



WESTINGHOUSE

**FIRST EXTERNAL ASSESSMENT
HEALTH SECTOR I
HONDURAS**

AID Contract No. PDC-1406-I-11-1129-00

February 1984

Submitted By:

**Westinghouse Electric Corporation
Health Systems
P.O. Box 866
Columbia, Maryland 21044**

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EXECUTIVE SUMMARY

The evaluation of the Agency for International Development/Ministry of Health of Honduras Health Sector I Project (No. 522-0153) is the first external assessment of the project.¹ The principal objectives of the evaluation were to determine if the project is still valid and necessary; to determine what, if any, mid-course corrections in project design, organization, and management are required; and to assess the proposed reprogramming document in light of the evaluation's findings.

The evaluation concluded that the basic project design is still appropriate, and that the flexibility that has characterized the project's evolution and implementation has permitted it to respond to the Ministry of Health's needs and priorities. Although project activities are behind schedule, implementation delays are due in large part to the initial delay in approving the overall technical assistance contract. Other major bottlenecks in project implementation are lack of sufficient counterpersonnel and continuous deferral of the creation of permanent positions required to institutionalize the project; tortuous procurement, construction, and payment processing procedures and requirements (GOH and AID); a logistics system that shows promise, but is still a major impediment; communication and coordination problems within and among AID, MOH, and other parties directly and indirectly involved in the project; and the lack of synchrony among project activities resulting from a combination of the factors above. Overall, the pace of project implementation is acceptable, particularly in view of the many external factors that have slowed progress considerably.

A series of measures could be taken to accelerate and improve the project implementation, and specific recommendations are provided in the

¹The evaluation was conducted by Westinghouse Health Systems, under AID Contract No. HS 15,563.

body of the report for each of the eighteen project subcomponents. The major recommendations can be summarized as follows:

1. Certain project subcomponents (such as the rabies and sexually transmitted disease elements), which are no longer of high priority to the MOH, should be reconsidered and possibly eliminated.

2. Core project activities (such as logistics, management and planning, and maternal and child health) should receive more intensive effort during the remainder of the project life.

3. AID should move swiftly and decisively to ensure that the Government of Honduras creates and fills the permanent positions critical to project implementation and sustainability.

4. Short-term technical assistance in specialized areas should be used flexibly in support of project components such as malaria and maintenance.

5. Steps should be taken to ensure that the PCU's coordination of financial aspects of project implementation is complemented by adequate technical and programmatic coordination. Originally planned as the responsibility of the GCEDI, this function does not appear to be adequately carried out, to the detriment of the project.

6. AID should adopt formalized implementation strategies, identifying critical activities, dates and responsible parties, which are then monitored according to a PERT chart.

7. An AID project support officer should be assigned to the project on a permanent basis to reinforce the technical management of the project.

8. The project should be evaluated on a regular basis, and evaluation should be included as a management tool as part of the "Management and Planning" component of the project.

A number of changes are recommended in the Reprogramming Document, consistent with an overall recommendation that the next phase of the project concentrate on the consolidation of critical systems (management and planning, logistics, maintenance and supervision) and on high priority technical health interventions. The evaluation recommends that the project not diversify into additional areas such as oral health. Specific suggestions are made for scaling back the proposed activities, particularly in view of limited absorptive capacity on the part of the MOH.

GLOSSARY

AID	Agency for International Development
CDC	(U.S.) Centers for Disease Control
CESAMO	Centro de Salud (with medical officer)
CESAR	Centro de Salud (rural, no medical officer)
CONAME	Comision Nacional de Medicamentos
ESF	Economic Support Funds
EPI/PAI	Expanded Program of Immunization
GCEDI	Grupode Coordinacion Ejecutiva y Desarrollo Institucional
GOH	Government of Honduras
MCH/FP	Maternal and Child Health/Family Planning
MOF	Ministry of Finance
MOH	Ministry of Health
MSH	Management Sciences for Health

ORS	Oral Rehydration Salts
ORT	Oral Rehydration Therapy
PAHO/OPS	Pan American Health Organization
PCR	Program and Capital Resources Office (AID)
PCU	Project Coordination Unit
PTL	Project Implementation Letter
PIO/C	Project Implementation Order/Commodities
PIO/T	Project Implementation Order/Technical Assistance
PP	Project Paper
TA	Technical Assistance
TB	Tuberculosis
UNICEF	United Nations Children's Fund
VHWs	Village Health Workers

I. INTRODUCTION

Purposes of the Evaluation

This evaluation of the Agency for International Development/Ministry of Health of Honduras Health Sector I Project (No. 522-0153) is the first external assessment of the project. More than three years have elapsed since the Project Agreement was signed (on July 31, 1980). During that period a variety of factors -- including delay in meeting Conditions Precedent to disbursement of funds, delay in the employment of a project coordinator and delay in awarding a contract for technical assistance, coupled with interruptions that naturally follow a high turnover in personnel in both A.I.D. and the Government of Honduras -- have contributed to the slow implementation of the Health Sector I Project. (See Table 1 for a list of critical dates in project implementation, and Tables 2 - 4 for an overview of changes in personnel in key positions). Consequently, although three years have elapsed since the Project Agreement was signed, and less than one year remains in the life of project, project activities really commenced barely one and one-half years ago. The Mission is currently contemplating an extension of the life of project, a reprogramming of remaining project funds, and the addition of a considerable amount of new funds for both ongoing and new activities.

The objectives of this evaluation are several:

- To assess progress to date in project implementation.
- To identify major bottlenecks impeding project implementation.
- To evaluate the adequacy of project inputs.
- To analyze the institutional and external constraints to project implementation.
- To review and critique the proposed reprogramming of project funds and new activities.
- To recommend solutions to implementation problems and suggest alternative approaches for achieving the objectives of the project.

Evaluation Methology

The evaluation was conducted by a multidisciplinary team of three consultants (Abby L. Bloom, Team Leader, Dr. Petra Reyes, and Dr. Harry Feirman) with extensive experience in LDC health program design, implementation and evaluation (including A.I.D. policy and program analysis, health management and administration, financial analysis, health worker training and performance evaluation, MCH/family planning program design and administration, social epidemiology, and community participation in health programs). The team received invaluable support from two Ministry of Health counterparts named by the Director General of Health, Dr. Fidel Barahona and Lic. Daisy Mejia. The evaluation scope of

work was divided up among the consultants, but the final product is the result of their cumulative efforts and the conclusions of this report reflect the consensus of the entire team.

The evaluation is based in part on a review of project documentation maintained by A.I.D., the Project Coordination Unit, the normative divisions and working groups of the Ministry of Health, and Management Sciences for Health and the Academy for Educational Development and the malaria advisor (who are providing technical assistance to the project). The team reviewed project files, planning documents, scopes of work, implementation letters, PIO/Ts, PIO/Cs, periodic activity and supervision reports, financial records and reports, consultant's reports and other background documents (including MOH division files, warehouse records, the health sector assessment, etc.).

A second major source of information was lengthy interviews with A.I.D. staff (including Human Resources Division staff, the Controller's Office, and the Program/Loan Office (PCR)); Project Coordination Unit staff; technical advisors (including employees of Management Sciences for Health, the Academy for Educational Development, and the project malaria advisor); Ministry of Health personnel involved directly and indirectly in project activities (including permanent staff and those contracted with project funds); and staff in other ministries whose functions affect the project's implementation. The team visited the directorates of three health regions: II (Comayagua); V (Santa Rosa-Copan); and VI (La Ceiba and Tela), and central ministry facilities (e.g., the central warehouse). A list of persons interviewed is included in the Appendix (Table 6).

The focus of the evaluation, determined jointly by the MOH and A.I.D., is project implementation. Since project activities have been underway for such a brief period, this is an evaluation of process, not impact. The team was guided by a lengthy series of topics and questions centering on three principal areas: 1) the subcomponents of the project, 2) the project's own administrative systems, and 3) the participation of key institutions (A.I.D., the MOH, and other government agencies) in project implementation. (See Appendix A for MOH/A.I.D. "Scope of Work") This report concentrates on several critical health systems which have received considerable attention in the Health Sector I Project: Management, logistics, mass media, supervision, and administration and maintenance. Because of their importance to the project's success, the evaluation report provides most detail on the management/administration, logistics, maintenance and training aspects of the project. Finally, the team studied the influential role of "external factors," such as macroeconomic conditions, political commitment, availability of funds from other donors, potential duplication of resources and competition for scarce GOH counterparts, on the long term success of the project.

II. PROJECT BACKGROUND

The Health Sector I Project was developed in response to the recommendations of a comprehensive health sector assessment completed in 1980¹. That assessment endorsed the Government of Honduras' commitment to extending coverage of health services, particularly to rural and marginal urban areas. It also identified a series of structural, functional and environmental impediments to achieving the GOH's health sector goals, including poorly defined guidelines and norms in service programs; deficient support systems (supervision; management and logistics; administration; and information systems); and a relatively new, integrated approach to service delivery at the periphery (i.e., community level) that while well-conceived, was not functioning effectively². In spite of its political commitment to extension of health services, most of the government's health budget continues to be dedicated to hospital-based health care. The Health Sector I Project was designed to improve non-hospital-based health services. Although resources would be concentrated at the central level, the objective was to improve operations and service delivery at lower levels in the health system in the various health regions.

The project's purpose is straight-forward and ambitious: "...to increase the effectiveness, efficiency, coverage and use, of the (public) health care system in Honduras..." The project consists of a series of 17 somewhat distinct, but interrelated subcomponents. The subcomponents, an amalgam of discrete programs and systems support functions are:

A. Health Service Programs

1. Malaria Vector Control
2. Rabies Control
3. Immunizations
4. Diarrhea Control
5. Tuberculosis
6. Sexually Transmitted Diseases
7. Maternal and Child Health/Family Planning Services

1 Assessment of the Public Health Sector In Honduras,

(1975-1985)USAID/Honduras, 1980. The Assessment is a detailed, excellent analysis of health sector constraints. Many if not most of its conclusions and recommendations are still applicable today.

- 2 A full description of the pyramidal health system in Honduras is contained in the Health Sector I Project Paper and in the recently published research report, "Estudio de Alternativas de Financiamiento de los Servicios Basicos de Salud en Honduras," 1983.

B. Systems Support Functions

8. Epidemiology Training
9. Drug Procurement ("Basic Medicine List")
10. Logistics Systems
11. Maintenance System
12. Management and Planning
13. Mass Media for Village Health Workers
14. Teacher Training
15. Supervision
16. Continuing Education for Village Health Workers
17. Continuing Education for Ministry of Health Employees

Among the subcomponents, highest priority was assigned to management, logistics and maintenance system improvements. Each of the project components is described in detail in the "Amplified Project Description," Appendix B.

The evaluation team reviewed the progress of implementation through September 30, 1983. As of that date, 79¹ percent of the life of project had elapsed. According to A.I.D.'s financial records, 44 percent of project grant funds (\$1,958,621 of a total of \$4,426,000) and 23 percent of project loan funds (\$2,519,445 of a total of \$10,965,000) had been expended.²

The following section contains a review of progress and problems in each of the seventeen components.

III. SUBCOMPONENT ANALYSIS

1. Malaria

Malaria Control support comprises 56 percent of the Project's Health Technologies allocation and fully eleven percent of total project financing. The component is a vertically structured program within the Vector Control Division which has its own budget and administrative services structure. Coordination with other normative divisions of the MOH is minimal. While varying degrees of collaboration exist on the operational level, there currently appears to be little integration with the services delivery system. Project support for this component is largely intended to strengthen the program's technical capacity and to expand the range of control technologies employed. Though the total number of confirmed cases of malaria has decreased since 1982, the epidemiologic picture is incomplete. Effects of unusual ecological

1 Calculated according to the life of project anticipated in the Project Paper.

2 Expenditures = the sum of disbursements and accruals.

conditions on the vector have not been fully analyzed, and the potential for malaria resurgence is a continuing threat. Because of the cyclical activities required by the program, timing and continuity are crucial to maintaining effective vector control.

A. Technical Assistance

An entomologist, contracted directly by A.I.D. on a long-term basis, has provided 30 of 42 months of TA stipulated in the PP. Initial host-country contract negotiations delayed this TA by one year. Short-term vector control training assistance was provided twice. The third element of specified TA has not been carried out because it was considered technologically inappropriate given local resources. Instead, a larval control expert was identified, but was never contracted.

Delays in TA, notably the delay in contracting the long term advisor, have decidedly impeded effective implementation of the program. Above all, the lack of appropriate technical advice on procurement specifications for vehicles and difficulties experienced in procurement have resulted in continuing problems such as non-functional vehicles and incomplete technical equipment and commodity orders. Implementation of essential vector control measures was delayed until Project Year 3.

The long term TA scope of work is consistent with the PP and sufficiently broad to cover the variety and range of assistance to be provided to the Vector Control Division but not identified in the PP. The change in the focus of short term biological control TA is consistent with vector control priorities. Malaria advisors selected for the technical assistance seem technically capable, but to date the long-term advisor has not developed a work plan.

As the MOH counterpart, the Division Chief, also the Director of a Teaching Hospital, is considerably senior to the entomologist. The working relationship between these counterparts is not without difficulties. Other senior staff of the division appear to work closely and collegially with the advisor in a variety of technical and problem-solving matters. Time limitations prevented the team from assessing the extent of transfer of skills and knowledge from the advisor to the working group. Major impediments to technical collaboration are the continual logistical (i.e., procurement) and administrative (i.e., travel related) problems involving respectively the A.I.D. and the MOH. They consume a major portion of the advisor's time.

B. In-Country Training

Training courses to date have generally followed the PP plan with some changes in categories of personnel trained and the timing of courses. These resulted from delays in TA inputs and untimely access to A.I.D. funds. According to the Division Chief, the program has achieved to date 85 percent of its targets; detailed information about

the number of courses, trainees, and methodologies were not readily accessible and neither technical appropriateness nor quality could be judged. Training information seems to consist primarily of expenditures. Apparently some of the scheduled training has also been supported with non-A.I.D. funds.

C. Overseas Training and Observational Travel

Observational travel to a technically important site in Brazil had been scheduled for the Division Director, but instead the Director visited a different site, accompanied by the Sub-Director General of Health. Overseas training is still scheduled for the MOH Entomologist and the Director. The entomologist was to begin training in the U.S., but since he did not have the English language capability required, he will be sent to a course in Latin America. The scheduled training seems appropriate for the stated objectives of the program and the candidates are those identified in the PP.

D. Construction

Insecticide warehouse construction, scheduled for Project Year 3, has not yet begun, although the land for four of the seven warehouses has been obtained by the MOH. Delays have been caused by legal complications involving location of sites safe for insecticide storage, as well as by difficulties in determining land ownership and acquisition of titles. Faulty and delayed communication between MOH staff and A.I.D. are reported to have further complicated the process. Delays in construction have not only impeded vector control activities, but have caused health hazards. Highly toxic insecticide continues to be stored in open and public spaces such as health establishments. Yet insecticides have been used since the beginning of the project, according to plan. It would appear that the PP technical design was deficient, in that it permitted misalignment of the schedules of commodities and construction schedules.

E. Commodities

It was not possible to verify whether all the commodities were ordered according to plan. They were partially received and distributed according to plan, though with delays. Vehicles and other equipment were inappropriately equipped, due to faulty or incomplete specifications. A considerable amount of technical equipment is similarly incomplete and lying idle. Virtually all funds for commodities have been expended. About 30 percent of the commodities have not yet arrived. Six pick-up trucks, purchased for the malaria program, have been assigned to the MOH motor pool by the Directorate General. This was due to a purchase of malaria vehicles (subsequent to A.I.D.'s purchase) by the Japanese. Without the trucks, the project's ultra low volume insecticide sprayers cannot be used. A determined effort should be made either to repatriate the trucks to the malaria program or to develop a rationale for leaving the trucks where they are.

The GOH receiving, clearing, inspection, verification and distribution system is weak at best, and the procurement information flow between the Coordinating Unit, the Division of Vector Control and A.I.D. is said to be less than desirable. Delays in implementation of control activities are obvious; less so is the excessive amount of the technical advisor's valuable time being devoted to attempts to rectify the problems.

F. Personnel

Additional personnel and per diems programmed in the PP were to be provided with counterpart funds during year 1. Delay in project implementation and change of the Vector Control assistants to a new cadre of personnel not foreseen in the PP has resulted in a revision of the personnel element. The administration position has been filled part of the time. Although the Division Director stated that these requirements have been met, circumstances of the interview did not permit verification of the actual status of the personnel complement. There has been some turnover and counterpart information is not readily accessible.

G. Other

The general MOH delay in payment of salaries and the shortage of and delay in per diem payments are said to have a deleterious effect on the program. Since timely cyclical activities are crucial to effective malaria control, the resource flow problems related to the budgetary planning cycle tend to render major resource investments, e.g. domiciliary spraying, very cost-ineffective. Critical vector resistance studies and other investigations specified in the PP, which necessitate an insect colony, cannot be carried out until appropriate space is available to house such a colony.

Recommendations:

1. The team was informed by MOH personnel that funds for program activities begin to flow only in the second quarter of the year. This causes a particularly serious problem for malaria control. As the vector does not respect the budget cycle, delayed intra-domiciliary spraying becomes very cost-inefficient. AID should negotiate with the MOH and Hacienda a separate draw-down mechanism, perhaps even with ESF funds if need be, to enable the control program to carry on its essential control activities during the months of January through April.

2. The main objective of this subcomponent is to expand vector control technology, particularly larval control. To encourage and facilitate this to the greatest extent possible:

- a. add funds to support larviciding and insure a larvicide supply;

b. add funds to support a regional invitational seminar to be held in Honduras, with some short term support for someone to organize it (to stimulate interest and generate momentum for this element);

c. add funds for some flexible short term TA to help the malaria advisor in some specific areas as needs arise; e.g., a malariologist to review the technical aspects of the program.

Expenditures

(\$000, A.I.D. only)

	<u>Planned</u>	<u>Actual</u>
Technical Assistance	236	94.6
In-Country Training	0	0
Overseas Training/ Observational Trips	27	0
Construction	156	0
Commodities	602	569
Personnel	25	8.8
Other (per diem)	0	35.7

*Includes insecticide.

2. Rabies Control

Rabies control was included as a component in the project because the population of rabid animals in Honduras is growing, and with it the number of reported cases of people infected with rabies. A comparison of actual and planned activities and expenditures by end of FY83 shows slow progress in attaining training goals, but timely purchase of equipment:

Planned Activities

- 60 persons trained in rabies control
- Dog cages and transport containers (unspecified quantity)

Actual Activities

- 26 persons trained (1 seminar in rabies control)
- 10 cages purchased; transport containers purchased

Planned Activities

- Motorcycles (8)
- Training materials and community education

Actual Activities

- Motorcycles purchased
- Unspecified quantity of training/educational material purchased

Expenditures

(A.I.D. only) (\$000)

	<u>Planned</u>	<u>Actual</u>
Training	4.8	3.9
Equipment	24.7	4.9*
Technical Assistance	0	1.1

It was not possible to determine why substantially fewer people were trained than originally planned, nor whether the seminar adhered to a technically sound strategy and curriculum, nor were we able to track down the current status and use of motorcycles. Training has been provided to fewer than one-third of the number of rabies inspectors who should have received training by the end of FY 83.

