PD-ABN-773

A.I.D. EVALUATION SUMMARY - PART I

1. BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS.
2. USE LETTER QUALITY TYPE, NOT "DOT MATRIX" TYPE.

IDENTIFICATION DATA

A. Reporting A.I.D. Unit:
Mission or AID/W Office BOLIVIA
(ES# _____)

B. Was Evaluation Scheduled In Current FY Annual Evaluation Plan?
Yes [X] Slipped [ ] Ad Hoc [ ]
Evaluation Plan Submission Date: FY ____ Q ____

C. Evaluation Timing
Interim [X] Final [ ]
Ex Post [ ] Other [ ]

D. Activity or Activities Evaluated (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report.)

Project No.	Project /Program Title	First PROAG or Equivalent (FY)	Most Recent PACD (Mo/Yr)	Planned LOP Cost (000)	Amount Obligated to Date (000)
511-0594	Community and Child Health	88	7/94	16,500	11,291

ACTIONS

E. Action Decisions Approved By Mission or AID/W Office Director

Action(s) Required	Name of Office Responsible for Action	Date Action to be Completed
1. Amend the project to add $3.5 million to the Diarrheal Disease/Cholera, Immunization and Chagas' Components and to revise the PP and PROAG descriptions of the Integrated Child Survival Component as recommended.	Mahlon Barash	8/92
2. Develop strategies to focus the implementation of the integrated child survival component on water and sanitation, training and institutional development.	Charles Llewellyn	4/92
3. Redefine organizational structure and supporting technical assistance for CCH Project.	Charles Llewellyn	6/92
4. The GOB will be required to fill vacant items in the Project Health Districts and requested to create new items to absorb Project personnel.	Charles Llewellyn	6/92

(Attach extra sheet if necessary)

APPROVALS

F. Date Of Mission Or AID/W Office Review Of Evaluation: (Month) 2 (Day) 28 (Year) 92

G. Approvals of Evaluation Summary And Action Decisions:

	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
Name (Typed)	Charles E. Llewellyn	Alvaro Muñoz-Reyes	Elizabeth Visnic	Carl H. Leonard
Signature	[signature]	[signature]	[signature]	[signature] for
Date	3/4/92	3/4/92	3/4/92	

ABSTRACT

H. Evaluation Abstract (Do not exceed the space provided)

The project proposes to assist the government of Bolivia's (GOB) Ministry of Health (MOH) to reduce infant, child and maternal mortality through assistance to national immunization and diarrheal disease programs, an integrated child survival component in selected health districts, and a pilot Chagas' disease component. The project is being implemented by the MOH through a project management unit (PMU) assisted by two institutional contractors. This mid-term evaluation (11 - 12/91) was conducted by a TvT Associates team on the basis of review of project documentation, field visits and interviews with project, GOB and USAID officials. The purpose was to measure progress towards achieving project implementation targets and to provide analysis and recommendations for future improvement. The major findings and conclusions are:

* The immunization, diarrheal disease and Chagas' components are functioning well and should be continued with additional funding.

* The complex integrated child survival component lacks definition and focus. Although considerable progress has been made, administrative and managerial problems have reduced its impact. The project should focus the component on three areas- integration of water and sanitation with education, training of MOH personnel, and institutional development. Specific strategies should be developed for institutional development, community participation, health promotion and education, data collection, monitoring and evaluation, and training.

* Technical assistance for the integrated child survival component should focus on developing strategies and plans, instead of implementation.

* Operations research should be conducted on alternative financing options.

The evaluators noted the following "lessons":

* Water and sanitation and child survival must be interdependent for long-range health impact.

* The most important resource in delivering PHC services is the front line health worker.

* Projects which have different objectives, strategies and resource needs often function more efficiently under separate management and financing structures.

COSTS

I. Evaluation Costs

1. Evaluation Team

Name	Affiliation	Contract Number OR TDY Person Days	Contract Cost OR TDY Cost (U.S. $)	Source of Funds
James N. Becht	TvT	Delivery Order 7		Project
Geri Marr Burdman	TvT	IQC PDC-0085-I-	96,000	
Bernard J. Fisken	TvT	00-9087-00		
		72 person days		

2. Mission/Office Professional Staff Person-Days (Estimate) 15

3. Borrower/Grantee Professional Staff Person-Days (Estimate) 30

b

A.I.D. EVALUATION SUMMARY - PART II

SUMMARY

J. Summary of Evaluation Findings, Conclusions and Recommendations (Try not to exceed the three (3) pages provided)
Address the following items:

- Purpose of evaluation and methodology used
- Purpose of activity(ies) evaluated
- Findings and conclusions (relate to questions)
- Principal recommendations
- Lessons learned

Mission or Office:	Date This Summary Prepared:	Title And Date Of Full Evaluation Report:
USAID/Bolivia	January 31, 1992	Midterm Evaluation of the Community and Child Health Project (511-0594) 1/31/92

The purpose of this scheduled mid-term evaluation was to measure progress towards achieving project implementation targets and to provide analysis and recommendations aimed at improving performance during the remaining life of the project. The evaluation was conducted in November-December 1991, during the 14th quarter of this six-year project, by an external three-person team. A participatory approach was used, beginning with a Team Planning Meeting and involving project, technical assistance contractor and Mission personnel. Data collection methods included a review of documents, key informant interviews, field site observations and community focus groups. Debriefings were held with the project management unit, institutional contractor, USAID project committee and HHR, and senior Ministry of Health officials.

The goal of the CCH project is to improve the health status of the urban and rural population. The project purpose is the improve community health by reducing infant, child and maternal mortality through child survival interventions, institutional development and community participation. The initial project design called for concentrated effort in 11 health districts, in three departments, and increasing the capability of the MOH department -and district- level institutions and community organizations to plan, implement and sustain child survival interventions.

The Project Agreement was signed on July 28, 1988, initially committing $16.5 million in A.I.D. funds and $5.5 million in Government of Bolivia (GOB) funds over a five year period to support (1) the National Diarrheal Disease Control Program, (2) the National Immunization Program, and (3) an Integrated Child Survival effort to strengthen the operational capacity of the MOH health districts. Later, a Chagas' Disease Control component and $2.5 million in GOB counterpart funds were added to the project and the project assistance completion date was extended to July 1994. As of November 1991, a total of $9.4 million (57%) of A.I.D. funds had been expended or committed for project activities.

The project is managed by a specifically created project management unit (PMU), whose executive director is contracted by the GOB and is directly responsible to the MOH Director General of Health. John Short & Associates (JSA Healthcare) was contracted by USAID in November 1989 to provide long -and short- term technical assistance, assistance in local procurement including the management of field operational expenses and local contract personnel (with PL-480 funds), and support for participant training activities.

The CCH project seeks to combine three distinct strategies of assistance under one management structure. The DDC/ORT control and immunization components primarily provide commodity support to existing national-level programs and require frequent coordination with other donor agencies as well as MOH national normative divisions. The integrated child survival component provides technical assistance, training, commodity, and operational support to strengthen child survival and water and sanitation interventions and support systems in selected health districts. This component supports the current MOH strategy to decentralize and management and sustainability of primary health care services in rural areas. The Chagas' disease control component is a pilot, experimental effort which seeks to identify appropriate models to break the transmission of this endemic disease and eventually contribute to the formation of a national Chagas' Disease Control Program. These efforts are being

carried out in health districts other than those selected for the integrated child survival activities.

This consolidation of distinct strategies, primarily for A.I.D. focused programming and budgeting convenience, is one of several factors which has complicated project management and has caused confusion in implementation priorities, organizational structure and functions, and the roles of the various implementing agencies. The project design also underestimated the type and number of staff needed for financial management and procurement, as well as the capabilities of the MOH Department of Environmental Sanitation (since disbanded by the MOH) to implement the water and sanitation activities. The institutional contractor (JSA) was given both administrative (line) and technical advisory (staff) responsibilities. Also, the JSA team was not in place until early 1990 (the seventh project quarter) due to delays in contracting and, unfortunately, the Chief of Party subsequently resigned prematurely. Overall leadership and management advisory capabilities were allegedly very deficient. The position remains vacant.

The process of implementation and the availability of financial and material resources were significantly delayed, in part due to inexperience with PL-480 accounting requirements, which has caused frustration and a loss of project credibility within the MOH and health districts. JSA has been absorbed under the management structure of the PMU and overly burdened with administrative tasks at the expense of providing needed technical assistance, particularly at the department and district levels. No advisors have been placed at the regional sanitary units as was originally proposed in the project agreement.

The integrated child survival component is currently assisting four Health Districts, with a fifth District to be included in early 1992 through a sub-contract with Project Concern International. Resources have been concentrated at the District level with very little support provided to the regional sanitary units. A very positive and encouraging development has been the (albeit delayed) introduction of water and sanitation model which utilizes appropriate technologies, facilitates community participation in decision making and management, and appears to be potentially sustainable. To date, three systems have been completed and sixteen are in construction, almost all by contracts with non-governmental organizations (NGOs). The current methodology, however, does not yet integrate the child survival interventions in community organization or health promotion and education, as a unified, coherent effort at the community level.

Baseline surveys and health education needs assessments have been carried out in each of the districts. These studies were done only in the communities in which water and sanitation projects would be implemented and where the greatest impact was felt to be forthcoming. An ambitious and comprehensive health education plan has been developed, based on district-specific needs, but has not yet been implemented. Some district-level and off shore participant training has been undertaken but not within the framework of a global training strategy and plan which includes the strengthening of management functions as well as child survival technologies.

Institutional development and community participation, two of the three thrusts of this project, have not received the attention and focus needed to assure the sustainability of project benefits. To be sure, a number of activities and resources have been applied which can and may contribute to these objectives, but in the absence of focused, coherent and comprehensive strategies and plans these efforts may be diffused and, perhaps, even ill conceived. Project energies to date have focused on the delivery of resources and services, which in some cases, particularly in terms of the regional support structures, may be counterproductive to the development of sustainable systems and models. The degree to which institutionalization should take place within the MOH is an issue on which the MOH Director General of Health and the CCH Executive Director have different opinions. All parties agree, however, that local self-financing mechanisms must be developed to enhance and sustain community and District operations. These are two critical areas for which technical assistance has not been anticipated or forthcoming.

The following recommendations are generic to achieving an overall impact through more effective and efficient implementation and provide a basis for actions in individual areas:

1. The institutional contractor (JSA) should continue to provide technical assistance through the end of its current contract (July 1973) and then be evaluated to determine whether an extension is in order. A capable and functional Chief of Party should be hired without delay.
2. The principal agency participants --PMU, MOH, JSA and USAID-- should initiate a concerted process of organizational development and strategic planning as soon as possible. The process should be on-going and directed by a seasoned outside facilitator.
3. The project management structure should reflect and support the operational differences between administrative and technical functions, the managerial independence between the integrated child survival and Chagas' components, and the institutional autonomy of the CCH/PMU, the MOH Health Districts, and JSA.
4. The project needs to develop coherent and unified strategies and feasible but focused implementation plans for institutional development, community participation, health promotion and education, data collection, monitoring and evaluation, and training.
5. The Government of Bolivia must fill currently vacant positions and create new positions for critical staff in all project Districts as stipulated in the Project Agreement.
6. The integrated child survival component should focus its efforts on a strategy of integrating water & sanitation, health promotion & education, and improved management support systems. A "full service" strategy should be developed for those select communities with water and sanitation systems, and a second broader strategy would improve health promotion/education and management support systems for the remaining communities in the Health district.
7. JSA should provide technical assistance to design and conduct operations research to identify and test alternative local financing mechanisms, appropriate staffing patterns, and cost analysis.
8. The project should strengthen its financial liquidation system with the PL-480 Secretariat by: accepting the Secretariat's offer to provide training; engaging the USAID/ARD office as an honest broker; adding key PL-480 issues to the District field manual; and developing PILs to resolve impediments.

Lessons learned or confirmed in this evaluation include:

* Water and sanitation and child survival must be seen as completely interdependent if any long-range impact on health at the community level is to be sustained.
* The most important and indispensable resource in delivering PHC services is the front-line health worker, sufficient in numbers and appropriately trained.
* Resources and technical assistance requirements for health promotion and education often underestimated and inadequate to ensure sustainable benefits.
* A data collection, monitoring and evaluation plan should be developed very early in project life so as to guide priority interventions and assure regular analysis and use.
* Technical assistance needs at the district and area levels are very basic. Advances take place one step at a time, requiring continuous and flexible technical assistance.
* Projects which have different objectives, strategies and resource needs often function more efficiently under separate management and financing structures.
* Projects which involve several autonomous implementing agencies require high levels of communication, coordination and negotiation.
* Organizational development and team building are essential at the inception as well as at all critical phases of a project in order to clearly define roles, expectations and operational plans of action.

ATTACHMENTS

K. Attachments (List attachments submitted with this Evaluation Summary; always attach copy of full evaluation report, even if one was submitted earlier; attach studies, surveys, etc., from "on-going" evaluation, if relevant to the evaluation report.)

Midterm Evaluation of the Community and Child Health Project (511-0594)
January 31, 1992.

COMMENTS

L. Comments By Mission, AID/W Office and Borrower/Grantee On Full Report

The Mission compliments the team on a thorough, concise evaluation of a very complex project. The recommendations are practical and insightful.

The Mission is in general agreement with the findings of the Evaluation. The project is operating well, especially the Diarrhea, Immunization and Chagas' Disease Components. The more complicated Integrated Child Survival Component has been successful for the most part, but could be improved with stronger attention to the management issues described in the Evaluation, and has suffered from a lack of focus and overall vision.

The JSA Healthcare contract may be continued, provided that JSA Healthcare can provide a strong Chief of Party as Management Advisor. Should they be unable to fill this position, HHR, in consultation with the RCO, will review possible alternative contracting options including revision and/or termination of the JSA institutional contract.

The project will be amended in August 1992, based on the results of this Evaluation, providing $3.5 million additional resources for the Immunization, Diarrheal Disease and Chagas' Disease components. Internal Strategy planning sessions will be held to recommend modifications to the Integrated Child Survival Component of the Project Paper and Agreement. Recommended changes may include reducing the number of districts from 11 to 6, and concentrating on the three synergistic areas of water and sanitation, training, and institutional development. The PACD will be extended until July 28, 1995.

XD-ABD-773-A
ISN 15797

FINAL REPORT

MIDTERM EVALUATION OF THE COMMUNITY AND CHILD HEALTH PROJECT (511-0594)

Delivery Order No. 7

under

IQC PDC-0085-I-00-9087-00

Prepared for:

U.S. Agency for International Development

La Paz, Bolivia

Prepared by:

James N. Becht
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January 31, 1992

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ACKNOWLEDGMENTS

The evaluation team gratefully acknowledges the support and cooperation of all the CCH Project and JSA Healthcare staff in making this an informative, productive and positive experience. In particular, we recognize and appreciate the health district personnel who willingly gave of their time and insights.

The team's work was greatly facilitated by the efficient planning and backstopping of USAID/Bolivia Office of Health and Human Resources and TvT Associates central staff.

Finally, special thanks are due to Silvia Eguino, Consuelo Mercado, Milenka Orlandini, and Gloria Eguino for their very efficient clerical and logistic support, always provided in a cheerful and attentive manner.

ABBREVIATIONS AND ACRONYMS

A.I.D.	U.S. Agency for International Development
ARD	Office of Agriculture & Rural Development (USAID)
CCH	Community and Child Health Project
CDC	U.S. Centers for Disease Control
CHW	Community health worker
CIEC	Centro Interdisciplinario de Estudios Comunitarios
COP	Chief of Party
CS	Child survival
DDC	Diarrheal disease control
DSA	Departamento de Saneamiento Ambiental (MOH Department of Environmental Sanitation)
EPI	Expanded Programme on Immunization
GOB	Government of Bolivia
HHR	Office of Health and Human Resources (USAID/Bolivia)
IBRD	International Bank for Reconstruction and Development - World Bank
ICC	Interagency Coordinating Committee
IDB	Inter-American Development Bank
INEDER	Instituto de Educación para el Desarrollo Rural
JSA	JSA Healthcare/John Short & Associates, Inc.
MOH	Ministry of Health
MSCI	Medical Services Corporation International
NGO	Non-governmental organization
ODSPA	Organizational development/strategic planning approach
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PACD	Project Assistance Completion Date
PAHO	Pan American Health Organization
PCI	Project Concern International
PHC	Primary health care
PIL	Project Implementation Letter
PIO/C	Project Implementation Order/Commodities
PIO/P	Project Implementation Order/Participant Training
PIO/T	Project Implementation Order/Technical Assistance
PL-480	Public Law 480; also, the Bolivian agency charged with managing proceeds from the sale of PL-480 commodities
PMU	Project Management Unit
PP	Project Paper
PRITECH	Technologies for Primary Health Care Project
PROAG	Project Agreement
PROCOSI	Programa de Coordinación en Supervivencia Infantil (NGO child survival network organization)

PSC	Personal Services Contract
PVO	Private voluntary organization
SANEBOL	Empresa de Saneamiento Básico
SU	Sanitary Unit (MOH Unidad Sanitaria or Regional Health Office)
TAACS	Technical Advisor in AIDS and Child Survival
UNICEF	United Nations Children's Fund
VBCP	Vector Biology Control Project (MSCI)

CONTENTS

		Page
Acknowledgments		i
Abbreviations and Acronyms		ii
Contents		iv
Executive Summary		vi
I.	Evaluation Objectives and Methodology	1
II.	Findings: Project Interventions	2
	Component Strategies	2
	Health Promotion and Education	3
	Institutional Development	4
	Training and Human Resources Development	8
	Community Participation	8
III.	Findings: Project Management and Support	9
	Availability of Financial Inputs	9
	Management Structure and Capacity	10
	Administration, Procurement and Logistics	11
	Evaluation Indicators and Data Systems	15
	Technical Assistance	17
IV.	Conclusions	21
	Project Components and Community Participation	21
	Institutional Development	22
	Project Inputs	23
	Project Management and Coordination	23
	Project Evaluation and Monitoring	27
	Technical Assistance	28
V.	Recommendations	30
	Intervention Strategies	30
	Institutional Development	31
	Project Budget and Duration	32
	Project Management and Coordination	32
	Project Monitoring and Evaluation	34
	Technical Assistance	35

VI. Lessons Learned 36

ANNEXES

A Evaluation Team Members and Statement of Work A-1
B Evaluation Schedule and Institutions and Persons Contacted B-1
C Reference Materials C-1
D Logical Framework: Child and Community Health Project D-1
E Country Map: Location of Project Districts E-1
F Comparison of Indicators of Impact and Effectiveness F-1
G Schedule for Liquidating PL-480 Funds: Non-Chagas Account G-1
H JSA Accomplishments (prepared by JSA Healthcare) H-1
I List of Funding Sources of CCH Project Personnel I-1
J List of Project Implementation Letters J-1
K Revised Project Budget (PIL-13) K-1
L Current Project Organization Charts L-1
M Financial Status Report (6 November 1991) M-1

EXECUTIVE SUMMARY

PROJECT BACKGROUND

The Community and Child Health (CCH) Project (511-0594) is USAID/ Bolivia's first bilateral assistance project with the Ministry of Health (MOH) since 1980. Political imperatives and social turmoil caused A.I.D., in the interim, to turn to supporting non-governmental organizations (NGOs) for improvements in health conditions. The return of democratic rule and stability in the public sector in the mid-1980s created the circumstances favorable to developing and negotiating the CCH Project. This project builds on the MOH/A.I.D. ground-breaking experiences in the development of a decentralized rural health system from 1975 to 1980 as well as the advances of NGO and multilateral child survival activities with the government in the following decade.

