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AN EVALUATION OF  
HEALTH SECTOR LOAN 075  
FOR THE PERIOD COVERING CY-1975

A.I.D.  
Reference Center  
Room 1656 NS

NOVEMBER, 1976

BOGOTA, COLOMBIA

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## EVALUATION

LOAN 075

CY 1975

Health Loan 075 for \$17,300,000 to finance local currency and dollar costs of goods and services was signed February 28, 1975. A carry over of \$2,847,000 from Health Loan 069 was made for programmatic purposes resulting in a total of \$20,147,000 being available for the program. This two year loan was designed to strengthen and solidify the advances and directions established by the initial two year Health Loan 069 which was for 1973-74. In this respect the goals and objectives remained the same, however, the experience of the first loan supplemented by a second health sector analysis resulted in some adjustment in types and amounts of specific program support.

A logical framework was developed for the first loan and used as the basis for annual loan evaluation. On developing the new loan it was determined that the earlier logical framework was still generally applicable. Meetings held with Colombian health professionals resulted in change at the input and output levels but the goal and objective statements remained essentially the same. The detailed evaluation of 1973, which can be seen in the 1974 health sector analysis, was carefully streamlined for evaluation of CY 1974 evaluation of Health Loan 069. As the latter format was well received, it was decided to use it again, keeping in mind that this format is the result of a conscious use of management by exception to locate weaknesses and difficulties in the health program and, therefore, is not an exposition of the successes achieved.

The COC reported to the USAID achievements against planned output targets in the health sector activities during CY-1975 in a comprehensive report entitled "Informe sobre el Desarrollo de los Programas de Inversión del Sector Salud" which is presented to AID each quarter. The data contained in those reports is extensive and, rather than repeat it, we have presented here only our evaluative comments. The reader interested in examining the data on which these comments are based must review the above mentioned report at the USAID/Bogotá Mission or at the Latin America Bureau Evaluation Office. This has been supplemented by some additional information from discussions with government health personnel and "Informe al Congreso de la República de Colombia 1975-1976."

The following is an evaluation using the logical framework format, adjusted as indicated above. Initially are the Goal Summary Statement, Objectively Verifiable Indicators, Achievements and the Mission's Comments. Secondly, are the Purpose Statements in the same format as the Goal. Thirdly, is the Output section which, because of its voluminous detail, has been summarized in two sections: a statement of the Output and the Mission's evaluative comments on the activities which were realized toward achieving that output. Fourth is the Input section, which follows the same format as that used for the Goal and Purpose. Lastly, is a brief summary statement of progress and problems encountered during the loan's implementation.

A.I.D.  
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Evaluation - 1975

A.1 Narrative Summary	A.2 Objective Verifiable Indicators
<p>Sector Goal - To improve the level of health in the Colombian population, by providing public health services to an increasing number of that portion of the population not served by private medicine and the special group health systems.</p>	<ol style="list-style-type: none"><li data-bbox="769 547 1279 617">1. Increase life expectance at birth by 5 years by 1980.</li> <li data-bbox="769 872 1350 1048">2. Mortality and Morbidity caused by "reducible" illnesses will disappear from the top ten causes of death and hospital admissions in 10 years.</li> <li data-bbox="769 1338 1342 1442">3. Government health expenditures will increase monotonically as a percent of GNP.</li></ol>

A. 3 Achievements	A. 4 Comments
<p>1. Though a census was done in 1973, this information still is not available.</p> <p>2. Studies have indicated that the mortality and morbidity data collected by DANE (National Office of Statistics) through civil registration means are grossly underreported. Though DANE continues receive some of this type of data it is not longer compiled for public use. A new data collection system is being implemented.</p> <p>3. The GOC investment budget in the health sector, as a percent of the total investment budget increased as follows: 1972 - 10.2%; 1973 - 12.4% 1974 - 12.9%; 1975 - 16%.</p>	<p>1. Gross mortality rate has been steadily decreasing from about 16 in 1964 to 9 in 1975. This is presumptive evidence that average length of life is increasing. It is not possible to say if it will increase by 5 years between 1970 and 1980.</p> <p>2. We expect that the present extensive efforts of the Ministry of Health and DANE supplemented by the National Health Survey scheduled for 1977 to improve information collection and compilation and will provide good estimates of this type of information. AID is supporting several programs which should decrease reducible disease ie, water, sanitation, vaccinations and nutrition.</p>