Recommendation

1. A.I.D. should consider the purchase of additional cages from unexpended project funds, but otherwise eliminate this area of activity from the reprogramming proposal.

3. Immunization

Immunization against major communicable diseases is one of four health service priorities of the Ministry of Health. (The other three are malaria vector control, diarrheal disease prevention and treatment, respiratory disease prevention/tuberculosis treatment). The objective of this subcomponent is to assist the MOH to increase immunization coverage through an integrated program, i.e., to increase coverage through outreach from regional health facilities (CESAMOs and CESARs) rather than through sporadic, vertical, centrally-based campaigns. Although periodic vaccination campaigns continue to be critical to increasing vaccination coverage, progress has

*This excludes the motorcycles which were funded under a previous project.

been made towards improving the ability of local health facilities to provide immunizations year-round.¹ Unfortunately, realization of this goal has been hampered by continuing deficiencies in the cold chain and a lack of sufficient vaccine supplies. The MOH's immunization activities, which fall under the aegis of the Epidemiology Division, receive considerable support (technical assistance, educational materials, and vaccines) from the PAHO (OPS) Expanded Program for Immunization (EPI/PAI). A.I.D.'s support through this project complements and reinforces this effort.

A. In-Country Training

The training records kept were not compiled in such a way that we could readily compare the training planned with that which has actually taken place. Training records were available for immunization activities, but courses funded by the project were scattered in the files and time did not permit a systematic review of personnel trained. (See also: "Continuing Education for Ministry of Health Employees", below.)

B. Commodities

Two types of commodities were funded in the Project Paper: two vehicles and EPI training modules. Only one vehicle was actually charged to the Immunization subcomponent and we were unable to ascertain its status. The EPI training modules were purchased, received, and used in training workshops.

C. Other

A functioning cold-chain was included in the PP as an output of this component, but cold-chain activities were financed under the "Logistics" sub-component, and a full discussion of progress in this area is included in subcomponent 10., "Logistics System", below. It is worth noting that a varying proportion of the refrigerators is actually functioning at the CESAR and CESAMO level. Field visits confirmed that the delay in receipt of spare parts is undermining the other cold chain activities. The supplies of spare parts given those who completed training was not sufficient to bridge the gap until the main delivery of spare parts arrives.

1 At this writing, extensive preparations are underway for a massive week-long immunization campaign that begins in four days. Radio stations have been saturating the country with project-financed vaccination messages, posters and stickers are in evidence, and virtually the entire MOH staff will forsake its regular activities to work in the immunization activities for the week.

A.I.D. project funds seem to be crucial to the effective implementation of vaccination activities, but they are seen as a means of augmenting sparse resources to fund routine operational expenses. Project counterpart funds are said to be the principal monies used support supervisory visits ("viaticos") by central office personnel. Counterpart funds are also reported to be used to purchase gas, and to pay the expenses ("viaticos") of nurse auxiliaries participating in vaccination campaigns. None of these activities were to be financed by A.I.D., according to the PP, and we could not verify that project funds are in fact being substituted for GOH counterpart in this subcomponents. This requires further investigation by A.I.D. and the MOH.

Expenditures (AID only)
\$000

	<u>Planned</u>	<u>Actual</u>
National and Regional Workshops	35.2	9.5
Vehicles	20.	10.4
Materials	2.0	1.1

Recommendations: None.

4. Diarrhea Control

Diarrheal Disease Control is one of the MOH's highest priority programs. It has received substantial political support from the Ministry, impressive financial support from external donors, and strong operational support from regional level personnel. It is generally recognized as one of the world's most comprehensive and successful diarrheal disease programs of national scope. Support for diarrheal disease control in the Health Sector I Project consists of in-country training for health personnel at all levels and purchase of equipment (rehydration tables) commodities (oral rehydration packets, spoons, and training materials), and support for mass media and supervision (funded under other project sub-components).

A. In-Country Training

The plans developed for training in diarrheal disease control were the general work plans of the Diarrheal Disease Control Department, part of the Epidemiology Division of the MOH. The training appears part of an integrated strategy and program, and the curricula

reflect a comprehensive approach to diarrheal disease prevention as well as treatment, with ample recognition of the role of environmental sanitation and proper nutrition (including lactating and weaning). The MOH decided not to hold the national seminar planned in the PP, but instead to concentrate on training at the regional level.

B. Commodities

There are some unresolved issues related to planning and timely delivery of commodities in the national oral rehydration program. A.I.D. has allocated to the purchase of ORS packets nearly three times the amount originally budgeted in the PP. (According to the last Quarterly Report, A.I.D. had financed the purchase of 1.8 million ORS packets plus raw materials for another million packets). The MOH is receiving huge quantities of pre-packaged ORS salts from several donors. The warehouse, which ships at most 50,000 packets per month to the regions, currently has a 36-month supply in stock. The warehouse reports that consignments are sometimes turned back by the regions because the regional warehouses are saturated with ORT packets. At both of these levels, inordinately large supplies of ORT packets are reportedly exceeding the space available. Yet there are conflicting reports about the adequacy of distribution and availability at the CESAR level. A UNICEF consultant is at present implementing a nationwide inventory of ORS supplies, with needed guidance being provided by the project's MCH/OR advisor. As a result of this study, A.I.D. will be better able to determine if combined donor assistance has resulted in a surfeit of commodities, or if there is a deficit, and/or to what extent erratic supplies are a function of the logistics system.

C. Personnel

MOH counterparts in this sub-component are dedicated, eager, and well-qualified. Their skills constitute an appropriate mix for this project. They have nearly met the projected number of supervisory visits planned as MOH counterpart under this component (31 of 36 supervisory visits planned).

D. Other

A number of activities unspecified in the PP have been undertaken in support of the diarrheal disease component. For example, an MSH advisor assisted the department in calculating national and regional diarrhea incidence rates for the purpose of developing coverage goals and predicting ORS packet requirements. Counterparts themselves have not learned to use these computer-assisted approaches, but they certainly appreciate the technical assistance provided by the advisor.

MOH personnel identified a need for more intensive training of community-level personnel (VHWs), and for additional educational material for VHWs and mothers. Project counterparts also perceive a need for additional training for themselves in various aspects of diarrheal disease control.

The ORS packets financed by A.I.D. have neither a date of manufacture nor an expiration date. When questioned about this, warehouse personnel in one region replied that they had been told that the packets have a limitless shelf life. This should be verified and, if necessary, new shipments should include an expiration date on each packet.

Expenditures

(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
In-Country Training	41	11
Equipment (ORS Packets)	80	28.1*

Recommendations:

1. The MOH must determine whether or not ORS packets are indeed moving to the community level, and, if not, the cause of the bottleneck.

2. Stocks of ORS packets and supplies should be reviewed for expiration date and quality. If the excess supplies are useable, it would be inappropriate and not cost-effective to continue procuring large quantities as long as adequate supplies exist, for the warehouses cannot accommodate them. This will require coordination between AID and UNICEF, the two major ORS donors.

5. Tuberculosis

Although accurate statistics on the prevalence of tuberculosis are non-existent, the disease has become a Ministry of Health priority. However, an effective program is hampered by health workers' lack of knowledge of how to diagnose and treat TB, by erroneous notions held by the population at large, and by a scarcity of diagnostic material and equipment and a means of transporting diagnostic specimens.

*Also includes \$2,500 for audiovisual equipment

A. In-Country Training

The local TB training planned in the project has by and large been carried out. Like most training funded by the project, it has not been evaluated nor does there seem to be any mechanism for assessing the impact of training on service delivery. A national seminar was conducted in 1982, but we have not been able to verify that the national workshop planned for Medical and Nursing School instructors in fact took place. We were unable to ascertain whether the training was appropriate, and there is no evidence of pre-or post-testing. In short, although large numbers of personnel have been trained, it is impossible to gauge the quality, appropriateness for the level of personnel trained, or the effect of the in-country training.

B. Overseas Training and Observational Travel

The overseas training and trips funded under this subcomponent raise a number of questions. Although numerous candidates were nominated for overseas training (nine were to have been trained by the end of FY'83), only two have been trained in microbiology, and one (the current Division Chief) in health services research. Although the latter training was undoubtedly useful to the MOH in a broad sense, it was clearly not planned under or directly related to the TB sub-component. A fourth individual trained overseas with funding from this component was not involved in the MOH's TB program. We could not determine what need this person's training met nor how it fit into the TB strategy.

Of the two observational trips planned, only one was made, by the former head of the TB Department, who now directs the Science and Technology Unit.

C. Other

The special TB studies originally planned were never carried out and, according to the reprogramming document, these funds will be transferred to the Science and Technology Unit. Mass Media campaigns planned under this component are well underway, but on the eve of a national TB campaign, much equipment and material (particularly sputum cups, medicines and lab equipment), has recently arrived in-country, but has not been distributed to CESARs and CESAMO. Lab equipment and vehicles budgeted under this subcomponent have all been delivered, according to AID's latest Quarterly Report.

The involvement of MOH personnel in this subcomponent and their knowledge of the project have suffered from poor communication. Understanding of project objectives and resources are vague, and the haphazard selection process for scholarship candidates has undermined morale.

A.I.D. project funds are valued as a critical source of financing for travel and per diem funds for supervisory visits, which were supposed to have been financed as part of the GOH counterpart in this activity. While the department is aware that the project, in a revised form, continues to have a TB component, it is unclear to them precisely how the project, in its revised form, can contribute to strengthening the TB program.

A.I.D. is funding MOH activities aimed at increasing public consciousness of TB, and of the fact that it is a curable condition, and helping produce educational materials (through the mass media sub-components). A.I.D. is further helping the MOH diagnose active TB cases through purchase of sputum cups and laboratory equipment. However, there is a real question about whether or not the MOH has the capacity to respond to the anticipated increase in demand for TB care, should these efforts prove successful.

A comparison of planned and actual expenditures, at the end of FY 83 is as follows:

<u>Expenditures (AID only)</u>		
<u>\$000</u>		
	<u>Planned</u>	<u>Actual</u>
<u>Special Studies</u>	21	
<u>Scholarships</u>	18	7.95
<u>National and Regional Workshops and Observational Trips</u> (Includes materials)	17	4.964
<u>Equipment (2 Trucks)</u>	79.5	20.7 (Charged to logistics subcomponent)

Recommendations:

1. The recently appointed director of this program should be fully briefed by AID and the PCU on remaining project resources, and what is planned under the reprogramming.

2. A.I.D. should discuss with the MOH the priority of TB and consider financing the purchase of medicines (or helping PANI produce the same) to meet the increased demand generated by other A.I.D.-financed activities.

6. Sexually Transmitted Diseases

A combination of technical assistance, national seminars, regional workshops, training for medical and nursing and laboratory technology, students, regional workshops, observational trips, short-term overseas training (scholarships), lab equipment and mass media materials was originally planned to strengthen the MOH's activities in preventing and controlling sexually transmitted diseases. No specific plans were developed for technical assistance and the MOH decided not to obtain these services, but the reasons for this are not known. The MOH also decided to cancel the observational trips. We could find no plans for mass media nor any draw-down of funds for this activity. Training in the health science schools is meant to have occurred, but it is not clear to what extent of these activities were implemented according to a technically sound strategy and curriculum.

As of the end of FY 83, activities implemented in this component have included only local training (regional workshops in which 81 persons were trained plus the medical/nursing/ laboratory courses in which an indeterminate number of people were trained.); purchase of laboratory equipment; and participation of two MOH personnel in a congress on sexually transmitted diseases.

A comparison of planned and actual expenditures as of the end of FY 83 shows that progress in this component in all areas (except equipment purchase and regional training) is lagging.

Expenditures (AID only) \$000

	<u>Planned</u>	<u>Actual</u>
<u>Technical Assistance</u>	8	1
<u>Scholarships</u>	3	0
<u>National and Regional Workshops and Observational Trips</u> (Includes materials)	22.5	4.4
<u>Laboratory Equipment</u>	26	10.5*

*Approximate. Was charged to "Logistics" subcomponent.

Recommendations: None

7. Maternal and Child Health (Family Planning)

Although the PP identified Maternal and Child Health as a high priority for the MOH, and eight percent of AID's project support was assigned to MCH activities, progress in this subcomponent has been minimal. The MCH/FP subcomponent is in the throes of reprogramming, with strong support from the Director General of the MOH. Virtually no activities planned under the PP have been executed. Instead, funds have been used for a series of other purposes: funding the TA of the Man Media for VHWS advisor, developing new MCH norms, training parteras, and financing two part-time, long-term MCH/Or advisors.

A. Technical Assistance

TA in MCH was originally planned as part of the mass media subcomponent. However, within the last few months a part-time MCH-Family Planning Advisor has been employed by the main TA contractor, MSH. The PIO/T describes a broad range of responsibilities and tasks appropriate to the aims of the project, and the advisor is well-qualified for the MCH/FP advisor role. As mentioned above, A.I.D.'s Program and Capital Resources Office believes the overall TA Scope of Work is sufficiently broad to include this specialized technical assistance.

Since this project subcomponent is being revised in the the wake of the advisor's arrival and submission (and MOH approval) of a new MCH/Family Planning strategy, discussion of this area is deferred to Section VI., Proposed Reprogramming of the Health Sector I Project.

Recommendation: None

8. Epidemiology Training

Support provided for this component includes 6 weeks of expert TA to conduct an Epidemiologic Surveillance Seminar; four in-country training workshops, and 3 months overseas training.

The Director of the Epidemiology Division repeatedly was not available for an interview to discuss the status of these activities, (although the team leader did meet with him to discuss immunization activities) because the evaluation coincided with the most intensive stage of preparations for the National Immunization Week. The pertinent information could not be obtained elsewhere.

Expenditures

(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
Scholarships	12	6.4
Per Diem and course supplies	21.2	1.2

9. Basic Medicine List

This activity has evolved into one of the more successful and promising areas funded under the Project. It has also expanded considerably beyond compiling a basic formulary to an ambitious effort to rationalize and fortify the basic drug system of the MOH. Prior to the Project, in response to chronic problems of drug supply and inequitable distribution, the Unidad de Medicamentos was formed within the Hospital Division of the MOH to study these problems and develop and effect solutions. To facilitate more rational and cost-effective drug purchasing, a basic medicine list was developed. With implementation of the Health Sector I Project, the Basic Drug List has assumed far greater importance in that it is a key element in the Project Strategy to strengthen the overall logistical capacity of the MOH. A National Drug Commission (CONAME) was formed with representatives from the Administrative Division, and its Purchasing and Warehouse Departments, from the Unidad de Medicamentos and the Sub-Dirección General. This permanent Working Group reports directly to the Dirección General, and is being advised by MSH in the development and implementation of the Logistics System. The basic element of the system's model is the process of planning drug supplies based on a functional and technically sound Basic List that takes into account factors such as use, cost, etc. AID is providing project support to revise and update the list and to develop a mechanism for keeping the list current.

A. Technical Assistance

Two months of external TA have been converted into several months of local TA, currently being provided by a pharmacologist, to work with the CONAME sub-group in revising the Basic List. This TA seems appropriate and fills an expressed need of the sub-group.

Additional TA not indicated in the PP Plan is provided to the group directly and indirectly (within the larger CONAME working group) by the Logistics TA advisor. The Logistics scope of work specifies responsibility for incorporating the work already done on the list into the logistic system. In reality, his assistance to this sub-group appears to far exceed what was deemed necessary in the scope. Since the TA Workplan for Logistics, on the other hand, does specify the tasks to be accomplished by the sub-group, the advisor's assistance to the group is consonant with the workplan.

Implementation of the specified tasks is proceeding as planned. The group is finalizing the Drug List by level of services, accompanied by Treatment Guides. Community/CESAR and CESAMO levels have been completed and work is about to begin on the hospital levels. Additionally, the group is working on a Quality Control Register, a Register of Providers, and a Price Information System. These are preliminary steps leading toward the eventual development of a National Formulary.

It is evident from the interviews that the CONAME counterparts have acquired a range of skills and most importantly "systems thinking" as a result of working in a team with TA personnel.

B. Overseas Training

One short observational trip contemplated in the PP Plan has not yet been made.

Expenditures

(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
Technical Assistance	10	0
Observational Trips	1.5	0

Recommendation:

1. CONAME is setting norms for treatment based on what health facilities ought to be doing. A review of drug requisition patterns from various hospitals, regions, and CESAMOs (some requisition directly, not through the regions) indicates that a better grasp of actual treatment practices, prescription preferences, perceptions and knowledge of pharmaceuticals would reveal a wide discrepancy between normative and actual practice. Some practical operational research would be most useful for programming Continuing Education courses for physicians prior to the implementation of Basic Drug Lists at the hospital level. The study could be applied to a sample of Central Warehouse requisitions and consignments, followed up with interviews in Tegucigalpa and the regions.

Background to the Logistics and Maintenance Components (10. & 11.)

Though logistics and maintenance are closely related and integral elements of the administrative services support structure, they are analyzed separately here. These components determine to a great degree the effectiveness of the MOH at all levels and support for their development comprises 34 percent of total project funding. The PP determined that neither system was functioning well enough to support effective health services. To insure successful implementation of the Project, the PP intended to give the project a headstart by specifying 3 Conditions Precedent (CPs) for the implementation of the logistics and maintenance systems: training activities, development of operational procedures and guidelines for the supply and logistics system were to have been linked with the construction of warehouses, maintenance workshops, and with the purchase of the equipment and materials for each building.

A third CP stipulates a plan, with dates by which the GOH was to absorb the positions of maintenance personnel hired with AID Loan Funds. Because of implementation delays, the dates for meeting all three conditions were extended; the first CP was met one year later and the second eliminated after expiration of the extension with a covenant added to the Project Agreement. The third CP expresses AID's concern with insuring carefully planned, coordinated and detailed implementation of the project inputs in logistics and maintenance. A GOH payment mechanism for personnel was negotiated in October, 1982, whereby Maintenance positions were to be assumed by the MOH beginning in 1984. Though the mechanism was then approved by AID, it was renegotiated in July, 1983, so that AID will continue to finance 67 percent of the positions in 1984. This CP articulates AID's belief that the positions financed by AID, together with the equipment and facilities provided under the project, create a minimum necessary maintenance capability for the MOH by the end of the project. That is, absorption of these personnel - i.e., payment of their salaries and their employment on a permanent basis (servicio civil) were deemed as crucial to the project's success as AID's financial contributions.