The project agreement was signed in July 1988, initially committing $16.5 million of A.I.D. funds and $5.5 million of Government of Bolivia (GOB) funds over a five-year period to support: (1) the National Diarrheal Disease Control (DDC) Program, (2) the National Immunization Program, and (3) an Integrated Child Survival effort to strengthen the operational capacity of the MOH health districts. Subsequently, a Chagas' Disease Control component and $2.5 million in GOB counterpart funds were added to the Project and the project assistance completion date (PACD) was extended to July 1994. As of November 1991, a total of $9.4 million (57 percent) of A.I.D. funds had been expended or committed for project activities.

The goal of the CCH Project is to improve the health status of the urban and rural populations. The Project's purpose is to improve community health by reducing infant, child and maternal mortality. These are to be achieved through child survival interventions, institutional development and community participation. The initial project design called for concentrating efforts in eleven health districts and increasing the capability of the MOH department- and district-level institutions and community organizations to plan, implement and sustain child survival interventions. The goal, purpose and design statements did not substantially change with the addition of the Chagas component.

The Project is managed by a specially created project management unit (PMU) whose executive director is contracted by the GOB and is directly responsible to the MOH Director General of Health. John Short & Associates, Inc. (JSA Healthcare) was contracted by USAID in November 1989 to provide long- and short-term technical assistance, assistance in local procurement, including the management of field operational expenses (PL-480 funds), and training services to the Project. Oversight of project activities is provided, albeit irregularly, by a Project Executive Council, which is comprised of MOH and USAID officials and the Project's executive director.

The CCH Project seeks to combine three distinct strategies of assistance under one management structure. The DDC/ORT control and immunization components primarily provide commodity support to existing national-level programs and require frequent coordination with other donor agencies as well as MOH national normative divisions. The integrated child survival (ICS) component provides technical assistance, training, commodity and operational support to strengthen integrated child survival, water and sanitation interventions, and support systems in selected health districts. This component supports the MOH strategy to decentralize the management and sustainability of primary health care services. The Chagas control component is a pilot, experimental effort which seeks to identify appropriate models/strategies to break the transmission of this endemic disease and eventually contribute to the formation of a national Chagas' Disease Control Program. These efforts are currently being carried out in health districts other than those of the ICS activities.

EVALUATION OBJECTIVE AND METHODOLOGY

The statement of work for this evaluation specifies the objective: ". . . to measure progress towards achieving project implementation targets including provision of financial, technical and material inputs; institutional development objectives at the District and Department levels; and quality and quantity of child survival and water and sanitation services delivered in each district, as measured against baseline data collected at the outset of each district program."

A team of three external specialists was sent to Bolivia by TvT Associates to perform the work. The USAID/Bolivia Office of Health and Human Resources organized and facilitated a team planning meeting which was conducted during the team's first week in La Paz. The team spent a total of four weeks collecting and analyzing data and preparing a final report. Data collection methods included a review of documents, key informant interviews, field site observations, and community focus groups. Separate debriefings were provided for USAID, the project management unit and the institutional contractor (JSA), and senior Ministry of Health officials.

At least two team members visited each of the four project districts and the corresponding regional sanitary units, to conduct interviews, make observations and collect additional data on the status of project implementation. One evaluator also visited the Chagas project in Chuquisaca. Project and JSA staff, as well as the USAID evaluation officer, accompanied the evaluators on these trips in order to enhance participation and immediate feedback in the process.

FINDINGS AND CONCLUSIONS

This consolidation of distinct strategies, primarily for A.I.D. programming and budgeting purposes, is one of several factors which has complicated project management and caused confusion in implementation priorities, organizational structure and functions, and the roles of the various implementing agencies. It has also contributed to inefficient management. The project design also underestimated the type and number of staff needed for financial management and procurement, as well as the capabilities of the MOH Department of Environmental Sanitation (DSA) to implement the water and sanitation activities. The institutional contractor (JSA) was given both administrative (line) and advisory (staff) responsibilities. Also, the JSA team was not in place until early 1990 (the seventh project quarter) and, unfortunately, the Chief of Party (COP) subsequently resigned prematurely. Overall leadership and management advisory capabilities were allegedly very deficient.

The process of adaptation (paper to practice) and implementation and the availability of financial and material resources were significantly delayed (computers and motorcycles, for example, were delivered only recently to the districts, with only 43 percent of the LOP remaining, and four-wheel drive vehicles have not yet arrived). This caused frustration and a loss of project credibility within the MOH and health districts. The GOB has failed to make progress on filling vacant positions and absorbing new personnel at the district level. JSA has become absorbed under the management structure of the PMU and overburdened with administrative management tasks at the expense of providing needed technical assistance, particularly at the department and district levels. This has compromised JSA's ability as an independent provider of analysis, advice and complementary support as well as USAID's ability to hold JSA accountable to its contractual obligations. The organizational structure of the project confuses functions and lines of authority, does not respect institutional autonomy and, thus, limits accountability.

Inconsistencies have developed between the project design (project paper, MOH project agreement, JSA contract), the realities of implementation (administrative demands, questions of strategy, etc.), and the ability of the implementing agencies to carry out their anticipated responsibilities (MOH, JSA and USAID). In some notable cases (increased CCH and JSA staffing to handle financial and procurement administration, and the shift to NGOs to implement water and sanitation projects), these inconsistencies have been resolved. In others, however, particularly those concerning roles, functions and obligations of the participating agencies, none of the interested parties has taken adequate initiative and follow-through to effect timely, negotiated and lasting adjustments.

A significant portion of A.I.D.'s financial resources allocated to the national DDC/ORT and immunization components have been committed or are being programmed. This will alleviate the pressures on project staff who can now devote

more focused attention on the ICS activities. The Chagas component has begun field implementation in two areas, including a very promising integrated and community-based model through the "Cardinal Mauer" Bolivian British Project, an NGO in Chuquisaca. This component has just gotten underway in 1991 and essentially operates independently of the ICS strategy.

The Integrated Child Survival component is currently assisting four health districts directly, with a fifth district to be included in early 1992 through a subcontract with Project Concern International (PCI). Resources have been concentrated at the district level with very little support provided to the regional sanitary units. A very positive and encouraging development (albeit delayed) has been the introduction of water and sanitation model which utilizes appropriate technologies, facilitates community participation in decision making and management, and appears, at least on the water side, to be potentially sustainable. To date, three systems have been completed and sixteen are in construction, almost all by NGOs. The current methodology, however, does not yet integrate the child survival interventions, in community organizations or health promotion and education, as a unified, coherent effort at the community level.

Baseline surveys and health education needs assessments have been carried out in each of the districts. These studies were carried out only in the communities in which water and sanitation projects would potentially be implemented and where the greatest impact was felt to be forthcoming. An ambitious and comprehensive health education plan has been developed, based on district-specific needs, but has not yet been implemented. Some district-level and off-shore participant training has been undertaken but not within the framework of a comprehensive training strategy and plan which includes the strengthening of management functions as well as child survival technologies.

Institutional development and community participation, two of the three thrusts of this project, have not received the attention and focus needed to assure the sustainability of project benefits. To be sure, a number of activities and resources has been applied which can and may contribute to these objectives, but in the absence of focused, coherent and comprehensive strategies and plans, these efforts may be diffused and, perhaps, ill-conceived. Project energies to date have focused on the delivery of resources and services, which in some cases, particularly in terms of regional support structures, may be counterproductive to the development of sustainable systems and models. The degree to which institutionalization should take place within the MOH is an issue on which the MOH Director General of Health and the CCH Executive Director have different opinions. Both parties agree, however, that local self-financing mechanisms must be developed to enhance and sustain community and district operations. These are two critical areas for which technical assistance has not been anticipated or forthcoming.

RECOMMENDATIONS

The findings and conclusions of this midterm evaluation lead to a number of specific recommendations, which are presented in Chapter V. The following recommendations are generic to achieving an overall impact through more effective and efficient implementation and provide a foundation for actions in individual areas.

1. **The institutional contractor (JSA) should continue to provide technical assistance; also, a capable and functional Chief of Party should be hired without delay.** Increased and focused technical assistance is needed and the alternatives to a JSA contract present more disadvantages than advantages. The next COP should provide vision and be a skilled manager, negotiator and analyst. A strong independent contractor is needed to balance and complement interagency forces. The key to success will be coordination, mutual respect and sound management.

2. **The principal agency participants--CCH, MOH, JSA and A.I.D.--should initiate a concerted process of organizational development and strategic planning as soon as possible.** A number of critical issues exist which can only be resolved through joint, open review and redefinition. The process should be on-going and directed by an experienced outside facilitator. It should begin shortly after the new COP is in place. This process could be viewed as post-evaluation follow-up and action planning. The products would include a coherent "mission" statement, agreement on current priorities and agency roles, and the redefinition of an efficient organizational structure to manage project implementation.

3. **The project's management structure should reflect and support the operational differences between administrative and technical functions, the managerial independence between the ICS and Chagas components, and the institutional autonomy of the CCH/PMU, the MOH health districts and JSA.**

4. **The Project needs to develop coherent and unified strategies and feasible but focused implementation plans for institutional development, community participation, health promotion and education, data collection, monitoring and evaluation, and training.** Needs assessments should be undertaken for institutional development, community participation and training. Institutional development should focus on strengthening management functions; community participation should include management decision making; health promotion and education should include nonformal educational methods and techniques; data collection, monitoring and evaluation should include provision for immediate feedback and local analysis; and, training should focus on improving staff performance and be competency based.

5. **The Government of Bolivia must fill currently vacant positions and create new positions for critical staff in all project districts in CY1992 as stipulated in the project agreement.** Adequate human resources are essential to achieving project

goals. PL-480 funds might be used to reimburse the cost of new GOB positions on an annually decreasing scale, thereby assuring the gradual absorption of operational costs by the GOB.

6. **The Integrated Child Survival component should focus its efforts on a strategy of integrated water and sanitation, health promotion and education, and management support systems.** The overall needs and organizational capacity of the community should be the primary criteria in designing implementation methods. The major demonstration effort should focus on those communities targeted for water and sanitation projects. A second strategy should be developed to provide health promotion and education and management improvement on a broad scale. District support systems should focus on local programming, local financing, financial management, logistics, supervision, information, and maintenance.

7. **JSA should provide technical assistance to design and conduct operations research to identify and test alternative local financing mechanisms, appropriate staffing patterns, and cost analysis.** The results of these studies may prove invaluable in sustaining and replicating project models. The Project must begin to demonstrate innovative and positive results in order to influence change in the MOH and other districts.

8. **The Project should strengthen its financial liquidation system with the PL-480 Secretariat by: accepting the Secretariat's offer to provide training; engaging the USAID/ARD office as an honest broker; adding key PL-480 issues to the district field manual; and, where appropriate, developing FILs to resolve impediments.**

Clearly, the status quo in project organization and management and issues of strategy cannot continue if the Project is to make significant and lasting progress in the remaining two and a half years. The CCH Project stands at a crossroads, with a number of critical issues to resolve. Nevertheless, the potential is at hand to improve the effectiveness of implementation and cause significant and sustainable change at both the community and district levels.

I. EVALUATION OBJECTIVES AND METHODOLOGY

The objective of this evaluation is "to measure progress towards achieving project implementation targets. . ." (Statement of Work, p. 3) with particular emphasis on the Integrated Child Survival component. As a midterm process evaluation, it provides analysis and recommendations aimed at improving performance during the remaining life of the project. The evaluation focuses on "the effectiveness of the implementation strategy, how effectively the CCH office and contractors are managing the implementation strategy, and the viability of the impact indicators and data collection systems."

TvT Associates was contracted by USAID/Bolivia to conduct this midterm evaluation. A team of three external specialists was sent to Bolivia to perform the work. (A listing of the team members, their areas of concentration, and the evaluation scope of work is provided in **Annex A.**) It should be noted that neither a sanitary (civil) engineer nor a Chagas' disease specialist (epidemiologist) was required by the scope of work. The technical aspects of these interventions, therefore, will not be addressed.

The USAID/Bolivia Office of Health and Human Resources organized and facilitated a team planning meeting which was conducted during the team's first week in La Paz. The team spent a total of four weeks collecting and analyzing data and preparing a draft report which was left with the A.I.D. Mission. Separate debriefings were provided for USAID, the project management unit and the institutional contractor (JSA), and senior Ministry of Health officials.

At least two team members visited each of the four project districts and the corresponding regional sanitary units to conduct interviews, make observations and collect additional data on the status of project implementation. One evaluator also visited the Chagas project in Chuquisaca. Project and JSA staff, as well as the USAID evaluation officer, accompanied the evaluators on these trips in order to enhance participation and immediate feedback in the process. **Annex B** contains a schedule of these visits and a list of persons contacted. **Annex C** provides a list of documents and materials reviewed by the evaluators. The project logical framework (**Annex D**) was used as a basis for the evaluation. A country map with the location of project districts is provided in **Annex E.**

A project of this magnitude and complexity, particularly with the involvement of a number of implementing agencies, requires a great deal of communication, coordination and joint decision making to be successful. For this reason, a follow-up workshop, where the participating organizations from all levels can review and take action on the evaluation findings and recommendations, would be highly desirable.

II. FINDINGS: PROJECT INTERVENTIONS

COMPONENT STRATEGIES

The components of the Project are: (1) National Diarrheal Disease Control Program Commodity Support, (2) National Immunization Program Support for the Expanded Program of Immunization (EPI), (3) District Integrated Health/Child Survival Program, and (4) Chagas' Disease Control.

Three distinct strategies requiring different management and administrative capabilities that are used follow:

- Commodity support for nationally established programs for child survival (ORT, EPI);
- Operational, training, technical assistance, and commodities support for the national strategy of integrated services (integrated district-level support); and,
- Demonstration (pilot) effort designed to focus on Chagas' disease control (to identify appropriate interventions and to contribute to the development of a national strategy).

While there is overlap among the components of the Project, each has distinct parameters. Placing the four components, with three distinct strategies, under one management unit has created a substantial administrative challenge.

In view of the complexity of the project, it was noted early on that the collection and use of performance data would be crucial to ensuring effective management and implementation of the components. However, there was no systematic plan for analysis of performance developed at the outset of the project.

Reports indicate that the distribution of oral rehydration salts (ORS) is seriously constrained. Although the supply of ORS is apparently adequate, distribution from the national to the regional, district and area levels is not systematic nor dependable. Because of periodic shortages, personnel at some district and area levels assume that there is overall scarcity of supply.

The EPI program support has largely consisted of purchasing vaccines and syringes, with some funding provided for physician training in epidemiology as well as for community immunization educational campaigns.

The integrated health component has operated in four districts to date. The overall focus has been on planning, administration, health and nutrition education, and improving the overall infrastructure.

The water and sanitation subcomponent has undergone major changes and is presently a focal point for CCH activity. The program focus now includes social promotion and training in direct collaboration with community water and sanitation management committees. Water systems have been completed in three communities to date and thirteen additional systems are under construction. The total number of water systems to be constructed during the life of the project has been reduced to 120 from the 160 initially proposed. There is increasing awareness of the need for integrating health and child survival activities with the achievements of water and sanitation.

The advantage of this integrated approach is that child survival activities can augment the water program, giving the communities a twofold benefit. The water and sanitation project provides tangible results in breaking the transmission of diarrheal diseases. A community that gains organization and management experience through its water and sanitation committee can embark on health promotion. The water committee, which assumes a decision-making role in the operation and maintenance of the community water system, can take on the responsibility not only for health promotion and educational activities related to water and sanitation but also for the basics related to child survival, particularly ORT and the promotion of breast feeding and other health-related areas.

HEALTH PROMOTION AND EDUCATION

Until recently, health promotion and education has been limited to specific community activities and has not responded to a planned global strategy. Most community health education activities have included small group talks, one-on-one education in the homes and health posts and some radio spots with specific child survival messages. In the case of the Chagas program in Chuquisaca, a health education strategy has been developed and implemented by the local NGO sub-contractor that includes clearly defined motivational and participatory methods to effect behavioral change.

Project and JSA personnel are credited for recognizing that the educational activities to date were isolated interventions and did not correspond to a global strategy. For this reason, a needs assessment or diagnosis was made in the four project districts and the resulting recommendations have led to the development of a comprehensive proposal by the subcontractor CIENTIFICA.

An essential part of the proposed strategy is the design and development of a series of modules, as well as the planning and implementation of:

- a registry of educational materials,
- an inventory of human resources and institutions,
- preparation and development of educational materials,
- training of trainers (departments and districts),
- health personnel training (at all levels),
- assistance and supervision,
- correspondence training courses,
- design and use of mass media, and
- monitoring and evaluation.

The proposed global strategy by CIENTIFICA is very thorough and technically sound. It includes the use of nonformal, adult education methods and techniques, immediate feedback and local analysis of information and materials.

While health education has not been a central focus of the Project to date, clearly it is evident that careful thought and planning have occurred in recent months. The proposed plans are ambitious and far reaching; however, there continues to be a need to develop a strong conceptual framework and focus before implementation.

INSTITUTIONAL DEVELOPMENT

The Ministry of Health (MOH) is both implementor and recipient of project services or benefits. On the one hand, "the MOH Sanitary Units in each Department will have overall responsibility for planning and supporting the program to be implemented by each District" (Project Paper, p. 10), and "the basic management responsibility for Project implementation rests with the individual Districts. . ." (PP, Attachment 1, p. 11). In addition, the CCH Project aims to "strengthen the Sanitary Units' capacity to provide . . . technical, management and financial support" to the Districts (PP, p. 8). At the same time, however, the proposal assumes that the "MOH, particularly at the regional levels, [already] has sufficient institutional/ administrative capability to implement the Project. . ." (Logical Framework, Assumption 3 of Purpose).

These statements, overlapping and somewhat contradictory, have contributed to confusion and difficulty in determining precise operational relationships, responsibilities and accountability between the project management unit (PMU), the Ministry central divisions, the sanitary units, and the health districts. In a number of instances, the use of "MOH" in Project documents is indiscriminate and may refer to any or all of these levels. In the absence of precision and agreement, project strategies for implementation and institutional development have been left to the discretion of the individual players to the extent to which they control project and counterpart resources.

These are critical issues because the Ministry, with the support of the CCH and other donor projects, is embarking on a major strategy which emphasizes the "strengthening of health services; active, organized and conscientious community participation; regionalization of health services; [and] inter- and intra-sectoral coordination." (PP, p. 6) The fundamental and indisputable element of this strategy is the decentralization of management responsibilities to and the strengthening of the health districts.

The Ministry of Health is currently undergoing a restructuring of functions and responsibilities at the regional level to support regionalization and decentralization. The effectiveness of these efforts, which relate directly to the CCH Project, will depend in large part on reaching agreement on operational relationships, roles and definitions among the various donor agencies and implementing divisions. This is particularly critical regarding efforts at institutional development within the Ministry of Health and the provision of technical assistance by the donor agencies.