A. 1 Narrative Summary	A. 2 Objective Verifiable Indicators
	<p>4. Medical consultations per population served per year in Public Health Facilities will increase from .3 in 1972 to 2.0 in 1980.</p> <p>5. The population growth rate will decline from 2.9% in 1973 to 2:00% in 1980.</p>

A.3 Achievements	A.4 Comments
<p>4. 9 million consultations were made in 1975 through the Ministry of Health and its dependencies or about 5 consultations/person served by the government compared to .33 in 1972. In absolute numbers of consultations this is a 3.4% increase since last year and 18% increase since 1971.</p> <p>For all hospitals in 1971, hospital discharges were about 53,4/1000 inhabitants; in 1975 - 51.2/1000 inhabitants. There was an absolute increase in numbers of discharges of 9% during this period.</p> <p>5. The 1973 census in conjunction with other studies indicate the 1975 population growth rate is now 2.2 - 2.4%/year.</p>	<p>4. While the consultations person is growing faster than the population the hospital discharges/1000 persons is not. GOC figures and estimates indicate beds/1000 population are staying approximately the same. This is in part planned as occupancy rates are low (overall - 64%) ie, an increase in beds/population is not indicated until a higher occupancy rate is achieved. While it is tempting to think increased outpatient consultation may be related to or the cause of decreased hospital discharges considerably more analysis is required to support such a view. It seems unlikely the goal related to consultations will be reached.</p> <p>5. There has been a remarkable decrease in population growth rate in Colombia in the last 10 years. In large part this can be related to increased knowledge and use of family planning methods. Both the Ministry of Health and Private groups have been involved.</p>

B.1 Narrative Summary	B.2 Objectively Verifiable Indicators
<p><u>Sector Purpose:</u></p> <p>1. Creation of a regionalized integrated health delivery system in Colombia, including:</p> <ul style="list-style-type: none"><li>- Provision of infrastructure to support the system.</li><li>- Development of intra and inter-sectorial mechanisms of coordination.</li><li>- Efforts to lower costs of system by cost effectiveness analysis.</li></ul>	<p><u>End of Project Status:</u> (CY 77 unless otherwise stated).</p> <p>1.a. Integration and regionalization of all major health services established according to Plan.</p>

B.3 Achievements	B.4 Comments
<p>1.a. A decree in 1975 established 87 specific geographical regions which delineated regionalization areas. MOH has developed manuals of norms, procedures and organization at Servicio Seccional de Salud and Regional levels. There is much greater definition of levels of care through MAC (modulo ampliación de cobertura) development. 10 MAC-1 (rural delivery units) units were begun 1975. Some 1800 are to be in by 1982 which will provide the basic health services to the 36% of the population (rural-marginal city) defined as either having no or unsatisfactory access to health services. There is a schedule for implementing the MAC-1's. MOH plans to improve communication in health system through use of more telephone and radios was cancelled.</p>	<p>1.a. Actual implementation of regionalization throughout the country is quite <u>variable</u>. With <u>few notable exceptions</u> integration of various services related to health with health services is very poor. MOH has defined various levels of care as MAC-1 (local) MAC-2 (regional) and MAC-3 (University). MAC-1 is first priority. Most, if not all, MOH personnel are well informed about MAC. AID plans to assist the MAC-1 implementation through provision of vehicles through the Health Loan. We are impressed with the intent of this Government to carry out their plan to increase service delivery and coverage to the poor. The MAC-1 Unit; is an integral component of the National Food and Nutrition Plan.</p> <p>AID provided technical assistance to define communication alternatives. It became apparent an appropriate system would cost 6-7 times the available funds and DNP-MOH felt it would be better to postpone this project. AID reallocated dollar funds (1.5 million dollars) for other equipment.</p>

B.1 Narrative Summary

B.2 Objectively Verifiable Indicators

1.b. Increased delegation of functions to auxiliary, technical and paramedical personnel.

1.c. Intensified outreach services.

