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WORLD VISION INTERNATIONAL, ROMANIA PROGRAM OFFICE

**PRIMARY HEALTH CARE PROJECT, CLUJ-NAPOCA
MIDTERM EVALUATION REPORT
April 21-May 4, 1993**

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Joe Wray, MD, MPH

EXECUTIVE SUMMARY

Purpose of Evaluation: Assess project achievements to date and make recommendations for future directions of the project.

Project Background: The World Vision Primary Health Care (WV PHC) project in the Judet of Cluj-Napoca, Romania, is under the direction of Dr. Virginia Canlas, with a staff of one other expatriate and five Romanian health professionals, including her deputy, Dr. Mircea Lapusan, and a full-time health educator, Dr. Mariana Cuceu, as well as supporting staff. The WV headquarters staff in Bucharest provides back-up, supported by WV in Monrovia, California. The project, originally scheduled to begin in late May 1991, and continue through May 1994, got securely under way only in May 1992. Dispensaries in two districts of Cluj—Zorilor and Manastur—and in the rural communities of Feleacu and Maguri Racatau are participating.

Project Objectives: The general objective of the project is to improve the delivery of PHC services and to increase community support of PHC. Specific objectives include establishing a senior project advisory committee in Cluj, providing education and training activities for both health personnel and the public, establishing a management information system, providing equipment and supplies to the dispensaries, encouraging and motivating medical students toward PHC, enlisting community leaders to support PHC, and producing health education/promotion literature.

Activities to Date: The advisory committee has been recruited and established, but the members have been displaced from the health administration posts; new members will be recruited. A wide variety of educational and training activities has been carried out in dispensaries, schools, and elsewhere dealing with such issues as breast-feeding, family planning, AIDS, etc. KAP surveys were conducted in three of the communities, used to identify PHC priorities, and intended to provide baseline data for evaluation. Medical students participated in these surveys and the project team has met with medical student groups. Three substantial workshops or conferences have been held: a Primary Health Care Seminar in October 1992 for over 60 health personnel; a Family Planning Workshop in January 1993 for 17 physicians and 4 nurses; and a PHC Awareness Workshop in April 1993 for dispensary staff, community leaders, and others. Romanian physicians played key roles in all three of these activities. Educational brochures on family planning and breast-feeding have been published; others are in preparation.

Accomplishments to Date: The WV PHC team members are proud of the many classes and training exercises they have carried out and of the three workshops. They are also proud of the active role of Romanian faculty in the workshops. They have no doubt that both medical personnel and the lay public have acquired new information about many aspects of PHC and that their behavior has changed as a result. Conversations with people in many places suggest that the pride is justified. In addition, the workshops seem to have convinced some of the participants that they can do things on their own, and they are taking initiative and responsibility to get things going.

The KAP surveys, as spelled out in the body of this report, were of limited value because of flaws in the questionnaire as well as in the data processing. Thus the specific results cannot be used as a quantitative baseline for evaluation.

The workshops, the teaching activities, and the other interactions between the WV team and the health-care community of Cluj, have produced an understanding of the project on the part of the latter and a level of trust that was not present in the beginning. Now it is likely that several things not possible earlier can be done. These include getting more community support for PHC activities and working with faculty members from the medical school to improve the teaching PHC for medical students.

Little progress has been made in improving the supply and equipment situation in the participating dispensaries.

Key Recommendations: Even with a no-cost extension, the remaining life of this project is limited. For that reason the most important recommendation is to begin now to transfer responsibility for project activities to Romanian individuals and institutions, with the WV team providing back-up and support rather than carrying out the activities. As detailed in the report, the advisory committee needs to be changed somewhat to include current directors of health at the Judet level and encouraged to take more responsibility for project management. There is a need to develop a better agreement on the content of PHC needed in Cluj and to review present health-care activities in the light of that agreement.

In line with the first recommendation, the workshops, conferences, and educational and training activities need to be turned over to Romanians. In the case of health education, expert technical assistance is recommended. The management information system must be kept as simple as possible, based on the PHC activities agreed upon, and capable of operation without a computer. Technical assistance is also recommended if it is decided that further KAP surveys are required. An assessment of supplies and equipment is needed, and WV should do what it can to meet some of those needs, but emphasis should be placed on finding self-sufficient ways of meeting such needs. A work plan based on these recommendations is needed and the accomplishment of agreed-upon activities should provide the basis for evaluation in February 1994 to determine whether or not a no-cost extension, through May 1995, is justified.

I. INTRODUCTION

As stated in the most recent PHC project quarterly report, "The World Vision Primary Health Care (PHCP) project was designed with [the] aim of assisting the Romanian health-care system to build up community-based general health services, in close collaboration with Romanian specialists, health authorities, and communities. The project is developed in one region, the Cluj County, and is funded by the United States Agency for International Development (USAID) [and in part by World Vision International]. Its formal start date [was] September 1991. The overall goal of the project is to assist communities and health professionals in Cluj County in improving the responsiveness and effectiveness of their health-care service, by reorienting and reinforcing community-level service delivery along Primary Health Care (PHC) principles."

The original "Detailed Implementation Plan" (Appendix I) was submitted to USAID on June 25, 1991, and the project was scheduled to be carried out between July 1, 1991 and December 31, 1992. When actually approved by USAID, it was to extend from 24 May 1991 to 31 May 1994. For various reasons there were significant delays in getting the project under way and the implementation plan was substantially revised (Appendix II) on May 22, 1992. A nurse, Ms. Laurel Stevens, was recruited in September 1991 and carried out the initial activities. Dr. Virginia Canlas, the present project director, arrived in Cluj in April 1992; Dr. Mircea Lapusan was appointed Deputy Project Director soon afterwards, and Ms. Megan Kerr replaced Laurel Stevens as Technical Coordinator in September 1992. Recruitment of staff is continuing to this date; thus, although two years of the time scheduled for completion of the project have passed, it has, in fact, been staffed and operational for little more than a year.

II. EVALUATION PROCESS

A. Objectives of the Midterm Evaluation

The specific objectives set for the evaluation of the WV PHC project were as follows:

1. To assess the progress of the project toward achieving its goals.
2. To make recommendations on project direction for the remainder of project life.

B. Evaluation Methodology and Schedule of Activities

As the consultant appointed to carry out this midterm evaluation, Dr. Joe Wray reported to the World Vision headquarters office in Bucharest on Wednesday, 21 April and on Friday, 23 April, was briefed by WV staff in Bucharest, including World Vision's Regional Director, Mr. Loc Le-Chau, and by Program Directors Dr. Virginia Canlas, Ms. Pamela Forsyth, Ms. Joanne Gates, and Dr. Mihaela Oala. In addition, Dr. Wray met with Mr. Alan Noble of the WVRD headquarters staff in Monrovia, CA, and with David Sleight, Finance Manager, and Ann Marie Baker, Human

Resources Manager, in the Bucharest office. There were also conversations with Dr. Mary Ann Micka, who is the USAID Human Resources Development Officer and responsible for A.I.D. health activities in Romania, and with officials at the Ministry of Health, including Dr. Alin Stanescu, Director for Health Programs and Reform, and Dr. Alexandru Opran, Minister for Health Care.

On Friday evening Dr. Wray flew to Cluj-Napoca, where the PHC project is being carried out, and remained there until May 1, 1993. The primary evaluation tools used included interviews with key personnel, a number of site visits, review of project documents, and group discussions, as follows:

- In the project office formal interviews and informal discussions were held with all the staff members, both part- and full-time, expatriate and Romanian, on numerous occasions. Project staff interviewed included Dr. Virginia Canlas, the project Manager, her Deputy, Dr. Mircea Lapusan; the Technical Coordinator, Ms. Megan Kerr; and the four health educators—Dr. Mariana Cuceu, who is full-time, and Daniela Glansca, Doina Malai, and Marieta Filip. Informative conversations invariably occurred while traveling to field sites as well.
- The dispensaries that are participating in the project were visited. Interviews were held with Dr. Maria Marta in the Zorilor district of Cluj and with Drs. Gabriela Ona and Corina and Marieta Filip, the nurse in the Manastur district. (The latter two are also part-time health educators employed by the project.) Further interviews were conducted in the rural dispensary in the village of Feleaca with Drs. Maria Suci and Liasa Raza, and in the more remote village of Maguri-Racatu with Drs. Mihai Dragomir, Susana Leb, and Kiss Sandor. In each of the facilities leisurely visits with the medical and nursing staff and a tour of the facilities were also made. In the two rural dispensaries, the directors of the villages schools, both of whom are enthusiastically participating in health education activities, were met. Dr. Rosca had recently returned from a WV-sponsored visit to Indonesia where he participated in a family-planning training program.
- Four members of the original project advisory/monitoring team—Drs. Camelia Banu, Camil Casanu, Georghe Geanta, and Radu Vinereanu—and the newest member, Dr. Ioan Bocsan, who is both the Professor of Epidemiology in the medical school and the newly appointed Deputy Director of the Directia Sanitate of Cluj, were all met.
- Professor Vasile Surcel, Director of the First Gynecologic Clinic of the University, and his assistants, Drs. Augustin Rosca and Dan Ona, were visited. Surcel and Rosca carried out the Family Planning Training Program last January and are eager to do more. They have already initiated a course in family planning for the medical students. The not-yet-opened World Bank-sponsored Family Planning Center, where Dr. Georghe Geanta is the director, was also visited.

