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PROJECT CONCERN INTERNATIONAL

Nonprofit nongovernmental health care training and development organization

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"Involved in Mankind"

July 15, 1980

RE: MATCHING GRANT
AID/SOD/PDC-G-0279
PIO/T No. 938-0137-73-3899402

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REPORT ON CURRENT STATUS

OF

EVALUATION ACTIVITIES

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REPORT ON CURRENT STATUS OF EVALUATION ACTIVITIES

INTRODUCTION

Project Concern International (PCI) is dedicated to helping others improve their health status through the development of appropriate Primary Health Care (PHC) training and delivery systems. Such systems should be affordable, socially acceptable, and accessible. All PCI projects under the AID Matching Grant aim to develop such systems, demonstrate their feasibility to the host country, and contribute to local capacity to assume responsibility. Each project, of course, is unique and, hopefully, corresponds to local needs, priorities, and desires.

PCI is committed to the necessity of evaluating programs to assess their effectiveness and usefulness, especially with respect to meeting the stated objectives of each project.

Evaluation at PCI begins with routine monitoring, as recorded and summarized through each project's monthly narrative progress report and financial report. Progress is further summarized semi-annually in reports to AID, as required by the Matching Grant. The format for the monthly field reports has been developed and refined over the past year in order to make them more evaluative. We are still in the process of identifying common and

useful statistical indices which can be reported by each project each month (e.g., patient contacts, nutrition lessons). However, at present, statistical reporting is not yet standardized for all projects. The degree to which such standardization is feasible or desirable, given differences between projects, is under review.

Formal, periodical evaluations--both internal and external--are planned for all PCI projects. These aim at measuring progress in terms of processes and effect on health. Over the past two years, formal evaluation activities have been conducted in Bolivia (process), Guatemala (needs assessment), and Mexico (cost benefit analysis).

Recent staff visits to all PCI projects constituted an internal evaluation/program review to determine progress, problems, directions, and 1981 budgetary needs.

PCI projects are evaluated in terms of community health worker (CHW) effectiveness, training curriculum appropriateness, and impact on health. In the short term (1-3 years), processes may be measured, e.g., numbers of personnel trained, immunizations, home visits, referrals, etc. In the intermediate term (3-5 years), PCI will strive to measure initial effects on health and affordability of services. In the long term (5-7 years), the ultimate objectives of replication, self-reliance, and positive impact on health attitudes, practices, and status can be assessed.

Pursuant to the terms of our AID Matching Grant, this report on the current status of PCI evaluation activities is organized by country program funded under the Grant, following the AID Project Evaluation Summary (PES) format provided.

THE GAMBIA

SUMMARY

Within the framework of PCI's general goals and objectives, PCI in The Gambia seeks to aid and support the Gambian government's stated goal of "health for all by year 2000." This goal is operationally defined by the Gambian Ministry of Health as the provision of one CHW per 500 population to deliver PHC services in the rural areas. Under the terms of our agreement with the Ministry, dated June 28, 1979, PCI undertook to provide during the first year one expert trainer and financial resources (including salary) totalling approximately \$100,000 ^{FOR WHAT SPECIFICITY?} in support of PHC program planning and the training of trainers, supervisors, and CHWs. Originally, a highly decentralized approach was envisaged by the Ministry, involving our training of 10 medical auxiliaries (health post personnel) who, in turn, would train 100 CHWs in their catchment areas. In working with the Ministry to plan this program, these auxiliaries were found to be insufficiently qualified to become effective CHW trainers. Instead, three higher level health personnel in the Ministry (with prior training of CHW preparation) were identified. The current plan is to work with these trainers, on a "Phase I" basis in one rural district, to train CHWs. [With PCI assistance, the Ministry is now proceeding with curriculum development, community organization, material procurement, logistics planning, and other prerequisites. The first group of 20 CHWs should begin training in January 1981.] The experience gained in this Phase I program will be carefully monitored and evaluated as an integral part of the planning process for a national CHW program. It is expected that such replication may begin, with WHO support, by the end of 1981, if Phase I appears reasonably successful.

EVALUATION METHODOLOGY

Planning activities and progress towards implementation of Phase I are carefully monitored through monthly reports submitted by the PCI field director. A recent week long visit to The Gambia by PCI's Africa Program Director served as a general review of PCI's role and contribution as we begin our second project year. This review involved discussions with PCI staff, host country, and other donor agency officials, review of program documents, attendance at planning meetings, and consideration of past and projected budget needs.

Initial formal evaluation of Phase I is contemplated for mid-1981, following the training and assignment of at least one class of CHWs. Since these CHWs will have just graduated, this evaluation will necessarily be limited mainly to processes (number of CHWs, attrition, cost, review of curriculum, participant and community feedback, etc.) Based on baseline data collected, some subsequent assessment of impact on health will follow at a later date.