B.3 Achievements	B.4 Comments
<p>1.b. Manuals related to research in delegation of function were distributed. MOH has further defined functions of auxiliary workers as part of MAC. Courses and continuing training have been initiated related to the presently accepted ideas of delegation of function. PRIMOPS (Programa de Investigación en Modelo de Prestación de Servicios de Salud) (University of Valle - Tulane low cost deliver project) has done much to define roles.</p>	<p>1.b. The effect of the manuals distributed in 1974 is unknown. However, the Ministry has made many decisions as to the appropriate delegations of function. It appears that the phased input of MAC-1s will allow the opportunity to adjust some roles as experience dictates.</p>
<p>1.c. Initiation of MAC-1 system. MAC-1 has priority over MAC-2 and MAC-3.</p>	<p>1.c. The MAC-1 norm includes a local hospital providing supervision, supplies and periodic MD visits to a health post (1-2 nurse, auxiliaries) which has 6 promotoras (home health visitors) each of whom is responsible for about 1000 people within 2 hours transportation time from the promotora's home.</p>

B.2 Narrative Summary	B.2 Objectively Verifiable Indicators
	<p>1.d. Intensified patient referral.</p> <p>1.e. Increased T.A., supervision and evaluation from higher to lower levels.</p> <p>1.f. Health planning and administration done on a regional basis for the majority of the major health regions of the country</p> <p>1.g. More rational location, use, and staffing of health institutions within each region.</p> <p>1.h. Quality and quantity of professional and auxiliary personnel and their efficiency increased through planned training and placement programs, improved curricula and incentives in relation to regionalized plan.</p> <p>1.i. A stronger single mechanisms for channeling funds, planning, designing and supervising implementation of National Hospital Plan.</p>

B.3 Achievements	B.4 Comments
<p>1.d. MAC systems include patient referral plan.</p>	<p>1.d. -</p>
<p>1.e. Planned as part of MAC systems.</p>	<p>1.e. This seems to be the weakest part of the MAC system. It needs better definition.</p>
<p>1.f. The main hospital of each of the 87 regions is to be the site of the region health planning and administration (This is the MAC-2 level).</p>	<p>1.f. Personnel at MOH recognize that many of the staff at the regional hospitals still are not interested in being responsible for the health of persons outside of the hospital and also they are insufficiently trained to carry out this function. MOH is training key individuals.</p>
<p>1.g. The FNH-AID access model did not progress past early computer print outs. Dr. David Eaton is developing a simplified access model with the Ministry of Health. The Ministry is developing personnel norms for staffing and functions according to MAC needs.</p>	<p>1.g. Dr. Eaton has established good working relations with MOH personnel and expects to receive funding from AID/W to initiate the project early 1977.</p>
<p>1.h. The Human Resources Division is undertaking an inventory of health personnel in Colombia as well as developing a human resources planning model.</p>	<p>1.h. Work is progressing but there are no results yet. Hopefully this will improve the integration of human resources into the National Health Plan.</p>
<p>1.i. All major reorganization is complete. Construction Management Consultants of Houston provided initial assistance in scheduling multiple projects. One FNH member is being trained in these techniques in Houston.</p>	<p>1.i. We believe FNH hospital Construction Management has been improved.</p>

B.1 Narrative Summary	B.2 Objectively Verifiable Indicators
	<p>1.j. Sectional Health offices (21) with trained hospital auxiliary personnel preparing statistical tabulations.</p> <p>1.k. Implementation of strategy to strengthen capability of MOH Planning Office.</p> <p>1.l. Hospital Fund reorganized and strengthened according to basic recommendations of PAHO.</p> <p>1.m. Vehicles distributed according to health delivery system requirements.</p> <p>1.n. Staffing of medical institutions in accordance with levels of medical attention.</p> <p>1.o. Increased use of health facilities availability/use ratio.</p> <p>1.p. % of deaths certified by physician increased.</p>

