaged by the project for the three-month period June-August 1983. Baseline data (health statistics) were established during this consultancy. The consultant also established an on-going surveillance system (evaluation system) for 9 diseases at 6 sentinel health facilities. A copy of the consultant's final report is attached as Annex 4.

8. Thirty-one health committees had been formed by the end of August 1983. A committee president had been chosen for each of the 31 formed committees. Each of the 31 presidents had received an orientation.

9. Training of VHW's will commence in October 1983. There will be a 5-day mini-course for 10 VHW's, four times each month for 3 months. By the end of December 1983, 40 VHW's will have been trained, the training consisting of 3 five-day mini-courses for each VHW.

Reason for Shortfall. The time required to do groundwork activities, including the formation of VHC's and the selection of VHW's, was not taken into account by the project paper. It was unreasonable to assume that the PHC idea would be accepted and implemented with such rapidity that it would be possible to complete the training of 16 VHW's by the 12th month of the project.

10. Twelve health personnel from district health facilities were trained for EPI activities during the week of July 4-9, 1983. This training

was also attended by 6 regional health personnel from the mobile Grandes Endemies unit in Loubomo.

The project advisor decided that vaccination activities should begin in Mossendjo Town rather than in the villages. The evaluation team supports this decision. It is better to begin activities where they can best be supervised and where the impact will be greatest (i.e., in population centers) and then gradually extend such activities to rural areas, as resources permit.

EPI activities were begun in Mossendjo Town on August 9, 1963. By the end of December 1963, EPI activities are expected to be extended to all 10 arrondissements of Mossendjo Town and to 12 of 30 villages in the district.

Significant Management Experiences.

There have been several significant management experiences.

1. As has already been mentioned, the management experience in implementing a PHC system has been that a great amount of time and effort must be expended on groundwork activities before attention can be turned to improving and increasing health services and improving health status of the target population. A project of this type should be dedicated to the establishment of a solid PHC infrastructure that can stand on its own, and upon which a viable PHC system can be developed. To the extent that this occurs within the 2 years of the project, attention can then be turned to improving services and the ultimate improvement of the health status of the target population. The project document seems to stress the improvement of services and health status while not giving adequate recognition to the primacy of infrastructure establishment. The management experience is that infrastructure establishment must be given top priority.
2. It has also been mentioned that many of the project's output targets are unreasonable. These unreasonable targets generate unreasonable expectations by those responsible for monitoring project progress. It is extremely frustrating for a manager to discover that there are output targets for his project which work counter to the project's purpose. Yet that is precisely what happens in this project. To try

to achieve all the output targets listed in the project paper by the 24th project month would mean short-changing the attention that must be paid to establishing a basic PHC infrastructure. To achieve all the output targets, it would be necessary for CARE personnel to take a direct and very active part in program operations. The ultimate result would be collapse of activities when project support is withdrawn. For a project of this nature it is far better for progress to be slow and enduring than it is to have rapid progress that collapses when project support is withdrawn. The management of this project reacted to this dilemma by independently developing its own list of priorities.

3. While perhaps not qualifying as a significant management experience, Intermediate Goal No. 2 (MCH center providing referral services) is representative of the confusion caused by some of the output targets in the project paper. What does "providing referral services" mean? It is hoped that VHW's and health professionals will refer all contacts who are pregnant women as well as women with small children, to the MCH center for enrollment in a routine health care program. A major role of the MCH center is thus to have it serve as a center for receiving referrals. To be sure, when problems are encountered by MCH staff that they cannot handle, they will refer patients to the hospital, but the MCH center is not intended to serve primarily as a referral center in this sense.

Output Changes Needed to Achieve Project Purpose.

Some output modifications have been suggested in earlier portions of this section. More generally, the evaluation team feels that the project's output targets should have focused more on indicators related to the development of a PHC infrastructure and the establishment of health services than on utilization of health services and impact on health status. Utilization and impact must follow infrastructure development and the establishment of health services. See Section 22, item 3 for some suggestions of more appropriate output indicators for a PHC project of this type and duration.