Institutional development is one of the three primary objectives of the CCH Project. However, the Project has yet to develop a specific strategy for achieving this objective. Such a strategy would include the definition of "end of project status" (EOPS) indicators, target institutions and specific constraints to be overcome, the role of non-governmental organizations (NGOs), and a coordinated set of activities or interventions, at a minimum. Now, in its third year, the Project has none of these to guide and coordinate MOH, donor and technical assistance actions.

Institutional development is a concern primarily within Component III, District Integrated Child Survival. Component I, National Immunization Program Support, mentions the use of a logistics and cold chain system and the development of the supervision and surveillance systems as expected impacts (PP, p. 11), but more than two-thirds of the proposed component budget is for commodities. The entire budget of Component II, National Diarrheal Disease Control, is for commodities. In fact, the project paper states that "the project will not identify nor claim any intermediate service delivery or institution building outputs associated with this component." (PP, p. 12) There is no mention of institutional development in the amendment which establishes Component IV, Chagas' Disease Control.

Institutional or organizational development is a complex and time-consuming undertaking. It involves changing the ways organizations operate internally, and often the way they interact with other organizations. It is much more than the provision of needed commodities, supplemental personnel, and other inputs. It requires agreement on institutional objectives and strategies as well as management structure and processes. It also necessitates addressing the social as well as technical and administrative constraints which may exist in the organization.

Within the Ministry of Health, a number of institutional constraints exists which directly affect the degree to which CCH project interventions are effectively implemented and, equally important, project benefits can be sustained. It is unlikely that these constraints and their interrelationships can be adequately identified and overcome in the absence of a cohesive and targeted strategy and plan of action which focus on the objective of institutional development. Also, it is critically important that the Ministry have a unified and recognized strategy and plan of action for institutional development which apply equally within the MOH and for the initiatives of the various international donors.

At the present time, no such strategy nor plan of action has been developed by or for the CCH Project to address the objective of institutional development in a comprehensive, focused and integrated manner. The Project has not undertaken a diagnosis of institutional constraints, their underlying causes and effects on project objectives, particularly at the regional level, which exercises indispensable support functions, and also relating to health financing at the district and local levels.

In fact, the CCH Project has consciously by-passed the sanitary units (SU) in its development and support of the health districts. Other than initial orientation workshops, there has been no systematic process of joint analysis and planning involving PMU, the technical assistance contractor, and regional and district officials in any of the health regions. At best, an SU staff person has been designated as "regional coordinator" to serve as a focal point for CCH activities in each regional office. These appointments were to compensate, in part, for the lack of technical assistance advisory teams which were called for in the project paper and project agreement but which have not been provided. Among the reasons given for circumventing the SUs are frequent management turnover, lack of interest without personal compensation (the World Bank and IDB have established a practice of topping off salaries in order to secure active involvement in their projects), and negative interpersonal relationships between Project and SU staff. Rather than deter involvement, these constraints should be reason enough to pursue joint analysis, planning and resolution of the problems.

The CCH Project has contracted with three local non-governmental organizations (NGOs) to implement the water and sanitation activities in the health districts. This was done after the Project determined that the MOH Division of Environmental Sanitation was not capable of providing these services. The Project has also recently contracted an international private voluntary organization (PVO), Project Concern International (PCI), to carry out training and other developmental activities in a fifth health district. The use of NGOs/PVOs to augment the capacity of the MOH and extend primary health care coverage in Bolivia is appropriate and has been encouraged by the MOH and USAID. Nevertheless, it is not apparent how the use of NGOs is being incorporated systematically and formally into an extended

"institutional capacity" of the sanitary units, for example, the development of policies and guidelines.

The issue of institutional development is directly related to three other issues which are discussed in more detail elsewhere in the report. The first is the type and placement of technical assistance. JSA Healthcare, the institutional contractor, has not provided consultants who specialize in organizational development; there are no advisors at the regional level and, in only one case, are what can be considered advisory/developmental functions being provided by a full-time district worker. Second, training has been conducted in technical areas and for specific tasks, such as filling out data forms; there is, however, no comprehensive training plan which incorporates the needs of institutional development and, particularly, management functions. Third, no indicators and benchmarks have been established to monitor progress and measure the effectiveness of the Project's efforts towards institutional development.

The project paper, specifically the Institutional Analysis (pp. 45-48), presents a generally accepted litany of MOH institutional and management deficiencies: lack of coordination among units; redundancy of tasks; little analysis of data and no feedback; underutilized and ill-equipped facilities; understaffing and shifting of positions (items); underpaid and poorly trained personnel; lack of motivation, supervision and continuity; etc. The Project has not undertaken an assessment of institutional needs and priorities specific to the regions and districts in which it is working. Nor have specific plans of action been defined for institutional development and management improvement based on priority needs at the operational level. Initially, MOH sanitary unit directors submitted, on request, "wish" lists for their share of project resources. These were rejected by the PMU as inappropriate but no joint analysis and planning with the SUs has followed.

The Project Paper proposes four areas of "institutional outputs" at the district level (PP, pp. 15-17). These deal with human resources (staff training, CHW training, and the filling of staff positions) and the development of administrative subsystems (local programming, HIS, supervision, training, and patient referral). To date, some progress has been made in training, annual planning (logical frameworks for each district), and data collection. Significantly, the MOH has yet to fill vacant positions, return to the project districts those positions which were "loaned" to other sites, or create additional positions to absorb personnel hired by the Project on a temporary basis.

A number of "service support outputs" was proposed for the sanitary units (PP, p. 17). Of these, SU personnel has provided some training to district staff and CHWs, the regional coordinators have made supervisory visits to the project districts, and the SUs have been involved in supplying vaccines, ORS packets and some additional commodities. These activities, however, do not represent anything new or

improved in terms of management systems or functions. Of particular importance, neither the SUs nor the technical assistance contractor has designed or undertaken any management assessments or operations research as proposed.

TRAINING AND HUMAN RESOURCES DEVELOPMENT

Specific training and human resource development activities have included one-on-one training as well as courses on administration for district directors and participatory teaching methods, and courses for auxiliary nurses and others at the community level. To date, however, these activities do not respond to a global strategy for training and human resource development nor have specific teaching/learning objectives, content, methodology, and resources been defined.

Two MOH employees (of a proposed 20) have received extended training outside of the country. Additional personnel have been trained in country by the Project in epidemiology and the use of the EPI information survey research software. A proposal is currently being reviewed by which master's level training would be developed and supported through the Nur University in Santa Cruz.

COMMUNITY PARTICIPATION

While community participation is recognized as a vital component of the project, the most concerted effort has been in the water and sanitation areas where the beneficiaries have been directly involved in decision making. Also, the Carrasco Valle Health District has worked closely with the men's and women's agrarian syndicates, has organized at least four well-structured health committees, and additional committees are in formation. The other districts are also in the process of forming community health committees.

As with institutional development and training, no explicit strategy and action plan have been developed to define and guide the community participation efforts.

III. FINDINGS: PROJECT MANAGEMENT AND SUPPORT

AVAILABILITY OF FINANCIAL INPUTS

The most recently revised overall project budget (see **Annex K**) is contained in PIL No. 13. The total project budget of $24.5 million (U.S.) is funded from four sources: an A.I.D. Direct Account; an A.I.D. Special Account; and, two PL-480 Secretariat Accounts. The A.I.D. Direct Account represents payments over which the USAID/Bolivia Mission exercises control, such as contracts for the purchase of certain goods and services. The JSA contract and the CDC contract are examples of service contracts handled through the A.I.D. Direct Account. The A.I.D. Special Account represents payments over which the CCH project management unit (PMU) exercises control. One PL-480 account is dedicated for Chagas activity (Component IV); the other PL-480 account is for immunization and integrated child survival activities (Components II and III).

The total project budget amount of $24.5 million (U.S.) is financed as follows: $16.5 million A.I.D. contribution (both the Direct and Special Accounts); and, $8 million PL-480 contribution (both accounts).

A.I.D. and PL-480 each pay for particular project costs. A.I.D. finances all of Component I, while the remaining three project components are jointly financed by A.I.D. and PL-480, according to specific line item allocations. However, the financing mix of the Project can become somewhat complex. In an attempt to clarify which organization pays for which project personnel, we have attached **Annex I**. This annex indicates personnel that are paid out of the A.I.D. Special Account (Fondos CCH - USAID); the A.I.D. Direct Account (Fondos JSA); the Chagas PL-480 Account; and, the non-Chagas PL-480 Account. One clarification is needed to this annex. District directors appear on this table because they receive a travel allowance from the Project, although their salaries are paid by the Government of Bolivia (GOB). It is important to note that, in general, field personnel and field operating costs are being financed by PL-480 funds. Thus, delays in receiving funds from the PL-480 Secretariat would have a great impact on field operations and morale.

In order to determine the availability of A.I.D. funds, A.I.D.'s Project Financial Status Report of November 6, 1991 (see **Annex M**) was reviewed. In addition, selected project-related staff members were asked their opinions on the availability of A.I.D. funds for each of the Project's four components. The general consensus seemed to be as follows:

- Although there are funds not yet spent in each component, a large percentage of these funds has already been committed or is in the process of being programmed. This is particularly true for Components II and IV. The percentage of budgeted funds not yet

committed for Component II is 12 percent and for Component IV, less than 1 percent.

A.I.D. apparently has a long-term commitment to Components I, II, and IV and would probably put additional funds into these areas, whether through this project or a future project.

A.I.D. may wish to keep the level of funding for Component III unchanged, but may wish to redefine the focus of this component. Redefinition might include focusing on a lesser number of districts than originally intended (that is, 6 rather than 11). Redefinition might also encompass greater emphasis on water and sanitation.

A.I.D. may wish to redefine the focus of Component I which presently emphasizes ORS procurement. Persons interviewed indicated that some of these monies might be reallocated to education and/or distribution. It was suggested, however, that any reallocation of these funds should be based on a written plan that treats relationships to other components, for example, the training activities of Component III.

MANAGEMENT STRUCTURE AND CAPACITY

It is important to note that CCH is not a separate legal organization. Although registered with the GOB, it is not a corporate entity under Bolivian or U.S. law. Rather, CCH is a time-limited project in which numerous organizations participate, including: the Ministry of Health; USAID; the PL-480 Secretariat; and, various contractors, such as JSA Healthcare, the Centers for Disease Control (CDC), Medical Services Corporation International, and, currently, four private voluntary organizations (PVOs).

The project agreement (as modified by PIL 16) indicates that the Project has an executive committee consisting of the Minister of Health, Undersecretary of Health, Director General of Health, Project Executive Director, TAACS Advisor, and, in an advisory capacity, the JSA Chief of Party. In theory, this committee might provide broad policy direction for the project, including helping to institutionalize the project within the Ministry over the long run. To date, the Committee has functioned irregularly.

The project agreement also indicates the establishment of a technical council which would meet monthly. The purpose of this council is to supervise the progress of all four project components and resolve operational and technical problems.

JSA is a contractor hired by USAID/Bolivia to perform a variety of tasks, including: staffing certain project positions; providing technical assistance and, training; and, monitoring PL-480 funds. Since the award with JSA is a contract and not a grant or cooperative agreement, there is a significant involvement of USAID/Bolivia in monitoring the JSA contract. This monitoring is provided by the HHR office of USAID/Bolivia.

Initially, the CCH administrative infrastructure needed to support this project was seriously underestimated. As it became evident that additional and highly skilled technical people were needed to deal with financial management, procurement, and administrative support, these individuals were later added.

ADMINISTRATION, PROCUREMENT AND LOGISTICS

The Project has had a slow start-up, as evidenced by the following chronology. The grant agreement was signed on July 28, 1988; the JSA contract was signed on December 4, 1989; and, the majority of persons staffing the Altiplano Sud District have been on board for less than one year. There are multiple reasons causing this slow beginning, but clearly a principal factor has been creating from scratch an administrative structure for a complex project with multiple organizational participants.

In retrospect, the Project should have anticipated the administrative burden in dealing with the highly specialized requirements of USAID and PL-480 by initially assigning more administrative persons to the Project. Unfortunately, the Project started out with a limited number of persons with limited familiarity of critical areas, such as financial reporting requirements of PL-480, procurement requirements for PL-480 and A.I.D. handbooks (such as Handbook 11 for A.I.D.-financed procurements). If the Project had had on-site internal experts familiar with PL-480 and A.I.D. rules and regulations, the Project might have advanced more quickly and confronted fewer problems.

The Project now appears to have developed substantial internal capability in the handling of PL-480 and A.I.D. matters.

Another significant factor affecting the administration of the Project has been the long delay in placing an appropriate Chief of Party (COP). The initial person nominated in the JSA proposal was eventually replaced prior to arrival. The second nominee who was chosen and placed did not work out. A timely-placed, strong COP might have provided a sense of vision, pulled together the Project's many players, and helped overcome project impediments. To fill the vacuum of no COP, the JSA Health Education Specialist, who is also the Deputy COP, took over JSA contract management responsibilities, thereby taking time away from her technical obligations.

An additional concern expressed about JSA is a perception that JSA headquarters is apparently reducing its involvement in international operations and is concentrating on its U.S. domestic operations. Key internationally-oriented persons have left JSA headquarter's staff and not been replaced, raising the question of JSA's willingness and capability to provide technical support to the JSA contract in Bolivia.

Interviews with Project staff indicated that there has been some ambiguity as to what the JSA role is in the Project. Opinions were expressed that JSA is a technical advisor (that is, in health education); an implementor (that is, in water and sanitation); and, a manager (that is, in monitoring PL-480 funds). It is possible that JSA has been involved in all of these roles as the Project has gone through a process of defining itself. Thus, as PL-480 accounting became a problem area, JSA was obliged to take a more active role in resolving PL-480 financing issues. Thus, as more of the procurement function was delegated by the local USAID Mission to the Project, JSA took a more active role in implementing the water and sanitation activity. An early-placed, strong COP could have helped sort out these roles in consultation with A.I.D. Mission program staff and the Project's executive director, bringing a more unified vision of JSA's approach to the evolving project.

At initial meetings between the evaluation team and project-related persons, the financial status of PL-480 funding was expressed as a key problem area. Therefore, a considerable portion of time was spent by one evaluation team member reviewing this area.

The basic problem with the PL-480 Secretariat has been the slow liquidation of funds. To better understand the liquidation issue, a brief description of the PL-480 financing procedure follows. The PL-480 Secretariat issues two advances to the project management unit (PMU): one for Chagas activity and one for non-Chagas activities. The PMU then must render an adequate accounting of at least 70 percent of these advances. Once the PL-480 Secretariat accepts 70 percent of the accounting for the prior advance, it will then issue a new advance.

It has been difficult for the Project to render an acceptable accounting for 70 percent of the advance primarily because of two reasons: certain documentation did not meet PL-480 norms and certain costs incurred did not conform to line items in the approved PL-480 budget.

The effect of delayed funds replenishment by the PL-480 Secretariat has been to slow down project activities. For example, personnel in the Carrasco Valle District cited the postponement of training programs due to a lack of available funds. A second effect of delayed PL-480 replenishment has been the tremendous amount of administrative energy expended by Project personnel at both the central and district levels to deal with the PL-480 Secretariat. Hopefully, once the PL-480 issue(s) is (are) resolved and the PL-480 liquidation system is smoothly functioning (which

appears to be underway), this energy can be redirected to other administrative areas supporting the Project.

To provide some historical perspective on why the Project has had difficulty in satisfying the PL-480 Secretariat's 70 percent adequate accounting requirement, the example of the Altiplano Sud District is presented. This example is somewhat representative of the PL-480 situation that occurred in other districts. The Altiplano Sud District began incurring local project expenses in September 1990. At that time, there was no district administrator in place. Thus, the district director (a physician) was responsible for incurring and accounting for project expenditures. The district administrator was hired in January 1991. A training workshop on financial management of PL-480 funds was conducted by Coopers & Lybrand in February 1991. Therefore, project expenses for the period of September 1990 through January 1991 (a five-month period) were incurred without having a system in place at the district level that could appropriately account for PL-480 funds.

Although the accounting records for District Altiplano Sud for the period following the Coopers & Lybrand training would probably meet PL-480 Secretariat norms, these cannot be approved until the earlier accounting records for the months of September 1990 through January 1991 have been accepted. At this writing, it is anticipated that the few remaining issues outstanding on the earlier months for Altiplano Sud will be resolved by the end of December 1991.

The relationship with the PL-480 Secretariat appears to be somewhat strained not only because the initial accounting submitted by the local districts did not meet PL-480 norms, but also because certain project transactions took place that were unacceptable to the PL-480 Secretariat. These included: the purchase of a Chagas vehicle without meeting GOB requirements; paying a salary topping (sobre-sueldo) to an MOH official; and, lending funds from the Chagas PL-480 account to the non-Chagas PL-480 account.

Clearly, progress has been made in developing adequate accounting records which would meet PL-480 Secretariat norms. The Coopers & Lybrand workshop was helpful in this regard. However, the individualized training provided to district administrators by Andrés Yale (JSA) and Daysi Vera (PMU) must be singled out as a key reason that district-level accounting is being adjusted.

At this writing, the status of the three other district's PL-480 accounting submissions is:

> two districts are relatively current, having cleared up the initial five-month period and a majority of subsequent months; and,

- one district (Totora) is still behind in clearing up its accounting records. (Apparently the person occupying the position of district administrator for Totora is not appropriate and a replacement is being sought.)

A recent problem area (which should be able to be corrected easily) arose when the PL-480 Secretariat sent a letter to the Project asking for the submission of appropriate quarterly technical reports. Although the A.I.D. program office is primarily responsible for technical program oversight of the Project, apparently there is a courtesy requirement that quarterly technical reports be submitted as well to the PL-480 Secretariat. One PL-480 staff member feels that these reports have not been submitted in acceptable form. For example, some report elements are in English rather than Spanish. This should be a rather simple matter to resolve. However, the PL-480 Secretariat's letter indicates that it will stop disbursing funds to the Project until acceptable reports are presented.

The PL-480 Secretariat has also defined as a problem area the project accounting records arriving in large batches (de golpe), rather than in small batches. This is to say that the accounting records for a several-month period are sent, rather than for a shorter period. According to PL-480 staff, this puts a strain on their review staff. The Project may delay submitting these accounting packages until they refine the materials so that they would be acceptable to the PL-480 Secretariat. Then, this large batch of materials is submitted to the Secretariat in order to meet the 70 percent requirement, so that a replenishment can be received. This size-of-the-batch problem should be resolved over time as the project catches up on the older months outstanding and moves toward a system of submitting batches for a monthly period.

According to the PL-480 Secretariat, the current status of the two PL-480 accounts in meeting the 70 percent adequate accounting level is that the Chagas account has met 50 percent and the non-Chagas account has met 28 percent. According to Andrés Yale, the non-Chagas account expects to submit accounting information by the end of December 1991, which would meet the 70 percent requirement (see **Annex G** attached). It is forecast that the Chagas PL-480 account will submit accounting information which will exceed the 70 percent requirement by the end of December 1991. Project accounting personnel indicate that the central office and Sucre office of Chagas are fairly current on accounting, while the Tarija and Cochabamba offices of Chagas are behind on accounting.