- At the medical school, Mr. Loc Le-Chau and Dr. Wray spent an evening discussing PHC and medical education with 15 or 20 medical students, of which perhaps six were intensely interested.
- On every occasion, the consultant was treated with the warmest possible hospitality and given full cooperation in carrying out the evaluation.

Three days in Bucharest were spent collating and analyzing the observations made and information obtained, and formulating reasonable and feasible recommendations for the future of the project. While an abundance of information was gathered, the time-consuming process of assimilating and adequately understanding the myriad interpersonal and sociocultural factors that affect what can or should be done was difficult and frequently frustrating.

C. Limitations of this Evaluation

Although the WV PHC project got off to a slow start, and the team has been assembled over a period of several months, the team has been very busy and many activities have been carried out. The result, is that much has been done to achieve the objectives spelled out in the project implementation plan—too much to cover everything satisfactorily in a one-week field visit. Thus, in the process of writing this report, it has become clear that information is lacking about many issues or aspects of the project. These deficiencies may have led to misunderstanding of what is happening and the possibility of omissions in this report.

III. EVALUATION FINDINGS

A. Background: Health Care in Romania

The achievements of the WV PHC project to date are considerable, mixed, and cannot always be related clearly to stated project goals or to activities carried out. Project achievements need to be viewed in light of the fact that Romania is not a Third World country. In spite of the disasters of recent decades, Romania is a country with a rich cultural and intellectual history, a well-educated population (a literacy rate, for example, that is probably higher for both men and women than that in the U.S.), and is abundantly supplied today with people who are eager to learn.

It must be noted, however, that under the old regime, health-care activities were carried out on an extremely rigid and authoritarian basis, and health-care personnel who failed to conform to the prescribed norms were penalized and punished in other ways. Thus there are also many people who remain depressed and who are reluctant to take responsibility or initiative—and some of these are in high places. It must also be noted that the habit of waiting passively for authorities to give orders is deeply ingrained and cannot be expected to change overnight. For that reason those who are willing and eager to change deserve the best possible support and encouragement.

In many ways the existing infrastructure—including hospitals, polyclinics, dispensaries, and "health points"—is remarkable, even if many of the facilities are deteriorating. The network of health-care facilities and the abundance of health personnel throughout the system is unbelievable when compared with that in most countries. If ways can be found to exploit that system—to maintain it, to improve it where needed—in the face of the mounting economic problems in Romania today, it provides an excellent infrastructure for the provision of PHC.

In addition, the patterns of care prescribed for the home-visiting and health supervision of mothers postnatally and for children under the age of five, put in place long before PHC as we know it was "invented," present a rich variety of possibilities for improvement if they can be maintained. Much has been made of the fact that the infant mortality rate (IMR) in Romania is among the highest in Europe, and this is seen by some to reflect deficiencies in PHC. In fact, the Romanian IMR is lower than that in many neighborhoods of New York City and Washington, D.C., where the excessive rates are attributed to socioeconomic and cultural factors as much or more than to health care. The same attribution can reasonably be made in Romania. It is certainly possible to identify specific deficiencies in the MCH programs, but the existing patterns are not bad, immunization coverage is excellent, and it may well be that the IMR has been reduced nearly as much as possible by health care alone.

Brief mention of some of the paradoxes that exist in the Romanian health care system today points up some of the issues and problems:

- Although preventive medicine as we know it may not be taught in medical schools in Romania, there is surely an appreciation of the importance of prevention. Some health official long ago decided, not unreasonably, that every child should be immunized. Rather than leaving this essentially to chance, as is done in many places, laws were passed that, among other things, made immunization compulsory, required the police to enforce the requirements, and meted out penalties to health personnel when certain standards weren't met. Some Romanian physicians, understandably, resent the totalitarian approach so much they lose sight of the benefits of immunization and of the genuine benefits to children when there is total immunization coverage.
- Out of a concern to increase survival, another Romanian health authority, at some point in time, decided that doctors should be penalized if a patient under their care died. This led to a variety of well recognized abuses and was repugnant to most physicians. For example, it was revealed that when there is a stillbirth, the obstetricians record it as a live birth and pass the baby on to the pediatricians so that these will be held responsible. In order to assign blame (or pass it on to someone else), all cases of mortality are formally reviewed, an ordeal when the purpose is punitive. Such reviews, however, can and should be carried out, not to penalize, but to try to learn whether there were factors that might have been avoided that contributed to the death.
- Appreciation of the importance of preventive medicine is also apparent in the excellent pattern of ante- and postnatal home visits that are carried out, both

by the child-care and the mother-care specialists—the sort of schedule that has been recommended as ideal by MCH consultants for decades but is almost never possible to implement for lack of personnel. While there may be omissions in some of the care—the lack of family planning, for example—the important thing is that the infrastructure is there and the visiting schedule is totally accepted by the health personnel. The extravagant abundance of personnel in Romania makes it possible. What should be of concern are the likely effects of the economic situation, as the number of personnel available shrinks, as well as the impact of whatever is done to "privatize" care.

- One other item of maternal care deserves mentioning here. There is a great deal of concern throughout the world today about maternal mortality. One of the most widespread and vexing problems is what to do about women who are at high risk of obstetrical complications and live in remote areas, far from a first referral hospital. One solution that has been proposed, but rarely tried effectively, is the utilization of "maternity waiting homes"—facilities where women can wait, as they approach term, so that if complications do arise, they can be sent quickly to a hospital. In this context it was intriguing to find that the maternity-waiting-home concept is used routinely in the participating Health Center at Maguri-Racatau which has ten beds—yet another "old" practice that deserves to be continued indefinitely.

≡B. Assessment of Progress Towards Achieving Project Objectives

1. *Health Education*

Both the original and the revised project implementation plans emphasized the health education activities to be carried out in this project. Conversations with the team and a review of project documents reveal that indeed many such activities have been carried out. Furthermore, observations in the project office in Cluj as well as discussions with the project team, both expatriate and Romanian, revealed great interest and enthusiasm for these activities and satisfaction with those that have been carried out. Team members have prepared informational brochures and also given many classes on breast-feeding and family planning for mothers (and even some fathers). They have also performed some AIDS educational activities, including a class prepared for the police of Cluj who deal with the prostitutes that serve the truck drivers who now pass through Cluj rather than Yugoslavia on their way to Europe. In addition, they are working with senior teachers in the two rural project sites to provide relevant health education to the school children in those communities.

The Revised Implementation Plan (RIP) called for the development and implementation of a health education strategy and went on to state:

The institution with primary responsibility for the health education in the Cluj area is the Center for Preventive Medicine and Health Education Laboratory, and World Vision's health education strategy has been planned in close contact with the Center The Center

is theoretically responsible for health education for all sectors of the population, but has inadequate resources and is not able to provide any appreciable amount of health education except for children in schools. World Vision will support the center's work through the provision of equipment and funding for materials. (RIP, p. 4)

A health education strategy has been developed, based on perceived findings from the KAP survey, and is reflected in the specific objectives spelled out in the RIP (pp. 7 and 8) and discussed below. If the strategy is available in written form, it was not seen; nor is it known whether or not there were significant inputs from the Center for Preventive Medicine in the development of that strategy. The Director of the Center, Dr. Camil Caseanu, is a member of the project Advisory Committee. He made it clear in conversation that he is in general agreement with the WV project, but he personally is concerned about alcoholism, smoking, etc. If WV has provided support to the Center "through the provision of equipment and funding for materials," this was not made clear in the evaluation.

In the section entitled "Lessons Learned from the Progress of the Project to Date" (section 2.1, pp. 2-4), the Revised Implementation Plan states:

Health education, which is at the core of PHC, is not an easy issue to tackle in Romania. Where health education is carried out here, it is usually by teachers or health professionals with no special training in health education, and the teaching style is didactic and authoritarian rather than participative. While the methods already in use in Romania need redeveloping, methods formulated in Third World settings are inappropriate for this society. This is recognized as a major problem which the staff currently employed is not qualified to resolve without assistance. Efforts are being made to recruit as an addition to the team a qualified and experienced health educator who will be in a position to identify appropriate methods and to train Romanian staff in community health education.