EXTERNAL FACTORS

Insufficient planning capacity at the Ministry level--due mainly to lack of adequate manpower--has limited the rate of progress. The Director of Medical Services, who has responsibility for PHC, is often required to travel to Geneva or Brazzaville on WHO business. Decision making in his absence is difficult due to limited delegation of authority. WHO has developed plans for a national PHC program in The Gambia which at times has created doubts about the role and status of PCI participation on a pilot

project basis. This issue seems now to be finally resolved with the Phase I project seen clearly as the first, experimental step towards national, WHO-supported PHC.

INPUTS

PCI can maximize the value of its contribution by remaining flexible. There are many donor agencies anxious to assist in The Gambia, but many have narrow restrictions governing use of their funds. Working directly with the Ministry, PCI can play a role in coordinating inputs and filling in the gaps.

OUTPUTS

The original targets of training 10 trainers and 100 CHWs have not been met and no longer apply. This is a function of a collaborative and evolutionary planning process which is now progressing very well. As noted above, PCI is assisting three trainers with prior training, and current targets call for completing all prerequisites and beginning the training of the first 20 CHWs by January 1981. Forty CHWs will be trained in the Phase I program. The experience will be evaluated and applied, with modifications as indicated, to other parts of the country. PCI will support this larger replication effort through evaluation and planning assistance, but not operational support.

PURPOSE

The project purpose is to assist the Ministry to develop and test appropriate models of training and delivery for PHC. A timetable for training and fielding CHWs has been set and constitutes a valid EOPS to describe achievement of purpose.

GOAL/SUB-GOAL

This project contributes to the goal of making adequate PHC accessible to all Gambian citizens by year 2000, to be provided in the rural areas by one CHW per 500 population. This project will help lay the foundations for realization of this goal, with larger scale assistance on a national level expected from WHO.

BENEFICIARIES

Rural Gambians will benefit through better access to basic health services aimed at preventing disease and promoting better health.

UNPLANNED EFFECTS

None to date.

LESSONS LEARNED

Too early for comment.

SPECIAL COMMENTS OR REMARKS

None.

BOLIVIA

SUMMARY

PCI has worked with the MOH in Pando, Bolivia since 1977 to establish an effective rural health delivery system. The focus of PCI's effort has been the training and administrative support of rural auxiliary nurses and their supervisors. A formal evaluation of the program was conducted by PCI and the MOH in October 1979. As a direct result of that evaluation, PCI will continue to provide technical support and funding for the program's in-service training and supervision components until 1982. In July 1980, the local Pando Health Department assumed administrative responsibility for the rural system and increased the number of salaried administrative positions to assure program continuation.

Also as a result of the evaluation, PCI was invited to extend our program to another area of Bolivia where a model primary health care program, based on the delivery of services by volunteer community health workers can be developed. In April 1980, a feasibility study of three proposed sites was carried out by PCI and the MOH. In August 1980, joint planning will begin for the new program site in the District of Oruro.

FORMAL EVALUATION - OCTOBER 1979:

METHODOLOGY

- Objectives: -- To describe the state of health care in rural Pando
- To assess progress towards the goal of establishing a viable rural health delivery system and the appropriateness of the strategy employed

- To identify problems related to the implementation of a rural health care delivery system
- To provide the basis for the projected transition of the program to the MOH
- To introduce local health department staff to the process of program evaluation and planning

Evaluation participants included PCI Bolivia field team, the Coordinating Unit of the MCH, local Pando Health Department staff, as well as representatives from WHO/PAHO and the Bolivian School of Public Health.

Data collection was kept as simple as possible and only existing sources of information were used: i.e., health post activity reports, PCI and MOH records, etc. An evaluation meeting of all of the participants listed above reviewed the collected data, discussed possible alternative solutions to problems encountered, and made concrete recommendations for program improvement.

EXTERNAL FACTORS

The original Pando program strategy involved the training and support of volunteer community health workers as rural primary health care providers. The experience of the rural auxiliary nurses has proven our original program assumption, that volunteer community health workers would be effective in Pando, to be incorrect. The predominant socio-economic system of the Pando, debt peonage, precludes the existence of autonomous, centralized communities which are capable of supporting and/or utilizing the services of a CHW. The

evaluation team agreed, in this case, that the solution to the health problems of the Pando are far beyond the capacity of the MOH or of a low-cost, primary health care program. They recommend enforcement of existing agrarian reform laws as prerequisite to future programs in Pando. They also concluded that Project Concern should extend its efforts to another area of Bolivia where pre-existing conditions would permit training of CHWs as the primary care providers of the rural health delivery system.

INPUTS

The evaluation has resulted in continuation but reduction in direct PCI funding and technical assistance for the Pando program. At the same time, the MOH has assumed increased financial and administrative responsibility toward complete program takeover by 1982.