Andrés Yale foresees 1992 as an even stronger year in dealing with PL-480 accounting because of the following measures:

- Strengthening the budgeting system, so that district budgets are in greater conformity with the overall PL-480 budget;

- Installing a computer system in each district, with built-in accounting controls;

- Having districts send their monthly accounting information to the Project's central office within five days after the end of month; and,

- Strengthening the present district accounting manual.

The Project's involvement in procurement has undergone a change over time. While the Project has always had a large procurement activity, it was perceived initially that USAID would perform much of the procurement directly. However, due to the local USAID Mission current philosophy of delegating procurements to projects in general, this project has undertaken more of the procurement function than was originally anticipated. Since the Project was to become directly involved in making large-scale procurements, the Project went through the certification process, which meets Handbook No. 11 requirements.

The Project's move to strengthen its procurement capability was driven not only by A.I.D.'s desire to delegate the procurement function, but also by an overestimation of the MOH's capacity to implement water and sanitation projects. Thus, at least three people are now involved in the procurement/logistics function for the Project.

There also appears to be a movement towards having the Project handle an increasing amount of local purchases directly, rather than having these handled by USAID.

While the Project has had financial reporting difficulties with PL-480, discussions with the A.I.D. controller's office indicate satisfaction with the Project's financial reporting to USAID. The Project is responsible for reporting to USAID financial activity of the A.I.D. Special Account. This is the account which is handled by the Project. A.I.D.'s Direct Account is handled by the USAID Mission and includes expenditures for contracted goods and services. Although financial reports from USAID on this account have been registered by JSA in the quarterly program reports, apparently these reports have not been sent directly by the controller's office to the Project. This information is available and there is an A.I.D. directive for the controller's office to provide such financial information to projects.

EVALUATION INDICATORS AND DATA SYSTEMS

The proposed evaluation plan (Project Agreement, Attachment I, pp. 12-13) briefly outlines three elements: the collection of morbidity and mortality baseline data through community surveys; annual performance reviews for each district based on annual workplans and budgets; and, an ongoing monitoring and evaluation system

which incorporates implementation targets, baseline data and the indicators proposed in the logical framework (**Annex D**).

Baseline surveys were undertaken in the four initial project districts in 1990. Only communities selected to receive project-funded water systems were included in the surveys. A community-based health education diagnostic survey was also carried out in the four districts in 1991. Initial workplans were prepared for each district for 1991; more refined and detailed annual workplans, including logical frameworks, have been developed by the district teams for 1992, based on reviews of 1991 performance.

To date, no formal monitoring and evaluation plan or system has been developed by the Project. One of the charges for this midterm evaluation was to review the indicators in the logical framework and assess whether they are still valid, if data collection systems are functioning, and if the information is being used for management decision making. In April 1990, a consultant, Ms. Sharon Benoliel, was commissioned by USAID to undertake a review of the indicators and to propose a plan for data collection, monitoring and evaluation. No action or follow-up was ever taken on her detailed and comprehensive report; in fact, neither the PMU nor the JSA consultants had knowledge of this report.

The logical framework was not presented in its standard format, which caused minor inconvenience in trying to relate indicators to outputs, for example. The indicator for goal achievement ("relevant human suffering indicators") is not at all specific. The indicators of purpose, or end of project status (EOPS), deal with changes in infant, child and maternal mortality and with "sustained institutional and community capabilities." Regarding the first, given the relatively small populations of the districts, the utility of changes in mortality rates is questionable. Also, all three rates are expected to decrease uniformly by 15 percent. One would expect differences based on circumstances and interventions. The second indicator lacks useful operational definitions of what can be measured.

Output indicators relate to key and appropriate aspects of the Project's purpose: (1) family health behaviors; (2) community involvement; (3) service delivery; (4) the MOH primary health care system; and, (5) regional support. One aspect that was omitted and which is critical to sustainability is the mechanism for financing health care system costs, including personnel, at the district and health center levels. Also, as above, important terms are not defined in ways that can be differentiated and measured (for example, "institutionalization" of interventions, "mechanics" of community involvement, "improved" support systems, "strengthened" primary health care system, and "changes" in family health behavior).

Annex F provides a comparison of indicators found in the logical framework, those reported in A.I.D.'s semi-annual project status reports, and those suggested by Ms. Benoliel. A separate column lists the data that are currently being collected and

reported by the Project from the baseline studies, the health education needs assessment, and the CCH quarterly reports. There is little consistency among these documents, both in the general areas of information and in the way similar indicators are stated.

The Project has collected and reported data related to goal and purpose-level indicators, except in the area of "sustained institutional and community capability." No data are being reported for output numbers one, two and five. For the other 3 output areas, the Project has reported on only 1 of the 19 indicators listed in the logical framework, that is, percent of women receiving prenatal care. However, data have been reported for nine other indicators which were not listed in the logical framework. Some output data (seven indicators) do appear on the A.I.D. project status report but not in the regular CCH quarterly reports.

Field personnel in the districts regularly collect and report a large amount of data for the MOH information systems, using up to twenty-one different forms in one of the districts. Data relevant to CCH information needs are not systematically extracted from these sources and reported to the PMU. MOH data are facility based and reflect only morbidity seen by MOH health workers and activities performed by them. Therefore, morbidity data for the facility's area of influence would be underreported, but service delivery statistics should be reliable since community outreach activities are also recorded.

TECHNICAL ASSISTANCE

The major provider of technical assistance to the CCH Project is JSA Healthcare, which signed a $2.5 million contract in December 1989. The current contract is due to be completed in July 1993, while the CCH Project itself has been extended until July 1994. JSA was charged with three primary responsibilities: to provide long- and short-term technical assistance; to assist in the procurement of materials and supplies; and, to support the participant training activities (JSA contract, Attachment I, p. 17). Performance to date regarding procurement and participant training activities is discussed in other sections.

JSA is supposed to advise USAID and the MOH regarding problems and constraints affecting the Project and to propose solutions for resolving them. The consultants are to collaborate closely with MOH counterparts, who were not specified in the scope of work. JSA also is responsible for preparing annual action plans, procurement plans, a comprehensive training plan, and quarterly progress and financial reports. The contractor has been complying, in varying degrees, with all of these obligations, with the notable exception that a comprehensive training plan has not yet been developed. A list of JSA accomplishments through October 1991 is presented in **Annex H.**

Another important provision in the technical assistance contract is that JSA would manage the "payment of salaries and other operating expenses of the Department and District level offices of the project" which are financed from PL-480 counterpart funds, and that it would "turn over the management of PL-480 monies to the appropriate Ministry counterpart no later than two years after project implementation" began (Attachment I, p. 18). After almost three and one half years, these funds are still managed within the PMU. The central and regional levels of the MOH have no involvement in managing project resources, except for the distribution of commodities provided under Components I and II.

In part, this delay was inevitable in that the technical consultant team did not begin to assemble until almost twenty months after the project agreement was signed with the Government of Bolivia. Another detriment to the effectiveness of the technical assistance provider was the alleged shortcomings, in leadership and management skills, of the JSA Chief of Party which led to his premature departure after a year and a half. During the past nine months, the Deputy Chief of Party has assumed the day-to-day management functions, which have significantly reduced the time she has for her primary job as health education specialist.

The operational relationship between JSA and the PMU, that is, the MOH Project Director and MOH contract staff, was not clearly defined in either the project paper or the technical assistance contract. The initial project management chart placed the JSA Chief of Party as the chief administrative officer in a line position under the MOH Project Director. This arrangement not only violated institutional autonomy but also diminished the technical assistance advisory function of this presumably independent contractor. Even though the project organization chart has been modified, working relationships have not.

Pressure from the A.I.D. Mission to move resources, a relatively weak Chief of Party, and a forceful MOH Project Director have combined to keep JSA primarily in a line management function at the expense of its technical advisory role. In fact, the PMU Director made it clear that in his view, JSA personnel were part of the PMU and under his control. The Director General of Health, on the other hand, indicated his preference that project technical assistance be more independent and flexible. The current situation not only compromises the independence and flexibility of technical assistance but also diminishes the degree to which JSA can be held directly accountable for certain contractual obligations.

The project agreement and the contractor's scope of work called for the placing of technical advisors at the national, regional and district levels. Including the Chief of Party/Management Advisor position, which is currently vacant, JSA has supplied the six technical consultants required in the scope of work assigned to the central PMU. In addition, JSA found it necessary to hire an administrative coordinator to develop and manage the PL-480 account, an administrator for the

water and sanitation component and four support staff. (An information systems consultant, a social promotion trainer for the water and sanitation activities and eight support staff have also been hired with USAID and PL-480 funds, under the MOH contract and directly responsible to the project director. The Chagas' unit has four staff based in La Paz paid from PL-480 funds and one consultant paid by VBCP.)

At the regional level (three departments), "the existing Sanitary Unit MOH field staff will be supported directly by. . .contracted Sanitary Unit-level Project staff including a Public Health Physician, an Administrative/Management specialist, a Health Education/Training Specialist, a Water and Sanitation Engineer and a nutritionist" (Attachment I, p. 11). As mentioned earlier, these personnel were to be managed by the technical assistance contractor and paid using PL-480 funds. To date, the PMU (not JSA) has hired only the three water and sanitation engineers (with A.I.D. direct funds) and each sanitary unit has designated (from its regular staff) a regional coordinator to serve as liaison and supervisor of project-related activities.

Interviews with the directors and other personnel of the three sanitary units revealed that the primary needs and requests for technical assistance at the regional level were in the areas of health promotion and education and in the strengthening of management support systems. The Director General of Health also indicated the need for providing technical assistance in management information systems (MIS), logistics, financial management, local programming, local financing, and maintenance. He stressed that these efforts involving CCH need to be closely coordinated with those of the World Bank-financed activities.

Using PL-480 funds, the technical assistance contractor was required to hire and manage "a small team of technical and management technicians to supplement the current. . .health services staff" in each project district. "Each team should include one Physician, an Administrator, a Health Education Technician, a Water and Sanitation Technician and a Nutritionist" and the MOH agreed to create positions (items) to absorb these technicians within three years. The team was to "assist the District's Medical Director" and staff "to plan. . .programs, design and conduct surveys, analyze. . .problems, design specific interventions, train and supervise staff, and evaluate progress." (Attachment I, pp. 10-11). In actuality, the project districts already had a medical director and few additional district-level staff. PL-480 funds have provided an administrator and secretary in four districts, a health educator in three districts, and a nutritionist, a statistics technician, and a water and sanitation technician in one district. The MOH has not created any items to absorb even these minimum staff positions.

JSA commissioned an internal evaluation which was conducted one month prior to the present midterm evaluation. The recommendations from this evaluation focus on the problem of PL-480 counterpart funding, district-level integration and

delivery of child survival services, and the phasing out of JSA technical assistance and transfer of functions to the MOH. The present evaluation team found this report very useful and generally concurs with its findings and recommendations.

Technical assistance is also provided to the Project by a medical epidemiologist from the Centers for Disease Control (CDC) through the TAACS (Technical Advisor in AIDS and Child Survival) program. This advisor provides "overall guidance" to the project, liaison with USAID, and direct technical assistance in epidemiology. In effect, he serves in three positions: a technical advisor; a representative of USAID; and, the manager of the Chagas' disease component. He is able to handle these three roles vis-à-vis the PMU by virtue of his relationship with USAID and his strength of character. Unfortunately, JSA has not had similar advantages. Additional technical assistance is provided to the Chagas' component through the Vector Biology Control Project. This is a relatively new intervention and was not included in the evaluation.

IV. CONCLUSIONS

PROJECT COMPONENTS AND COMMUNITY PARTICIPATION

The project components require distinct technical and administrative capabilities; having them placed under a single management structure has created substantial challenges.

Systematic collection and careful utilization of performance data are critical to ensuring effective management and implementation of the components. The lack of a carefully defined plan for monitoring, evaluation and feedback has seriously impeded project effectiveness.

Until recently, health promotion/education has been limited to specific community interventions and has not responded to a planned global strategy. While health promotion has not been the focus of the project to date, it is evident that careful planning has occurred in recent months; however, there continues to be a need to develop a strong conceptual framework and focus.

To date, there has not been a strategy for training and human resource development nor have specific teaching/learning objectives, content, methodology and resources been defined.

Very likely, the most critical link in the whole chain of delivering effective and integrated health services is the auxiliary nurse. This health worker is the primary channel between the community and the formal health system. Training programs must focus not only on the technical, administrative and promotional competencies of the auxiliary nurse, but also on the competencies of those workers who must provide support to her or him and the community committees and volunteers with whom they work.

Community participation is recognized as a vital component of the project but no explicit, comprehensive strategy or guidelines have been developed to direct project activities. The most promising results have been in the areas of water and sanitation, where the beneficiaries are directly involved in decision making.

There is increasing awareness of the need for building integrated health and child survival activities onto the achievements of water and sanitation. The crossover benefits in community organization and disease prevention are not yet being realized due to the lack of coordinated direction, planning and implementation.

The community motivation and participatory approach of the Chagas control program in Chuquisaca, which focuses on community education, home improvements,

and fumigation, is highly successful, in part because it augments an already established and clearly defined community-based health program.

There is a need for a comprehensive community health and nutrition education approach that ensures sustainability; it is critical that it respond to program priorities and be viewed as the focal point for all program activities.

INSTITUTIONAL DEVELOPMENT

The CCH Project has not developed a specific, cohesive strategy or plan of action aimed at targeting and coordinating activities to address the objective of institutional development. As a result, the various MOH units and agency participants are often not in agreement regarding appropriate strategies, for example, the role of the SU and the use of technical assistance. Also, those efforts which are being made will have limited and, possibly in some cases, counterproductive impact on institutional development by reinforcing existing deficiencies.

The PMU, while technically part of the MOH, does not always represent central and regional points of views. This is compounded by the absence of an MOH policy and strategy regarding institutional development and management improvement which applies to all international donor projects and related technical assistance. Intended roles and responsibilities are not explicit which leads to individual interpretation. This is not a question of who is right and who is wrong, but rather an indication that strategies and actions are not cohesive and mutually supportive.

Institutional development has been neglected at the regional level and only partially addressed at the district level. The PMU has done little to facilitate joint analysis and planning in the sanitary units. Technical assistance is concentrated in the central PMU and focuses on technical and service delivery issues. Non-governmental organizations are being used for the primary purpose of implementing services, in lieu of MOH deficiencies, and are not part of a defined institutional development strategy.

Institutional development has been viewed predominantly in terms of increased personnel and commodity inputs and has not focused on management functions and systems. A management improvement strategy needs to encompass the functions of: (1) planning and setting objectives; (2) mobilizing and coordinating resources; (3) organization (legal, systems, infrastructure, etc.); (4) training and staff development; (5) execution (procurement, logistics, supervision, etc.); (6) motivation and communication; (7) monitoring (inputs, operations, outputs, environment); (8) conflict resolution (among objectives, functions, personnel, etc.); and, (9) evaluation. The process of assessing current status and developing a comprehensive strategy of

institutional and management improvement would force the resolution of many issues currently facing the MOH and the Project.

PROJECT INPUTS

Given present programming plans, the funds budgeted for Components I, II and IV will be used up during the current project life. If the project life is further extended, additional funds would probably be required for these three components.

If the number of districts to be served is reduced (for example, from 11 to 6), the funds presently budgeted within Component III would need to be reprogrammed. There is uncertainty as to whether the project life for this component should be extended.

Since the current project life is longer than the JSA contract life, there may be a need to put additional monies into Component III. This would depend on: A.I.D.'s willingness to continue its contractual relationship with JSA; A.I.D.'s determination that Component III is indeed having sufficient impact; and, any cost savings that may result in reprogramming for a reduced number of districts to be served.

A.I.D.'s resolution of what to do with the existing JSA contract will impact on the project budget. At present, certain project activities are financed through the JSA contract. The existing JSA contract expires before the project life. Options in handling the JSA contract include: early termination with an alternative mechanism for handling project activities now treated by the contract; letting the contract expire and finding an alternative mechanism after the contract expiration date; and, extending the contract. The particular option chosen will have funding implications for Component III.

PROJECT MANAGEMENT AND COORDINATION

JSA needs to quickly place a strong Chief of Party who could provide vision and coordinate efforts to achieve project goals. This is dependent on A.I.D.'s decision to continue the JSA contract in its present form.

The Project Executive Committee is not functioning to its full potential. This committee could play a key role in institutionalizing the project within the MOH. There is some degree of skepticism as to whether the MOH will eventually pick up project personnel at either the PMU or district levels as items in the MOH budget.

The Project has made progress in meeting PL-480 adequate accounting requirements. Andrés Yale and Daysi Vera's efforts have contributed significantly

to this progress. However, to further strengthen the project's capacity to deal with the PL-480 Secretariat, the Project has the following opportunities:

- To take advantage of the PL-480 Secretariat's offer to provide a two-day technical training workshop. This presentation could be part of a larger CCH workshop focusing on accounting and financial management issues. Potential topics for a larger workshop might include the 1992 PL-480 budgeting system and computerization.

  Beside providing technical knowledge, a second benefit of a PL-480 Secretariat workshop would be improving relations with the Secretariat. The Project, by initially submitting unacceptable accounting information and entering into unacceptable transactions, had created an unfavorable impression with Secretariat personnel. A PL-480-sponsored workshop at which CCH staff demonstrated their keen interest in making things right with the Secretariat could help turn around the Secretariat's initial negative image of CCH's accounting capability.

  To take advantage of USAID's Office of Agriculture and Rural Development (ARD) to enter the PL-480 situation as an honest broker. It would be useful for ARD to review the norms being used by the PL-480 Secretariat in implementing the SAFCO law to assure that these norms are appropriate. Apparently no official regulations have been passed for the SAFCO law; the Secretariat is using its administrative norms. Interviews with the Project staff reflect a feeling that the Secretariat norms are excessively burdensome and inappropriate for a rural program setting. Further, Project staff sense that the Secretariat norms applied to this project might be more rigid than the Secretariat norms applied to other projects. Examples cited were PL-480 projects with San Simon University, Instituto Nacional de Estadisticas (INE) and Servicio de Caminos. An ARD review of the Secretariat norms applied to this project might have policy implications in that these norms might be overly restrictive for other Secretariat-funded projects as well. In performing its review, ARD may wish to pay particular attention to the following Secretariat procedures for this project:

  - A supporting document must be submitted for every expenditure, no matter how small the expenditure. Should there be a Boliviano level below which no supporting document is required? USAID rules and U.S. Internal Revenue Service rules permit a floor under which no supporting document is required (that is, $25.00 U.S.).

- Local purchases in excess of 100 Bolivianos require three bids. Is this a realistic requirement for a project operating in a rural setting? Can this project receive a waiver for rural purchases or can the Boliviano amount requiring bids be raised to a more realistic level?

- The Secretariat will not provide a subsequent advance until 70 percent, of the prior advance has been accounted for adequately. Instead of the required 70 percent can the Secretariat accept and replenish for adequate accounting submission packages of less than 70 percent? In other words, if the Project submits an acceptable accounting package of 20,000 Bolivianos, can the Secretariat replenish that amount, irrespective of whether it represents 70 percent of a prior advance? At present, the project is considering a PIL which would propose this rotating fund approach as an alternative to the present 70 percent requirement.

Since ARD has audit capability, if appropriate, ARD, as part of its honest broker role, could send in an auditor to assess technical accounting issues. Apparently, ARD has only recently become aware of these cash flow difficulties with PL-480 financing. It is probably the responsibility of the USAID/HHR Program Officer overseeing the Project to bring in and monitor appropriate A.I.D. resources.