Rather than identifying and recruiting a health educator, as described above, the decision was made to hire Romanians (three physicians and one nurse) to work with Megan Kerr on a part-time basis as health educators. As enthusiastic and committed as they are, none of the team members has had any specific education or training in health education, nor do they claim any special expertise in the field. They are simply using the limited reference material that is available and translating it to prepare lectures or for the preparation of other materials. It seems clear, therefore, that the need for a "qualified and experienced health educator" still exists.

The RIP called for specific health education activities designed to:

- Increase the percentage of exclusive breast-feeding at four months from 25 percent to 50 percent at final KAP survey. The team has prepared a

brochure (Appendix III) to provide information and encouragement for breast-feeding. In addition, classes have been given, both for health personnel and for mothers attending the dispensaries. Whether or not these activities will lead to the achievement of the specific project objective cannot be stated. The KAP surveys carried out in the project areas did not yield reliable baseline data—the necessary question concerning the duration of exclusive breast-feeding was simply not asked.

A national survey carried out by UNICEF and the CDC showed that well over 50 percent of infants were still breast-fed at 6 months, and that solid foods are introduced between 3 and 5.9 months of age in over three quarters of the infants. How long exclusive breast-feeding continues is not clear from this survey either, however.

Two specific results of the educational efforts were mentioned:

- a. People did not understand the importance of colostrum and were delaying the initiation of breast-feeding because of this. The classes are said to have corrected this, at least for some people.
- b. The Director of one of the major obstetric hospitals in Cluj was very impressed with what he has learned and is initiating rooming-in for newborns and encouraging initiation of breast-feeding immediately after birth in the hospital.

These were not specified objectives, but they are certainly worthwhile achievements.

- **Ensure that 50 of percent of mothers . . . know proper post-diarrheal feeding practices.** According to the information acquired during the evaluation, nothing has been done toward the achievement of this objective so far, although the possibility of preparing a brochure was mentioned. When and if activities toward this end are carried out, though, the KAP data obtained will not provide an accurate baseline.
- **Ensure that 50 of percent mothers know the importance of and the appropriate schedule for immunizations.** Some classes have been given, but it seems unlikely that much progress has been made toward achieving the specific objective. If this information is provided on a growth chart, as planned by Megan Kerr, it will help toward this end. Again, the KAP data in hand are inadequate for evaluation.
- **Ensure 90 percent immunization coverage over project lifetime.** Romanian law still governs the matter of immunization coverage—the requirement is believed to be 100 percent. Thus it is not clear just what the WV project has in mind in stating such an objective, nor is it clear what it can do about the coverage. There are said to be problems with the cold chain

as well as with the supply of vaccines. The WV project might help with the cold chain, but not much with the vaccine supply.

- **Increase the percent of mothers using modern contraceptives from 17 to 50 by the end of the project.** The WV team has prepared a brochure to provide brief information on reproductive anatomy and physiology, a description of various methods of contraception, and several pages for recording contraceptive practices (Appendix IV), the purpose of which is not clear.

It was said repeatedly that in Romania today there are three abortions for every "liveborn" delivery. Thus there is no question about the demand to limit births. What limits family planning (FP) is lack of adequate supplies of contraceptives, not motivation or desire to limit family size. FP education can be justified to the extent that it makes people more aware of effective alternatives to abortion and increases demand for modern contraceptives, but until such contraceptives are available in sufficient supply to meet the demand, it is of little avail.

One of the WV PHC project activities related to FP that has been carried out, although it was not mentioned as a specific objective, was a ten-day FP methodology course, conducted in January 1993. Health personnel, including 17 dispensary physicians and three midwives, were trained in the provision of modern contraceptives, including the insertion of IUDs. Several important consequences of this training are worth special emphasis:

- The physicians from the First Gynecologic Hospital who provided the training are proud of their results and are willing and eager to provide further such sessions.
 - They provided the course without getting caught up in a lot of bureaucratic complications. They simply worked with the WV PHC team, planned the course, and carried it out.
 - Having experienced that success, they did the same thing for a course for medical students in family planning.
 - The trainees are said to be no less enthusiastic than the trainers and would like desperately to have an adequate supply of IUDs. At the request of Dr. Canlas, ten IUDs were obtained from the UK (at a cost, unfortunately, of L8.40 each) and were available for insertion at the time of the evaluation.
- **Ensure FP education, etc., for 50 percent of couples, women, and adolescents by the end of project life.** As noted, lack of motivation is not a limiting factor. Making people aware of modern contraceptives is certainly worth while, but it is of limited value unless they are available.

That problem aside, classes have been provided to eligible women in dispensaries. In some cases husbands have been invited as well and are receptive. Once again, it is not clear how achievement of this objective will be measured.

- **Ensure AIDS and STD education as above.** The problem of AIDS in Romania has made the country notorious and is a source of profound concern to many health personnel. One of the characteristics of AIDS in Romania is that 95 percent of known cases are in infants and young children as a result of needle transmission. AIDS and STD education will do little to influence this, but the threat in the adult population is there and deserves attention.

Truck transportation from the Middle East, which formerly passed through Yugoslavia on the way to Europe, is now passing through Romania—specifically through Cluj—and that, plus the economic situation, has produced a significant increase in prostitution in Cluj. Given the well-documented role of prostitutes in the spread of AIDS in such circumstances, they are an obvious target for preventive educational activities. Dr. Mariana Cuceu, the full-time health educator, has taken much of the responsibility for this and, among other things, has given short courses for Cluj police officers who are in frequent contact with the prostitutes.

In addition, Dr. Cuceu would like to carry out a KAP study among the prostitutes in order to obtain the specific knowledge and understanding that would provide the basis for an effective AIDS prevention program among them. This is the kind of focused, problem-oriented KAP survey that should be encouraged in the WV PHC project.

2. *Establishment of An Advisory/Monitoring Committee*

Dr. Canlas was able to recruit five senior officials from the Judet Health Authority. Unfortunately, following the recent election and the appointment of a new Minister of Health in Bucharest, all of those officials have been dismissed and new ones appointed. Dr. Ioan Bocsan, Professor of Epidemiology at the Medical School, is the newly appointed Deputy Director of the Health Authority of Cluj and has agreed to serve on the Committee, as mentioned earlier.

Four of the Committee members, including Dr. Bocsan, were met during the evaluation. All of them were generally supportive of the project, but they did not convey the feeling that they "own" it—although such a sense of ownership is not easy to judge. As will be seen clearly below, if this project is to have any lasting effect on PHC in Romania, then, as the project enters its final phases, **the single most important thing to be done is to transfer responsibility for the project to Romanian individuals and institutions.** The Advisory/Monitoring Committee members can and should play a key role in this process, but if they are to do so, they must understand what is expected of them, be willing to be

involved—"own" the project—and have the political clout that is needed. Thus, as recommended below, the committee needs to be carefully updated and oriented concerning what needs to be done.

3. *Identification of At Least Five Opinion Leaders*

The present WV PHC team had hardly begun to work when it was agreed that this objective was unrealistic. It was argued that Romanians at the community level do not like to serve on such committees and are most reluctant to assume responsibility for promoting anything.

What the WV team did instead was to prepare and conduct a PHC Awareness Workshop, to which participating dispensary staff were invited along with key opinion leaders, including priests, police chiefs, teachers, etc., from the respective communities. This workshop was carried out on April 5 and 6, just prior to the evaluation, and was attended by 25 participants. The comments heard from organizers and participants alike suggested strongly that the workshop was genuinely successful in informing "community opinion leaders" about, and arousing their interest in, PHC problems. At the rural community dispensary in Maguri-Racatau, Dr. Mihai Dragomir, the chief physician, was explicit and enthusiastic about the effect the workshop had, both on his communication with leaders in his community, and also on their interest in health problems in their community and on their willingness to take some responsibility—for example, regarding the water supply in their community.

It appears, then, that thanks to the workshop and also because the WV team has earned the confidence of the dispensary teams, the climate has changed. The workshop served to inform opinion leaders about PHC problems that should be of concern to them, and the response of those leaders demonstrated to the dispensary staff that such people are interested in such problems and willing to get involved. Dr. Dragomir made assurances that he intends to follow up on the workshop and plans to meet with the leaders in his community at least once a month. It seems likely that others would do the same with a bit of encouragement.

4. *Equipping and Support for Service Delivery Centers*

The participating dispensaries, both urban and rural, are lacking a variety of supplies and equipment. The most common complaints, and quite likely the most important, concerned the lack of disposable syringes, which are said to be available only sporadically; and the lack of modern contraceptives, which are, for practical purposes, almost never available. Casual discussions revealed a variety of other supplies and equipment that were lacking in one or more places. The list included adequate sterilization equipment, "cold chain" equipment, laboratory supplies and equipment, consumable supplies, and drugs.

According to the RIP:

The exact needs and activities appropriate to each site will be determined according to the results of the preliminary survey . . . The appropriateness, types, and quantities of these requests will be assessed and other needs explored. (RIP, p. 11)

The needs assessment implied above is surely needed if a serious attempt to equip and support dispensaries is to be considered. If such an assessment has been made, this was not indicated.

