

CLASSIFICATION
PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-44

1. PROJECT TITLE Comm. Health Outreach, AOPS I, 0169/3, FY 83-85 (\$280,000) Ext. Comm. Health/F.P., AOPS II, 0181/3, FY 84-86 (\$436,000) Urban Health Comm. Devt. II, CMSCS, 0159, FY 85-89 (\$2,100,000)			2. PROJECT NUMBER See No. 1	3. MISSION/AID/W OFFICE USAID/Haiti
6. KEY PROJECT IMPLEMENTATION DATES			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country o. AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY)	
A. First PRO-AG or Equivalent FY	B. Final Obligation Expected FY	C. Final Input Delivery FY	<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION 7. PERIOD COVERED BY EVALUATION From (month/yr.) 3/83 To (month/yr.) 5/86 Date of Evaluation Review 9/9/86	
6. ESTIMATED PROJECT FUNDING			8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR	
A. Total \$ See No. 1				
B. U.S. \$				

See No. 1

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)

B. NAME OF OFFICER RESPONSIBLE FOR ACTION

C. DATE ACTION TO BE COMPLETED

The Private Sector Health Program evaluation is an example of the new Mission approach, highlighted in the FYs 1987 and 1988 Action Plan, to cluster where possible, project evaluations in the same sector to better assess how program activities are contributing to the achievement of Mission strategy objectives, in addition to addressing project specific issues and concerns.

The substantive purpose of this evaluation was to assess to what extent the above projects addressed the following pertinent elements of the Mission's Health Strategy which consists of increasing the availability of the key public health care interventions (e.g., immunization, ORT, nutrition surveillance, etc.) on a continuing basis to reduce infant mortality and morbidity by:

- improving technological packages for delivery of primary health care services;
- developing and strengthening self-financing mechanisms for meeting recurrent cost requirements; and
- improving private sector support for primary health care.

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T	_____
<input type="checkbox"/> Logical Framework	<input type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P	_____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

A. Continue Project Without Change

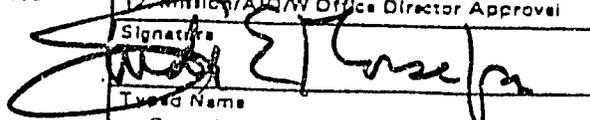
B. Change Project Design and/or Change Implementation Plan

C. Discontinue Project

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

Dr. Anthony Augustin, AOPS, Secretary General a.i.
 Dr. Reginald Boulos, CMSCS, Project Coordinator
 Adrienne Simms, USAID/PHO, Project Coordinator
 Debbie Kreutzer, USAID/PHO, Project Manager
 Robert Gilson, USAID/DRE, MEO; Daniel César, USAID/DRE

12. Mission/AID/W Office Director Approval

Signature: 
 Typed Name: Gerald Zarr, Director
 Date: 10/27/1986

ACTIONS DECISION APPROVED BY MISSION OR AID/W OFFICE DIRECTOR	NAME OF OFFICER RESPONSIBLE FOR ACTION	DATE ACTION TO BE COMPLETED
A. <u>PRIMARY HEALTH CARE SERVICES</u>		
<p>While the report discussed at some length the steps taken by the projects to develop improved methods to deliver health services to the target populations (p.50), it also identified the following program shortcomings, together with appropriate recommendations - approved by the Mission, AOPS and Cite Soleil Medico-Social Complex (CMSCS) - to address them:</p>		
1. <u>Oral Rehydration Therapy (ORT)</u>		
<p>Despite the major efforts made by MSPP in ORT over the last few years, there are some indications that commitment to this program is not as substantial as was originally believed. This stems from a general doubt about ORT as a technology for a variety of reasons, including an old enthusiasm in Haiti for intravenous rehydration, mothers' disillusion with ORS (oral rehydration solution) because it does not stop diarrhea and preference for OTC preparations which stop stooling. There is also evidence that some project field workers were not vigorously educating mothers about ORT nor actively promoting its use. AOPS has already taken initial steps to address this situation, including the organizing of a "mini-ICORT" meeting in Haiti, which was meant to remotivate upper-level health personnel, address some of the newer scientific issues, and resolve technical concerns. Other recommended actions include:</p>		
a) increasing ORS demand and availability for distribution;	AOPS/INSAC Health Com.	12/88
b) building up mothers' competency and utilization in ORT and ORS by: <ul style="list-style-type: none"> (1) strengthening ColVol (Community Volunteers) training in ORT and ORS usage, and (2) instituting rally post corners for ORT rehydration; 	AOPS/CHI INSAC	7/88
c) carrying out operations research to improve the delivery of ORT related services; and	AOPS/CHI CMSCS	9/89
d) supporting and promoting the use of ORT at the policy and leadership level.	AOPS	On-going