B.3 Achievements	B.4 Comments
<p>1.j. All Sectional Offices have auxiliary personnel trained to prepare the required tabulations.</p>	<p>1.j. Many new MOH data collection forms have been designed and are being used at least down to local hospital level. Others have been designed for health post and promoters use. Regional tabulation will take place at the regional hospital under the general supervision of the Servicio Seccional de Salud statistician. Development of the information systems is taking place as expected.</p>
<p>1.k. The MOH planning office has been expanded to some 60 positions compared with 15, 3 years ago.</p>	<p>1.k. The MAC plan seems to indicate a good level of planning competence. The GOC quarterly report for AID has progressively improved.</p>
<p>1.l. Completed.</p>	<p>1.l.</p>
<p>1.m. Done correctly for 069.</p>	<p>1.m. Vehicles are to be purchased through 075. Distribution will not be made until 1977. See Loan Commodity Purchase pg.28.</p>
<p>1.n. No evidence</p>	<p>1.n. Office of Medical Attention which has main national responsibility for this appears to be getting stronger.</p>
<p>1.o. No evidence.</p>	<p>1.o. -</p>
<p>1.p. 60% deaths are recorded by the civil registration system, 68% of the recorded deaths have no certification (1972).</p>	<p>1.p. This has not changed.</p>

B.1 Narrative Summary	B.2 Objectively Verifiable Indicators
	<p>1.q. Regional hospital key organization in providing in-service training and supervision to attached hospitals, health posts and centers in each region.</p> <p>1.r. Health posts manned by auxiliary nurses with scheduled doctor visits.</p> <p>1.s. Ministries of Agriculture, Education and Health jointly providing coordinated services of rural primary education, agriculture extension and credit, community development and health in several selected rural concentrations.</p> <p>1.t. Reduce cost for patient care in accordance with finding of special studies and pilot programs by 1980.</p>

B.3 Achievements	B.4 Comments
<p>l.q. Recent plans have clearly stated these responsibilities. Decree mentioned (a) above also backs idea.</p>	<p>l.q. No clear evidence that such hospitals have accepted these responsibilities.</p>
<p>l.r. Variable</p>	<p>l.r. Newly developed scheme for evaluating MAC-1's will provide evidence in this regard.</p>
<p>l.s. The Integrated Rural Development project provides some of this. The new Nutrition Plan seeks to coordinate appropriate areas of these minorities.</p>	<p>l.s. We believe there is some success in this regard.</p>
<p>l.t. MOH is doing macro-economic studies, the National Health Survey will pick up some household health expenditure information. No micro study is underway.</p>	<p>l.t. Speeding up the Financial Study proposed in 1972 was a 075 Loan Condition. AID provided some T.A. which may have encouraged Colombian progress. The health sector Analytic Model as originally conceived has been discontinued. Alternative less complex analyses have been proposed.</p>

B.1 Narrative Summary	B.2 Objectively Verifiable Indicators
2. Emphasis on certain identified priority health problems.	<p>2.a. Disappearance of reducible causes of death from list of top ten causes of death within 10 years.</p> <p>2.b. Reducing morbidity and mortality rates among mothers, and children under 15 yrs.</p> <p>2.c. No. of children under 1, covered by GOC Maternal/Child care program increased from 67% in 1974 to 71% in 1977; coverage of children 1-4 years increased from 20% in 1974 to 37% in 1977.</p> <p>2.d. Progressive expansion of malaria, yellow fever and yaws control. Yaws surveillance to begin in 1976.</p>

B.3 Achievements	B.4 Comments
2. a. See comments Goal Indicators.	2. a. -
2. b. MCH* believe Infant Mortality rate is 67/100 live births.	2. b. Basic data for this is poor. If true it is an improvement over 1972 but only minimal.
2. c. Not known.	2. c-
2. d. Malaria Consolidation Area same 1974 and 1975; Mortality rate decreased between 1974-75. Urban yellow fever 1974-60 cases in Uncontrolled cities; 1975-40 cases in Uncontrolled cities Yaws cases 1974-329 1975-142	2. d. Yaws surveillance will not begin in 1976; however, indications are that a zero case/year status will be reached soon-then surveillance will start.

\* Maternal Child Health (personnel).

B.1 Narrative Summary

B.2 Objectively Verifiable Indicators

2.e. Reduce mortality from measles, whooping cough, and tetanus to 1.0, 1.0 and 0.5, respectively per 100,000 inhabitants.

2.f. Reduce morbidity from diphtheria and poliomyelitis to rates of 1.0 and 0.1, respectively, per 100,000 inhabitants.

2.g. Reduce grade III protein-calorie malnutrition in children under five years of age by 85 per cent and grade II by 30 per cent by 1980.