Because of the importance given in the PP to coordinated, linked and phased implementation, it should be noted here that while the Division of Maintenance is an independent division, and logistical functions are located in different departments of the Administrative Services Directorate of the MOH, rather than in a single organizational entity.

10. Logistics System

To fully grasp the complexity and level of effort involved in "implementing a Logistics System", it is helpful to review some of the major problems that fall under this component.

The chronic medical supply shortages result from a combination of policy, technical and organizational constraints within the MOH and other Governmental organizations, notably the Proveeduría and the Ministry of Hacienda. A basic impediment is the unplanned budgetary process for medical supplies, which is not rationally linked to actual needs either on the micro or on the macro level. Nor is cost-effectiveness a factor in the planning process. Drug and supply procurement is based on previous institutional consumption, and bears little relationship to either need or actual demand. Nor is cost-effectiveness a factor in the selection of drugs. Bulk purchase is governed by policies determined outside of the MOH. Proposed solutions to drug shortage have included strengthening the domestic basic drug production capacity through PANI, and the establishment of a separate Proveeduría for the MOH. These proposals address more efficient procurement and an overall increase in drug supply and could also solve the problem of drug quality control. Either could result in a long-range solution but their impact would, however, depend on the establishment of rational supply programming mechanisms at all levels in the health system.

Operational linkages from procurement to warehousing are still poor for lack of a functional information flow and insufficient transport due to poor vehicle maintenance. Warehousing conditions are still totally inadequate, although embryonic improvements in warehousing functions are underway with the project support. The requisition process, particularly from hospitals to the Central Warehouse, is so unplanned and irrational that it seriously strains the fragile resource capacity of the warehouse to process paper and to distribute commodities. Organizational arrangements within the MOH and the lack of a vehicle control system inhibit Central Warehouse access to the general motor pool. Smaller vehicles are not routinely used for small consignments, and vehicles cannot be easily replaced temporarily when they break down. Variants of these major problems are found in each of the seven regions.

The Project Paper is somewhat internally inconsistent in its proposal for implementing the logistics system. It identifies organizational and administrative problems in the Administrative Directorate that cause the system to function poorly. It delegates supervisory authority over the logistical process and the development of normative aspects of the system to the Directorate. But it does not identify the most basic improvements that would be required in the Directorate for it to implement the new logistics system. The LOGFRAME never identified a number of assumptions that directly affect the implementation of the new system. In terms of TA specifications, the PP makes an unverified and unwarranted assumption that the Advisor would work with normative development specialists in the Administrative Directorate. (Who are these "normative development specialists?" No one fitting this description has been employed by the MOH.)

A. Technical Assistance

Project funds support 24 months of TA by an expert advisor to assist in the design and implementation of the system. The TA prescription is global, based on the aforementioned erroneous assumptions about the Directorate's organizational structure and technical capacity. The Scope of Work, on the other hand, relegates the design of the system to the advisor in consultation with the MOH. It inappropriately specifies adaptation of an already existing training plan. Neither the PP nor the Scope of Work are adequate guidelines for the range and complexity of the tasks required, given the organizational context of the MOH.

The purpose of the TA provided during the past eighteen months has been to encourage counterpart personnel to "gain new skills as normative development specialists" through a collaborative process of a) completing a Needs Assessment and developing a Workplan, and b) designing norms and procedures for all components of the system. Both the PP and the Scope of Work underestimate the additional TA requirements for implementing the system at the operational level in all 7 regions.

While the assistance provided is appropriate for the tasks required, and the person hired as advisor is eminently suitable, the delay of the Logistics TA has been a major impediment to project progress.

To augment TA for implementation of Logistics System components on the regional levels, a portion of the Regional Management Advisor's time has been allocated to Logistics.

The joint MSH/MOH workplan is sufficiently more inclusive than the Scope of Work, and is part of the overall MOH/MSH workplan, which links disparate parts of the organizational structure into a coordinated system. Unanticipated delays in construction and acquisition of essential equipment, parts, etc., particularly for the Maintenance Component, have not permitted implementation of the Logistics component to proceed according to the sequence of steps in the workplan.

Revision, systematization and expansion of an earlier Supply System Manual, developed by the Logistics Advisor during his previous employment with the MOH, and prior to inception of the Project, has been a milestone in establishing the normative aspects of the Logistics System. It rationalizes the administrative process and information flow with norms and procedures for each of the System components:

1. Planning/programming of supplies
2. Procurement
3. Warehousing
4. Distribution
5. Supervision/evaluation

With completion of the Manual, the essential normative elements of the Logistic system are in place. Normative development work continues in the area of medical supply programming (as described in the previous section on the Basic Medical List), and in the area of evaluation methodologies for the system.

Introduction of the system through training has been accomplished in all the regions and on the central level (see training section for more detail). All warehouses are now using the new CARDEX for inventory control and distribution flow, and are reorganizing, depending on the capacity of the facilities. Implementation is being carried out in stages. Regions III, V and VI are receiving TA in warehouse organization based on the Basic Drug List, as well as assistance with supply programming, requisitioning, reception, storage, distribution, control and evaluation of supply system information.

An information and monitoring system for local utilization, requisition and needs is being developed jointly with these Regions. Once these elements have all been successfully installed, implementation will phase into the other Regions. Except for the fact that the programmed warehouse construction has not yet been started, implementation is progressing according to the workplan. The delays in warehouse construction, however, are seriously impeding phased project implementation in this area, and construction must begin as soon as possible.

MOH counterparts to the TA Advisor are the members of the CONAME group who work with the advisor as a team. (see Component 9, Basic Medicine List).

B. In-Country Training

The PP calls for 32 courses to train people in the Division of Administrative Services and elsewhere and to train personnel on the operational level who use the system. Training output is to be "20 persons trained in Logistics." To date, these targets have already been exceeded. In Phase I of implementation, 9 Trainers in Logistics were trained by CONAME (Continuing Education) in one 80-hour course. In Phase II, 270 Trainers were trained at the regional level in 45-hour courses. They in turn trained 800 Auxiliary Nurses in 28-hour courses. Each group was trained in the specific parts of the Manual corresponding to their level of responsibility and functions.

To date all Warehouse functionaries, Regional Chiefs, Administrators, Nurses, etc. have also been trained. When the detailed supply systems are implemented in the regions, a large complement of personnel will receive further informal in-service training.

Objectives and course curricula are contained in the various components of the Supply System Manual, which also serves as the educational material. The Manual itself seems clear and appropriate; training methods and effectiveness of the training programs cannot yet be assessed.

C. Construction

The Construction of a Central Warehouse and 6 regional warehouses with maintenance workshops was to have been completed by mid-1983, but it appears that construction may not be completed until late in 1984. The last of 7 sites is being purchased. Final construction designs will be completed by the contractor for AID inspection by February 1984. Major delays occurred due to legal problems in determining land ownership, titles, etc. And, since the land is being purchased with counterpart funds, more than 25 bureaucratic steps are involved in purchasing for each plot.

Since the MOH did not have the in-house capacity to design the warehouse, a local firm was engaged to design five of them. The remaining two are being designed by an architect hired by the MOH, and who has since become also the Chief of the Maintenance Department in the MOH. He is very concerned that the PP does not include funds for the supervision of the construction in the 2 regions for which he is designing the warehouses.

D. Commodities

All of the commodities within this component are direct AID purchases. Neither MOH purchasing, nor Warehousing, nor the Project Coordinating Unit has any knowledge about the status of these commodities until they are advised by customs of their arrival. This lack of systematic communication causes additional problems for the MOH, since they are responsible for their reception, warehousing and distribution. Documents reviewed in the Central Warehouse do not indicate either the distribution nor the person responsible for authorizing and confirming the movement of the commodities. No one from the Project Coordination Unit has visited the warehouse. The Purchasing Department does not maintain a file of AID direct or local purchases, and finds that communication with the AID Health Office is best done through MSH.

As the AID Health Office has shifted commodities purchases among the various line items, and has apparently both subtracted and added items in this component, the actual status of these commodities is not clear. Except for the CESAR and CESAMO medical equipment, which was removed from the budget for appropriate reasons, it appears that the commodities and vehicles for the Logistics Sub-Component are in process. The procurement planning and tracking mechanisms between AID and the PCU are clearly inadequate.

Expenditures

(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
Technical Assistance	428	253.2
Construction	1,059	13.2
Commodities	1,229.5	800.2
Other (per diem)	0	12.4

Recommendations:

1. Although most of the purchasing under the original project has now been completed, a more functional commodity purchasing plan and a systematic communications mechanism for commodities should be established before the reprogramming takes effect.

2. The Administrative Division should be reorganized so that all of the logistics functions are clearly under the responsibility of one person.

3. An implementation sub-group for Logistics and Maintenance should be formed within CONAME and should include the new Director of Administration, the Sub-Direccion General and the appropriate departmental members and TA advisors. The objective of this group should be coordination and problem solving.

4. A Pharmaceuticals Substitution List/Guide within the framework of the Basic Medicine List should be prepared by the Basic Drug List Group for use in the Central Warehouse since it is unlikely that the MOH will be prepared to add a physician or pharmacist to the staff. The senior Warehouse staff should then be trained to use this Guide, which will eventually be changed with gradual implementation of the rationalized medical procurement system.

5. If the MOH decides to add a much-needed pharmacist or physician to the warehouse, this person could work on some operational research studies under the direction of the O.R. Unit.

11. Maintenance

A. Technical Assistance

The PP plan for 24 months of TA by a Maintenance Expert are general, but the CP specifies a linkage between TA and the maintenance/logistics systems components. One long term advisor provided by the contractor has completed 18 of 24 months of TA. Lengthy contract negotiations delayed the TA until the second quarter of 1982, thereby counteracting measures in the PP to insure a timely and systematic implementation of the two components.

The Scope of Work for technical assistance in maintenance is very broad, covering assistance to the MOH for the development of a maintenance services system for the entire health care delivery system, with emphasis on the health center level. The Scope of Work focuses appropriately on the outputs for this component; hence, the Scope of Work is consistent with the PP and general enough to accommodate the range of tasks that have expanded with the implementation of the program. In fact, there have been suggestions from MOH personnel that the range of tasks required for this assistance is too broad and technically diverse

to be covered by one technical expert. Since no additional TA was included under this component, the MOH has solicited and continues to seek additional, very specialized TA from other donor sources. The person hired seems appropriate for the major portion of the tasks identified, especially since this person had previously served as a consultant to the MOH in this capacity.

A joint Contractor/MOH workplan developed in 1982 addresses priorities in maintenance activities not specified in the Scope of Work. This seems both reasonable and desirable. Nevertheless, the content and orientation of the work plan reflect both the aims of the PP and the general objectives of the Scope of Work. Additionally, the workplan is coordinated with the other TA areas, reflecting the implementation concerns set forth in the CPs.

Implementation in general adheres to the workplan. However, a major MOH policy decision to concentrate on national implementation of the cold chain as the immediate priority has shifted resources and activity during 1983 to the refrigeration system. A succession of bureaucratic delays has hampered implementation of this and other concomitant activities. Maintenance depends on the timely availability of tools, parts, transport, workshop facilities and timely payment of per diem. Procurement delays have been legendary and too convoluted for reiteration here, except as examples: the Ministry of Hacienda y Credito Publico rejected the list of spare parts for refrigeration equipment and vehicles four times; regional workshops have not been constructed; trained technicians are in the regions with tools, but no parts although A.I.D. states that parts are purchased locally, when available, from the regional rotating fund; transport for maintenance activities is insufficient because regional maintenance vehicles are in disrepair, etc. Appendix C illustrates both the contractor's reported progress and the problems generated by the inadequacies of the logistical and administrative support systems.

Perhaps because the Scope of Work and the workplan are very broad there appear to be differences in perception among the contractors and MOH senior personnel on what in the Needs Assessment has in fact been completed and what is still to be done. There also appears to be a lack of definition of specific contractor responsibilities in the gargantuan array of maintenance tasks on the national level included in the project, and what technical assistance will be provided by other donors.

The principal maintenance issues seem to center on whether there is sufficient technical assistance, policy support and effort to yield a minimally functioning maintenance system.

A new and seemingly effective Maintenance Director has been placed in the counterpart position. Problems with inappropriate counterparts previously had impeded progress. Contractor proposals for reorganization of the Maintenance Department were accepted by the MOH,

and the functions of the section chief were restructured and refined, so that counterpart team capacity on the normative and operational levels has improved substantially. The momentum resulting from these organizational changes and the transfer of skills to the counterparts or their application could not be judged.

B. In-country Training

The production of training curricula and initial training of trainers and responsible operational level personnel has proceeded according to the phased plan. With the newly intensified MOH focus on the cold chain system, training plans were expanded to accommodate the training of all rural health services functionaries from nurses to health promoters and guardians in the preventive maintenance of three types of refrigerators. Programmed training in fact coincided with the arrival of refrigerators. Spare parts were sufficient for training purposes, but adequate supplies are still not available for refrigerator repair now that personnel have completed their training and returned to their posts. Until spare parts, tools and logistical support become available, the effectiveness of the training cannot be adequately evaluated. To date the evaluation/information system has been implemented only for the cold chain.

Courses given for the preventive and corrective maintenance of the other equipment categories and for vehicles have followed the workplan. However, lack of manuals for medical/clinical equipment is slowing down the training process in these areas. Training related to building maintenance is the last priority and will be initiated once building construction begins.

The establishment of the training system appears to be progressing well, and with curricula and methodologies that fit the training objectives of the workplan. The training itself appears to be coordinated reasonably well with the Human Resources Division. A course in which technicians were prepared as trainers for the maintenance of audio-visual equipment, not called for in the workplan, responds to a priority identified by the MOH.

Specialized technical training in automotive maintenance, electric/electronic and building maintenance will be given by INFOP, a national technical training institute, through a formal agreement with the MOH.

Given the volume and variety of training required under the three components listed in Appendix D, training plans and implementation status cannot be reviewed in detail here. The major issues that arise in relation to the training again concern the adequacy of TA being provided and the lack of adequate logistical and administrative support systems.

C. Overseas Training

So far, only three persons have been trained in specialized medical equipment maintenance. The Maintenance Department had prepared a list of needs and priority areas, then looked first to the U.S. for training. The AID Health Office reportedly was asked to assist in identifying training locations in the U.S. but has not responded to date. A list of 15 technicians requiring specific training is still "floating around"; they were not included in the MOH training plan for bureaucratic reasons. Because of these delays and the GOH's reported policy of paying only one month salary during training abroad, some of the persons selected are no longer available for overseas training.

Candidate selection follows an acceptable and functional process; the training fits into the overall plan and fills identified priority needs of the MOH.

The inconclusive situation of overseas training reflects the absence of effective technical coordination mechanisms between the MOH and AID and the lack of an implementation plan. It was not known who, if anyone, is responsible for identifying suitable overseas training programs and for facilitating the linkage.

D. Construction and Renovation

None of the regional repair workshops supported with project funds has yet been built. Yet they are an integral part of the warehouse construction scheduled under the logistics component (See Component 10 for details of construction status and problems.)

Serious delays in construction of the workshops continue to have a deleterious effect on program implementation. Maintenance personnel were hired under the project, trained, finally equipped with some tools and are now in the field without workshops or requisite stationary workshop equipment, etc. Causes of this disface, related to bureaucratic intransigence within and outside of the MOH, are discussed under "Logistics". The central maintenance workshop, however, has been remodeled and is sufficiently functional.

E. Commodities

Workshop tools were to be provided by AID during 1983. Spare parts for medical and transport equipment are counterpart contributions which could not be purchased by the government during 1982 for lack of funds. These have finally been purchased, but apparently only the automotive spare parts for some vehicles have arrived. Counterpart purchase of parts to date stands at about 50 percent with a major portion focused on the cold chain. It is reported that somewhere between 80 and 90 percent of the tools have arrived, but have not yet

been distributed to the regions. Bureaucratic obstacles were such that the Minister personally intervened in order to obtain entry permits for these materials. The elaborate and lengthy governmental inspection and clearance process has also further delay the acquisition of imported commodities described under the previous component. The logistical support and information system for commodities procurement, warehousing and distribution is inadequate. Another reported impediment in what is generally viewed as a hopeless process is lack of systematic communication with AID especially on AID direct procurement (as with tools).

Procurement is consistent with the needs of the MOH, in that it is all essential to attaining the minimal necessary maintenance capacity described by the PP. At the same time, the MOH's inability to meet the counterpart resource requirements for even the most minimal elements of the maintenance system raises serious questions about MOH resource allocation priorities and policies. It also raises questions concerning the GOH's capacity to provide adequately financial support to the project.

F. Personnel

Two important changes from the PP plan have been (1) a sharp reduction (from 59 to 45) in the total number of new technical maintenance personnel supported by A.I.D. funds, and (2) a change in the distribution of this personnel by specialization. The MOH negotiated these changes with A.I.D. on the grounds that the GOH would lack the resources and capacity to absorb the original number into the personnel structure as permanent positions. Electromechanics were reduced from 7 to 3; refrigeration technicians from 7 to 2; and artesans (e.g. carpenters, plumbers, etc.) from 25 to 12. In turn, 6 electricians and 2 drivers were added as new categories and the category of miscellaneous workers was expanded from 5 to 10. These changes seem to indicate a the cost-reduction rationale underlying the substitution of lesser-skilled workers. Total numbers obtained were not quite in agreement, and it is not immediately clear how many positions are currently filled. Beginning in 1984 the MOH is to absorb 33 percent of the 45 positions (currently about 41 are filled) as permanent, full-time positions in its budget. Should the GOH find itself unable to honor these terms of the Project Agreement for financial reasons, the concern over the GOH's long-term absorptive capacity would be heightened, and should raise serious doubts about the logic of extending additional A.I.D. support for the expansion of the health technology components.

The A.I.D. financed technicians and other workers were hired and trained in February/March 1983, but their one-year contracts ending in December 1983 were not approved by both the GOH and A.I.D. until the end of July. The contracting delay meant that these workers could not be sent into the regions where they were needed, but had to be

kept "occupied" without salary in Tegucigalpa. When finally sent into the regions, they went to work without the required equipment, spare parts, transport support, or technical supervision.

Until the necessary support for their work is in place, it will not be possible to judge whether they are sufficiently trained and functioning as contemplated in the PP.

G. Other

The revised Maintenance Work Plan focuses on implementing a supervision and evaluation system for the technicians in the region. Having implemented with impressive vigor the national cold chain system (and similarly the training of 8,000 parteras) it would seem appropriate for the MOH to apply equal concentration to the implementation of the most essential maintenance and logistic functions. A major organizational problem to be resolved is the dependence of the Maintenance Department on the Hospital Division for its financial support. For this crucial department to function effectively it must manage its own direct budget.

