

CLASSIFICATION
PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol: U-147

1. PROJECT TITLE Health Systems Development			2. PROJECT NUMBER 660-0057	3. MISSION/AID/W OFFICE USAID/Zaire ²¹⁹
			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) 83-7	
			<input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION	
5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING	
A. First PRO-AG or Equivalent FY <u>76</u>	B. Final Obligation Expected FY <u>81</u>	C. Final Input Delivery FY <u>82</u>	A. Total \$ <u>1,917,000</u>	7. PERIOD COVERED BY EVALUATION
			B. U.S. \$ <u>1,277,000</u>	From (month/yr.) <u>9/80</u>
				To (month/yr.) <u>3/83</u>
				Date of Evaluation Review

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which require the AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. USAID/GOZ should make counterpart funds available for operational expenses at Kongolo and Maluku through August 31, 1983. 2. The local DSP officials should, in collaboration with Peace Corps Volunteers and other organizations, initiate the following actions: A. Design and implement a revised fee structure that will cover operating costs of health centers and make them fully self-financing. B. Involve the community more closely in the building and management of health centers. 3. The DSP should provide a budget line item for direct support of the pilot zone of Kongolo.		

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS <input type="checkbox"/> Project Paper <input type="checkbox"/> Implementation Plan e.g., CPI Network <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Financial Plan <input type="checkbox"/> PIO/T <input type="checkbox"/> Logical Framework <input type="checkbox"/> PIO/C <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Project Agreement <input type="checkbox"/> PIO/P	10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT A. <input type="checkbox"/> Continue Project Without Change B. <input type="checkbox"/> Change Project Design and/or <input type="checkbox"/> Change Implementation Plan C. <input checked="" type="checkbox"/> Discontinue Project (as planned)
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11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles) Mr. Richard L. Thornton - PHO Division Chief Ms. Betsy Stevens - Consultant, International Science and Technology Inst Dr. Kankienza Muana'Mbo - Director of Project CitneChirwisa Chirhamolekwa - Assist. Director Ms. Laura Keyser, Peace Corps Coordinator	12. Mission/AID/W Office Director Approval Signature: <i>[Signature]</i> Typed Name: Richard Podol Date: 1 Aug 83
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Best Available Document

I. SUMMARY OF FINDINGS

This evaluation finds that the project achieved most of its outputs and accomplished its stated purpose of strengthening the GOZ's capacity to plan and deliver health services. The durability of project accomplishments is more problematical. How much the GOZ profited from this project institutionally, and how the lessons learned will be applied to other health zones remains to be seen. Four Zairian public health professionals received long-term training at Tulane University in the areas of Public Health Planning, Epidemiology, and Community Development. Twenty-four other Zairian health professionals received short-term training abroad and in-country. The GOZ, with stimulus both from this project and from other donors, prepared a National Health Plan in January, 1982. This document identifies the country's major public health problems and sets forth a sensible approach to addressing them over the next five years. An integrated, low-cost, health delivery system has been initiated in Kongolo zone. Its sustainability is in question and this evaluation is unable to make a prognosis for its durability. There are no concrete action plans to extend the system developed in Kongolo to other zones. However, the GOZ is in the process of organizing discrete health zones (124) throughout the country as a first step in this process.

II. BACKGROUND AND HISTORY

1. General

The Health Systems Development Project began in August, 1978, as a two-year project. The project had been authorized by the Mission Director in December, 1975, and the Project Agreement had been signed in June, 1976. An American long-term technical consultant (who arrived in October, 1978) and various short-term consultants worked with the Planning Cell in the Ministry of Public Health to develop the planning, administrative and logistical support capability necessary for organizing and servicing a national basic health care system that could be implemented through the health development zones. Kongolo zone in Northern Shaba region (eastern Zaire), was selected as a demonstration zone in which to introduce a prototype integrated health delivery system.

2. Mid-term Evaluation (1980)

a. Findings

A comprehensive evaluation of the initial project was conducted in July, 1980. This evaluation produced the following major findings:

(1) That the project, as planned, was provided inadequate time and resources to realize its objectives.