6. PURPOSE

Approved Project Purpose

There is not a section in the project paper which clearly sets forth the project purpose as such. What serves as the project purpose is a very general statement which appears under the heading, Introduction. This introductory statement reads as follows:

The purpose of this project is to assist the Government of People's Republic of the Congo (GOC) in accelerating the implementation of Primary Health Care (PHC) in the rural areas. Specifically, the focus will be in Mossendjo District of the region of Niari. Realization of the project goals will contribute significantly to an overall improvement in the health status of a rural population presently lacking basic health services, particularly for mothers and young children. In addition it will serve as a model and impetus for the expansion of primary health care services based on the establishment of a combination maternal, child health and primary health care training center.

The vague nature of this statement of purpose has been a problem for those responsible for project implementation.

Progress Towards EOPS Conditions.

EOPS conditions are represented by the Intermediate Goals and Project Activity Targets listed on pages 6 and 7 of the project paper. Progress towards these conditions has already been reviewed in Section 17.

There are several EOPS conditions which are not considered good descriptions of what will exist when the project is completed. These have also been mentioned in Section 17.

Relating EOPS conditions to what will exist when the project purpose is achieved is difficult, given the vagueness of the stated purpose.

Shortfalls as a Function of Output vs. Purpose, or Output vs. External Factors.

Output shortfalls have been thoroughly discussed in Section 17. The evaluation team does not feel that there is any major causal relationship between output shortfalls and the project purpose or external factors.

7. GOAL/SUBGOAL

Approved Project Goal and Sub-Goal.

The approved project goal reads as follows:

To improve the overall health and nutritional status of the 27,000 inhabitants of Mossendjo District by the year 1988 by:

- Reducing infant mortality by 50%
- Reducing maternal mortality by 50%
- Reducing the incidence of communicable disease by 50%.

To have an active program of primary health care operating in all forty rural districts of the country covering a population of 750,000 by the year 1988.

The approved project sub-goals are assumed to be the Health Objectives that are listed under the Final Goal. They are as follows:

1. 80% of pregnant mothers in target communities receiving basic prenatal care from trained VHW's.
2. 80% of at-risk pregnant mothers referred to dispensaries by VHW's.
3. 80% of village deliveries performed under hygienic conditions with proper post-natal care.
4. 80% of births, deaths, vaccinations and illnesses will be recorded by village health workers and regularly reported to the district health authorities.
5. Improved nutritional status among children 0-5.
6. 50% reduction in infant deaths due to diarrhea.
7. 80% of children 0-5 will be vaccinated against measles, TB, diphtheria and polio.

8. 80% of the cases of malaria, fevers, gastro-enteritis, skin infections will receive primary treatment locally.

9. 80% of cases of serious illness referred to a health facility by VHW.

Status of Goal/Sub-Goal Achievement.

The project is a two-year project. From the AID point of view the project is scheduled for completion by June 1984. The goal and sub-goals are to be achieved by 1988.

The evaluation team feels that significant progress is being made toward the establishment of a solid PHC infrastructure upon which a viable and effective health care system in Mossendjo District can be developed. This is, and should be, the first priority of the project. The project has not yet progressed to the point where it can impact on health services and health status. It will only be just beginning to do so when the project is completed. What happens to infant mortality and disease incidence between the 1984 completion of the project and the 1988 target for goal/sub-goal achievement will depend on the extent to which project activities are continued and strengthened by the GPRC and the established PHC system. A positive performance by the GPRC and the PHC system will be a certain indication that the project has been a success. Unfortunately, what happens between project completion in 1984, and 1988, will be completely outside the control of the project. Progress up to the time of this evaluation (August 1983) has been considerable. There is reason for optimism. There is no reason to believe that the project's goal and sub-goals will not be accomplished; but it is too early to make predictions.

The evaluation team would like to offer some comments on the goal and sub-goals:

- With regard to health objective number 4, above, it should be pointed out that vaccinations are supposed to be performed only by professional health personnel from established health facilities. There is no good reason for not recording 100% of vaccinations performed. The recording of vaccinations is something quite different from the recording of births, deaths and illnesses.