Instead, ten IUDs have been provided, as mentioned earlier, and a heterogeneous array of supplies—"stuff" might be a better word—has been sent out by World Vision International under the rubric of Gifts In Kind (GIK). That some of the GIK drugs were beyond their expiration date was noticed by at least one Romanian recipient and caused serious resentment. At least one team member admitted feeling ashamed of some of the "stuff."

In short, it does not appear that systematic efforts to achieve this objective have been made. On the other hand, the objective as originally stated was probably over-ambitious, to say the least. A reappraisal of the objective is in order, and could reasonably begin with the needs assessment described in the RIP. Once that has been done, the PHC team can determine how much responsibility World Vision can or should assume in this regard, bearing in mind that in the long run it is essential to find sources of supplies and equipment not dependent on World Vision or other outsiders. The use of such sources is, of course, justified to meet training or emergency needs.

5. *Development of a Management Information System*

The WV PHC project declared the development of a management information system to be an objective or output of the project, both in the original and in the revised versions.

- **Original:** (Objective No. 1.) "Develop a pilot health education strategy and a health information system for the monitoring of health activities."
- **Revised:** (Page 8) "To develop a management information system using records held at dispensaries."
- **Seventh Quarterly Report:** ("Output" 1.3, page 2) "Develop a Management Health Information System (HIS) for monitoring PHC activities."

The best manager in the world cannot assure the provision of quality services unless the health personnel know how to deliver quality services, and they have the supplies and equipment they need to do it. If there is a good management information system, however, the information it provides will make it clear that the services being provided are not what they should be, and it should help

pinpoint the reason, or reasons, for failure, which, in turn, will help identify what is needed to correct the problem.

The system will not provide the information needed, though, unless it has been designed carefully to do just that and is used effectively. This means that the manager must know what kinds of services the staff should be providing, to whom, how often, and what support is necessary, etc. Once those things are defined, then he/she can decide what information would help her/him determine whether or not what is meant to happen is happening, and if not, why not.

What should be made explicit in this is that the user of the information—the overall manager, the dispensary director, the Judet health official, or whoever—must be involved in deciding what is needed. To use the current buzzword, the users need to "own" the information to be able to use it well. They need to understand and accept the fact that the information system is for them, to help them provide good services or improve them, and not for some distant official to use for punitive purposes.

One former Romanian staff member, a physician familiar with computers, invested some time in the development of such a system, but he has since left the project and thus, to date, an MIS has yet to be finalized and implemented. At the moment, a recently hired staff member, Mr. Dorel Plescan, who is computer literate but has no experience in PHC, is attempting to install the EPI-INFO software program, which was sent out from WVI in Monrovia, California. Unfortunately, he lacks the instruction manual for the program and he is having a difficult time. Thus there remains an opportunity to try to develop an appropriate and useful system.

6. *Use of Medical Students in the Survey*

The original DIP envisioned a "partnership with the Cluj Faculty of Medicine for training and incorporation of public health concepts in the curriculum of the medical students." (p. II-4) The RIP proposed more modest expectations, as indicated. In fact, medical students did participate in the KAP, and those who did were most enthusiastic. At least two of those expressed the opinion that such activities should be included in the curriculum, and others were interested. What is of note is that, although the execution of the KAP surveys can be criticized for various reasons, as noted elsewhere in this report, the students considered it a worthwhile experience. There is no doubt that their interest in community health was aroused. What is apparent is that an activity that gets them out into the community provides an opportunity for experiential learning that is much needed, and the KAP survey, flawed though it may have been, served that purpose very well.

Thus, although the impact is limited in terms of numbers, the project has made progress toward the achievement of this objective. In addition, Professor Bocsan, in his dual role as a member of the Advisory Committee and as a professor in the medical school, is not only interested in developing a relevant

teaching program, but he is also in a position to do something about it. Given the clear expression of interest on the part of medical students and at least one key member of the faculty, it appears that the climate of receptivity has changed and that in the remaining phase of the project it is possible to make some progress toward the original goal of influencing the inclusion of PHC, or community medicine, in the medical school curriculum.

7. *Production of At Least Three Items of Health Promotion Literature*

As mentioned above, brochures on breast-feeding and family planning have been prepared and published. These are quite conventional in their approach and format, but they seem to have been well received. They would have benefitted greatly from the participation of a "qualified and experienced health educator," as mentioned above.

C. Assessment of Other Accomplishments and Activities

1. *Workshops and Conferences*

Although they were not specified explicitly in the project implementation plans—either the original or the revised versions—two conference/workshops and one training program have been carried out, as follows:

- October 1992. Primary Health Care Workshop with 80 participants.
- January 1993. Family Planning Training for 117 general practitioners (dispensary physicians) and four nurses.
- April 1993. Community Health Awareness Workshop with 25 participants.

It is clear from conversations with the WV project staff that these activities were carefully planned and carried out effectively, with extensive participation of Romanians. The evident results gave them a significant sense of satisfaction and accomplishment. Conversations with participants—Romanians in the Cluj health-care community—convey the impression that they learned new things enjoyably, liked the contact with new ideas and with each other, and would appreciate more of such activities. Thus, although it is impossible to quantify the impact, it seems likely that these are the most important activities carried out by the project. They are discussed further in the relevant sections below.

2. *Monitoring and Evaluation*

In the original project plan, KAP surveys were proposed as an essential element in project monitoring and evaluation. In the May 1992 revision, the KAP survey results were also seen as essential elements of the health care needs assessment. Accordingly, a huge effort was made to carry out KAP surveys in the two rural villages and the urban district of Zorilor and the results were, in fact, used to select priority interventions.

As part of the evaluation, the questionnaire and the tabulated data from all three surveys were reviewed. This was an extremely disappointing experience. The questionnaire left a great deal to be desired, and the processing and tabulation of the survey findings can only be called unsatisfactory—the way the questions were asked combined with the manner in which the answers were processed were such that either necessary information was totally lacking or was entirely inadequate for quantitative purposes and therefore could not be used as baseline data for project evaluation.

Problems with the survey were discussed at length with the senior PHC team members. Briefly, the questionnaire had been sent from WV headquarters and translated into Romanian. Some of the questions were poorly phrased; in other cases, the right questions had not been asked and essential information was simply not available. For example, there were no questions about how long the baby had been breast-fed or when the mother stopped breast-feeding altogether. In many other cases multiple answers were allowed, poorly recorded, and produced a very confused and confusing set of responses.

The way the data had been processed was even more disturbing. "SurveyMate," the computer program used for data processing, is a very sophisticated and useful program for processing KAP survey data, but it has to be "told" precisely what the investigator needs to know. In the absence of such instruction it reverts to what is called the default mode and cranks everything through in the same way. Sometimes that is appropriate for a data set; more often it is not—and in this case it was not. The result is that the survey findings were sufficient for impressionistic estimates of priorities, on some matters at least, but totally inadequate either for quantitative assessment of problems or for use as a baseline for follow-up evaluation.

The survey was not a complete loss. Regardless of the dubious value of the results as they were tabulated, it was clear that those who participated in the survey learned something and felt that the experience was worthwhile. This was especially true, as noted elsewhere, of the medical students. Thus, it appears that the team can mount and execute a survey; with a modest amount of technical assistance there is no doubt that they could obtain useful and valid information.

D. Sustainability

Whether or not a project is sustainable and whether or not the lessons learned or the methods developed are replicable are always matters for serious consideration in projects like the WV PHC project, even if they are not explicit goals. Sustainability is especially relevant when the execution of a project requires the recruitment of a staff and the utilization of facilities and equipment to provide services. The question then is, what will happen when the project is completed? How will the staff be paid and supplies and equipment be purchased?

Assessing sustainability in this case is even more difficult because the "project" is not a special entity. There is a project team, but its impact on PHC service delivery in the Cluj Judet is indirect, acting on and through the health personnel in the dispensaries that are participating, and other personnel in the Judet Directia and the medical school. As noted, the project team has been responsible for two workshop/conferences; for a two-week family planning training program, which was conducted by Drs. Surcel and Rosca, of the First Gynecologic Hospital; and for many classes, in dispensaries and elsewhere. Whether or not the lessons learned will be applied to improve service delivery or health behavior is beyond the control of the project. Whether or not some of the lessons can be applied depends, as stressed above, on the availability of supplies, and the WV project has had only minimal effect in that area—it cannot be said that delivery of services in participating dispensaries is dependent on the project: although once in a while the project might help. Thus, when the project is completed in 1994 or 1995, the services being provided in the participating dispensaries will go on, more or less the same as they are now, except for the fact that no one can predict what is going to happen to the Romanian economy.