A program implementation plan for the Oruro site is being developed and will define PCI, MOH and other contributing agency contributions according to program need and design.

OUTPUTS

As mentioned earlier (External Factors), incorrect program assumptions have invalidated the original plan to train community health workers in Pando. However, the evaluation team concluded that the PCI/MOH program has made a very positive contribution to the extension of health service coverage in Pando. Measurable program accomplishments include:

- Trained 30 rural auxiliary nurses
- 20 rural health posts operating
- Trained 3 rural auxiliary nurse supervisors

WHY
CONTINUE
AT ALL?

- Developed training manuals and curriculae for formal and on-the-job training of rural auxiliary nurses
- Established self-contained rotating drug supply system for rural posts
- Established rural supervision system and in-service training program for auxiliary nurses
- Developed administrative controls
- Trained MOH personnel to administer program

Long term program effects on health status have not been measured to this date.

PURPOSE

The originally stated purpose of the program to develop a low cost primary health care system based on the training and supervision of community health workers, is no longer applicable in Pando, as explained earlier (External Factors). Based on this fact and the evaluation results a new set of targets for project completion and turnover to the MOH has been established. The first conditions for that turnover were met by the MOH in July 1980, when administrative control was transferred to the Pando health department.

GOAL/SUB-GOAL

Again, external factors have affected the program's ability to achieve the magnitude of service delivery originally envisioned. However, considerable progress has been made towards the improvement of service

delivery (see Outputs). Due to the lack of sufficient baseline data, information, analysis of program impact on services and health status is currently impossible.

BENEFICIARIES

Rural auxiliary nurses serve communities which represent approximately 18% of the total rural population of Pando. The evaluation showed that the availability of health services in Pando has increased greatly since 1977. It also demonstrated the need to channel these services towards high risk groups and to increase the preventive and promotive activities in each community.

UNPLANNED EFFECTS - N.A.

LESSONS LEARNED

Significant obstacles encountered in the evaluation process included:

- Lack of sufficient baseline data to measure program results, progress, deficiencies, etc:
- Non-measurable goals and objectives as stated in the original PCI/MOH agreement
- Insufficient or irrelevant activity data collected by field program monitoring system

Actions are currently being taken to correct these deficiencies. A revised system, for the regular collection of activity data is being

implemented. In the planning and program development for the new program site in Oruro, these obstacles will be eliminated through systematic data collection, baseline surveys and specifically defined goals, objectives and targets. Data collected during the October evaluation will be used as baseline information for future analysis of the Pando activities.

ADDITIONAL EVALUATION ACTIVITIES

PRELIMINARY EVALUATION - APRIL 1980

METHODOLOGY

Objectives: -- To assess the degree of need in three specific sites for a primary health care program

-- To assess the appropriateness of pre-existing conditions in each of three sites for development of a model primary care system

-- Participants in this preliminary evaluation included -

- the PCI/Bolivia Program Director,
- the PCI/MOH Rural Supervisor, and
- the MOH Coordinating Unit of the Planning Division

-- A criteria for evaluation of the three proposed sites was developed by PCI's team and the MOH Coordinating Unit. Site visits involved interviews with MOH, community and other agency representatives in each. Sites were then rated according to their degree of

compliance with the proposed criteria. Findings of the study were presented to a joint PCI/MOH committee for their consideration.

Result: -- Both PCI and the MOH accepted the Department of Oruro as the most appropriate of the four sites for the development of a primary health care program. Program planning with the local Oruro health department will begin in August.

SPECIAL COMMENTS OR REMARKS:

In June 1980, PCI/Bolivia team leader, Greg Rake, presented the attached paper "A Practical Evaluation Experience in Rural Bolivia" at the NCIH Annual Conference in Washington, D.C.

NOTE : NO MENTION IF PROBLEM
OF PCI WITHDRAWAL FROM
OUT-PATIENT CLINIC HAS
BEEN RESOLVED - 3/8 REPORT
GUATEMALA
CONDITIONED RESOLUTION of
FORMAL AGREEMENT WHICH
IS NOT YET SIGNED

SUMMARY

In the town of Santiago Atitlan, Guatemala, Project Concern operates a maternal/child clinic, two nutrition education and rehabilitation centers, a rural health post and a health center with outpatient, emergency and minimal inpatient services. Since assuming responsibility for the health center in 1975, PCI's emphasis in Santiago has changed from clinic based, curative health care to disease prevention and health promotion through community education and involvement.

An evaluation by PCI of the health and nutrition status and the felt needs of the Santiago community in 1978, confirmed the impressions of our field staff and contributed to our commitment to work with the community in developing an appropriate primary health care system. [In August 1980, PCI will begin a training program for approximately 40 volunteer community health workers as a further step towards meeting this commitment.]