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2. <u>Breastfeeding</u>	AOPS/CHI CMSCS	4/87 - 4/89
<p>Breastfeeding in AOPS projects (or sub-grantees) needs more attention and should be handled systematically. At present, there is no explicit intervention in that area in any of the project sites visited by the evaluation team, although breastfeeding posters were found in almost every facility. Also, even though rural mothers traditionally need less help in this regard, there was evidence that they are not immune to the bottle-feeding practice, as illustrated by 15 out of 52 Carrefour-Poy mothers who were bottle-feeding their babies at the clinic while waiting for attention (p.131). The evaluation team endorsed the planned Cité Soleil breastfeeding campaign designed to follow a pre-test/intervention/post-test model, which shows promise. However, there is still a need for more systematic operations research to pinpoint problem areas, solutions and alternative approaches to promote the exclusive use of breastfeeding during the first months of life.</p>		
B. <u>SELF FINANCING CAPABILITY</u>		
<p>Developing and strengthening self-financing mechanisms for meeting recurrent cost requirements has been receiving increasing priority attention from CMSCS management during the last few years. Included in this effort are the establishment of different kinds of user fees and prepayment schemes, as well as sales of CMSCS products and fund raising. CMSCS is committed to carrying out short-term, targeted operational research projects to design and test more cost-effective alternatives for primary health care problems (p.50).</p>		
<p>The evaluation noted the foregoing accomplishments, but recommended that the following steps be taken to maximize revenue:</p>		
1. <u>CMSCS</u>		
<p>a) the Alvarez report recommendations, calling for improving production quality and expanding marketing efforts to increase sales volume, should be implemented (p.161);</p>	CMSCS	9/88

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b) fund raising efforts need to receive priority attention. The most promising area for fund raising is through the Friends of Cité Soleil in the U.S. (p.162);	CMSCS	On-going
c) CMSCS should establish a solid financial plan before it launches into new endeavors, such as the recent expansion of activities in Gonaives. While it strives to accomplish self-reliant objectives, it will continue to need the full support of its current donors for at least the next five years. In this regard, USAID is advised to carry out a gradual, planned reduction of supporting CMSCS' operating costs, over the course of the next few years (p.162); and	CMSCS	3/87
d) the industrialization plan, which sought to establish a competitive manufacturing enterprise whose profits would finance CMSCS' operating costs, should be tabled. A feasibility study was conducted by Witherspoon International Corporation, a private, non-profit business development firm based in the U.S. The study proved to be unusable and a more satisfactory feasibility study was not subsequently produced. Given the complex nature of an industrial undertaking, and the current political and economic state of instability, such a strategy seems ill advised, at least for the moment. Smaller, less complex efforts would have a better chance of success, such as the two-year project recently signed between OXFAM and CMSCS to establish small cooperatives in Cite Soleil (p.116).	CMSCS	9/88
2. <u>AOPS</u>		
The pertinent passages in the evaluation report discussed self financing capability at the field center level, not at the central, AOPS level. Currently AOPS, a consortium of health PVOs founded in 1983, is still working intensively on how to broaden and consolidate its membership base, and focusing primarily on field implementation problems. AOPS' long term institutional viability is critical to the achievement of Mission strategy objectives in the health sector, and it is time for that institution to begin serious planning in that regard. The Mission has just completed a contractor conducted evaluation of HAVA, the multi-sectoral, umbrella Haitian PVO association, and some recommendations made as	AOPS/CHI	4/87