In one particular area the matter of sustainability is in serious doubt. Dr. Mircea Lapusan, the Deputy Project Manager in Cluj, and the four part-time Romanian health educators employed by the PHC project, are all receiving salary supplements, which of course will not be continued when the project is completed. This is a problem in such projects all over the world. How do you elicit the participation of local people without paying them? And if you do pay them, what happens when the project, as such, is over? Fortunately, PHC delivery in the dispensaries does not depend on them. Furthermore, all of them are enthusiastic about what they are doing in the WV project, and their level of commitment is such that they are likely to try to find ways to continue their involvement somehow. At the least, the knowledge and skills they have acquired can be applied wherever they are.

There is no doubt that the activities carried out by the WV team and the interaction between team members and health personnel in the Cluj Judet have had some impact. What is reported here is brief, subjective, and impressionistic, but the interest and enthusiasm so clearly manifested by some of the people interviewed was most convincing.

- Health personnel talked about new knowledge—about the importance of colostrum, for example, or rooming in, or IUD insertion, or AIDS, and many other things.
- Health personnel convey the impression that after a long period of intellectual stagnation in Romania the workshops have provided new ideas and new knowledge, and they would like more.
- They talked about the fact that community leaders are better informed about, and interested in, PHC issues—and that they can communicate better with them. They seemed confident that such people can play a role in mobilizing community support.

- Some of the medical students expressed their interest in PHC and recognize the need to include better preparation for PHC service delivery in the medical school curriculum.
- Medical school faculty members are very enthusiastic about some of the things they have done. Some of them have taken independent action to provide courses that they think are needed. It is fair to say that they have been empowered.

Will these changes be sustained? There are many Romanian health personnel who have not been affected by the project. Many of them convey the impression that they do not believe significant change is possible. After years of totalitarian communism and Ceaușescu they look clinically depressed and burned out. Such people probably outnumber those who have changed in ways described above. But those who have changed are not likely to go back. Their new knowledge and skills and the changes in attitudes are there to stay, but the impact on PHC service delivery depends on a variety of factors over which neither the WV project team nor the Romanian physicians have any control. But a cohort of people who want to provide better service and know how to do so is bound to create a demand for whatever is needed.

IV. RECOMMENDATIONS ON PROJECT DIRECTION

A. Assumptions

The recommendations presented below are arranged roughly in order of priority, but a more important concern is to present them so that their interconnectedness is reasonably clear. There is meant to be a logical flow from one to the next, but that is not always possible. What is hopefully clear is that:

- The achievement of some objectives is essentially useless if certain others are not also achieved.
- The achievement of some objectives makes it easier to achieve certain others.
- In some cases activities required to achieve two or more objectives can be carried out simultaneously or in very close sequence.

Someone has said that the First Law of Ecology is:

Everything is related to everything else.

The same applies fully to PHC, and if this is forgotten, PHC programs suffer. Another old saying, which must have its equivalent in Romanian, is this: "A chain is only as strong as its weakest link."

This, too, applies to PHC in much the same way, but the extra bite in this one is the implication that if a link is missing, you have, in effect, no chain. In

PHC this means that if the missing link is any one of a number of the essential elements required for the provision of good services—adequate supplies or equipment, well-trained and motivated personnel, transportation, etc.—those services cannot be provided adequately.

These recommendations are made with the recognition that even with a "no-cost extension" the maximum life expectancy of the PHC project in Cluj is two more years. Everyone who has ever worked in a development assistance project like this one knows that two years is not a long time, even though it might seem longer when you are living through it. What the time constraint means is that the WV PHC team needs to face the fact that any lessons learned in this project and any methods or activities developed in it will simply be lost unless they are passed on to local people and are accepted, internalized, and implemented in local institutions. Such a transfer process cannot occur overnight; if it is to be completed successfully, it needs to begin now. This means that the WV PHC team members are required to make a radical and difficult change in their mind-set. They must recognize that starting now they must try to make it possible for their Romanian collaborators to do whatever needs to be done, provide them with whatever support and assistance they can, and not take over and do it themselves. Ari Kiev once made a very relevant comment:

Assuming responsibility that rightfully belongs to others is not unselfish behavior. When you take over a job that someone else ought to do, you are either showing them that they are really unreliable or that you can do it better; or worse still, that you are kinder and more solicitous of them than they are of you. You have done what they should have done.

It is also worth reminding ourselves that no one in Cluj-Napoca asked USAID to send a World Vision team there to "strengthen the grassroots infrastructure of the Ministry of Health through the introduction of primary health care strategies that have been proven to be effective in other parts of the world."¹

To be sure, some responsible authorities did agree to it, when asked later, but there is a strong suggestion of the imposition of foreign concepts and ideas. For that reason some of the goals or objectives of the original project plan were simply not realistic because they called for a level of cooperation and trust that were not present in 1991, or even 1992. Now, however, the WV team has been there long enough to earn some trust and confidence. Thus, some of the recommendations here are related to original project objectives because it appears that now there is a reasonable chance that they can be carried out.

Finally, it should be noted that this report and its recommendations are being presented with very real regret that the structure and time frame of this evaluation did not allow time for completion of the report, followed by time for

¹

One of the objectives stated in the original project implementation plan prepared in May 1991.

people to read it before its presentation, and then to conduct detailed discussions and feedback answer or questions concerning its contents or recommendations, from those who, it is hoped, will find it useful.

B. Recommendations

1. *What is the future role of the Cluj Advisory Committee?*

This needs to be considered for two reasons:

- a. Many of those who were initially invited to serve on the Cluj Advisory Committee for the WV PHC project, primarily because of the positions they held in the Directia Sanitate of Cluj, have been relieved of their duties as a result of recent political changes in the country. Thus, though they have supported the project, they no longer have the power they enjoyed until recently.
- b. If the WV PHC team is to begin now to transfer responsibility for actual implementation of project activities to Romanian individuals and institutions, as described above, as they should, the Advisory Committee will need to play a key role. To the extent possible it needs to include individuals who understand the project, are committed to improving PHC in Romania, and are in a position to play an influential role in that process.

It is thus apparent that the composition of the Advisory Committee and its role need careful evaluation and change as needed. Dr. Ioan Bocsan, who is the newly appointed Deputy Director, as mentioned earlier, has already agreed to serve on the Committee. It is important not to let the committee become too large, but it probably needs more representation from the newly appointed senior staff in the Directia Sanitate of Cluj and possibly from the medical school. The following is recommended:

That the WV team discuss with the existing committee members the urgent need for their support and involvement in the process of transferring responsibility for the PHC project to Romanian individuals and institutions. Their advice in the selection of new members of the Advisory Committee and guidance in carrying out the transfer process should be solicited.

2. *What is Primary Health Care in the World Vision PHC project?*

Although this is called the World Vision Primary Health Care project, it became very quickly apparent that there is great confusion over what the term "primary health care" means. Here, as is the case almost everywhere in the world, the definition of PHC seems to vary with the person who uses the term, and often what the listener understands is different from what the speaker had in mind.

The situation is complicated by the fact that PHC needs in industrialized countries are different from those in developing countries; patterns of morbidity and mortality are different, as are the resources available to deal with them. Moreover, almost everything that the development assistance community has done or written about PHC has been oriented toward the needs in Third World countries, and the ideas that many of us have are based on experience in such countries.

The lack of a shared understanding of PHC impedes program development and impairs collaboration, both between and within organizations. For that reason, it is essential to find a way to develop a common understanding of the **primary health care needs in Romania** both among World Vision staff and also among the members of the Cluj Advisory committee and the staff of the various Romanian agencies or organizations involved. What is important is **not** the details of the definition, but the **agreement** on a working definition of a pattern of care that all participants are willing to work toward. For these reasons it is recommended:

That the WV team give a high priority to the definition and development of a common understanding of PHC on the part of all individuals or agencies involved in the project. Toward this end, they should review the issues with the Cluj Advisory Committee, relevant medical school faculty, and the dispensary staff to seek a consensus.

A simple way to start this process would be to have all those involved review the WHO/UNICEF publication on PHC that was the result of the Alma-Ata Conference on Primary Health Care in 1978. The conference report was meant to describe the concept of PHC as it should apply **all over the world**, in industrialized and affluent countries as well as in the Third World. The definition of primary health care provided in the Conference Report² is as follows:

Primary Health Care addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services accordingly. Since these services reflect and evolve from the economic conditions and social values of the country and its communities, they will vary by country and community, but will include at least:

- Promotion of proper nutrition and an adequate supply of safe water.
- Basic sanitation.

²

Alma-Ata 1978: Primary Health Care. Report of the International Conference on Primary Health Care. Geneva: The World Health Organization, 1978.

- Maternal and child care, including family planning.
- Immunization against the major infectious diseases.
- Prevention and control of locally endemic diseases.
- Education concerning prevailing health problems and the methods of preventing and controlling them.
- Appropriate treatment for common diseases and injuries.
(Alma-Ata 1978. Primary Health Care, WHO, 1978, p.2)

It is clear that this definition is not significantly different from much of what is being done at the dispensary or health center level in Romania. The WHO/UNICEF Primary Health Care report spells things out in much greater detail and, in particular, deals with the operational aspects of PHC as well as with national strategies and international support.