Some persons interviewed expressed dissatisfaction with JSA in handling certain aspects of its contract, including: recruiting and placing an appropriate COP; monitoring PL-480 funds; and, having early in-house, on-site capacity in A.I.D. and PL-480 regulations. JSA has indeed made progress in having in-house, on-site technical people to deal with A.I.D. and PL-480 regulations, in particular through Andrés Yale and Daysi Vera with PL-480 and through Ned Olney with A.I.D. Procurement.

The Project has developed a district field manual which incorporates the Coopers & Lybrand PL-480 accounting manual. However, this field manual would benefit from having a dedicated section dealing with specific recurring PL-480 issues, such as accounting for the value added tax, using original supporting documents, obtaining bids for procurements, and obtaining original signatures. Since the Coopers & Lybrand PL-480 accounting manual dealt with a manual system rather than a computerized system, the district field manual should eventually treat the computerization issue.

According to Project personnel, the A.I.D. controller's office is not directly sending to the CCH accounting office a financial status report on the A.I.D. Direct

Account. This information would be helpful to the project management unit since expenditures from the A.I.D. Direct Account represent a significant amount of the overall project budget.

Persons interviewed expressed diverse and often strong opinions about what the Project is supposed to do, particularly in Component III. If there is not a commonly-shared perception of what the Project's programmatic goals and priorities are, it creates difficulties for formulating an appropriate project management structure. Further, it becomes somewhat problematic to evaluate the performance of various organizational participants, such as JSA, USAID/HHR and the PMU if there is not a team consensus on project goals and priorities. It might be well for key project-related persons to develop an organizational development/strategic planning approach (ODSPA) whereby this evolving project is revisited, in order to develop a current and common agreement on the scope of the CCH Project (particularly Component III). This ODSPA should be viewed as being practical, applied, and on-going. An outside facilitator not affiliated with the Project could be used--possibly a contractor such as WASH. In arriving at common goals, the project team then can determine the appropriate management structure to achieve those goals. This would help sort through the management roles and responsibilities for JSA, USAID/HHR and the MOH.

The Project's management structure could be more fully clarified through the ODSPA suggested above. Thus, decisions regarding the future relationship with JSA might better be delayed until after the ODSPA begins. Hopefully, the ODSPA would fully define JSA's areas of responsibility and provide evaluation benchmarks for JSA accountability. These benchmarks would build upon the scope of work documented in the original JSA contract.

Once JSA is evaluated for contract performance on appropriate and current benchmarks, A.I.D. has a number of options, including the following:

- Continue with JSA as a contractor until the end of the current contract life;
- Continue and extend the JSA contract beyond the current contract life; or,
- Terminate for convenience or for cause the JSA contract before the end of the current contract life.

If the JSA contract terminates before the project life, then A.I.D. will need to determine how to deal with project activities presently assigned to JSA. The options for A.I.D. in this regard are:

- Secure a replacement core contractor through the competitive bidding process, keeping in mind that competitive procurement could take one year;

- Secure a replacement core organization through a sole source award to a qualified non-governmental organization; or,

- Instead of securing a core organization, enter into personal service contracts with individuals for defined project activities. A concern here is that someone would need to manage these individual contractors. Hopefully, certain persons presently employed by JSA could be converted to personal service contractors.

The current organization chart (see **Annex L**) appears confusing and dysfunctional. The ODSPA effort should yield a revised organization chart which resolves the following areas:

- Three of the four components do not have a designated person as manager.

- The Chagas Component is administratively more self-contained and has a distinct programmatic focus. How should the Chagas Component organizationally relate to the rest of the Project?

- Component III has both technical and administrative dimensions. For example, health promotion and education is a technical dimension and accounting for PL-480 is an administrative dimension. A revised organization chart should clearly separate out the technical and administrative dimensions of Component III.

- The Project is a mix of autonomous organizations, such as MOH and JSA, under one organizational structure. This can confuse the reporting responsibilities of individuals working under the Project and the degree of accountability for required obligations.

PROJECT EVALUATION AND MONITORING

Data collection and reporting are partial and inadequate for monitoring and evaluating project activities and objectives. Also, information is available from MOH forms and project staff which is relevant and necessary but which is not being systematically recorded. Project staff and consultants have apparently not made the effort to analyze data needs and methods of collection and reporting to meet the requirements of sound management and the project agreement.

There is no need to repeat the very thorough work of Ms. Benoliel. USAID was negligent in not making the report available to the Project and ensuring adequate follow-up. The report identifies appropriate evaluation questions, presents a "menu" of indicators which are consistent with A.I.D. child survival guidelines and tiers, and suggests methods for data collection and analysis. It provides an excellent model to use as a basis in developing a project monitoring and evaluation system.

The CCH personnel and advisors have collected and analyzed valuable baseline data for the service delivery aspects of the Project, developed a computerized tracking system for the water and sanitation activities and worked with the MOH in refining its unified national information system. Also, computers have recently arrived for the district offices. The Project, however, has not developed a comprehensive data collection, monitoring and evaluation system as required by the project agreement. This affects the ability of A.I.D. and the MOH to monitor and evaluate CCH activities.

A major deficiency in the logical framework is the lack of specificity and indicators to measure progress toward the CCH objective of institutional development. The only indicator given for this very complex and important area is an "increase in [the] number of personnel functioning at [the] District level." There is no examination, for example, of sustaining basic management functions, infrastructure and support systems.

TECHNICAL ASSISTANCE

The relationship between the institutional contractor (JSA) and the project management unit was not clearly defined in the project paper or the technical assistance contract. It is apparent, however, that the contractor was expected to provide direct administrative services (procurement, local contracting, personnel management) which the A.I.D. Mission did not wish to provide and the MOH was not capable of providing. These factors, combined with the fact that the initial JSA Chief of Party was allegedly not a particularly strong management advisor or up to the task of leadership, has compromised its assertive and creative role as an independent contractor. In effect, the technical assistance consultants have functioned more as line implementors and coordinators of routine tasks and less as staff advisors, developers, testers, and trainers for new, improved and sustainable health support systems.

Interviews and project documents contained diverse and often strong opinions about the JSA contract, making it difficult to arrive at a definitive judgment on what should be the future relationship with JSA. This has been compounded by the changing role(s) expected of JSA and by the difficulty of starting a large, complex organization from scratch. Given the problems experienced by the Project, some project-related persons might choose JSA as the root cause for project difficulties.

Other persons might prefer viewing JSA as a contractor that has had some difficulties but has made progress in developing on-site capabilities and resolving these implementation problems.

The PMU has increased its own staff (through MOH direct contracts) and taken over direct management functions from JSA, rather than facilitate the transfer of these functions to permanent MOH "counterparts" as implied in the project agreement. The contractor, also without adequate explanation, has not provided the required technical assistance at the regional level. These developments are counterproductive to institutional development within the MOH and diminish the chances for sustaining project benefits, since the PMU is a temporary entity.

The intent of the project design clearly was to provide technical advisors/trainers in each district and sanitary unit, close to where problems could be identified and resolved and support systems could be improved and developed in a continuous and participatory manner. Instead, we find a pattern of building up the capacity of the central PMU, diminishing the role and influence of the technical assistance contractor, circumventing the regional management support structures of the MOH, and working with incomplete technical teams in the districts. All of this, in the rush to attain quantitative outputs, is to the detriment of institutional development and sustainability. This was made possible due to an ambitious project director, inadequate leadership and vision by the technical assistance contractor, and the preoccupation of USAID on moving resources and delivering services, that is, vaccinating children, installing water systems, etc.

V. RECOMMENDATIONS

The findings and conclusions of this midterm evaluation lead to a number of specific recommendations, presented in this chapter in terms of intervention strategies, institutional development, project budget and duration, project management and coordination, project monitoring and evaluation, and technical assistance.

INTERVENTION STRATEGIES

- There should be a pause in project operations in order to review progress to date and to focus on organizational development, strategic planning and team building in the areas of integrating child survival and water and sanitation activities, community participation, institutional development, and training. Roles and expectations of project participants should be analyzed and redefined.

- Health promotion and education should be a central focus of all project activities and must be viewed as an interdisciplinary process involving program staff at all levels (including physicians, administrators, nurses, social workers, dentists, nutritionists, engineers, water and sanitation technicians, community health workers, etc.).

- Any health promotion/health education intervention should respond to a carefully planned global program strategy with a clearly defined conceptual framework. Three areas of health promotion and health education should be targeted: school health, community health, and mass communication/social marketing.

- A training and human resource development strategy should be designed concurrently and in concert with the community health promotion and institutional development strategies.

- There should be a focus on strengthening linkages between water supply and sanitation and integrated health/child survival. Strategies to effect this linkage should be developed so that child survival activities can augment the water and sanitation program and vice versa.

- The Chagas component should be given continued and expanded support. Some of the exemplary integrated community-based health promotion techniques used in Chuquisaca should be replicated in the integrated health/water and sanitation areas. Various models of service delivery should be tested and documented and coordination with other

donors and the Ministry of Health should be strengthened in order to develop a National Chagas Control Program.

- Technical assistance should be provided to assist the team in defining a conceptual framework for health promotion/ health education and for developing specific teaching/ learning objectives, content, methodology and resources.

- Rural auxiliary nurses and area supervisory personnel are critical elements in the primary health care system. Training programs should focus on improving the competencies of these personnel in community organizations, nonformal education, and basic program planning, administration and evaluation, in addition to technical matters.

- A monitoring and evaluation plan should be developed that will allow for a regular analysis of trends toward achievement of the project's defined goals and purposes.

INSTITUTIONAL DEVELOPMENT

- The Government of Bolivia must begin to uphold its part of the project agreement by (1) filling all vacant positions at the district level, (2) restoring "loaned" positions back to the home district, and (3) providing new district positions as required. The costs of these health workers may likely be covered by bulk payments from PL-480 to the national treasury on an annually decreasing percentage basis, thereby assisting the GOB to gradually absorb project recurrent costs.

- JSA should provide a specialist in organizational development to assist the MOH to conduct a baseline of institutional development needs and constraints at the district and departmental levels. This diagnosis would form the basis for the development of a unified and coherent strategy and implementation plan to meet the project objectives of institutional development and sustainability. Both the diagnosis and the subsequent strategy should focus on strengthening management functions of community organizations, district health offices, and the MOH regional sanitary units.

- The global strategy and implementation plan for training supported by the project should include management as well as technical areas. MOH personnel and community leaders need to strengthen their capabilities to effectively carry out the management functions of: (1) planning and setting objectives; (2) mobilizing resources, coordination and negotiation; (3) organization; (4) training, staff development and

motivation; (5) execution, logistics and administrative systems; (6) communication; (7) monitoring and evaluation; and, (8) conflict resolution.

- The Director General of Health should instruct the CCH project director, the participating sanitary unit directors, and the JSA Chief of Party to prepare a unified strategy for institutional development in each SU and comprehensive plans for training and technical assistance which consolidate and integrate the needs and objectives of the CCH, World Bank and other bilateral assistance projects.

- JSA should provide technical assistance to design and implement a series of operations research studies aimed at identifying and testing alternative financing mechanisms and cost analyses. The results of these studies are essential for assuring the sustainability of project systems and benefits at the district and community levels. They will also provide valuable evidence with which to influence the replication of CCH models in other districts.

PROJECT BUDGET AND DURATION

- A.I.D. has already programmed a large percentage of the monies budgeted for Components I, II, and IV and may wish to keep the existing monies within these components. Any reprogramming of monies within Component I (Diarrheal Disease Control), away from procurement towards education and/or distribution, should be based on a written plan which would directly support the strategies pursued in the Integrated Child Survival/Water and Sanitation Component.

- The number of project-supported districts should be reduced from 11 to a maximum of 7 and no new district should be initiated with less than 2 years remaining in the project. The remaining funds within Component III should be reprogrammed to accommodate this reduction. Expansion of this component (funds and LOP) should be based on the development and subsequent effectiveness of strategies for integrating health promotion/education and water and sanitation, institutional development, community participation, and training.

PROJECT MANAGEMENT AND COORDINATION

- The participating agencies are strongly advised to initiate a process of organizational development (for the PMU/JSA), strategic planning, and team building to revisit project goals, objectives and operating structure. This should be an extended process and facilitated by an

experienced, external specialist. The outcomes of the process would include:

- Integrating the new JSA Chief of Party into the Project;

- Developing a common consensus of objectives and priorities, including the integration of the four components;

- Developing an appropriate management structure to achieve project goals and priorities. This would include assigning responsibilities to participating organizations so that they could be held accountable;

- Developing current and specific evaluation benchmarks for JSA, USAID and the MOH to use in determining JSA contract performance;

- Developing a revised organization chart that resolves the areas treated in the conclusions section of this report; and,

- Developing coherent strategies and implementation plans for institutional development and community participation.

• There should be a concerted effort to quickly choose and place a strong chief of party (COP). Many persons interviewed have almost a "white knight" theory, meaning that all the Project needs is the right COP to improve the Project. Clearly, the Project has been hurt by not having from its inception a COP who could have offered management and programmatic direction, in collaboration with the Project's Executive Director and USAID/Bolivia.

• The relationship with JSA should be examined after an evaluation based on specific and current benchmarks for JSA performance. Implied advantages of staying with the JSA arrangement are the time delay and contractual procedures involved in shifting to another contractual mechanism, whether it is a contract with an alternative consulting firm, a grant with an NGO, or a configuration of personal service contracts. However, if JSA is <u>not</u> performing adequately, then indeed another contractual mechanism should be considered.

• More thought needs to be given on how to make the Project self-sufficient over the long run. There may be a need to strengthen the Executive Committee, so that it can deal with the sustainability issue. Some interviewees are highly skeptical that the MOH will eventually

pick up Project people as items in the Ministry budget at existing salary levels. If this is the case, then some group should be thinking about alternative methods to sustain what the Project is doing.

- The Project should strengthen its financial liquidation system with the PL-480 Secretariat by: accepting the Secretariat's offer for a two-day training workshop; involving high-level Secretariat officials in defined program activities; engaging the USAID/ARD office as an honest broker; adding key PL-480 issues to its district field manual; and, where appropriate, developing PILs to resolve impediments.

- Efforts should be made to further engage the Secretariat in the Project. It may be useful to place a high-level Secretariat official on the Executive Committee, plus expand efforts to have high-level Secretariat officials visit rural community events, such as training activities and health fairs.

- Local purchases should be handled by the Project rather than by USAID directly, as appropriate. Project personnel feel that having the Project arrange for local purchases is more efficient than having USAID do so. This should be seen as part of the USAID trend to delegate the procurement function to the Project.

PROJECT MONITORING AND EVALUATION

- The project management unit should assign to a specific individual the responsibility of designing and implementing a project data collection, monitoring and evaluation system. JSA should provide technical assistance to support this indispensable effort.

- The CCH monitoring and evaluation manager, together with the JSA advisor, should develop a functional and efficient data collection, monitoring and evaluation plan. The objective of this system will be (1) to provide district, community and central project managers with timely and relevant information for management decisions, and (2) to provide A.I.D. and MOH officials with data by which to evaluate project effectiveness and eventual impact.

- The project management unit and JSA should review the consultant report of Sharon Benoliel as a basis for the above plan. This report provides not only a good model of what a comprehensive plan should entail but also an extensive list of indicators from which can be chosen the most appropriate and necessary for project monitoring and evaluation purposes.

TECHNICAL ASSISTANCE

- The JSA contract should be continued until its scheduled completion in July 1993. Continuing and increased technical assistance is clearly needed and the disadvantages in using alternative mechanisms, another institutional contractor or a series of personal services contractors (PSCs) appear to outweigh any advantages. The JSA contract should be revised to reflect current and projected needs and circumstances. Indicators of performance under the contract should be periodically reviewed and ultimately should be used to determine whether or not to extend the contract through to the PACD.

- The JSA Chief of Party vacancy should be filled as soon as possible with an experienced and capable individual. The next COP should provide vision and be a skilled manager, negotiator and analyst. A strong independent contractor is needed to balance interagency forces and preserve the benefits of objective analysis and uncompromised advice and action. High levels of communication and coordination with both the project management unit and the MOH district health teams, the regional sanitary units, and the national normative offices are of the utmost importance.

- Technical assistance functions should be structurally and operationally separated from administrative functions within the project management unit. Commingling of functions and organizational chains of command tend to confuse priorities and diminish accountability. JSA advisors should be relieved of their current responsibilities as district coordinators so that they may focus more of their energies on technical, research and development matters. These functions could be taken over by the MOH/SU regional coordinators and, in the PMU, Andrés Yale. The JSA contract and the project agreement should be modified to reflect these changes.

- JSA should provide significantly more technical assistance at the district and regional levels. Additional technical assistance is needed to strengthen institutional development at these levels and should be guided by the needs assessment and strategic plan recommended above, as well as the global training plan. Andrés Yale should dedicate more of his efforts to technical assistance and training at the regional and district levels and less to financial accounting. JSA should take the lead in designing and conducting operations research and other evaluative studies and communicating the results of these studies within the public and private health sector organizations.

VI. LESSONS LEARNED

- Resources and technical assistance requirements of the health promotion and education areas are often underestimated. Health education is a critical component, the basis of behavior change, and should be carefully planned and budgeted in order to ensure lasting effects and sustainability of projects. An overall strategy and conceptual framework is essential.

- Staff members who are committed to and knowledgeable about development work in the areas served are essential to the success of a project. A sense of teamwork and management support and understanding of team dynamics are critical factors.

- Organizational development and team building are essential at the inception as well as at all critical phases of a project in order to clearly define roles, expectations and plans for operation. This requires skillful facilitation as well as follow-up and on-going monitoring and adjustment appropriate to the team's growth and development needs.

- A primary factor in the transmission of diarrheal diseases is the lack of potable water and adequate sanitary and waste disposal facilities. Oral rehydration therapy and other child survival activities, such as growth monitoring, breast feeding and immunizations, are not substitutes for an improved water supply and sanitation program. Rather, they are supplementary. Water and sanitation and child survival must be seen as completely interdependent if any long-range impact on health at the community level is envisioned. The long range effect of improved water and sanitation on child survival is potentially very great.

- Monitoring and evaluation of performance is an important element of any project and should be designed not only to meet project implementation requirements, but also to satisfy long-term needs for sustainability. A data collection, monitoring and evaluation plan should be developed very early in the project life so as to guide priority interventions and assure the regular collection, analysis and use of relevant information.

- Technical assistance needs at the district and area levels are very basic. Often health workers lack the experience to comprehend the complexity of the overall health system and strategies for improvement. Development assistance takes place one step at a time. This requires permanent on-site technical assistance with broad experience to recognize opportunities and suggest and test alternative solutions.

Projects which involve several autonomous implementing agencies require high levels of communication and coordination. Each must recognize and support the contributions of the others and be willing to negotiate the most appropriate courses of action.

Permanent agency programs must address, to varying degrees, all aspects of the organization's operations. Time-limited projects, such as CCH, need to focus resources on those areas which will bring the most benefit to the permanent institutional program. They cannot circumvent the permanent institutional or community structures if they hope to be effective and sustainable.