PCI and the Guatemalan Ministry of Health will soon sign an agreement to strengthen and define our joint participation in Santiago Atitlan. Under the terms of the agreement, the Ministry of Health will be directly involved in the training and support of the CHWs as well as in annual joint evaluations of all of our health care activities in Santiago Atitlan. This agreement will be the basis for increased MOH participation in Santiago as PCI gradually reduces its assistance during the next three to five years.

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EVALUATION - HEALTH NEEDS ASSESSMENT--1978:

METHODOLOGY

In 1978, three years after PCI assumed responsibility for the program in Santiago Atitlan, a health assessment survey was conducted to:

- Identify areas of weakness in the health care program
- Determine health education needs
- Determine new directions/policy for the program
- Establish baselines from which to proceed with the program and against which measurement of future progress can be made

Participants in the design and implementation of the evaluation were PCI headquarters and field staff and community members. Information on 5-10% of Santiago's children under five years of age and their families was collected by 20 trained survey workers. Demographic, nutritional and environmental variables as well as health beliefs, felt needs and utilization of health facilities were examined. Although data was computerized and analyzed in the U.S., simplified evaluation results were also presented to the community health committee for their use in planning and implementing health related programs.

EXTERNAL FACTORS

As stated before, the evaluation results reconfirmed the need for increased emphasis in preventive and promotive health care and community participation.

Other external influences since 1978 include the change in Guatemalan government policy which calls for increased collaboration and coordination with PVOs. Also, the Guatemalan national health plan includes the

training of CHWs as a component of the primary health delivery scheme. The government PHC program is currently in its initial phase. PCI will collaborate directly with the regional pilot training program for CHWs in an attempt to impact a future program at the national level.

INPUTS

PCI inputs in Santiago have changed radically since 1975. Consistent with our international health program policy, PCI will begin in 1981 to decrease the financial contribution made to the program while promoting increased community and national responsibility in the Santiago area. Complete program turnover is expected by 1984.

OUTPUTS

Program activities are monitored on a monthly basis in Santiago. In addition, the nutrition education centers present annual reports on numbers of children recuperated, treated, etc. This statistical and descriptive information provides a basis for evaluation of program effect on health service availability. An impact analysis of the program will be conducted in 1981 to assess outputs in terms of change in health status, attitudes, and practices.

PURPOSE

The purpose and strategy of the program since 1975 has changed from health care relief to the training of local personnel and CHWs to provide and maintain basic health services with increasing government participation and support.

Why ↓
now when
we just
starting
training
of CHWs?

GOAL/SUB-GOAL

As mentioned above, an impact analysis of the program will be conducted in 1981. The goal of improved health status for the community will be measured at that time. We can state at this time that community involvement in health care is a reality. Improved access to health care and utilization of appropriate health services have also been achieved. It is anticipated that program turnover and replication will be facilitated by the PCI/Ministry of Health agreement, to be signed in August.

BENEFICIARIES

The program is reaching approximately 2,000 indigenous residents of Santiago Atitlan monthly with preventive, promotive, and curative health care. The major portion of this care (health education and growth supervision) is provided at the maternal-child clinic.

UNPLANNED EFFECTS - N.A.

LESSONS LEARNED

The 1978 study reconfirmed the now widely recognized fact that hospital or clinical care is inadequate in terms of disease prevention and thus lasting improvement in the quality of human life. The 1981 impact evaluation will presumably show not only the impact of the primary health care approach but will also serve as an interesting comparison of the two systems.

3/10 Report - M.H./PC, AGREEMENT BY
4/26/80 - WHAT HAPPENED?

MEXICO

SUMMARY

As described in the Matching Grant proposal, PCI currently operates the outpatient department of a maternal-child hospital and two PHC training programs in peripheral communities (colonias) of Tijuana.

Administrative control of the outpatient and inpatient facility will be turned over to the Mexican government through their Integrated Family Development charity (DIF) in August 1980. The PHC training program will be extended to at least two additional communities by the end of 1981.

COST/BENEFIT ANALYSIS, MATERNAL-CHILD HOSPITAL

METHODOLOGY

A cost/benefit analysis of the maternal-child hospital was conducted by PCI in 1979. A health planning specialist was contracted to compile information on hospital services, personnel functions and activities, beneficiaries and operating costs. Statistical data was analyzed and presented together with recommendations to the PCI Executive Board of Directors for their consideration and action. The results of this analysis indicated that the hospital activities (mostly highly specialized, relief care) were not consistent with PCI's program policy of PHC and community self-reliance. In addition, the cost of this specialized care per patient was extremely high and felt to be inappropriate. Steps were taken at that time to insure partial hospital self-sufficiency, to identify other possible funding sources and to establish a time frame for the withdrawal of PCI technical and financial assistance. The results of the study have also been

used for budget planning, redirection of hospital activities, and the reassignment of personnel tasks and responsibilities at the facility.