(2) That the skills of the long-term consultant were inappropriate to the requirements of the project.

(3) That there were a number of other factors that further hindered project performance. These included the delay between project conception and implementation, a complete change of AID and GOZ personnel associated with the project, and delays and non-arrivals of critical commodities. In addition, the period 1974-1980 had seen a general and serious economic decline. This coincided with the elimination of health from the stated national priorities.

As a result of these factors, the project had accomplished only a few of its objectives and these only partially. The project had established a planning cell in the Ministry of Health. However, the project had not produced either the national plans or the integrated replicable health delivery system planned under the project. The project had initiated some worthwhile activities to help establish a workable and replicable integrated delivery system. These included the introduction of planning and management techniques as well as the initiation of some basic, low-cost, preventive health interventions. These interventions had demonstrated that Zairians could identify and address some of their immediate health problems using only those resources and services affordable and potentially available at the rural village level. These interventions included:

(1) Initiation of a successful measles vaccination program in the town of Kongolo and in the villages of Kaseya and Kayanza.

(2) Initiation of a nutrition status survey in these same areas.

(3) Establishment of two village and four town health committees.

(4) Initiation of a water source protection program.

(5) Plans for family planning education.

b. Recommendations

The evaluation team presented USAID with the following recommendations which were accepted by the Mission:

(1) Termination of the contract with P&HS. Inasmuch as the project was nearing scheduled completion, it was suggested that the contract be permitted to expire as scheduled (August, 1980).

(2) Termination of two personal service contracts. Again it was suggested that these contracts be permitted to expire as scheduled (August, 1980).

(3) Continuation of AID assistance to the health sector in Kongolo, using Peace Corps Volunteers as the action agents.

(4) Provision by USAID of short-term technical assistance to the Department of Public Health on an as-needed basis.

(5) Extension by USAID of the life of the project through August, 1982, making use of the funds remaining in the project for the following activities:

(a) Provision of a national health planner to the Department of Public Health, for a period of up to three months, to assist the GOZ in the preparation of a National Health Strategy and an action plan for carrying it out. The same planner would also be responsible for refining the Zonal Health Plan which was then under preparation in Kongolo.

(b) Upon completion of such plans, provision to Kongolo of medicines and equipment for the twelve health centers and dispensaries that the GOZ medical team was preparing to open in the forthcoming year. USAID and the GOZ, using counterpart funds, would also provide cement, hand tools and visual aids for initiation of preventive health programs using Peace Corps Volunteers as the action agents. These inputs, to be provided on a non-replenishable basis, would provide an initial stock of equipment and basic medicines; restocking would be financed by revenues from sales of medicines.

(c) Provision of financing for per diem, transportation, and training aids for the training of village health agents in workshops as well as the retraining of salaried health workers under the supervision of Peace Corps Volunteers and the Medical Director of Kongolo.

c. Revised Project Papers

Based on these recommendations the PP was amended in September, 1980. The significant changes in project planning were as follows:

(1) Because of the project's innovations -- attitudinal changes on the part of the health care providers, changes in methods of financing pharmaceuticals, emphasis on preventive rather than curative health care, initiation of propharmacies and stimulation of community participation -- the project would limit its activities to only one zone (of Zaire's 215 zones). This would permit the concentration of scarce project and GOZ resources on the trial and modification of the new orientation. After the system had been successfully refined, it was envisaged that the GOZ could install the system, with its new orientation, in other zones on a phased basis consonant with the resources available to the GOZ.

Recent economic developments had made it unlikely that the health sector would receive increases in the levels of budgetary support from the GOZ. Indeed, it was considered likely that the levels of assistance might be reduced. Therefore, the project plan encouraged the Department of Public Health to look for alternative methods of providing health services that would not require additional resources. While the National Council was expected to continue to set long-term health policy for the GOZ, implementation planning was to be the responsibility of the Department of Public Health's Planning Cell. This group, composed of the directors of the five Department Bureaus and several technical specialists, was charged with the coordination of donor support to the health sector and was the central conduit for project assistance.