Making the report available to health personnel of all kinds, from the Directia Sanitate at the Cluj Judet level all the way to the dispensary level, in the public as well as the private sector, and as much to medical school faculty members as to students, would serve to stimulate thought and discussion and also to clarify many concepts so that eventually people can begin to agree on what it is that we are talking about. The WV team should schedule somewhat formal meetings with the Cluj Advisory team, the staff of the various dispensaries, interested groups at the medical school, and others for discussions of the WHO/UNICEF definition of PHC recorded above that would lead either to agreement on the elements of PHC that are needed in Romania today or to recognition that certain additional or more accurate information is essential for sound decision making, in which case KAP surveys, focus groups, or other information-gathering measures might be indicated.

Ideally the book should be available in Romanian, and its translation and publication are recommended. It is possible that the book has already been translated. What is more important than a translation, however, is to get the review and discussion process going. The Alma-Ata report is already available in English, French, and other languages. (A copy of the English version was left with the WV team in Cluj.) The language abilities of Romanians are such that many people could work with one or both of those languages without waiting for a translation. The urgent assistance of the WHO office in Bucharest should be sought to obtain a number of copies each of the English, French, and any other editions that might be helpful.

NOTE: Following the debriefing on May 4, 1993, with Dr. Micka and the WV staff in Bucharest, Dr. Wray visited the Ministry of Health with Drs. Virginia Canlas and Mihaela Oala and met the Adjunct Director General for Primary Health Care, Dr. Mihaelescu Nicolea. Among other things, he related that the MOH has prepared a description of the "package" of health care that general

practitioners are expected to provide at the dispensary level. After some discussion, it was agreed that this "package" is a reasonable representation of what the Romanian MOH thinks is needed in PHC. It was also agreed that the review and comparison of that document with the WHO/UNICEF Alma-Ata publication would provide an excellent and stimulating basis for initiating discussions in Cluj.

3. *What can be saved from the old system of PHC in Romania?*

Brief contact with people who worked in the health care system in Romania is sufficient to make it clear that there were many things wrong with the old system. The autocratic, dictatorial, punitive approach that characterized the system had many bad effects, one of the most important of which seems to have been the complete suppression of initiative and responsibility. People throughout the system learned to avoid accepting responsibility because they might well be punished for something for which they were not responsible or over which they had no control.

What is also apparent on brief exposure is that many of the activities carried out were and remain altogether appropriate for PHC. Earlier in this report, several examples of certain concepts of PHC that were applied in the old system—indeed are still applied—suggest that though the implementation was bad, the activities themselves were useful and undoubtedly contributed to health and survival. These activities need to be continued, perhaps with some modification, but because of their association with the old regime, some of them may be summarily abandoned. Others, as noted above, may be impossible to continue because of their cost.

Given the declared PHC goals of this project, there is a clear opportunity for the WV PHC project team to work with their Romanian counterparts to identify ways to continue to provide those activities in the existing system that represent good PHC. For those reasons, it is recommended:

That while the WV team reviews the definition of PHC with the Cluj Advisory Committee and the staff of the participating dispensaries, it should also review the current preventive activities, identify those that are consistent with good PHC, and make efforts to support and sustain them.

Such an undertaking probably was not possible at the start of this project, but by now it seems likely that participants have enough understanding of PHC per se and of the purposes of the project, and enough confidence in each other, to make it a worthwhile exercise. Indeed, finding out how to continue the best PHC activities of the old system, to eliminate unnecessary ones, and to add elements found to be lacking, until Romania's economy begins to recover, is probably the greatest challenge facing the health system of the country. Carrying out this review is a continuation and reinforcement of activities suggested in the recommendation above. It should serve to clarify further the

working definition of PHC and, perhaps more important, it will help dispensary level staff members understand the connection between the care they are already providing and PHC.

4. *What kind of care can be provided without the essential supplies?*

Based on observation and comments heard repeatedly from dispensary staff and others, it is a lack of supplies and equipment that is limiting the quality of care at the moment, much more than lack of knowledge and skills on the part of health personnel. The health care programs that were visited, both urban and rural, had an abundance of personnel, both doctors and nurses, and, although they may lack specific knowledge at times, most of the people know enough to provide decent care if only they had the essential supplies. The lack is apparent in almost every program, but it is especially obvious and serious in the realm of family planning.

A recent publication, **Rethinking Primary Health Care Training**, prepared by ACSI-CCCD staff under USAID sponsorship and available from the International Health Program Office of the CDC, includes the following:

While in-service training can improve health worker knowledge and skills, the ability to perform a task correctly does not in itself guarantee that services of adequate quality will be provided. . . . Monitoring of health service delivery . . . found that over 50 percent of performance problems were attributable to inadequate logistic support. Effective technologies, availability of commodities . . . and adequate resources are necessary if health worker skills are to result in improved service quality.

A first and continuing step in the improvement of a health care system is to diagnose the nature, extent, and etiology of service delivery problems. If inadequate skills or knowledge are identified as part of the problem, training will be required, but should be sequenced appropriately relative to other strategies to improve the quality of services provided. For example, **in-service training of personnel should ideally be done before community education designed to improve service utilization, and after the institution of a system that ensures the availability of needed supplies and drugs.** (Page 1, emphasis added).

This advice bears careful thought with regard to the WV PHC project. An obvious example of the need for such thought is the situation concerning family planning activities. The abortion rate in Romania is tragic evidence of the desperate desire to limit family size. Educational activities in the WV PHC project that are intended to persuade people to use modern methods of contraception instead of abortion, when a dependable and adequate supply of contraceptives is not available, are open to challenge. Raising hopes for better services and then failing to deliver them disillusion the public. Similarly,

teaching general practitioners and midwives how to insert IUDs, when an adequate supply of IUDs is not available, raises false expectations and produces frustration. For these reasons, and others like them, it is recommended:

That the commitment that was made, both in the original and revised proposals, to "support and equip" the service delivery centers, be reviewed carefully. A serious needs assessment should be carried out, followed by a realistic assessment of what exactly the WV project can provide in the way of *needed* supplies and equipment. Short-term provision of such things as contraceptives, etc., is worthwhile, but the long-term goal must be self-sufficiency.

It is recognized that neither WV nor USAID has unlimited resources. It is also recognized, as noted earlier, that the dispensaries are providing many PHC services with what they have available and that Romanian sources are absolutely essential in the long run. There is need now, however, for a few things—such as the contraceptives mentioned above, and disposable syringes.

- To identify such unmet needs, the WV field staff should carry out a needs assessment with the staff of each of the dispensaries in the project. What is required is a careful review of the minimum essential supplies and equipment needed for key PHC activities, an assessment of the resources that are available in each center, and then a serious effort to meet the unmet needs. It was learned from Dr. Nicholea at the MOH that the World Bank project will provide a basic list of supplies and equipment to over 400 dispensaries. He agreed to provide a copy of that list, which, like the GP service package, will make a good basis for discussion.
- Once the needs are identified, some of the most critical can probably be met by using funds available in the project budget. WV should work with USAID and other agencies to identify inexpensive sources in order to make the limited funds go as far as possible.
- Other needs may be met with GIK, but it is essential for WV to be very careful. WV has limited control over donations made to it, but it is under no obligation to accept—and send to Romania—outdated textbooks, expired or inappropriate drugs, etc. There is a clear need for WVRD to educate donors and also to recruit donors for specific essential items.
- In addition, with the needs assessment completed and a list of essential items in hand, WV staff can explore possible sources through other USAID projects, other NGOs, the multinational agencies, etc. This is an area in which cooperation among the many development and technical assistance organizations should be more effective than it is.
- According to a WVI brochure, WVI has carried out 6,441 projects benefitting 32.7 million people in 90 countries. If that is true, the need to provide adequate supplies cannot be new, and there must be someone,

somewhere in the system, who is experienced in dealing with logistics and supply problems, and who can provide advice or technical assistance to the team here.

- Most important in the long run is to work with Romanian agencies to develop their own logistics and supply system, to identify dependable and inexpensive sources, and, where possible, to seek support from multinational agencies that would make it possible for the Romanian agencies to become self-sufficient by producing their own IUDs or disposable syringes, etc.

5. *What should be done about the conference/workshops?*

As noted elsewhere, the two general conferences on PHC, held in October 1992 and April 1993, and the ten-day family planning workshop conducted in January 1993, are considered by both the WV PHC project team and the health care community of Cluj to be the most successful of the project activities that have been carried out. Dr. Canlas and her team successfully recruited a number of senior medical people from the Directia Sanitare and the medical school to participate as faculty in the workshop; they did so, apparently with enthusiasm, and were very well received. There is a lively demand for more, especially for the family planning training and, as noted elsewhere, Prof Surcel and Drs. Rosca and Ona are eager to carry on. For these reasons it is recommended:

That the WV team continue to sponsor and provide back-up for such workshops, assigning as much of the responsibility as possible to Romanians and local institutions.