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<p>a result to maximize revenue may be relevant to AOPS as well. In fact, AOPS is receptive and intends to contract a consultant in the future to assist in the development and implementation of an income generation program.</p>		
<p>3. <u>AOPS Field Centers</u></p>		
<p>The following measures were recommended for action at the AOPS field center level:</p>		
<p>a) CHI (Child Health Institute) should design appropriate studies on those programs with adequate data to determine, inter alia, the marginal cost of program expansion, the average cost of program operations by size and length of experience, and the annual recurrent costs of the program as it reaches plateau level. Cost analyses will provide more informed decisions regarding future program planning (p.162);</p>	CHI	4/87
<p>b) field centers are developing some innovative community based financing strategies, rather than relying on donor funding, to keep their program going, as AOPS grant funding expires. Most of these strategies seem to focus on how to generate funds to keep ColVols motivated to do a good job. The evaluation team believes that AOPS can play a central role in taking the lead in researching, brokering and coordinating these efforts (p.163). CHI will design appropriate studies for these activities; and</p>	AOPS/CHI	4/87
<p>c) USAID will explore possible sources of financing for these various studies</p>	USAID	8/87
<p>c. <u>PUBLIC & PRIVATE SECTOR COLLABORATION</u></p>		
<p>The evaluation team was impressed with respect to the amount of considerable progress achieved in public/private sector collaboration. For example, there seems to be a confluence of policy and program focus on limited primary health care interventions and coordination of activities at the field level. Moreover, to be eligible for AOPS assistance, AOPS insists that member PVOs be registered with MSPP and also have their community health programs approved by district health officials,</p>		

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<p>thereby making PVO programs fully integrated into MSPP's district level health plans. However, although there are numerous examples of coordination and integration, not all projects have reached the level achieved at the AMOSSE (Association Mixte des Oeuvres de Santé du Sud-Est) area, consisting of the La Montagne, La Vallée, Marigot and Cayes-Jacmel localities, where MSPP's District Director also functions as AMOSSE's Technical Director. In fact, some projects give the impression of having essentially perfunctory relationships with MSPP.</p>		
<p>As a way of intensifying coordination, AOPS should adopt the policy of having its coordinators do entry and exit interviews with local MSPP officials when on regular field supervisory or unscheduled visits. While such an action would not be too time consuming, it could help to alleviate field logistics and supply problems in projects where MSPP has had the responsibility for the provision of such services (p.55).</p>	AOPS	12/86
<p>D. <u>OTHER RECOMMENDATIONS</u></p>		
<p>Other actions recommended to restructure the projects are as follows:</p>		
<p>1. <u>Staffing Requirements</u></p>		
<p>a) AOPS should consider hiring a technical director who is strong in project development and implementation skills to help local centers set up field programs, develop more efficient rally post models, establish appropriate budgeting and reporting systems, etc. This function could be reinforced, though not adequately substituted for, by a simple management procedures manual for basic operations (p.155);</p>	AOPS	10/86
<p>b) AOPS needs to hire an Executive Director with good management skills to handle the reporting and documentation requirements so critical to an experimental project (p.155);</p>	AOPS	10/86

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c) optimally, each AOPS sub-grantee should have a medical and an administrative chief, with the doctor providing technical supervision and quality control, and the administrator managing operations. Both should be given adequate training in basic management skills, with only marginal amounts of theory, and focusing primarily on the practicum (p.155); and	AOPS/INSAC	6/88
d) CMSCS should separate the financial management and marketing/fund raising functions (p 155). CMSCS expects to hire two technically qualified persons to carry out those respective responsibilities on a full time basis.	CMSCS	3/87
2. <u>Monitoring and Evaluation</u>		
a) AOPS' management information system needs to be strengthened, at the field and central levels, to allow for easy location of reports and maintenance of accurate information. There is also a need to summarize the most important information element for feed-back purposes to ColVols, for effective follow-up and self monitoring of field performance (p.157);	AOPS/CHI	6/87
b) the target populations of AOPS field projects should be standardized and a policy decision should be made on priority age groups. The team recommends that both the 0-12 month and 13-24 month cohorts be assigned priority, the former for obvious reasons, and the latter because so much diarrheal mortality and morbidity seem to occur in that cohort. Not only should statistical categories be consistent across AOPS projects, they should also be compatible with MSPP reporting guidelines for target populations for primary health care, to allow for aggregate computation and conversion. Finally, baseline data should be included on all reporting documents where relevant, and presented in standard categories (p.158);	AOPS/CHI	6/87