Projects which have different objectives, strategies and resource needs (for example, integrated child survival and Chagas' disease control) often function better under separate management and financing structures.

The most important and indispensable resource in delivering primary health care services is the health worker. A PHC system cannot be adequately strengthened or expanded without sufficient, appropriate and trained staff. The CCH Project objectives are seriously compromised by the lack of sufficient GOB staff positions in the project districts.

ANNEX A

EVALUATION TEAM MEMBERS AND RESPONSIBILITIES

STATEMENT OF WORK

EVALUATION TEAM MEMBERS AND RESPONSIBILITIES

James N. Becht: MPH, DrPH (abd)	<u>Public Health Specialist/Team Leader</u> Institutional Development Evaluation Indicators and Data Systems Technical Assistance
Geri Marr Burdman: RN, Ph.D.	<u>Health Program Specialist</u> Component Strategies and Methodologies Health Education and Promotion Training and Human Resources Development Community Participation
Bernard J. Fisken: MBA, LPA	<u>Systems Specialist</u> Financial Analysis Management Structure and Capacity Administration, Procurement and Logistics

STATEMENT OF WORK

BACKGROUND

Bolivia has one of the highest infant mortality rates (IMR) in Latin America with the IMR in rural areas often exceeding 200 per 1,000 live births. The Maternal Mortality Rate (MMR) of 480 per 10,000 live births is the highest in the Western Hemisphere. The principle causes of infant mortality are diarrheal diseases, acute respiratory infections, prenatal diseases, and immunopreventable diseases.

The problems are the result of poverty, and very low coverage of modern medical services. This is compounded by very low water and sanitation coverage, high female illiteracy, dispersed population centers and cultural resistance to modern medical services among certain ethnic groups.

The goal of the six year Community and Child Health Project is to improve the health status of the rural and peri-urban populations through child survival interventions, institutional development and community participation. The purpose of the project is to reduce infant, child and maternal mortality rates in 11 project districts; increase capability of the Ministry of Health (MOH) Department and district-level institutions; and of community organizations, to plan, implement and sustain child survival interventions.

The Project includes four components: 1) Support to the National Diarrheal Control program through the provision of oral rehydration salts ($850,000); 2) Support to the National Immunization Program as programmed by the Interagency Committee for Immunization ($3,450,000); 3) Integrated Child Survival to strengthen the operational capacity of District health units in three Departments to improve and expand coverage of their populations with an integrated package of priority "child survival" interventions - immunizations, diarrheal disease control via oral rehydration, nutrition, acute respiratory infections, maternal care, and water and sanitation ($11,700,000), and; 4) A National Chagas' Disease Control component to develop appropiate technologies and administration ($500,000).

The total A.I.D. contribution to the Project is $16,500,000 and the GOB counterpart is $8,000,000 for a total of $24,500,000. The CCH Project was signed on July 28, 1988 and recently has been extended to July 28, 1994.

The Project works within the framework of the Ministry of Health. JSA Healthcare is the institutional contractor concentrating on the Integrated Child Survival Component and Medical Services Corporation International, through the Vector Biology Control Project, provides technical assistance to the Chagas' disease component.

ARTICLE I - TITLE

The Community and Child Health Project, Number 511-0594

ARTICLE II - OBJECTIVE

The objective of this mid-term evaluation is to measure progress towards achieving project implementation targets including provision of financial, technical and material inputs; institutional development objectives at the District and Department levels; and quality and quantity of child survival and water and sanitation services delivered in each district, as measured against baseline data collected at the outset of each district program.

Analysis and resulting recommendations should address the effectiveness of the implementation strategy, how effective the CCH office and contractors are managing the implementation strategy, and the viability of the impact indicators and data collection systems. The evaluation will also assess the utility of methodologies used in each project component and recommend modifications, as appropriate. The team will identify appropriate EOP indicators to support evaluation recommendations which will be used to assess the impact of this project on the health status of Bolivia in targeted areas. An assessment of the project's impact on health status will be limited to the existing impact indicators that the team considers valid.

ARTICLE III - SCOPE OF WORK

A Team Planning Meeting will be held in Bolivia at the beginning of the consultancy.

41

The contractor will conduct a mid-term evaluation to address the objectives defined above and identify any "lessons learned" in the first half of the project that might assist with making decisions during the remainder of the project. Specifically, the the contractor shall:

A) Assess the project to date in terms of the following:

1) the extent to which capabilities within the MOH department and district-level institutions to reduce infant, child and maternal mortality rates have been enhanced; and

2) the capacity of community organizations to plan, implement and sustain child survival interventions as a result of project activities (in areas where community organizations are being used).

B) Assess the organizational capacity to manage the implementation of the project. Does the management structure within and among the facilitating agencies (USAID, MOH, Contractors, etc.) lend itself to successfully meeting the project purpose? Identify and explain mid-project management adjustments, as needed, in order to achieve the goal of each project component.

C) Identify and explain any modifications to the technical assistance contracts that are needed to enhance the provision of inputs toward achieving the project s purpose within each project component.

D) Analyze the implementation and monitoring of the following systems within each project component (as appropriate) and make recommendations for modifications as needed.

1) Financial Management;
2) Training;
3) Host Country Contracting;
4) Procurement;
5) Commodity Distribution;
6) Data Collection and Reporting.

E) Review indicators in the logistical framework for each project component and assess the extent to which:

1) systems to measure indicators are in place;
2) baseline information is collected and analyzed;
3) information is gender disaggregated (as appropriate);
4) the original indicators are still valid measures for achieving the project purpose, and assess the project impact to date, to the extent practical, using these indicators. In the event that the indicators are no longer viable, recommend alternative measures to demonstrate end-of-project impact; and
5) information is being used for project management decision making and the administration of project inputs according to project priorities.

F) Assess the level of coordination and recommend how coordination among these entities could be improved:

1) Among project implementing agencies within each component;
2) Among project implementing agencies across project components;
3) Among the CCH office staff, the institutional contractors, and USAID;
4) Between the implementing agencies and the community;
5) Within the communities; and
6) Among donors, PVOs, NGOs, and/or other government programs working in the same area as the project.

G) Analyze the project's support for the Mission's Women in Development program.

H) Detail other lessons learned and make recommendations.

ARTICLE IV - REPORTS

The contractor will prepare a written report containing the following:

- AID Evaluation Summary Form 1330-5 (see attached)

- Table of Contents

Body of the report which should follow the format of the Scope of Work, and should not exceed 50 pages with an executive summary. It shall include a full statement of findings, conclusions and recommendations, and same should specify what entity should take the recommended action. It should also include a discussion of lessons learned.

Appendices are to include, at a minimum, the following:

a) Brief summary of the current status/attainment of project and institutional contract objectives;

b) Description of the methodology used in the evaluation;

c) List of institutions and persons consulted;

d) List of indicators to be used to show EOPS;

e) Summary of lessons learned; and

f) Summary of recommendations

B. Submission of the Report

The contractor will submit a draft report in English and make an oral presentation to USAID/Bolivia staff two days before the end of its in country work. The Mission will review and comment on the draft report promptly (within 1 week after the contractor's departure from Bolivia) and send the document back to the contractor.

The final report will be presented in both English and Spanish, and 15 copies in each language will be submitted to the Chief, Office of Health and Human Resources, USAID/Bolivia, within three weeks of the receipt of the reviewed draft report from the Mission.

ARTICLE V - STAFFING PATTERN AND QUALIFICATIONS

Ongoing support and direct input will be provided by 1) the USAID Project manager, 2) the USAID/Bolivia evaluation and monitoring specialist, and 3) project staff. A three person contract team is recommended to carry out the SOW:

1. Public Health Specialist/Team Leader who will have responsibility for the general direction of the evaluation and the writing of the report. He/she will have had extensive A.I.D. project evaluation experience and will be fluent in Spanish. He/she will be thoroughly knowledgeable of public health and child survival issues in Latin America and should be familiar with recent Bolivian experience in this area. He/she must be able to communicate effectively with the implementation agencies. An advanced degree in public health or medicine is highly desirable, and 10 years of consulting or comparable experience in public health is required. He/she should be an expatriate consultant , and will be primarily responsible for evaluating the accomplishments, and recommending changes in the orientation of the project.

2. Health Program Specialist who will assist the team leader in analyzing the Project's effectiveness in its implementation of training, supervision, district level programming, and other public health technical assistance activities. He/she will be an expatriate with a masters level degree in Public Health Administration or equivalent experience and be fluent in Spanish.

3. Systems Specialist who will be responsible for analyzing the project's implementation strategies and make recommendations for their improvement. He/she will have proven capacity in institutional analyses, including financing, procurement, personnel staffing patterns, and other administrative systems. He/she will be fluent in Spanish and can be either an expatriate or local consultant.

The contractor will submit the recommended candidates and two alternates for each position for consideration and approval of USAID/Bolivia.

45

CLEARANCES

1. Medical

The altitude of La Paz (12,500 feet above sea level) can have a deleterious effect on the health of persons with pre-existing medical problems and/or respiratory infections. Individuals with hypertension, diabetes, angina pectoris, coronary heart disease, asthma, emphysema, chronic bronchitis, or any history of heart attack, heart disease, or lung disease , should have a thorough evaluation by their physician prior to traveling to La Paz. Persons with any respiratory infection, such as a cold, bronchitis, or pneumonia should delay travel to La Paz until they have fully recovered.

USAID/Bolivia requires a doctor's statement declaring that the incoming short-term personnel are not affected by any of the above pre-existing medical problems. If such problems exist, a full physical exam is required prior to departure for Bolivia.

Adjustment to the altitude usually requires only a few days. Personnel should, if at all possible, limit their physical activity for the first 36-48 hours after arrival in La Paz.

Infectious hepatitis, amoebic dysentery, bacillary dysentery (including cholera), giardiasis, rabies and typhoid are endemic in Bolivia. Yellow fever and malaria are present in tropical areas of Bolivia. The usual sanitary precautions concerning food and water should be observed and all immunizations should be up to date prior to arrival in country. Gamma gobulin and typhoid vaccine are recommended for all adults. Yellow fever vaccine is required for all personnel travelling to tropical areas. Rabies pre-exposure prophylaxis (not the low-dose intradermal injections) is recommended for all personnel who plan to spend considerable time outdoors on foot. The Embassy Health Unit can advise personnel travelling to tropical areas concerning malaria prophylaxis on a case by case basis. The precautions and need for medications are determined by the duration of travel, the extent of exposure, and drug allergy history.

2. Security

La Paz has been classified by the State Department as a high security threat post due to attacks and threats against U.S. government officials and U.S. missionaries. Written country clearance is required from the Mission prior to arrival of each short-term consultant. It is a requirement that all visitors to post attend a security briefing in La Paz prepared by the Executive Office shortly after their arrival, in order to become familiar with measures to reduce individual vulnerabilities and to know what to do in case of an emergency. An appointment for the briefing will be arranged and transmitted in the concurrence cable.

116

ANNEX B

EVALUATION SCHEDULE

INSTITUTIONS AND PERSONS CONTACTED

EVALUATION SCHEDULE

22 November 1991:	Team Travel to Bolivia
25 - 27 November:	Team Planning Meeting in La Faz
2 - 7 December:	Field Visits to Health Districts
2 Dec.	J. Becht and G. Marr to Sacaba; B. Fisken to Cochabamba
3 Dec.	J. Becht and G. Marr to Totora
4-5 Dec.	J. Becht and G. Marr to Santa Cruz/Samaipata
6 Dec.	J. Becht and B. Fisken to Altiplano Sud
6-7 Dec.	G. Marr to Sucre
9 - 14 December:	Interviews, Analysis and Writing
11 Dec.	J. Becht to Cochabamba
16 - 18 December:	Debriefing and Writing
16 Dec.	Debriefing with CCH/JSA Staff
17 Dec.	Debriefing with USAID/Bolivia
18 Dec.	Debriefing with Ministry of Health
19 December:	Team Departure

INSTITUTIONS AND PERSONS CONTACTED

Ministry of Health: National Level

Dr. Jack Antelo S.	Director General of Health

USAID Mission to Bolivia

Carl Leonard	Mission Director
Clement Bucher	Regional Contracting Officer
Paul Hartenberger	Chief, Office of Health and Human Resources
Charles Llewellyn	CCH Project Manager, HHR
Dr. Joel Kuritsky	TAACS Advisor, HHR
Elizabeth Visnic	Evaluation Specialist, DP
Thomas Johnstone	Deputy Controller
Edmundo Ballivian	Chief, Financial Analysis Dept., CONT
Salvadore Pinzino	Food for Peace Officer, ARD
Luis Moreno	Title III Coordinator, ARD
Mahlon Barash	Office Project Development and Implementation
Matt Cheney	CCH Project Support Engineer, PD&I (PSC)

Community and Child Health Project: Central Office

Dr. Alvaro Muñoz-Reyes	Executive Director
Antonio Gomez	Information Systems Specialist and Coordinator foı Valles Cruceños District
Carlos Melgar M.	Administrative and Accounting Coordinator
Pastor Maldonado	Trainer/Social Promotion, Water and Sanitation
Daysi Vera	Accounting Assistant

JSA Healthcare Corporation

Jean Bwalya	Project Manager, JSA/USA
Rita Fairbanks	Health Education Specialist, Coordinator for Altiplano Sud District and Acting Chief of Party
Elizabeth Frias	Nutrition Specialist and Coordinator for Chapare Valle Puna District
Filiberto Ojalvo	Water and Sanitation Specialist
Edward Olney	Administrator, Water and Sanitation
Javier Palazuelos	Logistics Specialist

Dr. Jorge Velasco	Health Education Specialist (Científica) and Coordinator for Carrasco Valle District
Andrés Yale J.	Administration and Finance Coordinator

MOH: Cochabamba Sanitary Unit (Regional Health Office)

Dr. Magali de Zanier	Regional Director
Dr. Silvia Zapata	Chief of Tuberculosis Control Program and Coordinator for Chapare Valle Puna (Sacaba) an Carrasco Valle (Totora) Districts
Gustavo Clavijo	Environmental Sanitation Technician (DSA)
Abel Lizarazu	Regional Sanitary Engineer (CCH)

Chapare Valle Puna Health District

Dr. Antonio Quiroga	District Director
Berta Bustamante	Nurse Supervisor
Reynaldo Salomon	District Administrator (PL-480)
Dr. Guillermo Yañez	Health Educator (PL-480)
Paulino Huayllani	District Secretary (PL-480)
Nilda Zurita L.	Auxiliary Nurse, Ucuchi Medical Post
Guillermo Villarroel	President, Water Board, Catachilla
Felix Espinoza	President, Water Board, Chimboco

Carrasco Valle Health District

Dr. Ruth Magne	District Director (INEDER)
Dr. Alfredo Mendoza	District Dentist
Bertha Ines Choque	Nurse Supervisor
Claudio Luna	District Administrator (PL-480)
Teresa Gallinatte Vera	Health Educator (PL-480)
Edith Villegas M.	Auxiliary Nurse, Health Post, Epigana
Abram Jimenez	Auxiliary Nurse, Quehuiñapampa Health Post
Armando Baldivia	President, Health Committee, Quehuiñapampa
Dr. Oscar Sivila	Chief, Lope Mendoza Health Area
Marta Estrada	Auxiliary Nurse, Lope Mendoza Medical Post

Cochabamba Chagas' Control Project

Dr. Fanor Balderrama G.	Technical Coordinator (PL-480)
Encarnación Ricalde	Community Leader and Project Mason, Aramasí

MOH: Santa Cruz Sanitary Unit (Regional Health Office)

Dr. José Hénicke	Regional Director
Dr. Heber Vargas	Chief of Provincial Services and Coordinator for Valles Cruceñas and Chiquitania Sur Health Districts
Rita Medina P.	Regional Nutritionist
Juan Carlos Saavedra	Regional Sanitary Engineer (CCH)

Valles Cruceñas Health District

Dr. Oscar Lafuente	District Director
José Ojeda, President	Water Board, Yerba Buena Militar
Ovidio Limón	President, Water Board, Agua Clara

3 Members of the Water Board and 10 Members of the Mothers' Club

MOH: Chuquisaca Sanitary Unit

Dr. Fernando Nana Carpio	Director, Yotala Hospital
Dr. Mario Javier Baptista	Resident Physician, Yotala Hospital
Yolanda Noemi Siles	Graduate Nurse, Yotala Hospital
Rosa Garcia, Auxiliary Nurse	Yotala Hospital

MOH: La Paz Sanitary Unit (Regional Health Office)

Dr. Guido Monasterios	Regional Director
Marcelo Portillo	Environmental Sanitation Technician (DSA) and Coordinator for Altiplano Sud Health District
Humberto Claure	Regional Sanitary Engineer (CCH)

Altiplano Sud Health District

Dr. Alberto Tenorio	District Director
María Elena Anarosa	Logistics Manager (Laboratory Technician)
Miguel Conde F.	District Administrator (PL-480)
Teresa Ibañez	Nurse/Educator (PL-480)
Belinda Vargas	Nutritionist (PL-480)
Norma Rivera	Statistics Manager (PL-480)
Cesar Choque	Water and Sanitation Technician (PL-480)

Various community members in Colchani

PL-480 Executive Secretariat

Carlos E. Brockmann	Executive Secretary
René Zumarán V.	Technical Department and Project Coordinator
Frida E. Luna Z.	Chiet, Accounting Department
Enrique Yapur M.	Financial Department and Reviewer of Component 3

Non-Governmental Organizations

Jorge Salinas de Cordova	Executive Director, SANEBOL, Santa Cruz
Omar Andrade	Chief, Social Promotion, SANEBOL, SCZ
Dudley Connelly	Director, Project Concern International, LPB
Dr. Ignacio Caballeros	Medical Director, PCI, La Paz
Dr. Evaristo Maida	Project Director, PCI, Cochabamba
Raúl Bohrt P.	Research Associate, Centro Interdisiplinario de Estudios Comunitarios (CIEC)
Ruth Sensano	Executive Director, Proyecto Social Boliviano Britanico "Cardenal Maurer," Chuquisaca
Dr. Daniel Rivas	Director Médico, Proyecto "Cardenal Maurer"
Charo Arroyo	Administradora, Proyecto BB "Cardenal Maurer"
Lewis Thornton	Consultant, Instituto Internacional de Estudios Aplicados (INEA)

ANNEX C

REFERENCE MATERIALS

REFERENCE MATERIALS

Agency for International Development.
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Patacamaya, La Paz: sin fecha.

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Ministerio de Previsión Social y Salud Pública, Unidad Sanitaria de Cochabamba.
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Plan Operativo 1992. Distrito VI Chapare Valle Puna.
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Sacaba, Cochabamba: sin fecha.

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Plan Operativo 1992. Distrito III Valles Cruceños.
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ANNEX D

LOGICAL FRAMEWORK: CHILD AND COMMUNITY HEALTH PROJECT (511-0594)

LOGICAL FRAMEWORK: CHILD AND COMMUNITY HEALTH PROJECT (511-0594)

GOAL

To improve the health status of the urban and rural populations.

OVI

1. Decrease in the relevant human suffering indicators.

MOV

1. GOB records, World Bank and other international reports.

Assumptions

1. Economic conditions will not deteriorate.
2. Relative political stability will continue.

PURPOSES

To improve community health by reducing infant, child and maternal mortality.