[No formal evaluation of the Colonias program has been conducted since its initiation in 1977.] Monthly statistical and narrative reporting allows for regular program monitoring. Also, monthly team evaluation and planning sessions have been initiated, with PCI Latin America Regional Director participating. (An impact evaluation will be conducted in two colonias in 1982.) In addition, policy evaluation by PCI and the MOH will take place annually.

EXTERNAL FACTORS

Since the hospitals construction in 1972, the Mexican government has increased its investment in the health sector. Two large health centers, a new government hospital and several small community clinics are now operated in Tijuana by the Ministry of Health.

At the same time, the population of Tijuana has more than doubled in the last decade. Many peripherally located communities remain relatively isolated from existing health facilities and basic public services such as potable water, sanitation systems, electricity, and regular transportation. In this context, hospital based outpatient care, while important, is not the best investment of PCI funds.

INPUTS

PCI will increase its contribution in the Colonias during the next two years, expanding program activities to at least two additional colonias in 1981. In the Colonias, we will direct our resources towards improved

health care through health education, basic curative care and community health development.

Contributions to the hospital outpatient facility will be decreased according to the Mexican government's scheduled takeover of responsibility.

OUTPUTS

Program activities in both the outpatient and colonias outreach programs have increased health care services in the Tijuana area. Approximately 1,500 patients received treatment monthly in 1979-80. Fast CHW'S | Thirty CHWs are currently receiving training and will actively participate in a needs assessment of their communities in August. | Community projects are underway in both colonias.

Program accomplishments in both the outpatient and colonias areas have been less than expected. Labor and financial problems at the hospital have had a negative effect on all Tijuana programs during the first half of 1980. We anticipate that the turnover of the hospital will allow more staff time and effort to be placed on the community colonia program.

PURPOSE

The original purpose of the outpatient facility no longer fits the PCI Primary Health Care program policy.

The purpose of the colonias outreach program is to establish a primary health care system with active community participation, in valid. Progress towards achieving the objectives of the program is on-going. Lack of continuity of PCI Mexico personnel has had a negative effect on the

motivational level of the communities involved. We have taken steps to correct this situation and expect improved participation as a result.

GOAL/SUB-GOAL

Improved availability of health care has been a result of the program, especially on the peripheral communities. Impact on health status has not been measured and would be difficult due to the lack of sufficient baseline data.

Turnover of the hospital and outpatient facility to the Mexican government represents attainment of national self-reliance in relation to this activity. Increased community participation and government participation will be necessary to achieve self-sufficiency in the colonias.

It is extremely difficult to speak of goals and sub-goals for this program. Measurable overall goals and objectives have never been defined specific to program activities.

BENEFICIARIES

Beneficiaries of this outpatient facility can be defined as the 1,000 low income women and children treated monthly.

Now TRAINED [Beneficiaries served in each of the two colonias average 200 per month. In addition, 15 CIWs are receiving training in each.]

UNPLANNED EFFECTS - N.A.

LESSONS LEARNED

Lack of baseline data and measurable goals and objectives makes impact as well as policy evaluation difficult. Baseline studies in both of the

peripheral communities are currently being conducted with direct participation of the CHWs. The information collected will be used in program planning as well as future evaluation.

SPECIAL COMMENTS OR REMARKS - None

February 1, 1980

MEMORANDUM

TO: Field Program Directors
FROM: Dr. I. M. Lourie, Medical Director
Health Services Department
SUBJECT: HSD REPORTING SYSTEM

I. M. Lourie

The need for more and better evaluation of field operations--both as a vehicle for increased program quality and as a USAID requirement in the case of Matching Grant countries (Bolivia, Guatemala, Mexico, and The Gambia, at present)--has prompted us to develop a somewhat expanded and more standardized reporting system.

Most of you are already reporting thoroughly and most satisfactorily at the end of each month; and the system herein described should pose no great changes or hardships. The attached guidelines for monthly reports are meant only to help focus your thinking on your activities (completed and projected) and how these relate to your project goals and objectives. We at headquarters do not want reporting to be a "paper exercise" any more than you do; and you are encouraged to be as explicit and concise as possible. You are not required to include unimportant information simply in order to avoid empty sections. However, we do want to monitor rather closely the progress of your work and any changes in your plan of operations as they evolve. Use your best judgment as to what and how much to include. Also, your suggestions and innovations for improving the reporting system and format are most welcome.