(2) The following revised outputs were planned:

(a) A cadre of governmental health professionals, trained and capable of effective health planning.

(b) The preparation of a health sector strategy for identifying, rank ordering, and addressing the health problems of the country. This strategy would derive from identification, evaluation, and selection of alternatives, taking into consideration the resources available to effect the strategy. The strategy would include plans for activities at the zonal level.

(c) The establishment of a replicable integrated, health delivery system in Kongolo Zone.

(d) The preparation of detailed plans to extend the system developed in Kongolo to other zones.

(3) The following inputs were programmed:

(a) Drugs (with emphasis on those basic drugs that could be

safely distributed by non-medical personnel).

(b) Basic medical supplies and clinical equipment for the central hospital at Kongolo and the 12 dispensaries in the Zone of Kongolo.

(c) Two four-wheel drive vehicles for use in Kinshasa and/or Kongolo.

(d) Audio-visual materials.

These commodities were to be used for the development of the integrated health system in Kongolo. Replenishment of the commodities was to be financed by the sale of medicines.

(4) Activities

Over the two-year extended project period (August, 1980 - August 1982) the project would pursue the following activities as scheduled in the Kongolo Zone's health plan:

(a) Opening and stocking of the 12 dispensaries.

(b) Water source protection and environmental sanitation.

(c) Continuation and expansion of vaccination activities.

(d) Expansion of health education through village health committees to be organized by the project.

(e) Expansion of nutrition surveys, family planning education, and referral services.

(f) Development, as appropriate, of a system of propharmacies.

III. EVALUATION METHODOLOGY

This evaluation serves as an end of project assessment. The evaluation report, prepared by USAID, draws on a special consultant's report of activities in Kongolo prepared in mid-1982, the Peace Corps reports and especially the final report of December, 1982, and discussions with project personnel in Kinshasa and Kongolo.

IV. EXTERNAL FACTORS

Since the initial project design in 1975 and the amended PP in 1980, the general economic situation in Zaire has worsened. The unplanned/unforeseen events that adversely affected project implementation for the period August, 1980 through August, 1982 included fuel shortages (resulting in increased difficulties in transporting project personnel and equipment),

local unavailability of basic pharmaceuticals, unwillingness of the GOZ to employ certain Kongolo health workers, and long delays in receipt of salary payments by the GOZ-employed health personnel.

V. INPUTS

1. Technical Assistance

The revised PP called for 12 man-months of technical assistance to be available to the project on an as-needed basis. Three months of one technician's time (project-financed) were spent assisting in the preparation of the Kongolo Zone Health Plan. An additional three short-term months of technical assistance (centrally funded) were provided for sanitation and water management. Both technicians were competent and produced acceptable work.

2. Training

The revised PP programmed 65 months of long-term training abroad. This was intended to give Department of Health personnel increased capacities to conceive, plan and implement appropriate health strategies. Four Zairian public health professionals are presently completing Master's degree training at Tulane University.

3. Commodities

The revised PP called for provision of basic medicines and equipment for the 12 health centers to be opened during the 1980-82 period. Approximately two-thirds of all equipment specified in the Kongolo plan was procured and delivered to Kongolo.

4. Local Costs

Although the project has received programmed counterpart funds, those funds routinely have been received late due to chronically slow administration at the Ministry of Plan (which manages the funds). This problem, which is endemic to projects in Zaire, has occasioned considerable expenditures of time and energy by project personnel.

VI. OUTPUTS

The revised PP anticipated the following major outputs:

1. "A cadre of Department of Public Health professionals trained and capable of effective health planning." This output can be considered achieved.

The four health professionals (two of whom are senior personnel with policy formulation responsibilities) are completing their training in health planning at Tulane University. They are scheduled to return to their Department positions in mid-1983.

2. "The preparation of a health sector strategy for identifying, rank-ordering, and addressing the health problems of the country". This output has been achieved. The Kongolo Zone Health Plan was prepared in July, 1981, and the National Health Plan in January, 1982.