Expenditures

(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
Technical Assistance	373.5	273.3
In-Country Training	199.4	22.3
Overseas Training	102	2.8
Commodities	95	199.9
Personnel	123.8	29.8

Recommendations:

1. Add at least 12 pm of flexible short-time TA to help Arq. Emilio Rivera. This TA should complement what the TA advisor cannot do and/or does not have the time to do.
2. The central maintenance workshop must get a Chief post haste. AID should encourage this process.

12. Management and Planning

Overview - Management and Planning

Fortification of the Ministry of Health's management and planning capabilities is one of the major means through which the project will achieve the objective of improving the MOH's effectiveness and efficiency. Thus, the management and planning subcomponent is one of several highest priority activity areas, and was originally funded at \$2.5 million, or 16 percent of total AID project funding. The central element of this subcomponent is technical assistance, which accounts for nearly one-half of the funds budgeted for the management and planning subcomponent, and includes both the technical assistance provided by the main contractor, Management Sciences for Health, and the A.I.D. Mission Project Liaison Officer. (See Project Paper, Annex II, Exhibit E, p. 39.)

The accomplishments thus far in planning and management are notable, even though their full impact will be felt only after sufficient time has passed so that reforms can be adopted throughout the health system.

One of the major achievements to date is the integration of management training into all Ministry of Health training programs. Training curricula now include components on group dynamics, problem solving, organization of resources and basic administrative skills. One improvement in management that has had an effect on MOH-wide activities is the result of a study by an MSH advisor of document flow and processing. The advisor identified a number of unnecessary steps in the flow which the MOH agreed to eliminate, thereby accelerating the processing of documents. Another aspect of planning that has received considerable attention is drug procurement. Technical advisors have been an effective catalyst in the production of a basic formulary and guides for prescription of drugs.

One of the most impressive gains in health management to date issued from a centrally-funded (by A.I.D.) operational research study on health financing alternatives. (See Estudio de Alternativas de Financiamiento de los Servicios Basicos de Salud en Honduras, MOH, 1983.) This study, which was guided by advisors, for the first time quantified the amount that consumers are spending for health care provided by various sources (including the MOH), and for what ailments. The results of the study were brought to the attention of the President of Honduras, who was persuaded to modify most policy to permit health facilities to charge clients for the medicines they receive.

In general, the technical assistance provided in the planning and management subcomponent has stimulated, rather than substituted for, active MOH involvement in support of systems improvements. For example, technical advisors have helped the MOH produce a new supervisory manual, "Guide to Programming of Resources", in which scarce resources are rationalized by melding supervisory, resupply and accounting control functions into the

routine for a single supervisory visit. Similarly, improvements in the cold chain, coordination of disparate nutrition surveillance activities, and incipient reforms in regional warehouse inventory, receiving and distribution procedures have all resulted from the activities aided directly technical advisors funded under the MSH TA contract.

A. Technical Assistance

The concept of management and administration itself - and the appropriate role of TA in this area - has evolved and expanded as project implementation has proceeded. Nevertheless the technical assistance provided is indubitably consistent with the spirit of the PP.

The Project Paper calls for eight person years of technical assistance to support and complement the five additional national technicians to be added to the staff of the General Directorate of Health as part of the project. These individuals, who constitute the Executive Coordination and Institutional Development Group (Grupo de Coordinación Ejecutiva y Desarrollo Institucional - GCEDI), were to coordinate functions that intersect all technical areas, e.g., human resources, logistics and maintenance, etc. The Project Paper did not specify with precision the technical assistance to be provided. Rather, assistance was to be provided in the general areas of "Integrated Human Resources; Integrated Logistics and Maintenance; Information Systems; Program Evaluation; and Program Planning and Development." It is clear that the technical advisors are functioning in these general areas.

A second basis for determining whether the intended technical assistance has been provided are the descriptions of "Personnel and Specific Duties" in the technical assistance contract. The statements of responsibility in the contract are also vague, and could subsume a variety of subcomponents. (For example, AID's Program and Capital Resources Office views the scope of work for management and planning sufficiently broad to cover the operations research and maternal and child health activities of two MSH technical advisors). The descriptions of personnel and specific duties call for four (4) advisors: a Chief of Party, Health Planner (30 person/months); a Systems Analyst, Operational Research and Financial Advisor (18 person/months); a Human Resource Specialist (24 person/months); and an Advisor in Regional Management, Personnel and Finance Systems (12 person/month). The technical assistance in management and administration contemplated in the Project Paper has been provided, and, as far as the evaluation team could determine, the TA has been of very high caliber.

While the Project Paper calls for 96 person/months of technical assistance, the long-term advisors are providing 84 person/months of TA; the remaining 12 person/months of TA are for short-term T.A.

As previously indicated, there has been an evolution and expansion of the role of technical assistance in the management and planning sub-component. As suggested by the Project Paper, the sub-component (and the corresponding technical assistance) was initially intended to reinforce the ability of the General Directorate to coordinate and supervise various units within the Ministry of Health. The Ministry and contractor adopted a management systems approach. This approach adopts as its point of departure the development of guidance and support functions, rather than the formal administrative entities which nominally manage those functions. Thus the focus of the technical assistance became the enhancement of management systems (management processes). As a consequence, technical assistance has not been limited to the juncture between the normative and operating levels. Rather, the technical assistance has encompassed all levels (from the central MOH to the community), which are involved in a specific management function (e.g., supervision, logistics, etc.).

The evolution or expansion of the role of technical assistance seems appropriate in view of the de facto amendment or clarification of the Project Paper through the description of "Personnel and Specific Duties" which appeared in the technical assistance contract. Moreover, the expansion of TA in management and planning - and the concomitant growth of MOH's staff, has facilitated a more comprehensive approach to management and planning improvements.

As with other project inputs, the technical assistance was initiated later than originally planned. According to the Project Paper's implementation plan, technical assistance was to begin in 1981. However, due to problems in the Ministry of Finance (which questioned a specific provision of the contract, e.g., post differentials), the execution of the contract with MSH was delayed until January 22, 1982. Consequently, the Chief of Party/Health Resources Specialist did not arrive until mid-February, 1982; the Human Resources Specialist at the end of February; and the Systems Analysis/ Operations/Research/Financial Advisor at the end of March, 1982. The position of Regional Advisor in Management does not appear to have been filled until January, 1983. (Though MSH notes that the Regional Management Advisor was a new position created as a result of a change in their technical assistance strategy, the scope of work appears similar to that included in the MSH technical assistance contract.)

Is the scope of work adequate for the tasks to be performed? The problem identification/resolution process adopted by MSH progresses from a status assessment through an analysis of management problems to an assessment the resources available for solving the identified problem, to alternative strategies for solving the management problems identified. This is done jointly with MOH counterparts. The scope of work certainly establishes an adequate framework for this approach to the T.A.

The persons hired appear to be extremely well qualified for the specific duties and tasks required in the TA scopes of work. Technical assistance work plans do not reflect the work of individual advisors, but rather of the work group with which the advisor is involved. The principal exception is in information systems, where no functioning work group existed to develop the initial work plan for information systems activities (p.4 in the work plan). An information sub-group established in June, 1983, was composed of individuals from the Department of Biostatistics, who developed the revised work plan for the information area.

The initial set of work plans developed in June, 1982 were revised a year later as part of a Ministry of Health/MSH evaluation (see below). Both workplans tend to reflect the scope of work in both their content and orientation.

In general, the pace of implementation in management and administration has been slower than had been anticipated in the Project Paper and initial work plan. These delays are attributable to the general context which has tended to hamper implementation of all project sub-components. The factors contributing to delay include:

- Constant turnover of personnel in the first year and a half after the project was signed in the project coordination unit, in the General Directorate and Technical Divisions, (as well as at the Ministerial level), within AID, and in other relevant Honduran ministries (see Tables 2-4). During the past year greater stability has accelerated project implementation.
- Deficient communication among levels within the Ministry of Health and between institutional participants (Ministries of Health, Hacienda, Proveeduría, AID, etc.).
- The lengthy and complex GOH processes required to contract personnel (a minimum of 95 work days), make direct purchases (a minimum of 45 work days), and purchase through Proveeduría (a minimum of 34 work days). (Tables 5-8)
- Problems in creating an effective mechanism for expenditure of project funds.
- The precarious economic situation confronting the Government of Honduras.
- Lack of sufficient, trained counterparts.

B. Specific Tasks Within the Management and Administration Subcomponent

1. Local Programming

Based on the amount of technical assistance and counterpart effort, this is probably the major activity within the management and administration work plan. Implementation is at least one year behind schedule in local programming. Though there was an approximately four month delay in constituting the local programming work group, the major constraints tend to coalesce around two principal issues:

- Insufficient manpower to undertake the special activities funded by the project and at the same time carry out the regular (non-project related) functions of the Ministry. The tasks of the local program group have proven more extensive and time consuming than initially anticipated, and members of the group were not totally relieved of their permanent Ministry duties. Furthermore, the Ministry asked the local programming group to devote a substantial block of time, approximately three months, to a budget analysis, a task not originally contemplated for the group. In addition, their involvement in activities at the regional level (e.g., courses, workshops, normal supervision, etc.), limited the amount of time they could contribute to the local programming efforts. As the pace of project implementation increases, the demands placed on the limited pool of ministry personnel will only tend to intensify. Consequently, it becomes essential to address the twin issues of the absorptive capacity of the Ministry and the phasing, scope, and intensity of project activities.
- Lack of sufficient information and coordination among relevant participants: Regional authorities who were to have a role in the local programming activities were not fully aware of the nature of their involvement in the process. Further, it has been suggested that due to other responsibilities and work, and lack of a clear understanding of what was required, the technical and normative divisions have not responded fully to the information requests of the group.

2. Regionalization/Extension of Service Coverage

Development and implementation of a manual of organization and regional functions has progressed slowly, primarily due to lack of personnel. Some training work has been initiated in regions II and V. Development of a methodology for implementing the extension of services has also been inhibited in part by a lack of personnel. Initially perceived as the responsibility of a separate work group, the extension of services effort has been folded into local programming. When the work plan for this activity was evaluated, the belief was expressed that the development and implementation of a process for extending service coverage could not be realized absent an increase in MOH resources. Though initially programmed for completion at the end of 1983, the planned completion date has been postponed one year.

3. Information System

Among the areas which have experienced the most serious delays in implementation is the information system. The objective of this element was to improve the presentation and utilization of information. Few activities have been realized in this area. The major impediment has been the inability to purchase the interactive computer system. This is discussed in some detail elsewhere, and it is sufficient to note that the major delays were attributable to Proveeduría's cumbersome and lengthy purchasing process and the less than adequate communication and coordination between A.I.D. and other institutional participants. Non-computer related activities included in the work plan (such as the re-design and development reports) have been delayed due to the time required to resolve the computer procurement problem and the press of technical assistance duties in the advisor's other area of responsibility (administration). Activities in this area, particularly those related to the acquisition of the computer, are approximately 18 months behind schedule. Furthermore, it is not clear at what point the acquisition of the computer will occur.

In summary, two major themes emerge in the implementation of the specific elements of the management and administration sub-components. First, it appears the pace of implementation has suffered from the absence of a sufficiently large core group of persons to undertake project activities and at the same time carry out the non-project functions of the Ministry. Secondly, there appears to be a lack of communication and coordination among and between institutions participating in the project. Recommendations for resolving these issues will be discussed later in this report.

C. MOH Personnel Participation/Technical Assistance

The following discussion of the Ministry of Health counterpart participation will focus on the counterparts of two of the four technical advisors noted in the scope of work: the Human Resource Specialist, and the Systems Analysis, Operational Research and Financial Advisor. Counterparts to the advisor in regional management, personnel and finance, who is principally involved in the development of the cold chain, are addressed in the logistics subcomponent.

Ministry of Health counterparts have been employed to correspond with both the Human Resources Specialist and the Systems Analyst. The nature of their participation varies, with the Human Resources Specialist tending to work with his various counterparts as an active member of the local programming sub-group established by the GCEDI. The counterparts thus become the principal force in the development of the specific work products. The advisor functions as a facilitator and resource person within the group.

In contrast to the Human Resource Specialist, the Systems Analyst tends to work on a one-to-one basis with a specific Ministry of Health counterpart. Though the Analyst has occasionally worked with members of the GCEDI, he did not have a specific counterpart until August, 1983, when an Assessor was added to the Division of Administration in the Ministry of Health. The Analyst tends to provide specialized advice, and undertakes specific tasks individually or with the counterpart.

As is the case with the other areas of technical assistance, counterparts participate in the development and evaluation of the "Technical Assistance Work Plans." Counterparts have expressed dissatisfaction with the nature of their participation in some of these evaluations. In particular, several counterparts have suggested that the evaluation held in Tela in June of 1983, while undertaken for purposes of evaluating the technical assistance being provided, was redirected by the TA advisors to focus on the shortcoming of counterpart efforts. This reversal - the evaluators becoming the "evaluatees" - created resentment and some degree of mistrust that was still evident at the time of the current evaluation.

The scarcity of data available and the time limitations of the evaluation did not permit the evaluation team to judge whether or not, and if so, to what extent the counterparts are acquiring and applying new knowledge gained from the advisors. Given the lack of specificity in the Project Paper and the broad focus of the scopes of work, the use of technical assistance for activities in which the advisors have competence but which are not alluded to in either of the two documents, generally has not arisen as a major issue. However, it should be noted that the Human Resource Advisor did devote two to three months over the period October 1982-January, 1983, to helping the local programming group develop a mechanism for evaluating the Ministry's budget. (The advisor expressed the belief that such activities fall outside his scope of work.) There is at least one reported instance of diversion of TA resources in management/administration which is undocumented, and does not merit comment in this evaluation.

D. Overseas Training

Since 1981, approximately 23 employees from the General Directorate of Civil Service (Direccion General de Servicios Civil) have been sent overseas for training. The extent to which this training reflects that which was contemplated in the Project Paper is questionable. The Project Paper lacks detail on the nature of training to be provided and on the categories of personnel to be trained. But the stated purpose of the project component - to reinforce the capacity of the management levels of MOH - suggests that training opportunities be focused on management personnel within the Ministry of Health. The description of this project component notes that:

...To support and complement these personnel (the five persons added to the staff of the General Directorate), A.I.D. will provide eight work years of technical assistance, computer equipment and programmers to facilitate studies and better accounting procedures, and scholarships for key staff personnel (pp.31, emphasis added)...

Appendix C. Exhibit E, (of the Project Paper) notes that five person-years of courses for top-level civil service managers shall be provided. Both of these references have been interpreted as indicating the training of personnel from the General Directorate of Civil Service.

In discussions with officials from the Ministry of Health and AID, it was suggested that the rationale for training personnel from the General Directorate of Civil Services is that through such training Civil Service will better be able to develop salary scales and job classification schemes. This would enhance the ability of the Ministry of Health to attract and retain qualified personnel. It was further suggested that the General Directorate was the only unit which solicited these scholarships. If this is indeed the case, a question which must be addressed is why the Ministry of Health, which is attempting to develop its managerial capacity, did not itself take advantage of these scholarship opportunities.

E. Commodities

The principal purchase called for in the Project Paper was an interactive computer system compatible with those presently in use by the Government of Honduras. Though the initial implementation plan (as noted in the Project Paper) indicated a scheduled installation date during the first quarter of 1982, at the time of the present evaluation the computer has yet to be acquired. As previously indicated, the approximately year and a half delay has had an adverse impact on the development of a management information system for the Ministry of Health.

The inability of the project to acquire the planned computer system is attributable to a series of problems, some of which were beyond the control of those directly concerned with the project. The first in the series of problems which plagued the purchase of the computer was a reversal of a decision by AID to donate a computer purchased under another project, to the Ministry of Health.

In June 1982, AID offered to donate a WANG VS computer to the Ministry of Health if an appropriate plan could be developed for its use. Discussions with relevant individuals suggest that though the plan submitted in July 1982 was informally approved, and a verbal commitment made to provide the computer to the Ministry of Health, a formal decision was taken in September/October, 1982 to return the computer to CONSUPLANE.

Further delays in the purchase of the computer system occurred as a result of having to go through the Proveeduría for the purchase. It has been suggested that although an initial decision has been made to purchase a NCR mini-computer system, the bidding process had to be reopened in December with the receipt of bids from additional vendors. With the bidding and bid review process extended into April/May, further delays were caused by CENI. CENI, which is linked to Hacienda, has the responsibility of clearing and coordinating government computer purchases. In June, CENI, through Hacienda, requested additional justification for the purchase of the computer. Studies were undertaken in August of this year to provide the additional data required, with a resubmission planned towards the end of the year. To further complicate matters, there have been serious disagreements about the most appropriate computer configuration.

The types of problems noted above are indicative of those which have tended to affect overall project implementation: the cumbersome and extended process of purchasing commodities through Proveeduría, and sometimes inconsistent or, in this case contradictory, communications between AID and other relevant parties in the project, are not unique to this element of the project.

F. Personnel

As indicated in the Project Paper, eight counterparts were to be hired by the Ministry of Health, in conjunction with the management and administration subcomponent, of whom five would be added to the staff of the General Directorate of Health. Collectively, these persons form the executive coordination and institutional development group (Grupo de Coordinación Ejecutiva y Desarrollo Institucional - GCEDI). The remaining three counterparts constitute the Project Coordination Unit (Unidad de Coordinación).

With respect to the first group - GCEDI - the Ministry has hired four of the five persons called for in the Project Paper. However, one of the four positions, that held by the Chief of the Maintenance Division, is being used as a means of permitting the subsidization of a position which the Ministry could not otherwise afford to maintain. (It was agreed that the funding of this position would be limited to one year.) Due to his level of responsibility and duties within the Division of Maintenance, the Chief of Maintenance has little involvement in the activities of the GCEDI.

The fifth person who has been assigned to the GCEDI was initially a member of the Central Level Nursing Office. That office was dissolved, but the Ministry wanted to maintain the position, and transferred the individual to the staff of the General Directorate. The salary of this individual is supported through national, not project,

funds. In view of the financial situation confronting the Government of Honduras, it was mutually agreed that the fifth counterpart position would be eliminated.

Within the Project Coordination Unit the three positions allocated were filled as of September, 1981 (the Coordinator and Administrator were contracted in April, 1981 and the Procurement Officer in September, 1981). Though not contemplated in either the Project Paper or Project Agreement, a secretarial position was added to the Coordinating Unit's personnel complement in August, 1981, by agreement with AID.

In choosing the individuals to fill the positions in both the Coordination Unit and General Directorate's staff, it does not appear that a formalized selection process was employed. Rather, it appears that in most cases specific individuals were sought to fill specific positions. The extent to which such a process optimizes the likelihood of obtaining highly qualified and competent personnel is dependent upon the rationale underlying the specific appointments. Two of the Coordination Unit Administrators, selected for political reasons, were not overly successful in discharging their responsibilities, and have been replaced by an earnest, hardworking individual.