2.h. All public hospitals will be incorporated into the regionalized system by 1976.

2.i. Comadronas (empirical midwives) will be operating in the system under pilot programs by 1975.

2.j. Improved planning and administration procedures, trained admin. personnel and equipment in use by 1974.

B.3 Achievements	B.4 Comments
<p>2.e. Mortality/100,000 <u>1969</u> <u>1975</u>              Measles           13.3   7.7              Whooping cough   6.3   4.9              Tetanus           5.3   .3</p>	<p>2.e.f. This information is based on data reported. It is very likely under reported however the trend is encouraging.</p>
<p>2.f Morbidity/100,000 <u>1970</u> <u>1975</u>              Diphtheria       3.8   1.1              Polio             3.9   2.4</p>	<p>2.g. Health Loan includes funds for nutrition studies. New information system in MOH will collect some related data. National Health Survey has major nutrition section. Nutrition Loan signed AID-GOC 1976-which includes increased Bienestarina production and improved access to nutrition services.</p>
<p>2.g. No new data.</p>	<p>2.h. -</p>
<p>2.h. Unknown</p>	<p>2.i. The Government health system has never accepted this idea <u>except</u> they are willing to train Comadronas as promotoras if communities so desire.</p>
<p>2.i. PRIMOPS and Rural Reconstruction Movement are experimenting with the use of indigenous health practitioners.</p>	<p>2.j. Part of the planning office of the MOH is concerned with administrative development. There is continuing improvement in this area. Their progress reporting system is impressive.</p>
<p>2.j. Done</p>	

B.1 Narrative Summary	B.2 Objectively Verifiable Indicators
3. Functioning Health Sector Information System.	2.k. Reduce water borne diseases by provision of water systems to 100% of the people in rural communities (50-2,500 people); provision of sewage system to 40% of the people in rural communities by 1979.
	3. Accurate, timely data being produced and used in Health Sector Planning activities by 1976.

B.3 Achievements	B.4 Comments
<p>2.k. Change of water borne disease load unknown. % population of rural communities with water <u>1972</u> <u>1975</u>  sewage system 15% 13%</p>	<p>2.k. Priorities always seem to be for water systems; rather than for sewage systems; funding for rural sanitation continues to be of lower priority. The program and its direction continues to be very good.</p>
<p>3. It appears that the major part of the program will not be done until 1979. New, well-designed forms for data collection are being used country wide. The master sample design is nearly done, training of personnel is well advanced, but procurement of necessary equipment has been slow.</p>	<p>Though implementation is slower than originally planned, it is a strong, well-designed system. Extensive data collection will be done by Promotoras and at the health post level. The Nutrition Evaluation Office plans to use much of this information in the National Food and nutrition plan.</p>

The 7 categories of outputs listed here are aggregations of several hundred separate items reported on by the MOH. The categories are those which we felt most appropriately grouped the items for general comment.

1. Improved Planning, Administration and Information Systems (Ministry of Health) \*

Comment

We feel the progressive improvement in the stating of program plans and the noted progress in carrying them out (as seen in the CY 1975 quarterly reports) is indicative of assurance of direction and increasing confidence of the Ministry of Health Planning office. The office was expanded during 1974-75 and appears to be concerning itself with most phases of the health sector in concert with the various program implementing offices of the health sector. The specific program areas being implemented and reported on are organization, budget administration, personnel administration and supplies. Though achievement did not reach that which was planned at the beginning of the year, it is consistent with the lower level of funding received. In some areas achievement was considerably greater than execution of planned budget. Through the year there have been attempts to clarify the reporting, yet there remain some reporting of activity in percents which is not clear. The MOH is assisting in improving the planning at the departmental level.

Considerable progress has been made in improving the information system since improvements were initiated in 1973, though it is expected that the major portion of implementation will take until 1979. Trained statisticians or statistical aids are present at all State Health Departments, University Hospitals, Regional Hospitals and some Local Hospitals. Training for all positions is proceeding at about 200/yr, and will require 3 more years for completion. Forms for collecting service data have been improved and are being used and the master sample system has been completed through selection of segments in the 85 primary units in 2 out of 6 subsamples. This is sufficient to do major national surveys.