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A few notes of explanation:

1. The basic reporting requirement for the Field remains unchanged. You are asked, at the conclusion of each month, to submit a "Narrative Report" and a "Financial Report." It is the former which, in some cases, now needs to be a little more thorough and evaluative. Clearly, the first step towards achieving this is to list your short, medium, and long range objectives if not already done or in need of revision. These serve as reference points in your reporting.
2. Although the Narrative is reviewed first by the Regional Director, it is usually circulated widely at headquarters. Therefore, any information or communication of a personal, sensitive, or discordant nature is best handled in separate correspondence to the appropriate person. This is particularly important in communicating private information or opinions about project personnel. As indicated, any such separate correspondence should be marked "personal" on the outside envelope to avoid opening and screening in the mail room. (N.B. You should avoid using the term "confidential" lest it be confused with the Government security heading).
3. Section 7 ("General Interest Information") is mainly aimed at providing useful information on your activities to PR and the Walk departments.

Aside from these monthly reports (which permit activities and financial monitoring by headquarters), there is an annual budgeting cycle which requires information from the field at particular times (see attached Annual Report Guidelines). (PCI has recently changed its fiscal year to coincide with the calendar year, beginning 1981. This means that the existing budget will be projected through December 31, 1980, and a new one year budget will take

effect from January 1, 1981. This new budget will be presented to the Board of Directors for their approval in November 1980.

The first step in constructing the proposed budget will be taken, in the field, some six months before. Between the end of April and mid-June, you will be visited by your Regional Director. This visit, aside from other purposes, is timed to coincide with your timetable for submitting your budget request for the following year (beginning January 1st). The Regional Director will assist you in the preparation of this annual report, which is comprised of your Plan of Operations for the next year and corresponding Budget.

At the same time, also in conjunction with the Regional Director's visit, you are asked to review your current year's budget to determine any major changes needed for the remainder of the year. Any changes (either increase or decrease in budget) should be documented and explained by appropriate revisions in your current Plan of Operations. This exercise will, by necessity, entail a brief review of progress to date.

If possible, both your mid-year current budget review and your next year's budget request should be carried back to San Diego by the Regional Director. Otherwise it should be submitted within two weeks of his or her visit.

A schedule of reporting for HSD as a whole is attached to illustrate the entire system--both at the field and headquarters levels.

Also attached are the specific guidelines for your monthly and annual reporting.

Finally, let me reiterate that--while the reporting requirements outlined for you are certainly substantial--it is not our intent that they become overwhelming or counterproductive. Please consider this system experimental and subject to changes based on your most welcome suggestions.

Thank you.

ANNUAL FIELD REPORT GUIDELINES

I. MID-YEAR CURRENT BUDGET REVIEW

- A. Review Project progress to date: "Where we are and where we are going."
- B. Indicate specific changes in Plan of Operations
- C. Indicate any anticipated or needed changes (increase or decrease) in budget for the remainder of the year with explanations.

II. NEXT YEAR PROPOSED BUDGET SUBMISSION

- A. Provide Plan of Operations for next year. Use of Gantt Chart suggested
- B. Propose necessary budget for implementation

N.B.: Both reports to be discussed and refined in conjunction with Regional Director's visit to field, between end of April and mid-June. Submit within two weeks of visit (if not carried back by Regional Director).

HEALTH SERVICES REPORTING SYSTEM

	MONTHLY	QUARTERLY	SEMI-ANNUALLY	ANNUALLY																
FIELD	<p>I. <u>NARRATIVE REPORTS</u></p> <p>(See "Monthly Field Report Guidelines")</p> <p>II. <u>FINANCIAL REPORT</u></p> <p>(See "Monthly Field Report Guidelines")</p>			<p>In conjunction w Regional Director Visit (late April early June):</p> <p>I. <u>MID-YEAR CURR BUDGET REV.</u></p> <p>(See "Annual Report Guidelines")</p> <p>II. <u>ANNUAL BUDG SUBMISSION</u></p> <p>(See "Annual Report Guidelines")</p>																
ADQUARTERS	<p><u>ACTIVITIES REPORT</u></p> <p>Summary of past month</p> <p>• Prioritized activities for coming month</p>	<p><u>BOARD REPORTS</u></p> <table border="0"> <tr> <td><u>Due:</u></td> <td><u>For Meeting:</u></td> </tr> <tr> <td>Mid Jan . . .</td> <td>Early Feb</td> </tr> <tr> <td>" Apr . . .</td> <td>" May</td> </tr> <tr> <td>" Jul . . .</td> <td>" Aug</td> </tr> <tr> <td>" Oct . . .</td> <td>" Nov</td> </tr> </table>	<u>Due:</u>	<u>For Meeting:</u>	Mid Jan . . .	Early Feb	" Apr . . .	" May	" Jul . . .	" Aug	" Oct . . .	" Nov	<p><u>AID REPORTS</u></p> <table border="0"> <tr> <td><u>Prepare:.</u></td> <td><u>Due:</u></td> </tr> <tr> <td>Early Mar. . .</td> <td>Mar 27</td> </tr> <tr> <td>Early Sep. . .</td> <td>Sep 27</td> </tr> </table> <p>In Accordance With AID Guidelines:</p> <ul style="list-style-type: none"> • Progress toward objectives • Problems encountered/ action required • Proposed activities 	<u>Prepare:.</u>	<u>Due:</u>	Early Mar. . .	Mar 27	Early Sep. . .	Sep 27	<p><u>BUDGET REPORT</u></p> <p><u>Due:</u> July 15</p> <p>• Analysis and Justification</p>
<u>Due:</u>	<u>For Meeting:</u>																			
Mid Jan . . .	Early Feb																			
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Handwritten initials