While counterpart personnel within the Coordination Unit appear to be used as contemplated in the Project Paper (see Section IV, Administrative Systems), the situation is more problematic with regard to the personnel augmenting the General Directorate's staff. These individuals, who as previously noted constitute the GCEDI, were intended to coordinate (under the authority of the Director General), specific integrated functional areas such as human resources, logistics and maintenance, etc. However, rather than assuming management functions, they have been assigned specific technical tasks, e.g., the development of a local programming model, the development of a "Center" for administrative training, supervision models, etc. It is the Director General's view that these positions are being used to coordinate the different MOH normative divisions around specific problem solutions, rather than specific technical functions. Problem solution is carried out through the use of non-permanent work groups supervised and coordinated by the GCEDI. The personnel comprising the work groups are drawn from the normative, regional and establishment levels of the Ministry.

The Directorate General views the GCEDI as the mechanism which shall also supervise and coordinate continued implementation of those activities developed by the work groups. Numerous interviews confirm that the GCEDI does not function as a unit, but rather operates as a pool of individuals who tend to relate to the D.G. as individuals.

Turning from the general orientation of the GCEDI to specific activities of some of the counterparts participating in the group, the extent to which counterparts are being used as contemplated in the Project Paper becomes more problematic. For example, while the project does not contemplate undertaking hospital activities, one of counterparts is functioning essentially full time in this area. The Human Resource counterpart, though involved in the planning of an administrative training center, has little or no contact with the Human Resources Division's training activities and programs.

What is the actual role of the GCEDI? Does it function as a group? Is it a coordinating body, or does it perform specific technical tasks? How effective is it in coordinating distinct MOH normative divisions in multidisciplinary problem solutions? Does it have the capacity and staff to effectively institutionalize the products of the different work groups? Can a small group of individuals accomplish this broad mandate? The information gathered in the course of this evaluation raises serious, unanswered questions about the effectiveness and impact of the GCEDI as a coordinating link, and indicates that there are critical gaps impeding coordinated project implementation and communication within the MOH.

Expenditures

(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
Technical Assistance	960	698.3
Information System (Computer Programmers)	263	0
Personnel	422	144.8
Overseas Training	100	78.4
Commodities	0	41.5

Recommendations:

1. Establishment of a Coordination Function within the Directorate General

a) Reorient the Mission of the Executive Coordination and Institutional Development Group (GCEDI), from the provision of technical services to that of coordination and supervision of the normative divisions and operating units.

b) Increase the membership of the BCEEDI to five full time persons (see C.)

c) Assign a member of the GCEDI to the coordination of maintenance and logistics functions on a full-time basis (given the chief of maintenance's present responsibilities it is not possible for that individual to perform the logistics and maintenance coordination role within the GCEDI).

d) Expand the present role of the human resources coordinator within the GCEDI (development of a center for administrative training) to include at a minimum the coordination of training activities within the Ministry, assure the compatibility of training provided by the regions and assist the normative divisions in the identification of appropriate training courses for those persons to be trained out of country. Project funds should be used in future for training MOH employees only, not employees of other ministries (e.g., Servicio Civil).

e) Using the Project Activities Monitoring Plan (which should be reviewed at least monthly by AID, Division of Human Resources, MSH and the PCU), areas requiring technical coordination should be identified, and individuals or units charged with responsibility for the coordination.

2. Reinforcement of the Project Coordination Unit

a) Delegate to the Project Coordinator administrative authority and responsibility for project implementation planning and coordination.

b) For purposes of developing accurate quarter projections of project expenditures formalize under the authority of the Director General (or Project Coordinator) the submission of quarterly reports outlining proposed and realized project related activities; the required reports to be submitted by normative division heads and work-group coordinators.

c) For purposes of coordinating inputs (implementation plans) across subcomponents formalize the bi-monthly review of the normative division's work plans (cronogramas) for project related activities, delegating to the Project Coordinator the authority to reconcile conflicts which develop among the plans (see IV, A.1.).

3. Financial Mechanism

a) To help assure the solvency of the rotating fund, coordinate (through the responsible authority the scheduling of in-country training to conform with the rotating fund reimbursement cycle.

b) Review and formalize the mechanism by which information on loan (purchase through A.I.D.) and grant fund expenditures are forwarded to the PCU, MOH and MOF to assure that such transmissions occur in a timely fashion.

13. Mass Media for Village Health Workers

Mass Media for Village Health Workers was incorporated into the project as one means of addressing the dearth of support for these front-line information and service providers. The Health Sector Assessment had identified insufficient logistical, material, supervisory and community support for VHWs as barriers to their effectiveness and causes of disaffection and desertion. According to the PP and the "PROCOMSI/Health Sector I Implementation Plan" the mass media component, the project's main means of addressing these problems, was to be aimed principally at the health workers themselves (not at the population at large). The purpose of the component is "...to provide both recognition and continuing education to village health workers..." (emphasis added), and to provide "some" related health education to the community. Although the PP was quite clear about the intended balance between health worker-oriented media and client-oriented media, in actual fact the balance of activity has shifted much in favor of client-oriented media. Apparently an emphasis on the client was deemed preferable at least initially, until sufficient numbers of VHWs could be retrained so that the mass media could be put to good use. While the performance of the subcontractor (the Academy for Educational Development) in mass media has been extremely strong, the direct emphasis on the education of the client, and lesser (often indirect) emphasis on the education of the VHW, has meant that the project has probably not given as much support to VHWs as originally intended. (The decision to train 10,000 parteras, not planned in the PP, will obviously fill a large gap by upgrading the quality and effectiveness of that category of VHW).

A. Technical Assistance

Subject to the concerns expressed above, the TA provided was that which which was called for in the PP. The mass media advisor is extremely capable, dedicated and dynamic, and has responded to the MOH's priorities and needs in a timely fashion. The TA work plan accurately reflects the scope of work, and, with the exception of delays beyond the control of the advisor (e.g., the lengthy time required for local printing of some educational materials) implementation has been progressing as planned. The proposed methodology has been adhered to, and the media material that have been produced are technically appropriate.

B. Personnel

A second issue in this component concerns MOH counterpart personnel. The MOH has evinced strong interest in and support for mass media. Evidence of this high-level support is the fact that the MOH has been paying the viaticos of project personnel from the MOH's operating budget, rather than from project funds. However, this support has not led to an anticipated strengthening of the principal counterpart for this project, the Division of Health Education, raising a serious question about the institutionalization of progress made under this project. This transition, from externally-supported activity to an independent, fully functioning unit of the MOH, should have been occurring already because of the head start provided by the PROCOSI I Project. Yet it is clear that institutionalization has been slow to occur, and the TA advisor remains the principal conduit not only to the Health Sector I Project, but to other MOH divisions. Since the position of Chief of the Division of Health Education has been vacant for some time, transfer of skills to a permanent MOH employee has not occurred. Moreover, it is not clear that a physician would be the most appropriate counterpart for this activity. (It is the team's understanding that all Division Chiefs must be physicians.) We strongly suggest that the Ministry consider waiving this rule in order to employ an individual with mass media and education skills, and that it move rapidly to fill the Division Chief vacancy.

Because this component is a support function involving numerous (normative) MOH divisions, effective communication between the advisor and a diversity of MOH staff is essential. Communication lines have recently improved, as evidenced by the collaboration between the Mass Media advisor and the Maternal and Child Health Division (and its corresponding MSH advisors) on a new family planning campaign.

In sum, it is not clear to what extent activities under this subcomponent are in fact furthering the distinct objectives of this subcomponent, or are merely reinforcing the broader (entirely client-oriented) objectives of the Mass Media Health Practices PROCOSI Project.

Expenditures

	(\$000) A.I.D. only	
	<u>Planned</u>	<u>Actual</u>
Technical Assistance	576	170.6
Special Studies	50	0

Recommendations:

1. The MOH must fill the vacant Health Education Chief's position immediately, and absorb, as permanent employees, the other specialists in the mass media program. The MOH should consider waiving its policy that Division Chiefs must be physicians in order to attract a division chief with an appropriate mix of skills and experience.
2. A.I.D., the MOH and AED should review the objectives and work plans of the mass media program to determine whether it provides sufficient media aimed directly at continuing education of VHWs as opposed to client-oriented media.

14. Teacher Training

The objective of this component was to develop (in conjunction with the National University) a program to train nurses and physicians in educational methodology through a series of in-country courses and overseas training. For a variety of reasons internal to the University this program was never established. According to a Project Implementation Letter of 6/25/83, \$72,000 was transferred from this component budget to subcomponent 12 (Reinforcement of Management and Planning).

Expenditures

(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
Scholarships	250	34.5
Per diem, materials	215	12.2

15. Extension of Supervision

Supervision is seen by the MOH as the key mechanism for insuring the appropriate and effective implementation of the Government's national policy to expand the coverage of primary health care services. For some years now the MOH has been striving to implement a national system of supervision. The Project Paper contemplated project support to extend supervision coverage necessitated by the addition of a large cadre of auxiliary health workers. The extension of supervision is predicated on augmentation of logistical support and continuing education for all levels in supervision. A national model had been developed previously, but was found to be too complicated and theoretical for practical application. Hence, a Supervision Group was established under the Division of Planning to simplify the model and to develop and implement supervision guides appropriate to the MOH's supervision

philosophy and model. This supervision group was transferred in 1983 to the Programming Group, resulting in both increased coordination and acceleration of activities.

A. Technical Assistance

To support this component the PP stipulated 24 months of TA for management level training in supervision. The TA was initially provided by the contractor on a part-time or short-term basis to respond to particular needs. However, this system was not acceptable because appropriate short-term TA advisors could not always be obtained when needed. Hence, the approach was changed to in-house contractor TA, provided by the Planning Advisor (for development of norms and manuals) and the Regional Management Advisor (for assistance with implementation at the regional level). Changes in the TA were formalized in contract amendments. In this manner, the required TA has been provided.

The TA Scope of Work has a distinctly different focus from the PP, and calls for assistance with development of the normative aspects of a supervision system. This is not entirely consistent with the PP plan, which assumes the existence of these norms. Though these inconsistencies would appear to be significant, and the actual tasks required are broader than the PP foresaw, the fact is that both the PP orientation and scope are addressed in the work plan, and the TA required by both documents has been provided. Additionally, there has been assistance in implementation not called for. During the second semester of 1982 a management training plan was developed and management training was provided overseas to the two members of the Supervision Group, and to a senior technical functionary in the Human Resources Division. These people in turn trained regional teams in supervision management.

The adequacy and appropriateness of the technical advisors could not be verified objectively, but it appears that the TA has been appropriate and of high quality. It should be noted that the supervision effort is receiving continuous informal TA from several resident advisors.

Implementation, though slow because of the shortage of MOH personnel available to work on this system, is progressing according to the phased work plan. A revised national model was tested in two regions and modified. The Implementation Plan identifies the following stages:

1. Area level to Establishment (health center) Level: CESAMO and CESARES, and from these to the community level of volunteer personnel
2. From the Regional level to the Area level
3. From the Central level to the Regional level

Implementation began with training of all Regional level administrative teams in the design and implementation of the model. Trainers were the Supervision Group, assisted by technical advisors and team members from the Human Resources Division and Environmental Sanitation. Regional teams in turn trained Area Supervisors and personnel from the health center level. Regions now are implementing the model in stages. Special TA is being given by the contractors in three regions.

To date, Stage 1 is implemented to the health center level, but does not yet reach the level of the health volunteers. The major reason for the delay is basically the dearth of human resources at the Central Level. Although the manual is a milestone in the system, it is not an operational guide for the supervision processes and norms it establishes. Supervision teams in the regions are clamoring for simple, functional guides and the responsibility for developing these guides - inclusive of the technical and administrative aspects of supervision - lies with two persons at the Central level. To varying degrees, individual regions are developing their own guides, following the model as it pertains to their needs. Each level of supervision will eventually have its own guide.

On the operational level, the evaluation team encountered skepticism concerning the Central level's capacity to complete development of the projected material necessary for the system. Evaluation workshops have been held six months after implementation in three regions and a number of problems have emerged: logistical constraints are an impediment to supervision. Lack of vehicle control and maintenance mean transportation is not always available when needed. Though supervision vehicles are in the Areas, in some cases there are no drivers. On the positive side, the establishment of rotating funds in three regions is said to have had encouraging results. Coupled with the mentioned skepticism, there is also astonishing enthusiasm to push ahead and complete the system. A major accomplishment to be noted has been an evident change in the supervision philosophy from policing action to an educational process. Training has created great interest and a demand for more training and (judging from the sites visited), for more assistance and for appropriate materials and tools to carry out supervision.

Equally evident, however, is the frustration of personnel, particularly at the Area level, in that there is no delegated authority and an absence of administrative mechanisms to solve problems, and often no mechanisms to discuss and evaluate the outcome of supervision findings.

A recently completed Guide for Programming of Resources for Supervision is being implemented in three regions. Though somewhat complex, it hopefully will prove to be a useful tool for planning supervision.

Completion of the normative requirements of the system is a priority. Although all the appropriate steps are being taken, the process is slow. Expectations raised by training are not being met. Unless the process is speeded up somehow, enthusiasm may eventually turn into intransigence and loss of interest.

B. Training

In-country and overseas training has been provided as projected in the PP and the TA Workplan. Evaluation workshops and observations by TA advisors suggest that training in the use of the Manual has been effective, but that people are not yet trained to supervise. The reorientation process, i.e., the attitudinal changes required of this approach to supervision, have not yet been instilled, and will require continuing education.

Training has been carried out through the Division of Human Resources, with the participation of the Continuing Education Advisor. Until the system is sufficiently installed (with guides and logistical support), it is not possible to assess objectively the impact of the training on actual supervisory behavior.

C. Commodities

Supervision vehicles arrived at the port in March 1983 and were distributed to the regions in August.

D. Personnel

The two persons who comprise the Supervision Group fill the 36 month coordinator slot funded by the project.

Expenditures
(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
Technical Assistance	189	100
Training	1,418	28
Commodities (Trucks)	320	311.3

Recommendations:

1. The supervision component is lagging behind, and serious consideration should be given in the Reprogramming Document to reinvigorating this element.

2. The Supervision Manuals and Operational Guides may be too sophisticated. This observation was sustained by operational level personnel, who suggested that Central Level personnel are working on a theoretical level, and lack sufficient understanding of operational problems in supervision. Thought should be given to simplifying the manuals and guides.

3. It would seem appropriate to develop the Operational Guides in the regions and areas, rather than at the central level. Interim functional guides could be implemented, evaluated, revised, and put into practice while a "final" product is developed at the Central level.

4. The Supervision Group, with only two staff, is too small to manage the implementation of the system and the development of manuals, which has occupied most of their time to date. If the group cannot acquire additional staff, they should devote less time to production of manuals and concentrate their efforts on helping the regions implement their local plans.

16. Continuing Education of Village Health Workers

A series of short courses for VHWs was planned to reinforce their continuing education provided through mass media (Subcomponent 13), and thereby stimulate voluntary participation of communities in health activities. The Project Paper did not specify which of 4 categories of workers (guardian, partera, representante de salud, or collaborator de malaria) would be trained, only that 4,000 would be trained in 6 1/2-day courses. The curriculum was to be based on the findings of a study of current VHW knowledge and skills.

As described in "Subcomponent 17., Continuing Education for MOH Employees", health worker training at all levels had a fitful start, but is now progressing smoothly. (See 17. below for details on technical assistance.) This year, however, with strong ministerial support, some 7,000 parteras have been trained. Regional continuing education coordinators are in place, many of them reported to be individuals trained in a prior donor-funded project, who were never incorporated into the MOH's permanent employment rolls. Trained as trainers, each develops his/her region's curriculum.

Unfortunately, we were not able to assess the strength of the curricula, training materials, or courses, or their consistency with partera norms, developed under this project. Nor could we determine whether or not the MOH has plans to begin financing an increasing proportion of VHW subsistence during training, as stipulated in the PP. These items should be pursued.

However, the training of such a large number of parteras is impressive in itself, and demonstrates the MOH's commitment and ability to mobilize to meet an ambitious goal.

Expenditures

(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
Regional Coordinators	36	22.7
Per diem and materials	176	23.8

17. Continuing Education for MOH Employees

Continuing Education (CE) as contemplated in the PP plan is essentially in-service training for all levels of MOH personnel. It is also the key mechanism for introducing and implementing the technical content, norms, manuals, procedures, and administrative practices of the health technologies and services support systems being developed. The technical and administrative coordinating body is the Division of Human Resources (DRH). This Division similarly has responsibility for the continuing training of community level health workers and the parteras. A technical advisory/supervisory Continuing Education Commission (CONCORDEC), composed of the normative division chiefs, is intended to function as a communications link among the MOH departments. The CONCORDEC technical committee appears to have responsibility for reviewing course planning documents submitted from the regions, and for supervising the coordination of training programs. Human Resources Development in the PP accounts for 36 percent of the total project budget and encompasses an enormous quantity of training in support of the project components.

A. Technical Assistance

Thirty-six months of long-term TA are intended to assist the development and implementation of continuing education/training activities for components 16 (Village Health Workers) and this component simultaneously. Initially 12 months of TA was provided under a Personal Services Contract, which was later terminated when the assistance provided under this arrangement was deemed unsatisfactory. Instead, MSH was asked to provide short term assistance. The current TA advisor gave three months of assistance under the MSH general TA pool. An amendment of the MSH contract later added 24 months of long-term TA for all continuing education. Six months of short term TA supported the development of the DRH Information Center, under the supervision of the advisor. Long-term assistance began in January of 1983, running 24

months behind schedule. Six weeks of assistance to the Information Center have been provided thus far. The TA currently being provided is consistent with the general design indicated in the PP and clearly meets the needs of the MOH. Integration of the Continuing Education TA with the MSH TA is of significance, in that it has reinforced coordination of the TA provided.

The scope of work for the C.E. Advisor is consistent with the non-specific guidelines in the PP and is sufficiently general to encompass the range of activities required to implement a program that cuts across all MOH departments and operational levels. The technical expertise and experience of the person hired seems particularly appropriate for the advisor role.

The TA work plan is also the current revised MOH work plan for C.E., developed jointly with the advisor. From a technical and an administrative perspective, the revised work plan is a significant step forward in the implementation of the entire Project. Though it represents a deviation from the PP plan, it should rather be viewed as a mechanism to rationalize the original plan. A major defect in the PP was that the implementation plan for training was insufficiently elaborated. Each project component in the PP plan includes a sizeable training component. Training output targets were set without consideration for the coordination and resources support required to meet these diverse targets. Further, the plan failed to address the effects on service delivery of such an enormous training load. An inventory of courses conducted by the CONCORDEC in 1983 revealed no less than 170 separate courses programmed at the regional level and directed at the same groups of trainees. In addition to the training specified by the PP plan, the MOH was carrying out numerous other training activities not included in the project, many sponsored by other donor agencies, each with its own output targets.