6. *What should be done about WV PHC project training activities?*

That training alone is not enough to guarantee quality PHC service delivery does not mean that training should be abandoned. It does need to be carried out, but with other equally important elements in mind. As stressed above, there is limited value in training people to do things that they cannot be supplied and equipped to do. On the other hand, the development of a corps of well-trained people creates a demand for support, and it is often possible to obtain the necessary supplies once the demand is there. This is especially true of family planning. Because there are so many organizations that support family planning activities, alternate sources of supplies can often be found.

Observations suggest that a capacity and enthusiasm for training has already been developed in some of the collaborating institutions in Cluj. Given that potential, and the fact that the WV PHC project will continue for two more years at most, it seems clear that the team should start now to invest its training efforts to help develop such programs in the collaborating institutions. Those institutions are there to stay and will be able to continue the training activities.

Specifically, the two physicians at the University Gynecologic Hospital who carried out the Family Planning Training Program last January were very pleased with their results. They are enthusiastic and eager to continue such activities and insist that they can do so with little outside support. What is most impressive is their willingness to take the initiative. They have, as noted, begun to include a course in family planning for their medical students. Without getting involved in university bureaucracy, they are just doing it.

There is similar but less developed potential elsewhere in the medical school, and conversation with Dr. Bocsan suggests that he could be a key person in developing a strong course in PHC. What was even more impressive was the interest on the part of medical students, which surely deserves to be encouraged.

One of the initial specific objectives of the WV PHC project—collaboration with the Medical School of the University of Cluj in the development of a primary health care curriculum—appears to be much more achievable now than it was two years ago and is well worth pursuing.

What is not clear is which local institution within the health care system could serve as a base on which to build in-service training capacity for other health personnel. However, such a base should be sought in order to make it possible to pass on the knowledge and skills in training dispensary staff that the WV team has acquired. Nor is it clear just how the part-time team members can best be used after the project is completed, but it is important to find a way to utilize them. It is recommended:

That the WV PHC project focus its training efforts and energy on the development of strong training programs in local institutions, including the gynecologic hospital and the medical school, because these are the programs that stand a chance of surviving the project. If an institutional base within the health care system that is responsible for in-service training of other health professionals can be identified, the WV project team should share its training experience and support it.

7. *What should be done about health education?*

"Training," as used above, refers mainly to instruction and learning experiences provided to health personnel, at whatever level. "Health education" refers here to efforts to teach the public what they need to know about how to manage or prevent nutrition problems or disease.

As noted earlier, health education in PHC was given a high priority in the project implementation plans, and much of the time and effort of the PHC team has been dedicated to it. A great number and variety of health education activities has been carried out in dispensaries or health centers, schools, and elsewhere, and the project team, both expatriate and Romanian, are enthusiastic about such activities and gratified by the response so far obtained. As also

noted above, however, none of the team has the qualified training and experience in health education recommended in the RIP, nor do they have a great deal in the way of reference materials to work with.

The objectives expressed in the RIP to work with the Center for Preventive Medicine and Health Education Laboratory and to provide equipment and funding for materials may have been unrealistic. In spite of Dr. Caseanu's generally supportive attitude, the Center may lack the staff required to participate effectively in the activities carried out or production of the materials prepared by the project team. If there is the potential for collaboration there, it deserves to be pursued because of the need to find Romanian institutions to carry on such activities after the completion of the project.

What can be said is that the PHC team involved in health education in Cluj is working hard and with spirit, but could benefit from some guidance. It appears, in short, that the need for a qualified and experienced health educator that was recognized in the RIP remains. A feasible approach might include a workshop to train health educators. A former colleague of Dr. Wray's, Dr. Michele Shedlin, who is an experienced trainer and medical anthropologist and has been working as a consultant in similar training programs, would be willing to facilitate such a workshop or, if a workshop were not possible, to visit Cluj as a consultant to provide technical assistance. This might suffice (and she could work with Dr. Cuceu on the AIDS study at the same time).

Such workshops can be adapted to train trainers of health educators or to train health educators per se. The workshops may include training for health-education needs assessment, for the preparation of health education materials, and in advanced methods of health education. A week long workshop is adequate. A training manual for such workshops is near completion, and the principal author of the manual, Dace Stone, partners with Dr. Shedlin in carrying out workshops. The chance to test the manual in a situation such as that in Romania would be welcomed. It is therefore recommended:

That the WV PHC team explore the possibility of obtaining the services of a health education expert, such as Dr. Shedlin, to conduct a workshop or to provide technical assistance on health education needs assessment and methodology as soon as possible. If such an exercise is carried out, the staff of the Health Education Center of the Center for Preventive Medicine should be invited.

8. *PHC information needs and the WV PHC project: A Paradox*

Since the WHO/UNICEF Alma-Ata Conference in 1978 served to clarify and define the concepts of PHC for the world and was endorsed by the Ministers of Health from the 125 or so countries that participated in the conference, there has been what can truly be described as an explosion of information and publications about every conceivable aspect of PHC. USAID, the WHO, UNICEF, and scores of other organizations have spent hundreds of millions of

dollars by now. Moreover, a great deal of expertise has accumulated about how to communicate the information effectively to every segment of society.

The paradox in this is that in spite of the availability of literally tons of attractive, carefully written, useful books, conference reports, newsletters, pamphlets, journal articles, etc., there are PHC people out in the field who appear to be trying to reinvent a myriad of wheels. Granting that not everything written is appropriate for every place in the world, there is nevertheless a huge amount of resource material available that is useful and often not available to those who need it.

The lack of such material in the WV project office in Cluj was mentioned frequently, and it was clear that there are people there trying to "reinvent the wheel" without access to the expertise that does exist. Resource materials in the office were very limited and consisted mainly of the personal libraries of team members. Thus, the recently hired Romanian health educators who are bright and wonderfully enthusiastic, but have had little formal training or experience in health education, have very little to work with. There was, however, tremendous interest in obtaining such materials; several of the reference books brought by Dr. Wray, and the names of organizations and addresses as possible sources of other information, were eagerly taken and letters written even before the end of the evaluation. Given this situation, it is recommended:

That the WV PHC project identify and give high priority to acquiring a few of the standard resource books in PHC. More important, the project should get on the mailing lists of some of the many organizations that provide newsletters and other materials for various aspects of PHC.

Given the vast experience of WVI mentioned in the brochure, it is hard to believe that there isn't someone in the WVRD office who can provide assistance. If there is no such person, and WVRD is involved in helping people in 90 countries, such a person should be found!

WVI aside, USAID has funded scores of projects designed to produce materials and many of these materials are provided free. Dr. Micka's secretary should be able to provide the names and addresses of relevant people in Washington. The WHO and UNICEF offices in Romania should also be able to provide useful suggestions.

9. *What kind of management information system is needed?*

Although the development of a management information system (MIS) looms large in the project implementation plans, as noted, progress toward establishing an effective system has been limited. It is clear that records are kept and it seems likely that better use could be made of such records. It is no less likely that those records could be simplified and would probably be more accurate as a result. For that reason, the following recommendation is made:

That the PHC team continue the commitment to develop a management information system, but keep it as simple as possible and adapt it directly to the activities that have been determined to be essential elements of PHC for Romania, based on the reviews recommended above.

The need for active participation of the users in developing an MIS cannot be overemphasized, but if the WV PHC team carries out the recommended reviews of the concept of PHC and the existing PHC activities, the process can lead to the much needed sense of ownership.

The review should begin with a careful examination of the records that are now kept, in order to ascertain how much of that information can be used and how best to use it. Furthermore, as attractive as it is to base such a system on computer programs, a realistic assessment of the economic possibilities for the next few years suggests that the initial system ought to be based on hand processing of data.

10. *What is the role of KAP surveys in WV PHC?*

As noted earlier, the KAP surveys that were carried out in the two project villages and in Zorilor consumed a great deal of time and energy and produced some useful information. There were, however, some serious shortcomings, and these were discussed with the WV team in Cluj. Reprocessing the data and possibly repeating parts of the survey are not worth the investment of time and energy that would be required to do it well at this stage of the project. Instead, that investment would be better spent on developing the best possible management information system, as described above (and on the transfer process described above).

Later on it may become clear that the need for certain information is so great that some sort of investigation is warranted. In that case a KAP survey may be carried out, but it is possible that a focus group approach will yield the necessary information at much less cost. On the other hand, there is no question that the few medical students who participated in the KAP survey benefitted from it. Thus, if the medical school decides that regular participation in KAP surveys would be a worthwhile experience for all the students, a decision that the consultant personally would enthusiastically endorse, then such surveys might be carried out in one or more of the project sites. It is therefore recommended:

That at this time, the investment required to carry out a good KAP survey does not seem justified. If there is a good reason for carrying out one or more surveys at a later date, competent technical assistance should be obtained.