EOPS

1. Reduction in infant, child and maternal mortality in project areas by 15%.
2. Sustained institutional and community capability to maintain CS and water and sanitation interventions.

MOV

1. Surveys: Baseline and follow-up.
2. Output data below.

Assumptions

1. Sufficient funding will be made available by the MOH to carry on CS interventions.
2. That decentralized administration will be more effective than centralized.
3. MOH, particularly at the regional levels, has sufficient institutional/administrative capability to implement the project, with assistance provided by the Project.

OUTPUTS

1. Institutionalization of CS interventions at regional level.
2. Mechanics developed for in-depth community involvement in CS interventions.
3. Strengthened primary health care system and access to it.

.62

4. CS and maternal health services delivered to target population.
5. Increased number of functioning water and sanitation facilities.
6. Changes adopted in family health behavior.

OVI

1. Increase in number of personnel functioning at district level.

2. a. Increase in number of water and health committees functioning.
   b. Community resources dedicated to CS interventions.
   c. Community involvement methodologies developed, tested and implemented.

3. a. Increase in community-based provider team (CHVs):
      - Infants receive immunization,
      - Children under 5 years receive ORT,
      - Women 15-44 years receive TT2,
      - Pregnant women receive prenatal care,
      - Births attended by trained attendant,
      - Children under 5 years monitored for nutritional status,
      - Persons receive iodine for goiter peration.
   b. Continuous training in specific CS interventions.
   c. Improvement of physical infrastructure and equipment.
   d. Improved logistical system.
   e. Increased number of people exposed to health education.
   f. Improved health services referral system.
   g. Improved HIS.

4. a. 150 new water systems, or improved water systems.
   b. 1,500 latrines built and in use.
   c. 0 + M systems established and operational.

5. a. Increased immunizations coverage.
   b. Increased diarrheal disease episodes treated with ORT.
   c. Increased number of people adopting appropriate ARI treatment.
   d. Increased number of children with appropriate weight for age.
   e. Increased monitoring and care of high risk births.
   f. Health and sanitary education materials developed, tested and implemented.

MOV

1. MOH records and project reports from MOH and TA personnel based on informal and structured observation.
2. Survey.

3. Project reports.
4. Project reports and behavior assessment.

Assumptions

1. Sufficient MOH human resources will be allocated to the project.
2. MOH will strengthen existing mechanisms to promote participation.
3. Project will support and enhance existing positive traditional health habits.
4. Project will develop culturally acceptable means of improving health behavior.

INPUTS

Financial Summary

	USAID	GOB	Total
Personnel	1,357	1,090	2,447
Technical Assistance	2,816	778	3,594
Materials & Supplies	4,954	712	5,666
Other Costs	530	856	1,386
Equipment	3,490	0	3,490
Buildings	0	88	88
Training	327	1,146	1,473
Health Education	1,160	0	1,160
Research & Evaluation	893	133	1,026
Price/Quantity Contingencies	973	697	1,670
TOTAL	16,500	5,500	22,000

OVI

1. Pro Ag specifies financial contribution of USAID and GOB

MOV

1. Controller records.
2. GOB records.
3. MOH records.

Assumptions

1. USAID will make DA funds available.
2. GOB funds will be available for PL-480.

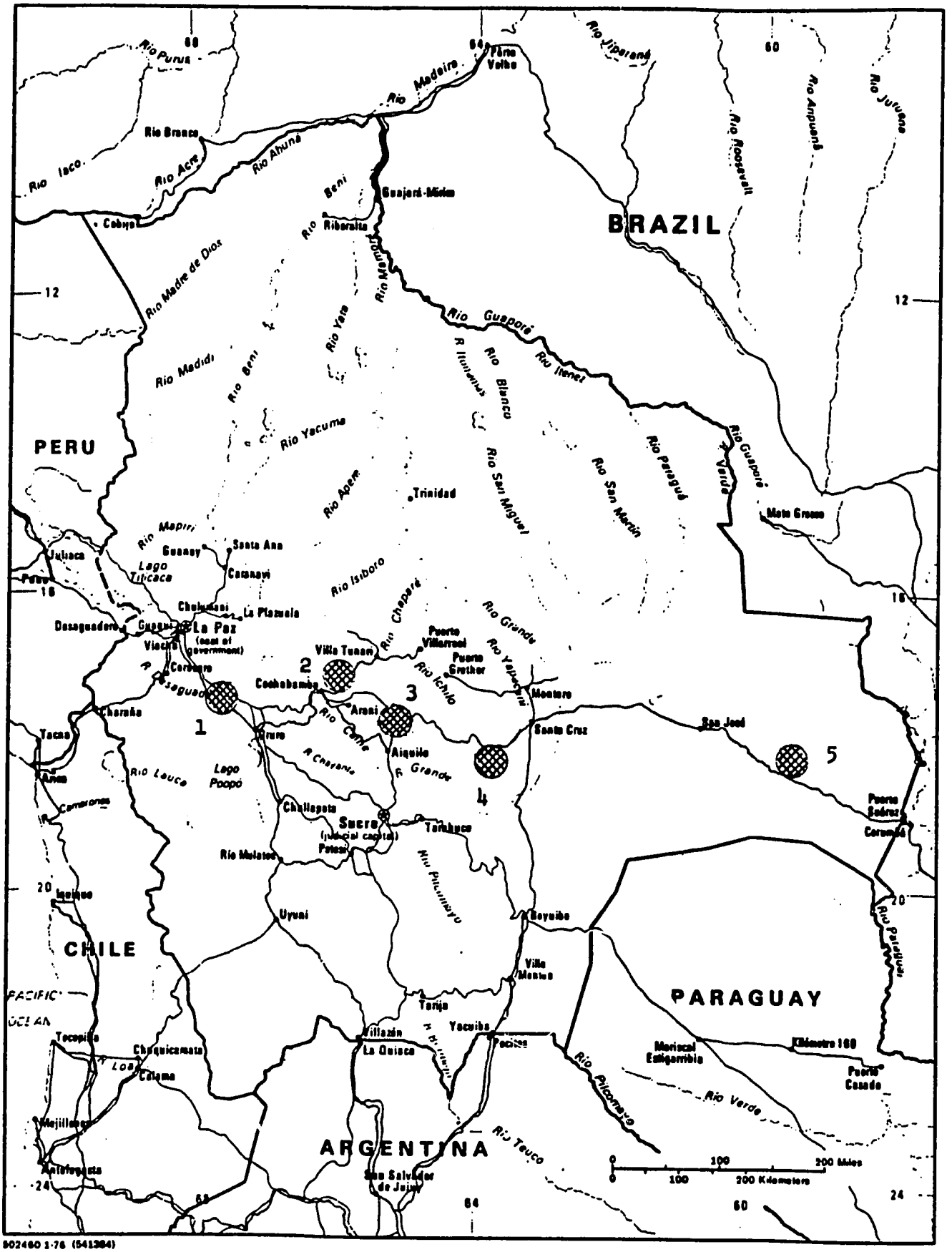
64

ANNEX E

COUNTRY MAP: LOCATION OF PROJECT DISTRICTS

COUNTRY MAP: LOCATION OF PROJECT DISTRICTS

Bolivia



502460 1-76 (541384)
Lambert Conformal Projection
Standard parallels 12°00' and 20°30'
Scale 1:8,500,000

1 - Altiplano Sud
2 - Chapare Valle Puna
3 - Carrasco Valle
4 - Valles Cruceños
5 - Chiquitania Sur (1992)

Railroad
Road
Airport

ANNEX F

COMPARISON OF INDICATORS OF IMPACT AND EFFECTIVENESS

COMPARISON OF INDICATORS OF IMPACT AND EFFECTIVENESS

LOGICAL FRAMEWORK (a)	PROJECT STATUS REPORT (b)	CONSULTANT ANALYSIS (c)	CURRENT REPORTING (d)
Goal-Level Indicators	**Goal-Level Indicators**	**Goal-Level Indicators**	**Goal-Level Indicators**
Decrease in the relevant human suffering indicators.		Percent change in < 5 years mortality by disease by district and country. Percent change in maternal mortality by district. Percent change in morbidity by (CS) disease.	Percent children < 5 yrs. with diarrhea, ARI within last 2 weeks.*
Purpose-Level Indicators	**Purpose-Level Indicators**	**Purpose-Level Indicators**	**Purpose-Level Indicators**
Reduction in infant, child and maternal mortality in project areas by 15%. Sustained institutional and community capability to maintain CS and water and sanitation interventions.	Reductions in infant, child and maternal mortality in 11 rural project districts. Increased capacity of MOH and communities to plan, implement and sustain CS interventions.	Percent children 12-23 mos. with wt x age < 2 sd below mean. Percent children 0-59 mos. with diarrhea who were treated with ORT. Percent children 12-23 mos. vaccinated by 12 mos. with BCG, DPT3, polio3, measles. Percent women 15-49 yrs. delivered in last 12 mos. with TT2. Percent infants 0-11 mos. breastfed and weaned at appropriate age. Percent women 15-49 yrs. in union currently using contraception. No. of hospital deliveries for high-risk mothers. Percent community-level births by trained TBAs.	Percent children< 5 yrs. with diarrhea who were treated with ORT.* # Percent children < 5 yrs. with BCG, DPT3, polio3, measles;* 12-23 mos.# Percent infants 0-11 mos. receiving liquid and solid foods by age.* Percent births by MDs or in MOH system.* #

COMPARISON OF INDICATORS OF IMPACT AND EFFECTIVENESS

LOGICAL FRAMEWORK (a)	PROJECT STATUS REPORT (b)	CONSULTANT ANALYSIS (c)	CURRENT REPORTING (d)
Output #1 Indicators: Institutionalization of child survival interventions at the regional level			
Increase in number of personnel functioning at district level.		Percent staff positions actually filled by GOB. Percent loaned positions restored to district. Time spent in position for each project staff person. Provision for staff positions in MOH budget.	
	Number of districts with CS operational plans implemented.	Number of districts added every year.	
Output #2 Indicators: Mechanism developed for in-depth community involvement in CS interventions			
Community involvement methodologies developed. Increase in no. of water/health committees functioning. Community resources for CS interventions.		Existence of action plan, strategy and phased steps. Existence of functioning committees by type. No. of trained community health promoters.	
Output #3 Indicators: Strengthened primary health care system and access to it			
		No. of training courses and participants organized by SU staff. No. of SU supervisory visits. Date and quantity of commodities delivered to each level of MOH.	Supervisory visits by district staff reported but not quantified.@
	No. of ORS packets delivered. No. of infants immunized. No. of women immunized TT2.	No. of immunizations, ORS packets distributed to beneficiaries. Annual implementation plans prepared.	No. of immunizations, ORS packets distributed in four districts.@ Completion of district annual operational plans.@

COMPARISON OF INDICATORS OF IMPACT AND EFFECTIVENESS

LOGICAL FRAMEWORK (a)	PROJECT STATUS REPORT (b)	CONSULTANT ANALYSIS (c)	CURRENT REPORTING (d)
Improved logistic system.		Administrative, logistic system established and functioning.	
Improvement of physical infrastructure and equipment.		Project equipment in place; being used and maintained.	
Improved HIS.		MOH HIS generating valid and reliable data.	
Increase in community-based provider teams (CHVs).	Number of persons trained: - long-term - short-term	No. of individuals trained by worker and type of training.	Total no. of people trained by gender.@
		Workers trained x district as percent of targets.	
		Trained personnel able to apply new skills.	
		Trained personnel able to effectively perform tasks.	
		Additional training needs identified and curriculum modified or developed.	
		No. and type of outreach activities launched.	No. of health fairs, est. participation by gender.@
Continuous training in specific CS interventions.		No. of CHWs trained in CS Dx, interventions, referrals.	
		Person hours per month spent in community.	
		Increased use/demand for health services.	
		Increased acceptance/use of ORS and immunizations.	

COMPARISON OF INDICATORS OF IMPACT AND EFFECTIVENESS

LOGICAL FRAMEWORK (a)	PROJECT STATUS REPORT (b)	CONSULTANT ANALYSIS (c)	CURRENT REPORTING (d)
Improved health services referral system.		Percent hospital admission derived from referrals.	
Increased number of people exposed to health education.		Use of health education materials by CHWs and auxiliary nurses.	Use of health education materials by district health personnel.#
Output #4 Indicators: CS and maternal health services delivered to target population			
Women who received prenatal care.		Number of prenatal visits.	Percent of women who received prenatal care in MOH system.*#
Children < 5 yrs. monitored for nutritional status.		No. of GM/P interventions.	
Infants received immunization. Women 15-44 yrs. received TT2.		Vaccination coverage.	
Children < 5 yrs. receive ORT.		No. of diarrheal cases Rx ORT.	
		Number ARIs treated.	
		No. of supervisory visits.	
		Number of home visits.	
Births attended by trained attendant.		No. of community talks.	
Persons receiving iodine.		No. of post-natal visits.	Percent women received post-natal care.#
		No. of people Rx with iodine.	
		Quality of performance of (health worker) duties.	

COMPARISON OF INDICATORS OF IMPACT AND EFFECTIVENESS

LOGICAL FRAMEWORK (a)	PROJECT STATUS REPORT (b)	CONSULTANT ANALYSIS (c)	CURRENT REPORTING (d)
Output #5 Indicators: Increased number of functioning water and sanitation facilities			
		Implementation plan developed for water and sanitation.	
160 new or improved water systems.	120 water systems constructed.	Percent of water and sanitation systems constructed, operating per implementation plan.	
15,000 latrines built and in use.	8,840 latrines built.	Percent of latrines built per implementation plan.	
O and M systems established and operational.		Percent of communities with functioning O and M schedules.	
		No. of maintenance technicians supported by regional SUs.	
		No. of additional technicians hired, trained, functioning.	
		No. of vehicles assigned to water and sanitation activities at SU level.	
		Level of community participation in O and M.	
		No. of breakdowns during six-month period.	
		Average no. of days/breakdown.	
		Average no. of days water and sanitation systems function without a breakdown.	
		Average no. of water quality tests in six-month period.	
		Percent tests with acceptable water quality.	

COMPARISON OF INDICATORS OF IMPACT AND EFFECTIVENESS

LOGICAL FRAMEWORK (a)	PROJECT STATUS REPORT (b)	CONSULTANT ANALYSIS (c)	CURRENT REPORTING (d)
Output #6 Indicators: Changes adopted in family health behavior			
Increased diarrheal disease episodes treated with ORT.		Percent mothers able to prepare and use ORS.	Percent mothers able to prepare and use ORS.#
		Percent diarrheal episodes < 5 yrs. Rx with ORT.	
Increased no. of people adopting appropriate ARI treatment.		Percent ARI episodes Rx appropriately.	
Increased immunization coverage.		Percent households able to produce vaccination card.	Percent children < 5 yrs. with vaccination card.* #
		Percent mothers knowing vaccination schedule.	
Increased no. of children, appropriate wt x age.		Percent households with soap in wash area.	
Increased monitoring and care of high risk births.		Percent households having or with access to latrine.	
Health sanitary education materials developed, tested and implemented.		Changes in overall community sanitation.	

(a) As presented in the project paper and project agreement.
(b) SAR, April - September 1991.
(c) Benoliel, Sharon. *Data Collection, Monitoring and Evaluation Plan.* April 1990.
(d) * Baseline Studies (1990). # Health Education Diagnostic (1991). @ CCH Quarterly Reports.

ANNEX G

SCHEDULE FOR LIQUIDATING PL-480 FUNDS: NON-CHAGAS ACCOUNT

PROGRAMA DE DESCARGO DE FONDOS PL-480

CUENTA NO-CHAGAS

RECURSOS RECIBIDOS

9/27/90	Bs.	465,000
8/27/91	Bs.	704,250
TOTAL RECIBIDO		1.169,250

PRESENTACION DESCARGOS POR EL PROYECTO CCH

ABRIL/91	Bs.	332,154.36		28%
JUNIO/91	Bs.	401,974.00		34%
JULIO/91	Bs.	433,974.00		37%
AGOSTO/91	Bs.	463,974.00	(*)	40%
SEPTIEMBRE/91	Bs.	863,500.00	(*)	74%

(*) VARIACION PORCENTUAL DEL + - 2%

Los descargos de estos fondos se realizarán a más tardar a fecha 20/12/91.

ANNEX H

JSA ACCOMPLISHMENTS (prepared by JSA Healthcare)

JSA ACCOMPLISHMENTS

BOLIVIA COMMUNITY AND CHILD HEALTH PROJECT

CONTRACT NO. 511-0594-C-00-0020-00

The following are the accomplishments made by JSA on the above-mentioned project.

STAFFING

JSA, in a timely manner, oriented and fielded all long-term technical assistance to the project. JSA also identified, oriented and fielded U.S.-based short-term consultants.

JSA project staff recruited, interviewed, recommended project staff for the Districts and for the water and sanitation activities.

FINANCIAL MANAGEMENT

Clarified and documented USAID and PL480 approval and disbursement processes for obtaining funds.

Made progress in obtaining PL480 funds. JSA became directly involved in the process i.e., supervising presentation of reports and obtaining documentation identifying solutions to certain problems which had caused the withholding of funds.

JSA contracted Price Waterhouse to conduct an external financial audit of the CCH Office.

SUBCONTRACTORS

Developed, negotiated, and executed a subcontract with Coopers and Lybrand. Accordingly Coopers and Lybrand designed the administrative systems for the project and developed manuals for District financial management.

Developed, negotiated, and executed a subcontract with CIENTIFICA. Accordingly, the local Health Educator was hired and began working effectively and coordinating activities in the Districts. Additionally JSA provided assistance to CIENTIFICA in setting up adequate overhead cost rates.

77

WATER AND SANITATION

Assumed responsibility for planning and execution of Water and Sanitation component of the project from the DSA. JSA identified and hired short-term consultant, Andrew Karp, to assist the Water and Sanitation engineer. There is now a global vision of how the water and sanitation component will be carried out, and a chronogram of activities has been developed.

Supervised the construction of two water systems, which have been completed. Initiated construction and community education in 17 communities.

Negotiated and contracted with NGOs for the construction of water systems.

PROCUREMENT

Recommended models, assisted in developing specifications, and tracked the USAID procurement of vehicles and computers.

Identified sources, purchased and shipped computer software appropriate for CCH office needs.

Identified sources, purchased and shipped PVC accessories for Water and Sanitation component.

TECHNICAL ASSISTANCE ACTIVITIES

JSA project staff were responsible for the following activities:

Initiated monitoring and supervision of district activities;

Promotion of child survival interventions;

Strengthened radio education programs and produced guidelines for elaboration and transmission of programs;

Initiated educational talks in District mothers' clubs, communities, and individual homes;

Established health fairs in the districts;

Developed a health education diagnosis;

Developed a health education bulletin;

Reviewed, revised, printed and distributed health education materials;

-18

Developed inventory of existing health education materials;

Supported the committe for the development and evaluation of health education materials;

Conducted training in potable water,

Conducted training for doctors, and auxiliary nurses;

Identified and sent people to be trained in health education and health education administration;

Conducted training in health education techniques;

Conducted training of health promoters in community participation, high risk pregnancies, prevalent diseases and ORT;

Conducted courses in nutrition education/community participation;

Conducted courses on nutritional surveillance;

Strengthened the community health committees;

Supported district promotion and training in EPI and ORS;

Supervised and assisted in the preparation of district operational plans; identified and contracted persons to conduct training in Log Frame to further facilitate preparation of plans;

Supported the establishment of the CCH technical library;

Established contacts both in the U.S. and in Bolivia in an effort to establish uniform systems in Water and Sanitation training;

Conducted social communication activities such as development of jingles, painting of murals, etc;

Initiated observation learning visits for health workers in the districts to exchange ideas and information.