With assistance from the continuing education advisor, the work plan systematized the training into three phases according to MOH priorities, for the years 1983-1985 -- respectively, Institutional Development, Technical Capacity Development and Community Participation Development. Training for the various project components has been distributed among the three training phases. A second major step was to rationalize the training content by making it functional and job-specific. With the previous unsystematic and fragmented approach, training received by health personnel was often unsuited to their work. Revised job/work and educational "profiles" were developed by the Programming Unit to make the training more appropriate to personnel's functions.

Actual practice has not conformed to this phasing of priorities because the institution-building systems (i.e. logistics, supervision, administration, maintenance) are still undergoing normative

and organizational development, and the development of technical capacity, i.e., training in the health technologies, is dictated by the Project Paper. Further, overriding this system of priority phases for training has been the MOH priority of implementing the nationwide cold chain and the training of 10,000 parteras. Nonetheless, the systematization of training has been a monumental accomplishment in that it has resulted for the first time in the development of training strategies. The first of these strategies has been the integration of separate training courses into 10-day functional training programs -- e.g. immunization, diarrhea, etc., designed to fit the work profile of each category of health worker. This approach has economized on time and resources. During 1984 a modular epidemiological approach will be developed whereby all MCH content (i.e., all health technologies) will be taught to the auxiliary nurses in a 6 day economy training package. Though considerable detail could be added, this overview of the TA/MOH work plan is intended merely to indicate the nature and the direction of the changes from the PP plan. The changes are technically and administratively sound. They will, however, result in different outputs than those in the PP plan.

Specific MOH counterparts to the C.E. Advisor are two senior technical personnel in the DRH who work with the TA advisor as a team. One of the important accomplishments in this respect has been a change in work style at the central MOH level through the process of learning by participation. Team work is also the key mechanism by which the advisor is transferring an array of his skills not only to the central level counterparts, but also to team counterparts at the regional and area levels.

B. In-Country Training

The PP plan contemplated an output of 7200 person weeks of short courses as total training output. As described above, training was carried out in a fragmented fashion until 1983, and a training information system has not yet been established at the central MOH level. Hence, information concerning the accomplishment of training targeted in the PP is very difficult to compile, and can only be reconstructed from existing financial data. Each department has files on courses given, but these are not always readily accessible. Two days of researching by the DRH itself produced only the following project output data:

<u>Year</u>	<u>Number of Courses</u>	<u>No. of Participants</u>	<u>Total Cost (L.)</u>
1982	29	724	103,683
1983	125	2,188	209,083

During 1982 financial problems stemming from the limited size of the A.I.D. rotating fund greatly inhibited the implementation of training activities. Hence, some of the training in that year was instead carried out with PAHO funds (and thus may well not be reflected in the above figures), and in the latter part of the year with loans from the Minister's funds. Logistical support problems also contributed to the delays.

Given the changes in the implementation strategy discussed above, the original output measures are no longer suitable for assessing progress. There clearly has been an enormous delay, but that in itself has probably not really affected the project as adversely as it might appear. Since the various system norms, manuals and forms have not yet been completed for various components, and since there have been equally lengthy delays in the procurement of equipment, tools and materials to support the training, it may on balance be just as well that the training has been delayed. Had more training occurred earlier, it also would have been carried out in the previous fragmented, unsystematic and often inappropriate manner.

A major accomplishment has been the recent focus on training trainers. A core group of trainers was established who have trained others, so that this process, according to MSH, is now in its fourth generation.

Curricula, course plans and testing materials were not readily available except in the regions visited, hence no judgment can be made about them on a national basis. It does appear, though, that there is great variability by region in these capabilities and reportedly, a need for further improvement of educational methodologies.

C. Construction

The equipment is in-country, but not yet in place, because the printshop requires remodeling to accommodate it.

D. Commodities

Books and other materials to support the continuing education program have not yet been ordered but equipment has been purchased. There has been delay in compiling lists and specification of items to be purchased.

E. Personnel

The Continuing Education and Information Center Coordinators are in place.

F. Other

The Information Center is being organized and existing educational materials are being catalogued. One of the outputs of this component is the distribution of the Continuing Education Magazine. It appears that two or three issues were distributed, but the quantities could not be ascertained.

Expenditures
(\$000) A.I.D. only

	<u>Planned</u>	<u>Actual</u>
Technical Assistance	297	271.4
In-country Training (per diem and materials)	562	754.2
Commodities	250	59.4

Recommendations:

Based on the assumption that the Regional Continuing Education Coordinator positions will become permanent MOH positions, the following recommendations are offered:

1. Because of the shortage of personnel at the Central Level in the Division of Human Resources, the responsibility for programming and approving courses according to the Continuing Education Workplan should be delegated to the Regional Coordinators, under the supervision of the Regional Directors. (At present, although the Regional Coordinators develop their own curricula, they must be sent to the central Ministry office for approval.)
2. The central level should give priority to the development and speedy implementation of a simple training information system which will facilitate monitoring of the various regional training activities at the Central level.
3. The overall training load should not be expanded until the information system is in place and training follow-up and evaluation has been initiated.
4. Decentralization of training has implications for budget management that should be addressed sooner rather than later.
5. The MOH should take immediate steps to institute a system for evaluating the quality and impact of training.

18. Operations Research

Operations research per se is not a separate subcomponent of the Health Sector I Project, but was identified as minor element of the main TA contractor's scope of work. (See Job Description, "Systems Analysis, Operations Research and Finance Advisor.") Studies on a minor scale were contemplated in conjunction with certain subcomponents (notably Tuberculosis and Mass Media for Village Health Workers). However, such a substantial commitment has recently been made to a full-blown program of operations research that this evaluation would be incomplete if it failed to assess what has de facto become an additional subcomponent.

The recent amendment of the contract with Management Sciences for Health to add two part-time, permanent advisors in OR, the creation of a Science and Technology unit in the MOH to coordinate and conduct operations research, and the use of project funds drawn from other line items (Tuberculosis and Maternal and Child Health) to support operations research activities add up to substantial and explicit, though nowhere formally articulated, commitment to a new area of project activity.

It can be argued that research (traditional operations research, or applied health services research, which probably more accurately describe much of the new research planned as a prelude to family planning activities) is essential to sound planning of any development program. Research can also be useful in demonstrating the utility of innovative program designed. Certainly the impact of operations research (financed through A.I.D.'s centrally funded PRICOR Project) in influencing MOH policy with regard to user financing of health services is impressive.

But applying the Mission's own evaluation criteria to this subcomponent raises the issue of the extent to which the strong emphasis on OR has departed from the PP and the scope of work. (See Section VI, "Review of Reprogramming Document" for a discussion of future OR activities.) TA in "health program investigations" was part of the MSH scope of work -- but as only one of six responsibilities of the Systems Advisor. This individual was to be responsible for the "Management and Planning Component" of the project described in detail by subcomponent 13, "Reinforcement of Management and Planning." But the PP did not even mention research in this subcomponent. It merely cited technical assistance in the use of a computer "to facilitate studies" and the only research activity actually planned under this component was "periodic evaluations" which (apart from the workshop in Tela which did not involve computer assisted analysis) have not been conducted.

In short, the TA provided in operations research is not consistent, in degree, with the PP. The change from the PP is significant. No TA work plan for the newly contracted OR/MCH advisors was available for review, and, as mentioned in the section on MCH, there is some question about what the balance between general operations

research and MCH/family planning should be. MOH counterparts in research were not originally envisaged, although one permanent MOH employee and one contract employee have been assigned to the Science and Technology Unit.

Recommendations:

See Section VI., "Science and Technology Unit/Operations Research".

Contingency Fund Expenditures
(\$000) A.I.D. only

<u>Planned</u>	<u>Actual</u>
1,266	210.7*

IV. Administrative Systems

This section on Administrative Systems focuses on issues internal to the project that affect the pace and direction of implementation. In addressing those issues, the point of focus is the Project Coordination Unit (PCU).

A. Planning for Project Implementation

A variety of implementation plans have been developed for the project. The most concrete of these is the integrated MOH/MSH work plan, initially developed in June 1982 and revised a year later (June/July 1983). The work plan identifies the activities and specific tasks required for implementation of some of the project subcomponents and establishes timeframes for their execution. The parties responsible for the implementation of the required activities are identified. The integrated workplan is limited to the realization of a specific task; the institutionalization of these tasks is not addressed. But the MOH has created permanent units to correspond with most of the temporary work groups.

The project implementation plans do not provide for coordination of inputs across subcomponents and institutional participants. This has not eased the problem of uncoordinated phasing of project inputs. For example, maintenance and logistics, distinct though interdependent sub-components, are developed and implemented separately. Thus maintenance personnel were contracted, trained and placed in the region without the requisite logistic system to make the necessary spare

*Commodities: ORS packets, plastic spoons, cups, oral rehydration tables.

parts available. The supervision module, which requires the collection of large quantities of addition utilization data, is developed and implementation has begun in the absence of data processing and analysis capacity in the Ministry.

The absence in the implementation plans that coordinate among project inputs is accentuated by the limited nature of the PCU's coordination role. Constraints by a lack of administrative authority, and the need to process and monitor the profuse project document flow, the PCU is reduced to the functional (financial and administrative) coordination of ongoing activities. The unit is not able to address the basic issue of the direction of implementation nor is it able to focus attention on efforts to bring together disparate project sub-components (i.e., technical coordination).

A second framework for project implementation is the workplan included in the PCU document "Informe Initial" (June 1983). As with the integrated MOH/MSH workplan, the PCU document identifies activities and specific tasks required for implementation of each of the project sub-components with timeframes for their execution. Reference is also made to the parties responsible for implementation. The principal difference between the two documents lies in the approach adopted for aggregating the implementation tasks. The MOH/MSH workplan divides implementation activities on the basis of the work groups established by the Director General.

In contrast, the PCU document takes a functional approach. Implementation activities are aggregated by the category of function to be performed across sub-components (e.g., training courses, scholarships, construction, transportation, equipment, etc.). In spite of (or perhaps because of) its sophistication, it is not clear whether the PCU document is actually being used for implementation purposes.

To maintain their utility, implementation plans require regular and periodic review and revision. Though the integrated MOH/MSH workplan has been revised once since its development in June 1982, certain elements do appear to have received more frequent review. The Project Coordinator meets with the MOH normative division heads on a bi-monthly basis to review the timeframes which had been established for the project activities under their direction. The Project Coordinator may suggest changes. However, since he lacks authority, the changes which are made in the timeframes ("Implementation Plans") are made by and large at the discretion of the division chiefs.

It has been suggested that attendance at these project review meetings is irregular and the meetings are called without specific agenda. The group consequently strays beyond the issues it is being called to consider, and tasks are not completed within the timeframes agreed upon. The fundamental issue concerning planning for project implementation, however, is that there is no implementation plan for the project as a whole which has been elaborated in cooperation with the normative divisions and regional staff, and which is in fact used to guide and monitor project implementation.

B. Financial Planning of Project Implementation

Annual project budgets are only rough estimates of likely expenditures, in part because they are not based on a realistic, accepted implementation plan. The annual budget is allocated quarterly on the basis of projected quarterly expenditures contained in the "Plan de Cuota". The PCU prepares the Plan de Cuota in which a certain amount of funds are requested to finance project activities programmed for the quarter. The basis for the Plan de Cuota are quarterly reports from MOH normative divisions and project work-groups (sub-groups related to the GCEDI) outlining their planned activities for the three month period. In general, such reports are not submitted to the PCU.* In the absence of programming data, the PCU makes its own estimates of program activities. Consequently, the quarterly budget request provides for an adequate flow of project funds only to the extent that the PCU's estimates reflect the normative division's or work group's actual programming.

The lack of complete, timely, accurate and consistent financial data does not permit financial plans to be reviewed on a regular basis so that they can be revised to reflect changes in implementation plans and/or changes in the financial situation.

The quality of the financial data is affected by three inter-related factors:

1.) Limited knowledge of Grant Fund Expenditures made by

A.I.D.: Data on grant fund expenditures tend to be forwarded in an untimely manner and are often not complete. For example, a quantity of fenitrothion was purchased, and payment made in September 1982. The PCU received the voucher for the purchase approximately one year later. The effects of such delays are twofold. First, expenditures realized in one period are posted in a later period. Second, knowledge of actual purchases may not be known to the operational unit requesting the commodities until such time as they actually arrive.

2.) Delays in the transmission and execution of financial documents: (See Appendix: "Transmission of Financial Documents").

*The lack of responsiveness is not an isolated occurrence, but rather part of a more general pattern of disregard for the PCU and its coordinating function.

3.) Inconsistencies in budget information among the administrative, coordination and operational organizations involved in the project: As noted in Table 10, Cuadro Comparativo de Valores segun Ministerio de Hacienda, de Salud y Unidad de Coordinacion, there are significant differences between the Ministries of Finance and Health, and the Project Coordination Unit on budget modifications, budget size and expenditures for grant funds and loan funds. The differences in loan and grant funds may be due to delays in transmission of documents. The reasons for differences in budget modifications and budget size are less clear.

C. Systems for Identifying Unanticipated Problems

A combination of informal and formal mechanisms are employed by the Project Coordination Unit for identifying unanticipated problems. To obtain information regarding project activities carried out by the MOH's normative divisions, the Project Coordinator relies on informal contacts and discussions with division chiefs. This information is supplemented by PCU visits from regional through establishment levels.

Project document transmissions are the principal mechanisms available to the PCU for monitoring project implementation. The flow of documents is monitored informally through the personal intervention of PCU staff members who visit the relevant institutions, ministries and agencies to ascertain their status. Though institutional participants, such as Proveeduría, maintain an information system for tracking documents, the PCU has found this system slow and inefficient.

Among the formal mechanisms used to identify problems are regularly scheduled weekly meetings are held with the Directorate General, Project Coordination Unit, AID and MSH to coordinate and discuss project activities. A second series of regularly scheduled weekly meetings designed specifically for the purpose of identifying potential problems and developing solutions are held with the Project Coordination Unit, AID and MSH. The time limitations of the evaluation did not permit the evaluation team to fairly assess and validate the effectiveness of these mechanisms for identifying unanticipated problems, particularly those which arise in the areas of budget and finance. However, the major issues that affect budget and finance are those that affect financial planning for implementation (i.e., inconsistencies in the financial data among the MOH, the PCU, MOF, and AID; delays in the transmission and execution of financial documents; and the PCU's and MOF's limited knowledge of grant fund expenditures made by AID).

The source of many of the problems confronting the project lies outside the PCU and the Ministry of Health, (e.g. the extended and cumbersome purchasing process through Proveeduría, the lack of permanent positions for project counterparts, etc.). Once a problem is identified,

for the relevant parties, those with the authority and/or resources to effect change, must be brought into the problem solving process. An example in which a persistent problem was resolved is the project's rotating fund. An example in which those with the necessary, much higher authority, i.e., outside the MOH, have not been involved to date in problem resolution is the postponement of permanent positions for project personnel under contract.

In attempting to reduce the bottlenecks affecting the transmission of project documents (purchase and payment orders) representatives of the MOH's Administrative Division were brought into the problem solving process, though their participation was irregular. Representatives of the Ministry of Finance, who had the authority to resolve the bottleneck, were not brought into the process in a timely fashion.

With regard to the the creation of permanent positions for the counterparts specified in the Project Agreement, the relevant parties were involved in the problem solving process (the Minister of Health, Finance and the AID Project Liaison Officer). The participation of these individuals brings to the fore a more complex and perplexing issue: Who speaks and is able to make commitments for the GOH? Within the Ministry of Finance, agreements signed at the political level are not accepted at the technical level. This issue has not been resolved. A much broader question which must be addressed is the extent to which sufficient resources and authority are made available to the Project Coordination Unit and/or institutional participants for effecting change.

As indicated, project implementation plans have been developed. Yet based on the sub-component reviews (Section III.) it is apparent that not all aspects of these plans have been carried out. The situation is attributable to a number of actors, which tend to coalesce around five principal issues:

1.) The absence of an effective entity to coordinate implementation activities: The Project Coordination Unit, though nominally charged with coordination, is limited in its ability to carry out this role in the absence of administrative authority. The PCU can only request cooperation from the relevant parties involved, requests which, as the previously noted, are not necessarily acted upon. The PCU's suggestions are not necessarily followed. While the PCU has recourse to the Director General, time limitations did not permit the team to determine whether such intervention has been requested and if so, granted.

The PCU functions primarily to facilitate the financial aspects of project implementation. Coordination of technical and programmatic aspects seems to fall between the cracks. It is not clear whether this is due to lack of

definition of responsibilities on the part of the PCU and A.I.D., or because of inadequate staffing and definition of responsibilities within the Unit. Communication with normative divisions and the PCU is generally reported to be inadequate.

Examples:

-- About 60 percent of overseas training for maintenance specialists has not been completed because no one has the responsibility locating appropriate training sites.

-- The PCU lacks information on cumulative training accomplished under the project, except for records on funds expended (versus people trained). Since these data are usually based on per diem, (viaticos), they do not accurately account for the number of people who were trained locally and therefore did not receive per diem.

The coordination role might have been carried out by the executive coordination group (GCEDI). However, as we have described, the group does not function as a group, but rather as separate individuals and who have assumed technical rather than managerial/administrative functions. It has been suggested that there has been a reluctance to delegate administrative authority to either of the two groups in an effort to avoid antagonizing division directors. Effective coordination requires that the entity charged with the function have some level of authority. Some clearly identified unit or individual, preferably within a permanent unit of the MOH, must be given the responsibility and authority for overall project planning, coordination, and implementation.

2.) Lack of adequate communications between and among institutional participants in the areas of programmatic and financial activities: This deficiency is exacerbated by the situation noted in 1.)¹

3.) Lack of resources and authority on the part of relevant parties to fulfill assigned roles. (See 1. above.)

1. A.I.D. Staff have noted that continuing attempts have been made to improve programmatic communication and, in their view, this communication is satisfactory. The evaluation team observed, in repeated instances, that in spite of these earnest efforts at communication, key MOH staff involved in project implementation lacked a full understanding of project objectives, resources and activities.

4.) Lack of detailed implementation strategies: The implementation plans note the activities to be undertaken and in general the party responsible. It does not appear that specific strategies have been developed suggesting how the responsible party and required resource might be mobilized for the task.

5.) The limited absorptive capacity of the MOH: The MOH lacks the financial resources necessary to support all the additional personnel required by the project. With the limited number of qualified personnel the same persons are required to assume multiple functions. Of the five positions on the GCEDI, one was never filled as it was recognized that the government would not be able to maintain that position with national funds. Similarly the total number of counterpart personnel have been reduced from approximately 75 to the 50-60.

A sixth factor which affects implementation is the degree to which the project's goals and the content and manner of providing technical assistance are accepted by the various political and technical levels within the ministry. While it is difficult to document such attitudes, it should suffice to note that there is skepticism in some quarters of the MOH about project objectives, activities, and the intensity of technical assistance.