These latter events may occur in remote areas and not come to the attention of health personnel, making 100% recording virtually impossible.

- To expect that a PHC program can have a significant impact on the overall nutritional status of the population may be expecting too much. A reliable assessment of any change in nutritional status would require a survey similar to the one supported by CARE in 1981. Even if such a survey did indicate a marked improvement in nutritional status, it might be difficult to establish a causal relationship between that change and PHC activities.

- Maternal mortality is estimated to be 46/10,000 live births, in the Congo. This works out to some 4 to 5 maternal deaths per year in Mossendjo District. It will not be possible to demonstrate a statistically reliable reduction of maternal mortality in Mossendjo District with such small numbers.

Relationship of Goal/Sub-Goal Achievement to Project Purpose.

Since it is not yet possible to measure progress toward goal/sub-goal achievement, it is not possible to discuss a relationship between goal/sub-goal achievement and project purpose achievement. Given the vague nature of the project purpose it may never be possible to discuss this relationship in any but an anecdotal fashion.

8. BENEFICIARIES

With regard to Sec. 102 (d) of the FAA, the only criteria applicable to this project are the reduction of infant mortality and the control of population growth.

Reduction of Infant Mortality.

This is part of the final goal of the project. Implementation of PHC (which is the project purpose), if done so as to assure that it will endure and prosper, should ultimately lead to a reduction of morbidity and mortality in the population having access to health services. The greatest reduction in morbidity and mortality will occur in the population under 5 years of age.

It is cautioned that measurable reductions in morbidity and mortality will probably not occur by the end of the 24th project month. If project implementation continues at its present pace, a solid PHC infrastructure and a significant level of PHC activities should be established by the end of the project. If PHC activities continue at this, or a greater level after the end of the project, reductions in disease morbidity and mortality for measles and pertussis, and mortality due to diarrheal illness, should be measurable by the end of 1965.

All members of the target community will benefit from these reductions of morbidity and mortality, but the population under 5 will likely benefit the most.

Control Population Growth.

Family planning or "Espacement des Naissances" will be an important component of the MCH services provided through PHC. The project has already received the commodities. Contacts have been made with the Family Planning Section of the MCH Division, MOHSA, to use their manpower resources for training local staff on methods to deliver this new service. Since family planning will be a service based in the MCH Center and at the hospital, and since other priority services need to be set up first, the project director and project advisor do not expect to start the distribution of commodities until 6 months after the MCH Center's opening.

It is not a primary purpose of this project to control population growth. It is, however, a well known demographic fact that a decline in the childhood mortality rate will, after a lag period, be followed by a decline in the birth rate. In this long-range manner, a successful PHC system could be said to ultimately be a factor in controlling population growth. Since control of population growth is not a GWC priority, the evaluation team does not feel it is appropriate to comment on who the beneficiaries of such a development would be.

2. UNPLANNED EFFECTS

Not pertinent at this time.

10. LESSONS LEARNED

1. If there is a significant difference between the time that AID considers a project to have started and the time that project implementation actually begins, early steps should be taken by both AID and the implementing organization to reach an agreement on a date against which project progress is to be measured. This is especially true for a project of only two years duration.

A lack of agreement on a project's effective starting date also causes confusion for project evaluators. For this evaluation, project accomplishments have been measured from the date the project was signed. This puts CARE at a disadvantage, but it is satisfying to note that even with this handicap, project implementation is proceeding admirably.

2. It is important to have a project paper that can be used as a guide for project implementation. In AID parlance, project purpose, goal and sub-goal have specific meanings and are supposed to relate to each other in specific ways in the project document. These topics should be treated under separate and specific headings. They should include an explanation of how they relate to each other. In the aggregate, they should present a clear notion of how project implementation is to proceed.

In the project paper for this project the statements of purpose, goal and sub-goals do not provide the guidance expected. The project advisor had to spend a considerable amount of his time deciding how project implementation should proceed. The evaluation team also found it necessary to spend considerable extra time trying to decide just which indicators project progress could fairly be measured against.