\* (Implementing Agency).

Relationships between the MOH office of information and DANE have been strengthened and work is progressing in the improvement of Morbidity-Mortality data. Presently death registration is only 60% complete of which 68% have an MD certification of cause. Morbidity data is available only on public hospital discharges. It is excellent. During 1977, 8 Social Security Hospitals and private hospitals will be part of morbidity reporting.

It has been very difficult to purchase the necessary calculators and computer discs (though funds have been available since 1974) due to bidding system problems. The GOC system for equipment purchase has presented problems in the past which continue and we see no easy solutions.

2. Broader personal health coverage by selected programs (Ministry of Health, Colombian Family Welfare Institute, National Planning Department).

#### Comment

The programs supported in this category include extension of services through regionalization, MAC, (see purpose indicator l.a.) Maternal-Child Health (MCH), Mental Health, Tuberculosis, Nutrition, vaccination and venereal disease. There is still no time-phased plan for implementation of the entire regionalized delivery system; however, the extensive planning and early time-phased implementation of the MAC-1 system is encouraging. We believe there is considerable commitment to this program and that it is a good program. MCH reporting at the end of the year estimated visits for the last 6 months. If the estimates are nearly correct the MCH consultations are considerably less than planned, despite complete funding. This has not been clearly explained; however, the MCH services are being integrated into the MAC delivery system which may have upset reporting and changed financing.

MCH promotoras are being retrained for MAC functions. The young mental health program still presents activity data as a general narrative or in terms of % budget spent. AID and GOC have discussed more useful alternatives. The TB reporting continues to be in terms of drugs and equipment purchased, though we have suggested that service data i.e. consultations etc. would be helpful. It is difficult from the output reporting to determine whether much progress is being made in the TB or chronic disease program. AID has discussed this with GOC personnel and has suggested improvements.

The nutrition activities of Colombia Family Welfare Department are generally the same as in the past years; however, efforts are being made to reorient their program as a result of the phasing out of US provision of food. Despite encouragement to report activities in substantive terms, part of the activity reporting is in terms of funds spent. As a result of increased attention of AID and GOC on nutrition (6 million dollar loan) we expect to have more influence in proper reporting.

The Nutrition Planning Program began late in 1975 with the establishment of the National Food and Nutrition Council subcommittee of Training, Technical Assistance and Pilot Projects. Chaired by the National Planning Dept. Nutrition Coordinator, it includes members from Ministry of Health, Agriculture, the Colombian Family Welfare Institute, the Technical Research Institute, and USAID. Initial projects were approved, including new intervention activities and base studies, for the carrying out of the Nutrition Plan. This committee has served as one vehicle for pulling together the various agencies involved in the Nutrition Plan.

GOC had an experimental program to increase the health duties of the malaria workers (i.e. health education, assistance). We understood the program was successful and negotiated a loan condition encouraging extension of the idea. As a result of internal bureaucracy and development of the MAC system, there has been no extension of this idea and we doubt that there will be.

### 3. Human Resources (Ministry of Health)

#### Comment

Clearly defined quantitative targets were prepared for the various job classifications. In general, only about 2/3 of the proposed training was done which was consistent with a decreased budget. The cut back appeared to be slightly greater in terms of months of training for technicians/ auxiliaries as opposed to professionals; however, the number of scholarships per group remained roughly in proportion. Further work is needed on indicators of progress of nursing school construction and education in facility maintenance. Studies are underway which include developing a human resources planning model, health personnel inventory for the country, occupational analysis and determination of personnel norms which we feel will provide valuable data.

### 4. Health Protection (National Institute of Health (INAS) Malaria Erradication Program (SEM), Ministry of Health.)

#### Comment

The direct campaigns run by SEM, Malaria, yellow fever and yaws were carried out and reported on in a reasonable fashion. All funds were received. 90% of malaria spraying was completed, however, 30% of programmed yaws program was not completed due to "operational difficulties" and 36% of the planned yellow fever program was not completed due to a yellow fever epidemic which required SEM personnel on an emergency basis.