D. Implementation - The Financial Mechanism

The inability to move loan and counterpart funds was recognized by all parties (AID, PCU, MOH) as a serious impediment to project implementation and actions were taken by A.I.D., the MOH and the Ministry of Finance to increase the flow of counterpart funds. The underlying issues have been identified in a series of internal AID/Honduras memos¹ as:

1. Loan Funds

a.) Limitation on the size of the "rotating fund". The normal reimbursement cycle for loan fund expenditures is approximately six weeks. To allow for what the Mission feels is an adequate cushion, the ceiling on the rotating fund would have to be set at a level equal to eight weeks of project expenditures (L.650,000). The initial ceiling of L.50,000 was raised to L.200,000 in October 1982 and to L.500,000 in August 1983.

b.) Bonding of Rotating Fund Manager. The manager of the rotating fund, the Project Coordinator, must be bonded. This is done through private bonding agents and validated by the General

¹ Some of which were translated and shared with the MOH.

Comptroller's Office. To handle an increased rotating fund the size of the bond must also be increased. The cost of the bond, which is expensive, is treated as a non-reimbursable expense by the Government of Honduras.

c.) Liquidation of fund. Reimbursement had been held up by the Ministry of Finance to comply with a regulation requiring the liquidation of rotating funds at the conclusion of the fiscal year.

2. Counterpart Funds

a.) Budgeting process. The budget ceiling assigned to the project by the Ministry of Health is based on previous years' budgets, and thus tends to fall below perceived needs.

b.) Cumbersome budgeting and expenditure mechanisms which affect per diem expenses and line item transfers within the project budget. The use of GOH funds for per diem expenses requires six weeks advance notice prior to travel. GOH regulations restrict line item transfers. The Coordinating Unit had not been fully cognizant of all relevant restrictions.

c.) Short time frame for use of counterpart funds. Counterpart funds usually cannot be utilized until late January (when transaction codes become available), and funds are usually not available during the last quarter of the year due to the Government's adverse financial situation. Consequently, purchases must be realized in the February-September period.

d.) Ministry of Finance perspective that Government expenditures must be restrained in light of the country's economic situation. A number of actions have been taken by the PCU, the Ministry of Health and AID to resolve these issues. The rotating fund's ceiling was raised to L.500,000 three months ago. With this increase it is generally felt that there will be sufficient funds to cover loan expenditures. Since the ceiling was increased, depletion of the rotating fund has ceased to be an issue. It should be further noted that with the planned conversion of the rotating funds capitalization for AID advances to ESF funds, AID/Honduras' outstanding advances problem may be alleviated somewhat.

With respect to the bonding issue, the Project Coordinator has been able to secure the appropriate bonding. However, the bonding fee remains a non-reimbursement expense which by the Project Coordinator has paid personally. Finally, with regard to the liquidation of the rotating fund, the project has received exemptions from this regulation because the fund consists of non-counterpart funds (whether this will become an issue when the rotating fund's capitalization is converted to ESF funds is not clear).

While the major issues involving the rotating fund (and thus loan fund expenditures) appear to have been resolved*, the problems with respect to counterpart funds have not been alleviated. Though the project's counterpart budget has not suffered cuts as extensive as those experienced by other Ministry of Health programs, budget cuts have occurred. The Ministry receives a global budget which it then allocates among its programs. Thus the effect of maintaining the project's counterpart budget is to force greater cuts in other Ministry programs than would otherwise be the case. Until the economy improves, a situation which is not deemed likely during the life of the project, the expenditure of counterpart funds will remain a problem.

Two further areas which are linked with the issue of the inability to move loan and counterpart funds deserve note. The first deals with the extent to which delays in transmission of documents has been resolved; the second the ability to commit to multi-year contracts.

As previously noted, extensive delays are encountered in the transmission of documents necessary to execute expenditures. The most significant of which are attributed to the Ministry of Finance. Though the process is complex and cumbersome (see Appendix, Transmission of Documents), it has been observed that the key issue is not necessarily one of bureaucratic reform, but rather policy change. When Government policy is directed at spending counterpart funds, transmissions tend to be expedited. Consequently, efforts designed to alleviate transmission delays must be directed at the root as well as secondary causes (government policy towards expenditures and transmission process reforms respectively). To date efforts directed at resolving the primary cause have not been with successful.

The issue of multi-year contracts affects all counterparts hired under the project but is especially critical in the case of the Project Coordinator. It has not been resolved. Contracting on an annually basis results in a delay of up to three months in payment of counterpart salaries, a situation which is less tolerable to lower level employees such as maintenance persons, who do not have the financial resources to sustain them.

Furthermore, lapses in contract periods threaten the ability of the project to utilize the rotating fund: the project coordinator can remain bonded and expend funds locally only when his contract is in effect.

* The solvency of the rotating fund might be put to the test, if, as was the case in the past, too many in-country training courses would be undertaken within too narrow a period of time to accommodate the funds reimbursement cycle.

Though the issue of multi-year contracts would be partially resolved if counterpart positions are made permanent, it would not solve the problems of the project coordinator, who remains only through the life of the project.

E. Evaluation

The monitoring of project implementation for the Ministry of Health is through the Project Coordination Unit, which submits quarterly reports to the Director General. These reports note the operational and financial activities undertaken during the proceeding three month period. Copies of the quarterly report are submitted to AID. Supplementing the quarterly reports are a series of regularly scheduled weekly meetings of the Project Coordinator and Administrator, Director and Sub-Director Generals, AID Project Officer and MSH Chief of Party. Though each of the participants provides detail on project implementation from their institutional perspective, the adequacy of implementation monitoring is ultimately dependent firstly upon the existence of a clearly defined standard against which to measure implementation is; and secondly, the completeness, timeliness and validity of the available data.

With respect to the first condition, there are a series of documents available to the Project Coordination Unit that serve as reference points against which project implementation may be monitored. These documents include the initial report of the Project Coordination Unit (Informe Initial Junio 1983), which has a detailed work plan and time frames for each project element over the life of the project, and the initial and revised Ministry of Health/MSH work plans. But because of the poor quality of data available to the Project Coordination Unit, these standards are approximations.

In the area of program activities, the Project Coordination Unit is dependent upon the MOH division chiefs to provide data on the status of such activities. The formal mechanism for acquiring this data is through quarterly reports which the division heads are supposed to forward to the unit. As discussed above, their response is erratic and the Project Coordinator lacks the means of assuring compliance. In the absence of formal reports the Project Coordination Unit must rely on informal contact and discussions to obtain the required data. This process has not proven adequate for monitoring program implementation. At the regional, area establishment (CESAR, CESAMO), and community levels, an information system does not presently exist to funnel data to the Project Coordination Unit. Information on activities, to the extent that it is acquired, is obtained through the Project Coordinator's visits to the region (usually to deliver checks for covering project related per diem expenses), communications with MSH or informal discussions with normative division heads.

As already noted, the Project Coordination Unit is reduced to monitoring implementation through a review of project document transmission (payment and purchase orders). Given the delay in receiving documentation with respect to expenditures from grant funds and loan fund purchases realized through AID, the review of document transmissions is a less than satisfactory means of monitoring project implementation (as noted by the Project Administrator, vouchers totaling approximately L 3 to 3.5 million covering the period 1981 to September/October 1983 were not received from AID until the end of that period). Furthermore, in the absence of data on the actual program outputs, it is possible to monitor the project only through an assessment of expenditures, not activities completed or underway.

F. Logistical Support for Project Implementation through the Project Coordination Unit

The Project Coordination Unit is composed of six persons (Project Coordinator, Project Administrator, Procurement Officer, an accountant, and two Secretaries), all of whom appear to be extremely dedicated and capable. Given the immense volume of documents the unit has to process and the frequent necessity of personally monitoring the flow of such documents through the offices of the various institutional participants, additional staff would appear warranted. Specifically, the Unit would profit from the addition of an Administrative Assistant for processing of expenditure documents related to the rotating fund.

To facilitate the work of the Unit, consideration should be given to increasing the unit's work space. At present the unit is housed in a single 18 M² office located within the Ministry of Health. The space is just sufficient for a visitor to walk around the six desks squeezed into the office. In acquiring additional work space an attempt should be made to maintain the offices within the Ministry of Health building.

With the addition of an Administrative Assistant, equipment such as a typewriter and calculator would be necessary.

G. Other Issues

Given the complex nature of the Project, the diversity of inputs, and the broad range of institutional participants the need for coordination and stability of personnel is a significant issue for project implementation.

As noted in Tables 2 thru 5 (Estructura Organizativa de las Dependencias del Gobierno de Honduras; Estructura a Nivel Regional;

Estructura Organizativa de la AID; Unidad de Coordinacion, Health Sector I), the project was initially being implemented in an environment with constant personnel turnover, which adversely affected implementation progress. In such an environment, the institutionalization of project outputs is difficult.

Recommendations:

1. A joint AID/PCU Project Activities Monitoring Plan should be developed. The plan should include critical dates, and a mechanism to signal when actions should be taken to avoid delay and permit contingency planning.
2. A functional, cumulative, training information system should be established jointly between the Regional Directorates, the PCU and A.I.D. The PCU should have responsibility for monitoring this system.

V. INSTITUTIONAL PARTICIPATION

A. Ministry of Health

Policy Level Support:

There appears to be strong support for the objectives of the project, i.e., institution building and strengthening of support systems, at a high level within the Ministry of Health (the Directorate-General). The objectives of the project are well understood, and commitment to its aims is evidenced by the fact that several new offices have been created to promote the institutionalization of project activities (viz., the Science and Technology Unit, CONAME, etc.) However, there is reason to be cautious about the likelihood of continuing budgetary support, given the recent budget cuts (particularly in 1983 and 1984) that the MOH has had to absorb. For instance, in 1982, the Ministry purchased no spare parts. To date counterpart funding has been adequate, but the Ministry is experiencing shortages of funds for operational expenses (i.e., for viaticos in support of ongoing, normative division activities).

There is an expressed commitment to hire counterparts, and to absorb their salaries and their positions of a permanent basis. However, this action has been deferred through a series of implementation letters, and we were unable to determine 1.) if the 1984 budget in fact includes funding for the 33 percent of counterpart salaries the MOH is meant to absorb that year, and 2.) whether the MOH will in fact be permitted to create the new positions required (or, alternatively, if they will be able to use existing slots to absorb counterparts). These decisions lie outside the purview of the Ministry, and there Ministry has little

influence over the priorities established by the government bodies who make these decisions.

Normative Level Support:

The evaluation revealed that most normative division chiefs were unfamiliar with the content of the Project Agreement, and were not aware of the project's various components. They think instead in terms of their own, much broader areas of responsibility. Offices such as Malaria, Human Resources, Purchasing (Compras), Warehousing, Maintenance, the branches of Epidemiology, Science and Technology, Maternal and Child Health (recently), Continuing Education, and Health Education look on the project with a varying degree of enthusiasm. These offices coordinate with the PCU, but view it largely as a financial unit to whom they report, and from whom they seek approval for expenditures. In general, they focussed on the project as a project when they had a specific gripe.

Regional Level Support:

Regional Directors interviewed by the evaluation team (Regions 2, 5 and 6) were well informed about project resources. However, to some extent the project is viewed as a means of topping off their budgets, particularly for operating expenses. We were not able to generalize about whether or not project documents are processed on time, but at least two of the Regional Directors stated that they find it necessary to hand-carry documents to Tegucigalpa to ensure timely processing. Counterpart funds are occasionally available, due to a paucity of MOH operating expenses.

Staff Offices

Staff Offices appear to assist in problem solving. The Purchasing Departments support the project's activities enthusiastically, although they are not fully aware of the scope of the project. They observed that they confront a lot of AID-generated problems because of lack of communication.

B. Ministry of Finance and Public Credit

1. Budget Office

The Budget Office intervenes at a number of critical points in the project implementation process, including contracting of personnel and the purchase of goods and services. In each of these areas the Ministry of Finance has imposed a cumbersome and complex process which tends to impede timely project implementation. The contracting of personnel requires nineteen separate steps and approximately 104 work days to

complete. As government regulations permit only single year contracting, the delays encountered in the contracting process remain a nagging issue. The delay in salary payments (up to three months) which are common in the contracting process, affects all contract personnel (e.g., workers hired for the maintenance subcomponent) who are least able to afford it. The Chief of the Division of Maintenance described a future problem: maintenance people hired for the regional jobs usually come from Tegucigalpa, and therefore often do not have a family support network in the regions to fall back upon when paychecks do not arrive. He thinks the delay in payments may have a deleterious effect on his regional operations as time passes.

Similar types of delays are encountered in the procurement of goods and services, since the minimum period for processing a local purchase is 45 days. It is important to note that these mechanisms are not selectively applied to the MOH or the project, but affect all government ministries.

Coordination between the MOF Budget Office and the project (PCU and AID) is strained, despite regular meetings involving the PCU, A.I.D. and the budget office analyst. The technical level in the Budget Office does not strongly support the project, and has raised questions regarding the pace and direction of project implementation. (It has been suggested that the project is not responsive to the true needs of the country. This office has also questioned the ability of the GOH to accomplish the changes encouraged by the project. A prevalent view expressed by a key individual in the Budget Office is that A.I.D., through the project is pressuring the Government of Honduras to take actions which it is financially and legally unable to perform (e.g., multi-year contracts and creation of permanent positions for employees hired with project funds). The Budget Office technical level personnel insist that government policy does not permit multi-year contracts, and given the adverse economic situation the government has placed a freeze on the creation of new permanent positions.

2. Public Credit

Public Credit's impact on project implementation is felt in the processing of payment orders through the rotating fund. The processing of payment orders is tortuous (39 steps, a minimum of 35 1/2 work days). After assiduous efforts, Public Credit has been able to reduce the processing period by five days.

From Public Credit's perspective, its coordination with the project is good. Its regular meetings with the PCU and A.I.D. are perceived as worthwhile. They provide a needed opportunity to discuss and resolve problems that may arise between Public Credit and the project management

team. A.I.D., on the other hand, believes that the Ministry of Finance and Public Credit is not promising adequate institutional support to the Project.

The Budget Office's refusal to create new positions for project personnel is a serious impediment to institutionalization of project inputs. In view of the MOF's strong stance on this issue, it may have to be resolved through recourse to higher authority.

C. A.I.D.

1. Project Management:

One area in which continuity has paid off is in A.I.D. project management.¹ The Health Sector I Project has been managed by the same physician (until recently under Personal Services Contractor, now a direct-hire A.I.D. employee) since implementation began. The project manager (technically the "liaison officer") is intimately familiar with the details of the history of the project implementation. He determined (wisely so) that the complexity of the project required administrative as well as technical and supervisory attention, and hired a full-time administrative assistant who maintains A.I.D.'s financial and programmatic project records. Both the project manager and his assistant repeatedly demonstrated their thorough knowledge of the project during the evaluation by filling in for the team, gaps in official project documentation, and by providing verbal accounts of how various implementation decisions had been rationalized.

It was evident to the evaluation team that access to, and communication with, the Director-General of Health was excellent.

A.I.D. provides overall guidance and management to the project through a series of routine measures:

1. Weekly meetings of the A.I. D. project manager, the Project Coordinator and the MSH chief of party. At these meetings quarterly project plans are reviewed and implementation problems discussed.
2. Weekly meetings of the same group with the Director-General of Health.
3. Quarterly A.I.D. mission project reviews, in which the Program and Capital Resources Division participates.

In addition, A.I.D. responds to the PCU's quarterly project reports. A.I.D. has identified as a major shortcoming the fact that these reports, listings of PCM activities, are not analytical or problem oriented, and has

¹ Continuity in the Project Coordination Unit has also been extremely beneficial to the project.

encouraged (without success) the Project Coordinator to make the reports analytical management tools. The PCU should experiment with a new, problem oriented report format.

The major weakness in A.I.D. participation in project implementation is lack of a "master plan" an overall planning strategy which identifies critical activities (and dates) by which these activities must be initiated and completed. Thus, A.I.D. lacks a system for monitoring achievement of critical implementation milestones, and has no mechanism for identifying specific steps critical to their achievement. A.I.D. monitoring consists largely of funding flow and control, activities planned and initiated. MSH, on the other hand, appears to have a fine-tuned system for monitoring management and implementation of their areas of responsibility, but this does not cover many administrative aspects of the program that only concern A.I.D. and the PCU, i.e., procurement. The MSH monitoring system cannot substitute for internal A.I.D. project monitoring.

Perhaps a more fundamental question is how the various A.I.D. offices define an implementation "problem", and how a matter assumes the status of a "problem". When in the process of problem development does the warning device sound. One example of a problem that was satisfactorily resolved was that of the movement of A.I.D. funds, which continued throughout 1982. Other examples suggest that among branches of the mission, there may be different perceptions about what constitutes a "problem" warranting swift resolution. In some cases, A.I.D. has tended in the past to react to problems after they have occurred, rather than planning so as to prevent problems. Active participation in project implementation by a PCR staff member could strengthen A.I.D.'s management of the project and improve communications on about implementation problems within A.I.D.

2. Project Implementation:

We were not able to evaluate whether or not implementation actions (PIL's, PIO's, budget approvals, obligations, etc.) are timely and accurate. However, experience has shown that A.I.D.'s financial mechanisms both facilitate (in the case of the recent rotating fund) and retard (viz. the difficulty of obtaining advances) project implementation.

For example, when GOH financial support to the project flagged, the project manager set up the meetings with Hacienda that resulted in the GOH rearranging their budget and increasing counterpart funding. Similarly, the increase in the rotating fund, initially an impediment to timely implementation, has facilitated progress.

On the other hand, the fact that A.I.D. has not always forwarded to the PCU vouchers for direct A.I.D. purchases indicating when purchases were requested was a problem cited by the P.C.U. Since the PCU is only appraised when commodities actually arrive in-country, it cannot plan future activities accordingly. (An example is the five pick-up trucks requested more than one

year ago under the maintenance component. A.I.D. never notified the PCU about the disposition of the request, although the evaluation team learned the pick-ups are being purchased.)

Another example is the perception, on the part of the MOF Budget Office that A.I.D. is reluctant to provide data on grant expenditures. This makes it difficult for the Budget Office analyst to establish MOH budget ceilings and makes this key individual reluctant to approve certain counterpart expenditures (i.e., multi-year contracts, permanent counterpart positions).

3. Project Evaluation:

The Project Paper stipulated annual evaluations. These are not necessary unless they coincide with meaningful implementation milestones. Evaluations should be timed to coincide with critical phases of the project, and an evaluation unquestionably should have preceded the reprogramming. Even MOH staff have remarked on the curiosity of spending a year reprogramming the project, only then to perform the first evaluation. If, as has been maintained, there was indeed an "informal" evaluation of the project, the conclusions should have been committed to paper for review by the relevant parties. The analysis of activities contained in the Reprogramming Document does not constitute a solid evaluation (See: Review of Reprogramming Document, Section VI, below.)