3. "The establishment of a replicable, integrated health system in Kongolo zone". This output has been largely achieved. A low-cost health care delivery system has been established in Kongolo zone. It is currently functioning as planned. Whether or not that system will be sustained and replicated remains to be seen. The status of the sub-outputs (major health activities) from the Kongolo Health Plan is shown on Table I.

4. "The preparation of concrete action plans to extend the system developed in Kongolo to other zones". This output has not been achieved. The GOZ has designated 124 official Rural Health Zones. Health system development planning for these zones is expected to be completed by 1986.

VII. GOAL AND PURPOSE

1. Purpose

The purpose of the project was to strengthen the GOZ's institutional capacity to plan and deliver health services. Certainly the GOZ's capacity has been strengthened to some extent. The preparation and publication of the National Health Plan in January, 1982, is the most apparent indicator of this strengthened capacity. Another indicator is the GOZ's increasing willingness to countenance local financing and local (decentralized) planning and management of rural health care delivery.

2. Goal

The larger goal to which project activities were to contribute was to establish and implement an integrated National Health Delivery System. There has been some progress towards this overall objective. Family planning services, vaccination, malaria treatment, and oral rehydration therapy have been established as the basic services for all systems. This policy decision is now being

implemented in the National Health Plan for 1982-86.

VIII. BENEFICIARIES

The immediate beneficiaries of this project are the 180,000 residents of Kongolo Zone who now enjoy improved access to basic preventive and curative health services. At present it is unclear what the spread effects may be. If the GOZ pursues its stated priorities and plans for 1982-86, as many as 6,000,000 rural people could benefit from similarly improved access.

IX. UNPLANNED EFFECTS

The implementation of this project reinforced GOZ, USAID, Peace Corps and other donor awareness of the challenging logistical (transport and communication) requirements in implementing projects in remote rural areas of Zaire. The GOZ has become more nearly persuaded of the legitimate need for freedom of administrative action and decision-making authority at the local level. The GOZ also has moved toward more reliance on user fees for services and commodities to underwrite the costs of health care delivery.

X. LESSONS LEARNED

The following useful lessons can be drawn from the experience with this project. They are directly relevant to future project undertakings in Zaire and may be more broadly applicable, especially for Africa.

1. The personal service contract negotiated directly by the Mission may be the most cost effective method of services procurement for a project that requires only a few consultants. This method should always be considered as a first option. For small technical assistance teams, institutional contracts are too cumbersome and too costly.

2. USAID should assume the responsibility for recruiting project consultants. AID/W may advise and assist, but USAID should not relinquish the responsibility. Ultimately it is USAID that must live with the personnel recruited to assist with project implementation.

3. In project planning, AID should take specific note of the work load that the project will place on participating local nationals. Government personnel particularly should be fully apprised of expected project demands on their time, and their commitment of necessary time and effort should be

assured before beginning project implementation. Generally it is not realistic to expect officials who already have a full work load to devote more than a fraction of their time to a new undertaking.

4. Project planning should assume worst-case scenarios. These are more likely than best-case scenarios. If planning assumes the worst case but finds the best, nothing is lost. If planning assumes the best but finds the worst (more likely), the project will be ill-prepared to accommodate the situation. This perspective is especially germane to implementation scheduling. A useful rule of thumb would be to anticipate actions taking about three times as long to complete as would seem necessary assuming best-case scenarios.

T A B L E I

ACTIVITY	Planned through 1982	Achieved	Planned for 1983 (additional)
Health centers opened and functioning	12	8	2-3
Self-financing system established/functioning in health centers	12	4	4-5
Health committees established and active	12	8	1
Nurses retrained	12	29	4
Water agents trained	12	23	6
Community health organizers trained	12	18	6
Midwives trained	as needed	2	4
Vaccination centers established	12	7	3
Children vaccinated	-	3000	4000
Water sources capped	12	35	12
Zonal health committee formed	1	1	-