The success of the Rural Sanitation division of INAS indicates that 20-50% of the planned major projects were completed and that they received 75% of the planned budget. However, if completed and initiated but not completed major projects are added, work did proceed on about as many projects as were planned. INAS rural sanitation has traditionally been underfunded or received their funds very late in the year. This year was no exception - much construction was delayed. We continue to think this division is very well designed and administered for its function.

Indicators for the program of port sanitation and epidemiological surveillance need to be more carefully defined. Though funding levels were less than planned, significant progress was made.

5. Facility construction, Production and Acquisition of Complementary Inputs (National Hospital Fund (FNH)/ Ministry of Health/National Institute of Health/Malaria Program/National Planning Dept.)

Comment

The reporting on hospital construction still has not evolved into an acceptable form despite several different attempts at reporting. DNP and AID have discussed this at length with FNH and it appears more discussions are in order. Several categories of biological production indicate complete or almost complete funding but only partial production of planned amounts. This is not explained.

6. Loan Commodity Purchase -

There are \$5,250,000 available for purchase of commodities. Purchase status is as follows:

A. Ministry of Health (MOH)

Vehicles - AID requested DNP-MOH to verify that the vehicles received from 069 were properly located and equipped prior to commodity purchase in Loan 075. Documentation initially sent to AID indicated they were located correctly but there was only about 40% verification on proper equipping. In large part, this was because of missing information.

Ministry inquiries later increased this percent and Ministry officials expressed their desires to assure completion of equipping. By the end of 1975, Loan 075 vehicle procurement was taking longer than planned but was in no immediate danger of missing the TDD.\*

Telecommunication equipment - The Ministry of Health, with AID technical assistance, outlined general and specific objectives for improving the health communication system as well as developed alternative equipment proposal and costs. It was found that costs exceeded funds available by 6-7 times and subsequently - early 1976 - the GOC decided they should not initiate telcom improvement at this time. In January, 1976, GOC requested reallocation of these funds for cost overruns of other US health loan dollar purchases and for purchase of vehicles to support the rural out-reach program. AID/C received Washington approval for reallocation June, 1976, and stipulated that only those departments which had properly located and equipped 069 vehicles by the time 075 vehicles arrived could receive 075 vehicles. Immediate progress was necessary to keep the process within TDD.\*

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\* At the time of completing this evaluation November, 1976, complex problems had developed which make it questionable whether procurement can be completed by TDD.

B. National Institute of Health (INAS)

Procurement of well drilling equipment is proceeding as scheduled.

C. Malaria Eradication Program (SEM)

SEM provided appropriate information for insecticides and audiovisual equipment soon after the loan was signed. Due to the need for AID to develop an environmental impact statement permission for purchase was not granted until April 24, 1976.\*

D. National Hospital Fund (FNH)

The FNH equipment request as presented, initially contained questionable items from AID's point of view. AID provided technical assistance from the U.S. in September, 1975 to assist in redeveloping the request. Specifications for 2/3 of the request were developed during this visit, with guidelines being developed for the remaining 1/3 of the request. The entire package was not agreed to by AID and FNH until May of 1976.\*

E. National Planning Department (DNP)

Despite a late start in forming the sub-committee on Training, Technical Assistance, and Pilot Projects mentioned above (p. 25 ), a short and long term training plan was developed for professionals from Agencies involved in the Nutrition Plan and training was initiated. Technical Assistance was contracted to assist in plan development.

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\* At the time of completing this evaluation November, 1976, complex problems had developed which make it questionable whether procurement can be completed by TDD.

7. Research (Ministry of Health, National Institute of Health)

Comment

The bio medical research being carried on by INAS is extensive and many studies are of a continuous nature. Adequate progress indicators have not been designed though several alternatives have been tried. The basic problem is finding suitable indicators of progress for ongoing studies. Many applied research subjects have been carried out since the Division of Special Investigation was begun and now the efforts of this division are directed toward completing the National Health Survey. A Direction of Research was set up in the Ministry of Health.