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c) project dossiers need cleaning out, dating and refiling so that the earliest documents are on the bottom. Documents that are milestones in the life of each AOPS project - agreements, technical and financial reports, periodic supervision and monitoring reports, census and recensus reports, etc. - should be included in every project file. A standard checklist to track those critical documents should be affixed to the inside front cover of every project file, with the date each was received (p.159);	AOPS	12/86
d) a registry of each supervisor's site visit should be kept at each site. This log should note the important issues, problems and solutions proposed during the visit. The purpose of this recommendation is to introduce a pattern into those visits, to provide immediate feedback for discussion and action at the project level, and maintain a record of visits and related outcomes (p.160);	AOPS	12/86
e) AOPS coordinators should prepare specific work plans, in line with clearly pre-established supervisory objectives, including detailed calendars and appropriate strategies (p.160);	AOPS	12/86
f) AOPS should coordinate the streamlining of reporting requirements to allow for the use of standardized forms to satisfy multiple reporting requirements of donors (p.158);	AOPS/CHI	6/87
g) all AOPS project centers should collect quantitative and qualitative evaluative data on a quarterly basis, in order to prepare timely reports on project implementatin status for feedback to staff and AOPS. AOPS should design and distribute an adequate supply of the forms, and assure that reports are submitted regularly and on time (p.159);	AOPS/CHI	6/87
h) AOPS and CMSCS should review the program indicators required by the AID/Washington Child Survival Reporting System to be sure that data being gathered respond to those requirements (p.159); and	AOPS/CHI CMSCS	9/86
i) AOPS should consider putting together a small, user friendly manual on its registration and reporting system for use by staff, donors, researchers and evaluators (p.159).	AOPS	4/87

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3. <u>Financial Management and Planning</u>		
a) <u>CMSCS</u>		
(1) The financial management capability of CMSCS needs to be strengthened. This is expected to be accomplished through the hiring of the Financial Manager (see Part D, Section d, page 7 of this PES);	CMSCS	On-going
(2) if revenues from service fees are to continue to contribute to self-reliant goals, the costs of service delivery must be identified and carefully monitored, so that they can be raised commensurately with increases in costs (pp.160-161);	CMSCS	9/87
(3) fees for some services probably can be increased, although not before the socio-political situation stabilizes. Deliveries and surgeries are two possibilities. However, rather than launch a major research effort, the complex should experiment with small increases, monitoring utilization carefully. Prescription charges might also tolerate slight increases, to perhaps 10 percent of unit costs;	CMSCS	On-going
(4) cost containment and control mechanisms or strategies need to be developed for the hospital. As a beginning point, the PRICOR study by M. Pipp, which identified unit costs for normal and Caesarian deliveries, needs to be repeated. Such a study will help identify the magnitude of cost increases and areas which are subject to control measures. Similar analysis needs to be conducted for other service units (p.161);	CMSCS	3/87
(5) budgeting procedures need to be developed and implemented at each center or activity unit. Sister-administrators should be assisted as needed by the Financial Manager to operate their facilities within their budgets. Timely flows of information will be required (p.161); and	CMSCS	9/87
(6) bookkeeping procedures for the notebooks need to be standardized for all centers and expenditure line items disaggregated into meaningful categories (p.161). The Financial Manager is expected to oversee this action.	CMSCS	9/87