OTHER

Identified the fifth district, Chiquitania Sur, and is negotiating a subcontract with PCI for the coordination of activities in that district.

Assisted in the preparation of necessary documentation for the extension of the Project.

Assisted in the preparation of necessary documentation for the restructuring of the Project.

Established coordination and collaboration with other donors, such as other divisions of the Ministry of Health, UNICEF, CARE, Planning Assistance, CARITAS, PROCOSI, World Vision, Food for the Hungry, INEDER and the Federation of PVOs.

ANNEX I

LIST OF FUNDING SOURCES OF CCH PROJECT PERSONNEL

LISTA DE PERSONAL CCH (POR FUENTE DE FINANCIAMIENTO)
LIST OF FUNDING SOURCES OF CCH PROJECT PERSONNEL

NOMBRE	CARGO
USAID	
KURITSKY, JOEL	ASESOR TECNICO TAACS USAID/B
CCH - USAID	
CABALLERO, FERNANDO	ASISTENTE A&S CCH LPB
CLAURE, HUMBERTO	INGENIERO REGIONAL A&S CCH LPB
LIZARAZU, ABEL	INGENIERO REGIONAL A&S CBB
LOPEZ Z, JUAN	OPERADOR RADIO CCH LPB
MALDONADO, PASTOR	ENTRENADOR EN PROMOCION SOCIAL A&S
MERCADO, CONSUELO	SECRETARIA CCH LPB
MUÑOZ-REYES, ALVARO	DIRECTOR EJECUTIVO CCH LPB
SAAVEDRA, JUAN CARLOS	INGENIERO REGIONAL A&S SRZ
CHAGAS PL-480	
BALDERRAMA FANOR	COORDINADOR TECNICO NAL. CHAGAS CBB
BERMUDEZ HERNAN	CHAGAS CBB
BURGOA JAIME	COORDINADOR ADM. NAL CHAGAS LPB
DE LA RIVA, PATRICIA	SECRETARIA CHAGAS LPB
MALDONADO MARIELA	SECRETARIA CHAGAS CBB
MUÑOZ-REYES, RODRIGO	COORDINAR EN EDUCACION CHAGAS LPB
ZELAYA, EDUARDO	MENSAJERO CHAGAS LPB
CCH PL480	
GOMEZ, ANTONIO	CONSULTOR SISTEMAS INF. CCH LPB
MELGAR, CARLOS	COORDINADOR ADMINISTRATIVO/CONTABLE
MOLLER, MARIA ANTONIETA	BIBLIOTECARIA CCH LPB
QUISPE, ALBERTO	MENSAJERO CCH LPB
VERA, DAYSI	ASISTENTE CONTABILIDAD-SECRETARIA
VILLAROEL, ERICK	ANALISTA DE SISTEMAS CCH LPB
D I S T R I T O S	
TENORIO, ALBERTO	DIRECTOR ALTIPLANO SUD
MAGNE, RUTH	DIRECTORA CARRASCO VALLE
LA FUENTE, OSCAR	DIRECTOR VALLES CRUCEÑOS
QUIROGA, ANTONIO	DIRECTOR CHAPARE VALLE PUNA
ZAPATA, SILVIA	COORD.DISTRITOS COCHABAMBA
CONDE, MIGUEL	ADMIN. ALTIPLANO SUD
LUNA, CLAUDIO	ADMIN. CARRASCO VALLE
BUSTAMANTE, JEANNETTE	ADMIN. VALLES CRUCEÑOS
SALOMON, REYNALDO	ADMIN. CHAPARE VALLE PUNA
JSA	
FAIRBANKS, RITA	JEFE EQUIPO, a.i. JSA LPB
FRIAS, ELIZABETH	CONSULTORA EN NUTRICION JSA LPB
LEMUS FREDDY	ASISTENTE LOGISTICA A&S JSA LPB
LOAIZA, MARIA ESTHER	ASISTENTE ADMINISTRATIVO JSA LPB
MONTES, SILVIA EGUINO DE	SECRETARIA EJECUTIVA JSA LPB
OJALVO, FILIBERTO	CONSULTOR A&S
OLNEY, EDWARD	ADMINISTRADOR A&S JSA LPB
ORLANDINI, MILENKA	SECRETARIA JSA LPB
PALAZUELOS, JAVIER	CONSUNTOR EN LOGISTICA JSA LPB
VELASCO, JORGE	CONSULTOR EN EDUCACION (CIENTIFICA)
YALE, ANDRES	COORDINADOR ADMINISTRATIVO JSA LPB
VBC	
LEA PLAZA, JUAN CARLOS	CONSULTOR EN SISTEMAS Y COMP. VBC

92

ANNEX J

LIST OF PROJECT IMPLEMENTATION LETTERS

LIST OF PROJECT IMPLEMENTATION LETTERS (17)

Nr.	Date	Purpose
1	Sept. 26, 1988	Project Agreement is legally binding
2	Oct. 28, 1988	Dr. Joaquin Arce Lema is authorized GOB Representative to CCH Project.
3	Feb. 8, 1989	AID Procedures for implementation of GRANT
4	March 27, 1989	Reimburses PAHO for syringes in amount of $ 141, 522.
5	March 30, 1989	Authorizes $ 2,000 for survey cost.
6	Aug. 3, 1989	Approves Temporary Action Plan and Estimated 1989 Budget.
7	March 9, 1990	Authorizes disbursements for project expenses in District III of Santa Cruz Sanitary Unit and Ayo-Ayo district.
8	April 3, 1990	Authorizes disbursements for project expenses in various Districts.
9	April 16, 1990	Approves 1990 Operational Plan and Budget for Parts of Elements II & III.
10	May 2, 1990	Revises "Project Management Unit" description. This replaces prior description contained in Grant Agreement.
11	Aug. 14, 1990	Approves PL-480 1990 contribution budget.
12	Nov. 16, 1990	Approves $ 500,000 budget for Chagas (Element IV) which includes $ 51,000 for Project Management Unit expenses.
13	Dec. 11, 1990	Shifts $ 150,000 from Element 1 to Element 2.
14	March 14, 1991	Provides for disbursements on project activities and acknowledges receipt of 1991 Operating Plan and Budget for Element III.
15	May 17, 1991	Sets forth procedures for implementing the Water & Sanitation Component of Grant. The budget for Element III is also revised.
16	May 22, 1991	Modifies description of Project Management Unit.
17	June 3, 1991	Extends Agreement form July 28, 1993 to July, 1994.

84

ADMINISTRATIVE LETTERS

No.	Date	Purpose
1	May 5, 1991	Provides budget for Element V - Immunization Activity.

ANNEX K

REVISED PROJECT BUDGET (PIL-13)

PROYECTO SALUD INFANTIL Y COMUNITARIA
COMMUNITY AND CHILD HEALTH PROJECT
(511 - 0594)

PRESUPUESTO REVISADO DEL PROYECTO/
REVISED PROJECT BUDGET

(US$)

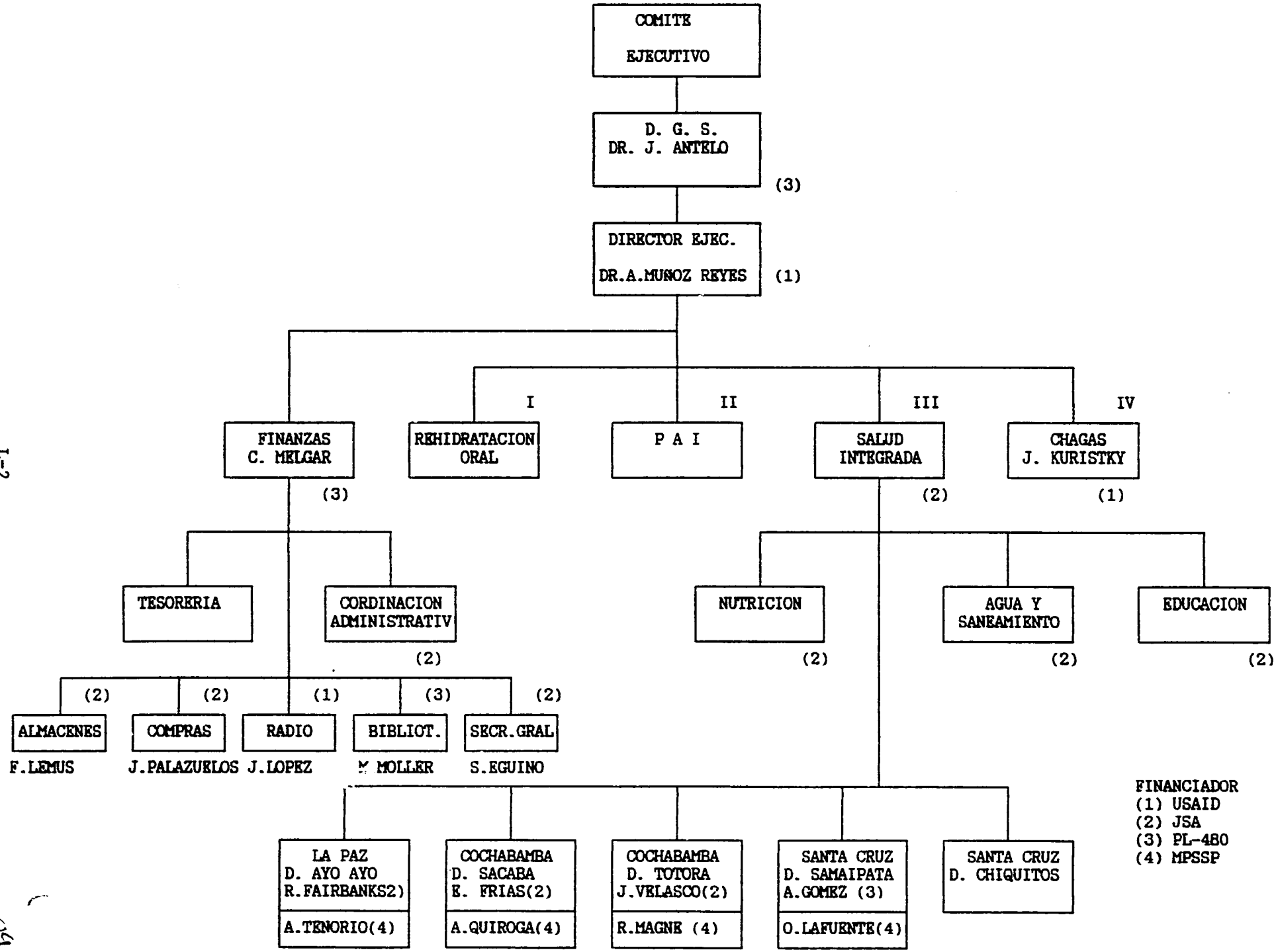
ELEMENTO/ELEMENT	AID ORIGINAL	AID TRANSFERENCIA/ TRANSFER	AID REVISADO/ REVISED	GOB
I. REHIDRATACION ORAL/ORAL REHYDRATION				
A. Asistencia Técnica/Technical Assistance	$ 0	$ 0	$ 0	$ 0
B. Entrenamiento/Training	$ 0	$ 0	$ 0	$ 0
C. Bienes/Commodities	$ 1,000,000	($ 150,000)	$ 850,000	$ 0
D. Otros Costos/Other Costs	$ 0	$ 0	$ 0	$ 0
Subtotal	$ 1,000,000	($ 150,000)	$ 850,000	$ 0
II. INMUNIZACION/IMMUNIZATION				
A. Asistencia Técnica/Technical Assitance	$ 0	$ 0	$ 0	$ 0
B. Entrenamiento/Training	$ 400,000	$ 0	$ 400,000	$ 300,000
C. Bienes/Commodities	$ 2,150,000	$ 150,000	$ 2,300,000	$ 1,000,000
D. Otros Costos/Other Costs	$ 750,000	$ 0	$ 750,000	$ 0
Subtotal	$ 3,300,000	$ 150,000	$ 3,450,000	$ 1,300,000
III. SI INTEGRADA/INTEGRATED CS				
A. Asistencia Técnica/Technical Assistance	$ 2,816,000	$ 0	$ 2,816,000	$ 776,000
B. Entrenamiento/Training	$ 327,000	$ 0	$ 327,000	$ 1,146,000
C. Bienes/Commodities	$ 3,644,000	$ 0	$ 3,644,000	$ 0
D. Otros Costos/Other Costs	$ 4,913,000	$ 0	$ 4,913,000	$ 2,276,000
Subtotal	$ 11,700,000	$ 0	$ 11,700,000	$ 4,200,000
IV. CHAGAS				
A. Asistencia Técnica/Technical Assistance	$ 400,000	$ 0	$ 400,000	$ 340,000
B. Entrenamiento/Training	$ 0	$ 0	$ 0	$ 50,000
C. Bienes/Commodities	$ 49,000	$ 0	$ 49,000	$ 2,080,000
D. Otros Costos/Other Costs	$ 51,000	$ 0	$ 51,000	$ 30,000
Subtotal	$ 500,000	$ 0	$ 500,000	$ 2,500,000
Total	**$ 16,500,000**	**$ 0**	**$ 16,500,000**	**$ 8,000,000**

81

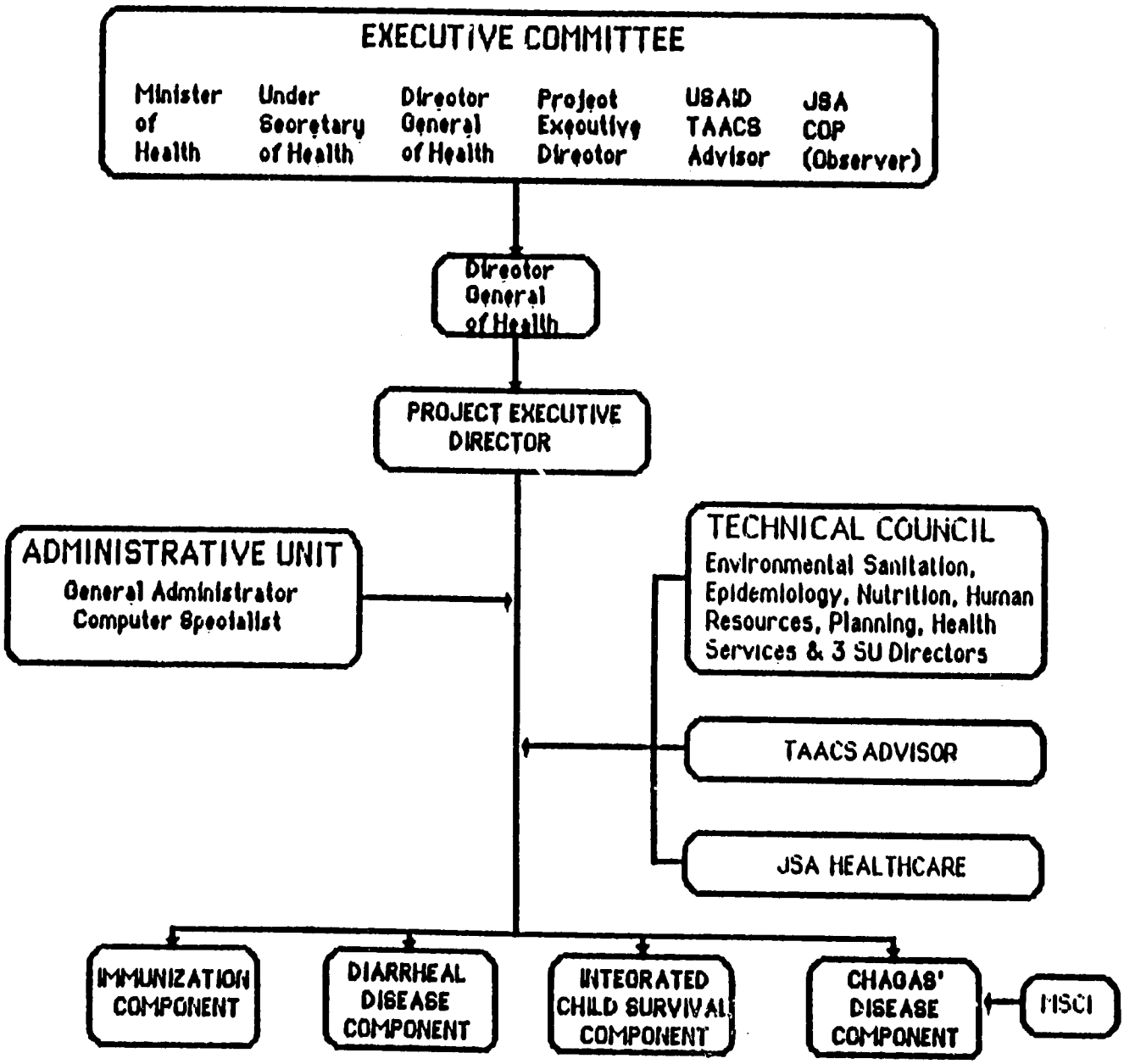
ANNEX L

CURRENT PROJECT ORGANIZATION CHARTS

PROYECTO DE SALUD INFANTIL Y COMUNITARIA



PROJECT MANAGEMENT UNIT
COMMUNITY AND CHILD HEALTH PROJECT



ANNEX M

FINANCIAL STATUS REPORT (6 November 1991)

PROYECTO DE SALUD INFANTIL Y COMUNITARIO
511-0594
ESTATUS DE FINANCIAMENTO
06/Noviembre/91
(US$)

	ELEMENTO	PRESUPUESTADO	PROGRAMADO	GASTADO	POR PROGAMAR
REHIDRACION ORAL					
01-C	BIENES	$850,000	$330,537	$3,637	$519,463
INMUNIZACIONES					
02-B	ENTRENAMIENTO	$400,000	$147,200	$147,200	$252,800
02-C	BIENES	$2,300,000	$2,149,523	$1,766,564	$150,477
02-D	OTROS COSTOS	$750,000	$737,000	$554,689	$13,000
	SUB-TOTALES	$3,450,000	$3,033,723	$2,468,453	$416,277
SI INTEGRADO					
03-A	ASTENCIA TECNICA	$2,816,000	$2,594,596	$1,416,119	$221,404
03-B	ENTRENAMIENTO	$327,000	$143,272	$42,272	$183,728
03-C	BIENES	$3,644,000	$2,016,562	$163,354	$1,627,438
03-D	OTROS COSTOS	$4,913,000	$779,597	$332,205	$4,133,403
	SUB-TOTALES	$11,700,000	$5,534,027	$1,953,950	$6,165,973
CHAGAS'					
04-A	ASISTENCIA TECNICA	$400,000	$400,000	$168,273	$0
04-C	BIENES	$49,000	$47,751	$15,527	$1,249
04-D	OTROS COSTOS	$51,000	$51,000	$19,467	$0
	SUB-TOTALES	$500,000	$498,751	$203,267	$1,249
	TOTALES	$16,500,000	$9,397,038	$4,629,307	$7,102,962

'92