D.1 Summary	D.2 Objectively Verifiable Indicators
<u>Inputs:</u>  <u>Implementing Agencies</u>  A. MOH B. SEM C. FNH D. ICBF E. INPES (INAS) F. DNP	Execution Targets:(1975)(000,000 pesos) I. AID funds requiring GOC counterpart A. <u>MOH</u> GOC           264.2 <u>AID</u> 72.3 Total           336.5  B. <u>SEM</u> GOC           117.0 <u>AID</u> 28.4 Total           145.4  C. <u>FNH</u> GOC           329.4 <u>AID</u> 5.1 Total           334.5  D. <u>ICBF</u> GOC           626.4 <u>AID</u> 20.0 Total           646.4  E. <u>INAS</u> GOC           174.6 <u>AID</u> 91.3 Total           265.9  II. AID Funds not requiring GOC counterpart  PRIMOPS           2.0 MCH           30.5 <u>DNP</u> 7.6 Total           40.1  III. <u>SECTOR</u> GOC           1511.6 <u>AID</u> 257.2 Total           1768.8

D.3 Achievements			D.4 Comments
I. AID funds requiring counterpart (000,000 ps)			<p>The fact that the sector as a whole exceeded the programmed budget was the result mainly of ICBF receiving considerably more through a 2% wage tax than anticipated at loan signing.</p> <p>US\$667,227 were deobligated resulting from a redetermination of the exchange rate.</p> <p>US\$1,441.153 were deobligated due to insufficient GOC counterpart.</p> <p>(1) 2,781,000 pesos were not paid due to overdisbursement in 1974.</p> <p>(2) There were two different program categories funded independently in INAS - Research and Rural Sanitation.</p> <p>(3) Established loan target was higher than Colombian budget law. AID paid against budget law.</p>
	<u>Actual</u>	<u>Exec.</u>	
	74	%	
A. <u>MOH</u>			
<u>GOC</u>	197.0	74.6	
<u>AID</u>	51.2(1)	70.8	
Total	248.2	73.8	
B. <u>SEM</u>			
<u>GOC</u>	126.8	108.4	
<u>AID</u>	28.4	100.0	
Total	155.2	107.0	
C. <u>FNH</u>			
<u>GOC</u>	205.0	62.2	
<u>AID</u>	3.2	62.2	
Total	208.2	62.4	
D. <u>ICBF</u>			
<u>GOC</u>	1139.7	181.9	
<u>AID</u>	20.0	100.0	
Total	1159.7	179.4	
E. <u>INAS</u>			
<u>GOC</u>	139.2	79.7	
<u>AID</u>	70.1(2)	76.8	
Total	209.3	78.7	
II. AID funds not requiring counterpart			
PRIMOPS	2.0	100.0	
MCH	28.3	92.8(3)	
DNP	7.6	100.0	
	37.9	94.5	
III. <u>SECTOR</u>			
<u>GOC</u>	1807.8	119.6	
<u>AID</u>	210.8	81.9	
Total	2018.6	114.1	

## Conclusion

While earlier sections of this paper gave examples of unexplained inconsistencies, poor reporting and incomplete analysis, the majority of the programs are proceeding generally as planned. We believe the intent of our assistance as begun with loan 069 and continued with 075 was carried out during CY 1975. (It is unfortunate that problems seem to be developing in dollar purchases in 1976.)

In August of 1974 there was a change of government. The slow down which occurred in the health sector, as well as in the government as a whole, continued into 1975 as new personnel were being recruited and were adjusting to their new positions. Despite this slow start, improvements initiated or encouraged in 1973 and 1974 continued. Specifically, progress was notable in implementation of the information system and in sector planning and administration. Of great importance was the strong emphasis given by the new Government to extending health services to those Colombians presently not having access, through the development of the MAC program (Modelo Ampliación de Cobertura). Extensive planning and initial implementation took place in 1975 and is continuing. The MAC system is part of the Colombian plan for regionalization and we believe this has helped solidify many regionalization components which AID has sought to have clarified through specific assistance and conditions of both health loans.

The MAC implementation and the initiation of the National Food and Nutrition program have been complementary and mutually supportive in specific health areas, i.e. more careful job definition and use of the health promotora, rural water and sanitation, and nutrition improvement.

We feel the required quarterly sector loan reports have improved since last year though some deficiencies are still apparent. An improvement of note is that the MOH has included a section of intermediate objectives (impact measures). They require considerable refinement. Where impact measurement has been attempted, the trends have been encouraging.

Completion of loan conditions has been mixed, with some completed extremely well, while others were acceptable for CY 1975 but needed improvements prior to CY 1976 disbursement.