MONTHLY FIELD REPORT GUIDELINES

N.B.: Any information of a sensitive or personal nature should be reported separately in correspondence to the Regional Director (or other appropriate person), and should be clearly marked "PERSONAL" on the outside of the envelope.

I. NARRATIVE REPORT: (for HSD Evaluative Use)

A. Summary of Month's Activities--

- Update on major areas of work
- Problems encountered and actions taken or recommended
- Travel
- Contacts, meeting, visitors
(include name, title, postal address, where possible)

B. Projected (prioritized) activities for coming month (see form)

C. Anticipated project developments, changes in Plan of Operations (Implementation Plan), and effects on budget

D. Progress toward goals and objectives and method of evaluation

- Statistics Useful. If applicable, provide "process measurement" data (e.g. number of CHWs trained, patient visits, health talks, etc.)

E. Personnel Matters

F. Specific Needs--

- PCI forms and other supplies
- Responses to questions
- Money
- Authorization
- Personal
- Other

G. General Interest Information--

- Personal info on yourself and local colleagues
- Anecdotes of interest on project area, country, etc.
- Other

H. Other commentary or elaboration

II. FINANCIAL REPORT:

- Complete "Summary of Monthly Operations" form
- List expenditures by account (using account sheets provided)
- Retain receipts at project site.

ANNUAL FIELD REPORT GUIDELINES

I. MID-YEAR CURRENT BUDGET REVIEW

- A. Review Project progress to date: "Where we are and where we are going."**
- B. Indicate specific changes in Plan of Operations**
- C. Indicate any anticipated or needed changes (increase or decrease) in budget for the remainder of the year with explanations.**

II. NEXT YEAR PROPOSED BUDGET SUBMISSION

- A. Provide Plan of Operations for next year. Use of Gantt Chart suggested**
- B. Propose necessary budget for implementation**

N.B.: Both reports to be discussed and refined in conjunction with Regional Director's visit to field, between end of April and mid-June. Submit within two weeks of visit (if not carried back by Regional Director).

A PRACTICAL EVALUATION EXPERIENCE IN RURAL BOLIVIA

Gregory Rake, MA; Anne Rodman, PA-C; Gale Morrow, MPH

PROJECT CONCERN INTERNATIONAL
Cobija, Bolivia

INTRODUCTION

Project Concern International is a non-profit, private voluntary organization dedicated to the development of low cost, primary health care systems in the United States and throughout the developing world.

In 1977 Project Concern and the Bolivian Ministry of Health signed a five year agreement to develop primary health care services in the sparsely populated, tropical jungle department of Pando. From 1977 - 1979 Project Concern has worked in conjunction with the Pando Health Department to train thirty auxiliary nurses and to develop support systems necessary for the delivery of health care in the rural area. Under the terms of the agreement, the Pando Health Department is gradually assuming responsibility for the management of the rural health care system.

PURPOSE OF EVALUATION

After two years of program activity, the Ministry of Health technical staff and Project Concern agreed that a general evaluation of the program was needed. The purpose of the evaluation was to describe the state of health care in rural Pando, to identify problems related to the implementation of a rural health care delivery system, to judge

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what progress had been made and to provide a basis for the transition of the program's management from Project Concern to the local health department. An additional aim of the evaluation was to introduce the local health department staff to the idea and process of evaluation and planning.

OBSTACLES TO EVALUATION

Anyone who has worked in a similar situation in a developing country will recognize the problems the Ministry of Health and Project Concern faced in doing an evaluation. The most pressing were:

- lack of reliable statistics
- lack of specific baseline data
- lack of funds for evaluation
- lack of time, or limited time budgeted for evaluation in the work plan
- the idea that evaluation is a futile exercise
- lack of expertise in evaluation, planning, and administration at the local level
- lack of reference materials
- fear of evaluation

We tried to plan the process of the evaluation to minimize these obstacles.

PROCESS OF EVALUATION

First, the Project Concern staff met with the Ministry of Health officials in La Paz and together agreed on areas, or components of the health care system to be investigated. These were:

- demography and social structure of the area
- Ministry of Health programs and the delivery of rural health care services
- training and continuing education of rural nurse auxiliaries
- supervision
- transportation
- communication and information
- supplies
- administration
- planning and evaluation
- personnel
- finance
- inter-agency coordination.