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b) <u>AOPS</u>		
(1) CHI should design studies on those programs with adequate data to determine the marginal cost of program expansion, the average cost of program operations by size and length of experience, and the annual recurrent costs of the program as it reaches "plateau" level. Cost analyses will provide the necessary basis for sub-grantees, (AOPS local centers), AOPS, and AID to make more informed decisions regarding future program planning (p.162);	AOPS/CHI USAID	4/87
(2) AOPS and INSAC centers need more management technical assistance, particularly in the area of financial management. The coordinators, who are all physicians, are untrained and unprepared to provide this assistance. They therefore should have some minimal financial management training to provide better routine assistance. In addition, the next coordinator to be hired should have a finance/statistics background, and should receive training to supervise the health aspects of the program. This action should ensure the in-house expertise necessary to help local centers experiencing difficulty with their financial management systems(p.162);	AOPS/INSAC	12/87
(3) all AOPS centers should designate a program administrator to receive training in financial management, either from AOPS or an alternative appropriate training institution (p.162);	AOPS	12/86
(4) all local centers serving a population larger than 20,000 should be required to do program budgeting, to identify annual program requirements and expected sources of funding (p.163); and	AOPS	9/87
(5) while most programs meet minimum standards of donor accountability, AOPS should continue the practice of on-site audit to assure that established standards are maintained. The AOPS accountant should provide guidance to the centers on financial accountability and control procedures. Financial reporting to AOPS needs to be standardized (p.163).	AOPS	12/86

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PART II

The contractors generated a wealth of information that is remarkable, given the time constraints involved. In general, Mission was impressed by the quality of the report and, along with the Grantees, considers it a fair assessment of the implementation status of the projects. The recommendations dealing with financial management, record keeping, reporting and monitoring matters were more useful than others and will help in rendering project operations more efficient. AOPS was particularly pleased with its report recommendations which should serve as a blue print for its Secretary General to tighten AOPS management and project operations. Finally, the Mission is satisfied that the scope of work was generally followed; however, due to the limited experience of the Primary Health Care Specialist with this type of evaluation, the technical elements of the evaluation are not as thoroughly analyzed and presented as would have been desirable.

However, Mission feels that the report could have been more easily and rapidly digested if the information contained therein were presented in a more integrated and streamlined fashion. In terms of overall format, we found some sections to be overlapping and repetitive, reflecting the lack of time allotted in the contract in integrating and polishing the document. For example, sections II.C ("Coverage and Impact"), VII.B. ("Coverage, Effectiveness and Impact") and Part VI ("Technical Issues") should have been consolidated for a more streamlined presentation; ditto for sections I.A. ("Program Management and Administration") and Part IV ("Program Management and Administration"); and sections III.A. ("Relationship to and Compatibility with the USAID/Haiti Action Plan") and VII.A. ("Compatibility with the USAID/Haiti Action Plan"). In similar future cases, Mission intends to include the costs of a professional editor in the contract budget to assume editing responsibilities.

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The Executive Summary is adequate, but major findings and recommendations should have been more integrated and developed. Moreover, the report failed to address the "project development impact" requirement in a separate section. Finally, Part I ("Introduction") should have been included in the Executive Summary.

With respect to the report recommendation suggesting researching how indigenous preparations could be upgraded in conformity with WHO guidelines (p.129), although Mission and CMSCS are not opposed to the use of home mixed preparations per se, we nonetheless feel that it would be ill advised, at this point in time, to launch into a new initiative that departs from the MSPP established policy of promoting the use of ORT prepared packages. Such an initiative on our part could confuse mothers, on the one hand, and lead to possible counterproductive relations with MSPP, on the other hand. For the moment, we concur with CMSCS' approach of focusing research on building mothers' competency in the use of ORT.

Although Mission and Grantees generally concur with family planning report recommendations made in pages 132-133, we have decided to implement them within the context of the recently obligated Private Sector Family Planning project (O189) with International Planned Parenthood Federation/Western Hemisphere region, acting as Grantee.

In summary, the Mission found the process of bringing together PHO, DRE and Grantee project directors to discuss and reach closure on action decisions set forth in the PES document to be extremely productive. Arrival at consensus on these decisions required detailed review of major evaluation findings and recommendations, and thorough consideration of alternative actions and their implications.

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