11. *What, if anything, should be done about nutrition?*

The nationwide nutrition survey carried out with technical assistance from the CDC in Atlanta and supported by UNICEF showed that the nutritional status of Romanian children under 5 years of age is quite good, although it varies somewhat in different parts of the country and with the educational level of the mother. The survey did show a considerable amount of nutritional anemia.

At the WV PHC project sites, physicians weigh the children regularly and, in some dispensaries at least, care enough to buy graph paper and plot the weight of the children. This is exactly what UNICEF is promoting so strongly and for which standard weight graphs are often provided. The graphs, usually called growth charts, serve to increase the mother's awareness of whether or not her child is growing adequately. They serve the same purpose, incidentally, for the health worker—doctor or nurse—who can see at a glance where the child's weight lies compared to the norms, and provide added stress on the importance of good nutrition when the child is not growing satisfactorily. The charts almost always include a space to record the immunizations a child has received and also include a variety of educational messages, depending on the local need.

In the U.S. or Sweden, for example, where nutrition is generally adequate, the number of children who benefit directly from having their weight plotted is small, but it can be immensely helpful for those who do have problems—for example, those who have a silent chronic infection such as tuberculosis. In New York City, the growth chart has been made more useful by printing on it the developmental landmarks—the age at which the baby normally can control its head, roll over, sit up, stand, walk, and talk. By observing whether or not the child has reached the level that is appropriate for its age, which is very easy with the chart, the care giver, and the mother, can recognize problems early. Very limited observations in a leagan suggested that the psychologists, and indeed all those who are involved in the care of children who are at least potentially normal, could also benefit from the use of a developmental graph.

Megan Kerr has thought about the potential usefulness of growth monitoring in the PHC project, has obtained materials from TALC at the Institute of Child Health in London, and has had one of the standard graphs recommended by the WHO translated into Romanian. She and the PHC team should continue these impressive efforts to produce an appropriate growth chart for the children in the PHC project communities. Thus, it is recommended that:

The development of a growth chart that will be useful in Romania should be continued, preferably with the assistance of UNICEF. The developmental landmarks, the immunization record, and appropriate nutrition education advice for the mothers concerning breastfeeding, the provision of iron-rich foods, and recommended feeding practices when the child has diarrhea should be included.

12. *What about a "no-cost" extension?*

What is clear about the WV PHC project is that many of the specifically defined objectives in the implementation plans have not been achieved, although some have. What seems more important, however, is that the project has had an impact on the concepts and attitudes of health personnel and others in Cluj that goes well beyond specific objectives. Although it is next to impossible to document or measure, conversations with the WV team members and with dozens of others involved directly or indirectly in the project leave no doubt that much has been learned, that new ideas about health care and how it should be delivered have been communicated and accepted, and new willingness to take on responsibility is apparent. Furthermore, as noted in several places in this report, it appears that the quality of communication and the level of trust that has now developed between the WV PHC team and their Romanian counterparts in a number of institutions are such that accomplishments impossible at the beginning of the project are now possible.

A review of the project budget reveals that as of early April 1993 some 59.6 percent of the funds committed by USAID remained in the grant, and 63.3 percent of the matching funds committed by World Vision Relief & Development were unexpended. This does not include the WVRD commitment of GIK contributions. Thus at the end of the first two years of a three-year project, well over half of the funds committed remain unspent. One reason for this, of course, is that the project got off to a slow start, and expenditures during the first year were disproportionately low. In spite of this, it appears that if the rate of expenditure so far this year continues, the funds remaining would be sufficient to continue the project for an additional year beyond the one presently planned. Thus, a "no-cost extension" of the project is financially feasible. Furthermore, Mr. Loc Le-Chau, the WV Regional Director, assured us that if the funds remaining should be insufficient for a full additional year, he will recommend that World Vision make up the difference. Thus, it seems reasonable to recommend:

That the WV team develop a set of specific objectives, based on these recommendations, and if a reasonable start toward the achievement of these objectives can be demonstrated by February 1994, it is further recommended that USAID approve the continuation of the project as a "no-cost extension" through May 1995.

C. **Recommendations: Summary Presentation**

These recommendations are based on the recognition that even with a no-cost extension, the WV PHC project has a life expectancy of two more years at most. For that reason the need for the project team to work with local people and institutions is paramount. Anything that has been learned, any program that has been developed, will be lost unless it is in the hands and minds of people in Cluj by the end of the project.

The recommendations are summarized here for presentation purposes, but they can only be understood fully in the context of the report as a whole. The recommendations are:

That the WV team discuss with the existing Advisory Committee members the urgent need for their support and involvement in the process of transferring responsibility for the PHC project to Romanian individuals and institutions. Their advice in the selection of new members of the Advisory Committee and their guidance in carrying out the transfer process should be solicited.

That the WV team give a high priority to the definition and development of a common understanding of PHC on the part of all individuals or agencies involved in the project. Toward this end, team members should review the issues with the Cluj Advisory Committee, relevant medical school faculty, and the dispensary staff to seek a consensus.

That while the WV team reviews the definition of PHC with the Cluj Advisory Committee and the staff of the participating dispensaries, it should also review the current preventive activities, identify those that are consistent with good PHC, and make efforts to support and sustain them.

That the commitment that was made, both in the original and revised proposals, to "support and equip" the service delivery centers, be reviewed carefully. A serious needs assessment should be carried out, followed by a realistic assessment of what exactly the WV project can provide in the way of *needed* supplies and equipment. Short-term provision of such things as contraceptives, etc., is worthwhile, but the long-term goal must be self-sufficiency.

That the WV team continue to sponsor and provide back-up for workshops and conferences, assigning as much of the responsibility as possible to Romanians and local institutions.

That the WV PHC project focus its training efforts and energy on the development of strong training programs in local institutions, including the gynecologic hospital and the medical school, because these are the programs that stand a chance of surviving the project. If an institutional base within the health care system that is responsible for in-service training of other health professionals can be identified, the WV project team should share its training experience and support.

That the WV PHC team explore the possibility of obtaining the services of a health education expert to conduct a workshop or to provide technical assistance on health education needs assessment and methodology as soon as possible. If such an exercise is carried out, the staff of the Health Education Center of the Center for Preventive Medicine should be invited to participate.

That the WV PHC project identify and give high priority to acquiring a few of the standard resource books in PHC, but more importantly get on the mailing lists of some of the many organizations that provide newsletters and other materials for various aspects of PHC.

That the PHC team continue the commitment to develop a management information system, but keep it as simple as possible and adapt it directly to the activities that have been determined to be essential elements of PHC for Romania based on the reviews recommended above.

That at this time, the investment required to carry out a good KAP survey does not seem justified. If there is a good reason for carrying out one or more surveys at a later date, competent technical assistance should be obtained.

That the development of a growth chart that will be useful in Romania be continued, preferably with the assistance of UNICEF. The developmental landmarks, the immunization record, and appropriate nutrition education advice for the mothers concerning breast-feeding, the provision of iron-rich foods, and recommended feeding practices when the child has diarrhea should be included in it.

That the WV team develop a set of specific objectives, based on these recommendations, and if a reasonable start toward the achievement of the objectives can be demonstrated by February 1994, it is further recommended that USAID approve the continuation of the project as a "no-cost extension" through May 1995.

D. Work Plan Suggestions

The recommendations and their justifications presented above are based on several assumptions:

- Among the many things that might be done, they deserve priority consideration.
- They are feasible, within constraints of time and resources.
- They will make a difference—in the effectiveness of the project or in its long-term impact—if carried out.

The fact that the recommendations are offered in good faith, and with good intentions, does not mean that everything that could or should be done is covered. Many people were consulted, a great deal of information was gathered, and prolonged and in-depth experience was applied in the interpretation of what was seen and heard. In spite of this, there may be errors or omissions. The recommendations obviously need first to be discussed among the WV PHC project staff in Cluj, with the WV team at headquarters in Bucharest, and with Dr. Micka. Once there is agreement about which ones the team is prepared to tackle, and whether or not other things should be included, the matter of timing and priority can be considered. As

mentioned, the recommendations are presented in a rough order of priority, but this may need changing.

When the decisions mentioned above have been carried out, a work plan can be prepared. Many of the recommendations offered above are followed by explicit suggestions for action. In other cases, the actions needed are implied in the discussion, either before or after the recommendations are specified. These are reasonably clear. In short, a work plan can be developed from the information provided here, if that is necessary.

Finally, with the completed work plan in hand, project leaders should review it with Dr. Micka and agree as to which of the actions can and should be achieved by February 1994, and what would provide acceptable evidence that they have been accomplished.