3. A project paper should be drafted with clear and fairly precise suggestions on interim and final project evaluation methodologies. Besides output targets to be monitored and assessed, there should be a list of other indicators to review. An evaluation team is not

obliged to follow project paper suggestions, but most evaluation teams would appreciate some well-thought-out guidelines.

4. A 1-year project to initiate PHC activities should not concern itself with morbidity and mortality reduction targets, except as an end-product to be realized at some point beyond the project completion date. The following is a suggested list of some of the outputs that should be given priority in a project of this type. Appropriate indicators and quantifications could be developed for these outputs:
 - development of health education materials
 - health education efforts
 - education efforts to promote the PHC concept
 - formation of viable VHC's
 - selection of VW's by VHC's
 - development of training materials
 - training of trainers
 - training of VW's
 - training of supervisors
 - development of baseline data for disease morbidity and mortality
 - development of baseline data for health services available (personnel, facilities, types of services available etc.)
 - utilization of health services (number of people seeking different types of services)
 - establishment of health information collection and analysis systems
 - development of supervisory activities
 - assumption of supervisory responsibilities by national and local staff.

5. Future design teams for PHC projects, as well as the AID officials responsible for monitoring such projects, should be more aware of the enormous effort that must be expended on the basic task of PHC infrastructure establishment before a PHC project can bring about an improvement in the health services available. Many of the statements in this project's project paper seem to assume that the infrastructure is inherent in the social and cultural fabric of the region and need merely be tapped like some artesian well. This leads

to unwarranted expectations for the project in terms of outputs, and places unfair expectations on those who become responsible for project implementation.

6. If it is true that it takes at least 2 years to develop a solid foundation upon which a successful PHC system can be established, then it follows that there would be some wisdom in providing modest follow-up assistance for projects that have been successfully implemented.

Successful completion of a project such as this one will mean only that a successful beginning has been made. Among other things, it should mean that project activities have been entirely placed in the hands of national and local personnel. If AID time and money has been invested in assisting a successful project beginning, there should be some interest in protecting this investment by making available types of assistance that could serve to further strengthen the project and assure its continued success. Advice, encouragement and guidance, at the very least, are still going to be needed. Appropriate assistance could probably be provided by consultants. The following is a list of possibilities for follow-on assistance that could be provided by consultants:

- assessment of PHC supervisory structure; recommendations for improvement, development of strategy for strengthening supervision
- development of a long-range in-service training plan, participation in in-service training
- assistance with overall long-range planning
- assistance with surveys, and with training of nationals to do surveys
- assessment of VHC performance
- assessment of health information system, recommendations for strengthening the system.

11. SUSTAINABILITY

Personnel.

The GPRC assigned a project director to the project in December, 1982, immediately after the arrival of the project advisor. This person is well-qualified, energetic and enthusiastic about his work. It has been possible for the project advisor to work through this person, rather than feel obliged to accept program responsibilities himself. The project director will be training a health agent (assistant sanitaire) starting in January 1984, who will be responsible for supervising PHC activities in the district after the project director has completed his work.

Additional personnel have been made available to the project by the GPRC (see Annex 5). These personnel have been designated from among local health staff, and will be integrated into the existing health structure (they will work at the MCH center). These personnel will continue to be paid by the GPRC. This is the preferred arrangement for assuring the continued presence of these personnel in the PHC system even after the present project is completed.

In summary, at this point in the project, it would seem that the indicators are positive with respect to the sustainability of national and local personnel at least within the area covered by this project.

Organization

In Niari Region, which includes Mossendjo District, an organizational home for the PHC direction seems to be emerging within the MORSA, particularly following the consensus reached during the July PHC Seminar, organized by CARE in Mossendjo. The emerging organizational home is with the Regional Director for Health, who is based in Loubomo. This is no doubt a result of the presence in the Region of the CARE project and the West German project, which together have forced a consciousness on the part of the Regional Director of the need to provide a focus for the overall coordination and direction of PHC activities in the Region. At this organizational level, then, there is progress toward an organizational arrangement that would be able to endure and provide continued direction to PHC activities after the CARE project is completed.