Each component was divided into the following segments:

- 1) a description of the component and its present condition;
- 2) an itemization of the component's costs, and 3) a summary of problems encountered within the component.

Next, the Pando Health Department and the Project Concern staff worked part time for three months gathering data, using only readily available sources of information. For example, we used financial and personnel records of the Pando Health Department and of Project Concern, demographic data from other agencies, interviews with local authorities, and the records from rural health posts. In preparing the materials for presentation, we felt that simplicity was important.

ANALYSIS OF FINDINGS

A meeting was held in the national capital to present the information gathered by the Pando Health Department and Project Concern and to discuss the problems identified. The meeting was attended by the Director of the Pando Health Department, Ministry of Health officials, the staff from the Bolivian School of Public Health, a WHO/PAHO expert on rural health and the Project Concern staff. In total, there were 35 participants.

At the meeting the Pando Health Department staff and Project Concern staff summarized the factual material of each evaluation component. A document which described each component and the problems encountered was given to each participant. As a catalyst for discussion the problem section of each component was followed by a list of alternative solutions which identified some advantages and disadvantages of each alternative.

Then the meeting broke up into small working groups in order to discuss the information presented. The participants used the document as a work book. Any additional difficulties which they perceived as problems were listed, even if some seemed trivial, others important, and others unsolvable. The listing of the solutions and their advantages and disadvantages was done by all so that there was no suspicion that they had been weighted or biased in one party's favor.

The format of the problem section of each component was extremely helpful in promoting productive discussions within the small groups. As an example, one of the problems identified in the component, "Programs and Services," was the inadequate coverage of rural health care services. Chart One

illustrates the format of the problem section.

CONCLUSIONS AND RECOMMENDATIONS

After the groups had discussed the problems among themselves, they presented their ideas to the others. And after further discussion, conclusions and recommendations for each component were made by the entire body. Thus, at the end of three days of meetings, we had concrete recommendations for all of the problems which had been identified.

The recommendations were as varied as the problems. Not all fell within the jurisdiction of the Ministry of Health. For example, it was recommended that the 1952 Agrarian Reform Act be enforced to end the system of debt peonage, which had hindered the provision of services. Other solutions were within the scope of the Ministry of Health, e.g. creating more jobs in the Pando Health Department for nurse educators, or finding funds for the continuation of the project. Others were to be implemented at the local level, such as allowing the rural auxiliary nurses to increase the prices of the drugs they use in the treatment of patients.

It was a great advantage in planning to leave the meeting with recommendations for action, rather than waiting months for a committee to respond to a report or to provide feedback. In addition, the full participation in the evaluation process by decision makers has encouraged a greater commitment to the implementation of the recommendations.

SUMMARY

After two years of program activities, the Bolivian

Ministry of Health and Project Concern developed an evaluation format and process which:

- **Provided a general overview of the health care services in rural Pando**
- **Identified problems related to the delivery of rural health care services in Pando**
- **Served as a vehicle for making specific program decisions especially those related to the transfer of program management to the Pando Health Department**
- **Introduced the idea and process of evaluation and planning to the local health department staff**
- **Achieved participation by the Ministry of Health, the Pando Health Department, and Project Concern in an evaluation process**
- **Was low in cost, and within the personnel and financial resources of the Ministry of Health and Project Concern**
- **Provided a model of evaluation which the Ministry of Health and Project Concern plan to use in the future.**

As a result of the evaluation, the Bolivian Ministry of Health, the Pando Health Department and Project Concern are in the process of implementing the recommendations.



CHART 1

PROBLEM

Rural health services reach about 20% of the population. 80% of the people do not have access to health care. What is the best way to increase the coverage of rural health programs?

ALTERNATIVES	ADVANTAGES	DISADVANTAGES
More Rural Nurse Auxiliaries	<ul style="list-style-type: none"> ● appropriate level of care ● under control of the health dept. ● continuity of care 	<ul style="list-style-type: none"> ● lack of job openings ● need training ● increases administrative and other costs
More doctors	<ul style="list-style-type: none"> ● under control of the health dept. ● continuity of care 	<ul style="list-style-type: none"> ● inappropriate level of care ● no system of supervision ● professional isolation
Train teachers as volunteer health promoters	<ul style="list-style-type: none"> ● receive a salary could volunteer ● live in rural area 7 months of year ● adequate level of care 	<ul style="list-style-type: none"> ● no control by health dept. ● poor continuity of care ● need training ● need supplies ● depends on their good will
Interdisciplinary mobil unit	<ul style="list-style-type: none"> ● under control of health dept. ● work in rural area 	<ul style="list-style-type: none"> ● no continuity of care ● need transport and food ● need training ● no funds available
Health education by radio	<ul style="list-style-type: none"> ● good coverage 	<ul style="list-style-type: none"> ● no direct care ● no trained people ● no funds