Recommendations:

A.I.D. should:

1. Develop a PERT chart to monitor the implementation of critical project elements.
2. Develop formalized implementation strategies, noting activities or tasks to be realized, means for accomplishing them, who has access to resources and authority needed to accomplish them, and specific strategies for influencing relevant parties to act.
3. Continue "Monthly Project Status Summaries" indicating (by project subcomponent) inputs, outputs, and progress towards goal.
4. Revise the Project Coordination Report format (already requested) to a problem-oriented approach.
5. Review and formalize mechanisms which would allow loan and grant expenditure information to be forwarded to the PCU and MOF on a timely basis. (In process)
6. Assign a project support officer to the project on a permanent basis.

VI. Proposed Reprogramming of the Health Sector I Project

The evaluation of the Health Sector I Project (Sections III - V above) provides an objective appraisal as a basis for analyzing the proposal to reprogram remaining project funds, extend the life of project, and add more funds for the continuation of current activities and the initiation of new activities.

The Rationale for Reprogramming

There are three principal arguments for reprogramming, extension, and addition of funds; evolving MOH policies and priorities; experience to date in implementing the project, which has shown that some components are underfunded and some overfunded; and the overly optimistic time estimated for project implementation at the outset.

The reprogramming of existing funds is premised on a recent clarification of Ministry of Health policies and priorities. Unfortunately, changes in policy, strategies, and priorities which might bear on the decision to reprogram are not detailed in the Reprogramming Document, and could usefully be added to strengthen the justification for the reprogramming among the subcomponents. A good example of evolving policy, strategy and related MOH activities is in the area of Maternal and Child Health/Family Planning. The MOH has recently approved a new MCH/FP strategy based on a "high-risk" approach to family planning. No such strategy existed when the project was originally designed, and consequently project activities in MCH/FP do not correspond with the new strategy. The strategy seems entirely appropriate, given the troubled history of family planning in Honduras over the past decade, and it provides ample justification for reprogramming this project subcomponent.

A second justification for reprogramming, i.e., for reallocating funds among subcomponents, is based on the experience in project implementation. Some subcomponents were underfunded - such as diarrhea control, in which quantities of oral rehydration packets and material required far exceeded the original funding allocation. Others were overfunded, or funded for activities that later appeared unnecessary. An example of the former is the subcomponent for supervision, in which it is proposed to reduce funding by one-third. An example of the latter is the funding for special studies in tuberculosis, which has already been transferred to the Science and Technology Unit. But here, again, the Reprogramming Document itself does not contain adequate detail to justify these changes.

Finally, the document notes that activities could not be completed in the time allotted under the original project agreement. It should be added that delays in beginning project implementation were substantial, especially when coupled with delays experienced once implementation began.

These arguments provide a strong rationale for reprogramming, extending the life of project for at least two years, and contemplating additional funds for ongoing project activities. In contrast, there is less justification presented for the addition of funds (and other resources) for undertaking the new activities proposed in the Reprogramming Document, but this concern is treated in detail in the overall issues section below.

The Reprogramming Process

According to the Reprogramming Document, the proposed modifications were prepared by a "Reprogramming Commission," comprised of representatives of AID, the MOH, and Management Sciences for Health. The document refers to "previous analyses" used as a basis for the reprogramming, but it is important to note that at no time during the implementation process had there been an evaluation of the project's implementation or impact. The "analysis" of subcomponents contained in the Reprogramming Document was neither analytical nor, most importantly, critical. For the most part, problems affecting implementation are omitted, and in many instances the document's conclusions are not accompanied by clear strategies underlying reprogramming of subcomponents. Obviously the reprogramming document can only be fairly assessed in the context of evaluation findings and recommendations.

An issue that arose repeatedly in the evaluation team's discussions with MOH personnel was the process for arriving at the reprogramming document. Several department or division chiefs expressed their concern that their priorities and needs may not be accurately reflected in the document because they were not involved in the process. It appears that many were asked to submit their future requirements, generally aware that these requirements might be incorporated into the new version of the project, but because they did not fully participate in the process, they were not fully apprised of the degree of flexibility in reprogramming and the financial resources that might be available to them to support their programs. In one case, a division chief felt that he has not been given ample opportunity to respond to assertions made in what was generally viewed as a "confidential" document (i.e., the Reprogramming Document), and he chose to express his concerns formally.

Finally, it is worth noting that although the reprogramming process is, like all AID projects is merely a proposal until formal approval is obtained, there exists within the Ministry of Health a prevalent assumption that the reprogramming is a foregone conclusion. The evaluation team was told on one occasion of a meeting in which a formal commitment was reportedly made. This impression, which has generated expectations that would be sorely disappointed if for any reason the document were not approved as written, can only be reinforced by statements such as the one found in the Reprogramming Document itself:

"Once this draft has been analyzed, a Project Amendment will be prepared for the signature of both governments, based on the results of comments received and a project evaluation...."

The assessment of the Reprogramming Document below reviews in turn each of the ongoing and new project subcomponents. Issues are discussed briefly in each section, and more fully in the overall issues section below. Where subcomponents are judged appropriate, the determination is based on the team's analysis of current needs and progress to date in the project.

1. Malaria

The increase in funding required for this component (caused largely by price increases due to project delays) and the shift in the loan/grant balance to adjust for the loan financing of TA are straightforward. The \$362,000 in additional equipment, for source reduction activities, is technically sound. However, there should be a more explicit description of the purposes of the motorcycles. (Vector control?)

The evaluation of the ongoing malaria program revealed that six pick-up trucks purchased for this program have been assigned by the MOH for other purposes. Without them, the malaria program cannot use some of the expensive equipment (ULV sprayers) already purchased. AID should seriously consider withholding future funding for malaria activities until these trucks are located and returned to the program.

Another issue that should be discussed within A.I.D and with the appropriate branches of the MOH is whether or not this component, as currently designed, is sufficiently oriented towards technology transfer, particularly with regard to vector control technologies, such as biological control.

2. Rabies Control

There is an inconsistency in the budget of this section. The budget shows an increase of loan funding of \$19,200; the narrative refers to an increase in loan funding of \$38,500 for the purpose of purchasing additional dog cages.

Although we were unable to ascertain to what extent cages already purchased are being used, the \$19,200 increase would be a useful contribution to this program. A.I.D. should consider purchasing these cages now, with existing funds, and eliminating this subcomponent entirely in the next phase of the project.

3. Vaccination Program

The requested increase, \$8,000 in loan funding, is for the purpose of training regional health personnel. The exact content and purpose of the seminars are unspecified, but this is a modest contribution to an activity of high priority.

4. Diarrhea Control

The reprogramming of this component has the dual purpose of reinforcing previously funded activities, and initiating two new activities. One of the reinforcing provisions is additional funding for oral rehydration packets. As noted in the evaluation of the implementation of the diarrheal disease control program (Section III. 4., above), expenditures for oral rehydration packets have far exceeded the amount budgeted in the original project. Additional funding would permit the interim purchase of additional packets until PANI could fill in the gap. This seems well justified. Other commodities include oral rehydration tables, baby scales, plastic spoons, and kerosene stoves. Among these the only questionable items are the rehydration tables. The quantity is large, and in addition to the tables AID has already provided under the current project, tables are being provided by one or more other donors. In fact in two of the three regional medical offices visited (both located in CESAMOs), the corridors were stacked high with rehydration tables from a European donor. They had apparently been there for some time awaiting availability of vehicles for delivery. Before this line item is approved, AID should insure that they are in fact needed and in the quantity suggested.

The second means of reinforcing current activities would be additional funding for training health personnel in the control of diarrheal diseases. Again, except for a mention of "community level personnel", no details are provided on the type personnel to be trained, or on course content, so it is difficult to assess this element. However, the evaluation revealed that oral rehydration has not been fully adopted as the preferred treatment for most diarrheas by practicing physicians (as distinct from physicians in training or those recently trained), and this influential group would be at least one likely target of training.

The new activities proposed under this component are more problematic. The scope of the evaluation was too comprehensive to permit the evaluation team to fairly assess the needs of PANI. (See section on "Domestic Production of Basic Medicines" below.) Thus the team could not adequately judge the type and level of support needed for PANI to produce the planned quantity (1 million packets annually) of OR packets. This new element should be reviewed in conjunction with the comprehensive feasibility study recommended prior to approval of the "Domestic Production of Basic Medicines" component.

The Reprogramming Document does not adequately describe or justify the "special studies in diarrhea" proposed. Etiology of diarrhea and administrative problems are two topics mentioned. In the case of the former, indeed little is known about the etiology of diarrheal disease in Honduras, and this information would be useful. However, we have to seriously question whether such a specialized study should be supported

under this project because it would require highly technically trained advisors, and such TA would not fall under the current scope. Also, such a study would be more costly than the proposed budget seems to allow. Finally, it is not clear who would conduct the research and, in particular, who in the Ministry could properly supervise it. Further justification of this element is required.

5. Tuberculosis

No mention is made in this section of whether or not training planned under the original project is to be abandoned. The transfer of research funds to the Science and Technology Unit may be appropriate. But there is a real question as to whether or not the TB department deserves more support, given that it is one of the four priority technological areas for the Ministry, and that the Ministry has been trying to increase use of health services for TB treatment. This should be further discussed with the MOH. If, as discussed in the Subcomponent Review, it appears that this program is generating strong demand in the absence of sufficient supplies of medicines at the community level, A.I.D. should consider purchasing medicine supplies until such time as they can be procured (possibly through PANI).

6. Sexually Transmitted Diseases

It appears that this program is no longer a high priority of the MOH, and in view of that the reduction in AID support is appropriate.

7. Maternal and Child Health

The articulation of the Maternal and Child Health/Family Planning subcomponent of the Reprogramming Document preceded several recent, significant developments in this area, and presumably will be modified to better reflect these new events. Discussions with the Director-General of Health confirm that a new MCH/FP strategy, designed by Dr. Danilo Velasquez, will become the basis for a high-risk-oriented strategy, and that family planning activities, in particular, will receive new emphasis. Thus the objectives listed in the Reprogramming Document, as well as the specific activities to be funded, will have to be realigned. The comments on this section are thus somewhat general.

A major concern in this subcomponent is the appropriate balance between studies and operational research, and service activities. The proposed budget calls for \$600,000 in Technical Assistance for 36 months in maternal and child health/family planning. This is in addition to the \$300,000 for technical assistance in operations research associated with the Science and Technology Unit. According to the project officer, this combination (or at least the figure of \$600,000 for only 36 months' TA in MCH/FP) is a substantial overestimate of the TA funds required in these areas. (In addition to the long-term TA, the operations research/

science and technology component calls for \$234,000 in short-term TA, further increasing that budget, but this is discussed in the OR/S & T section below). Interviews with various officials involved in this subcomponent indicate that the MOH probably has a higher interest in funding operations research in MCH than family planning service programs, and AID the opposite. As this component is developed further, and as the work plans of the new MCH/OR consultants are reviewed, the desired balance between research and services should be freely discussed and agreed among the parties concerned. Whatever the outcome, it is the firm conclusion of the evaluation team that TA for these two components, as currently budgeted, is heavily overfunded.

Another element of this subcomponent that will be subject to revision is the line item for contraceptives. As this report is written an advisor from the Centers for Disease Control is compiling an inventory of contraceptives in stock in MOH warehouses. It is widely reported that although there are massive quantities of contraceptives in country, many of them date back almost a decade, and if there are sufficient quantities to justify laboratory testing of their efficacy, the conclusions of this analysis should be factored in to the contraceptive supplies budget for this project.

A substantial amount of funding (\$40,000) is included in the MCH budget for overseas training. The purpose of this training, the people to be trained, and the specific courses are not identified in the Reprogramming Document. These details are needed to document this line item.

Finally, there is no indication of GOH counterpart funds in this subcomponent. These details must be provided.

8. Epidemiology Training

This subcomponent refers to epidemiology training for MOH personnel "at all levels." Is this to be taken literally? As the MOH moves towards regionalization, an enhanced capacity to program at the regional level according to regional health priorities assumes greater importance. In one region visited, the advantages of having a competent, dedicated epidemiologist on hand were evident. However, the modest amount of increased A.I.D. funding will clearly cover only a small number of personnel. More details are needed in this subcomponent.

9. Production of Basic Medicines (PANI)

The proposed increase of more than \$2 million to strengthen PANI's capacity to produce basic medicines used in the MOH system constitutes approximately one-quarter of the total increase in funding proposed in the reprogramming. The scope of work and the time allotted the team did not permit a full analysis of this new subcomponent. However, we have

reviewed all background materials to this subcomponent made available by AID and MSH, and have concluded that the magnitude and complexity of this investment warrant a detailed feasibility study by a competent specialist in drug manufacture before approval for funding is granted.

We suggest here some of the issues and questions that should be addressed in this analysis:

- The existing analyses permit comparison of only the current and projected costs of drug production by PANI with currently available alternatives (i.e., direct overseas procurement of drugs or local purchase through an existing distributor). No feasibility study has been done to compare production by PANI with production by a private, local firm that could be financed as an alternative under the project (or through some other AID project).

- As a parastatal, PANI is subject to the same bureaucratic problems and resource (particularly human resource) constraints as any other GOH entity. Does the existing analysis of PANI's administrative capability make unrealistic assumptions about resource availability? About bureaucratic impediments?

10. Logistics

Specific recommendations for strengthening this component are listed in Section III. 10. The warehouse equipment proposed in the Reprogramming Document appears technically sound and adequate.

11. Maintenance

The major issue in the proposed maintenance subcomponent is the ability of the MOH to finance required personnel and spare parts (see budgets 11a and 11b in Reprogramming Document). In 1982 no spare parts were purchased by the MOH. In 1983 the MOH spent Lps.300,000 (\$150,000) on this line item. But counterpart expenditures have fallen far short of the mark, and even though planned expenditures for both spare parts and personnel have been reduced drastically, serious questions about MOH counterpart funds remain.

The Reprogramming Document proposes a change in strategy with regard to overseas training. Initially, overseas training was proposed in those areas in which training was not available locally. Apparently without consultation with the principal counterpart for maintenance, it was decided to abandon overseas training in favor of local training through INFOP. The training abroad was intended for technical specialties for which instruction is not available in-country. According to the Director of Maintenance, it is much more expensive to bring instructors here than to send technicians abroad for special technical training. Has this change in strategy has been based on an adequate assessment of local training capabilities? There may be a problem of communication among

institutional participants involved in this activity, since the director for maintenance is still proceeding with plans to send staff overseas for training. There is still a list of ten people to be trained overseas under this component, with three to be trained during the next year. Another option is local training with the assistance of U.S. military personnel. The maintenance training strategy should be clarified before this subcomponent is approved.

It is recommended that a detailed proposal be presented which documents the minimal specific technical training needs, identification of specific local training capacity and additional training capacity, possibly available from Project Hope, the U.S. Military, etc. If trainers must be brought to Honduras, these costs must be included.

12. Management and Planning

The purpose of this subcomponent is to continue the general technical assistance funded by the project for two additional years. (The Reprogramming Document specifies that the existing contract with Management Sciences for Health will be extended.) The technical assistance proposed is identical to that provided now (permanent full-time advisors in management, planning, administration, logistics, maintenance, continuing education, and a regional advisor), with the single change being an increase in specialized short-term TA.

It is evident from the evaluation of project subcomponents that "Management and Planning" is not so much a subcomponent in itself as a TA pool for other project subcomponents (logistics, continuing education, etc.). The reprogramming document gives needed flexibility to the TA by increasing specialized short-term TA.

The delay in signing the original TA contract and in all components supported by this TA is sufficient justification for the extension. But a principal issue arises in the context of this "subcomponent", the question of MOH absorptive capacity, and specifically the ability of the MOH to use effectively the level of TA provided in this project. The question is not whether the TA and skills are needed. They are. Nor is there a question of commitment and willingness at the Director General's level to utilize the TA. The commitment is apparent. The real issue is the ability of the MOH to match external TA with permanent MOH counterparts and recurrent expense funding in order to make lasting use of the TA. Absent a tangible commitment of personnel and resources, the TA proposed is too intensive. This issue is discussed in Section VII below.

13. Mass Media for Village Health Workers

The increase in the mass media budget for materials production seems well justified. However, the issues raised in Section III. 13. concerning MOH commitment to adequately support the institutionalization of PROCOSI II should be resolved before continuing funding for this element is negotiated.

14. Training in Public Health Administration

(This subcomponent has been substantially revised and is therefore not reviewed here.)

15. Supervision

The supervision subcomponent of the Reprogramming Document proposes 12 additional months of TA. In the past this TA has been provided through short-term TA from the MSH TA pool, and by the MSH planning advisor. These measures have not been adequate to stimulate progress in this critical area. Therefore, the additional TA seems warranted.

16. Continuing Education for Rural Health Workers

This subcomponent seems to refer to an increase in loan funds "...for payment for services rendered by community volunteers." (emphases added) There is no explanation of this apparent contradiction in terms.

17. Continuing Education for Ministry of Health Employees

This subcomponent cannot be assessed because details on its purposes and content are inadequate. The increase in loan funding is to pay expenses for MOH employees in training through the end of the life of project, substituting for MOH counterpart for this purpose.

In view of the change in the Continuing Education Workplan, it seems inappropriate for training goals (metas) to continue to be determined centrally, as in the original PP plan. Does this approach really encourage the implementation of a training system? the development and expansion of an institutional training capacity and a capability on all levels of the MOH?

18. Community Participation

The Reprogramming Document proposes a new area of activity, "Community Participation," funded at a level of \$742,500 (\$480,000 grant; \$262,500 loan).* The logic underlying this subcomponent is curious: lack of community participation was identified as a factor contributing to the desertion of village health workers. (See: Consultant's Report, Jaime Bravo) The Reprogramming Document construes community participation

* Section III. 18. In a subsequent section of the Reprogramming Document, a total of \$680,000 (\$432,000 grant, \$250,000 loan) is budgeted for Community Participation. These numbers should be reconciled.)

(presumably community interest in and use of the services of VHWs) as an important means of stimulating VHWs to continue providing services, and hence extending the reach of the health system. Community Participation is also viewed as a means of generating funds to recompense these workers. Missing from this component is a description of how community participation will benefit the community, rather than the health system.

The description of the community participation activities emphasizes a series of activities which will not necessarily lead to increased community involvement because they are "top-down": studies, methodology, establishing a corresponding structure in the Ministry of Health, and development of a community participation manual. There is no mention of actually developing a local financing system, working with community members, or enlisting the support of already functioning village organizations, all crucial to successful community participation. (See: Honduras Social and Institutional Profile for a comprehensive description of community organization.) In short, as currently proposed, this component is provider- rather than user- or community-oriented. Some of the activities listed are probably not needed. If this activity proceeds along the route proposed - with intensive (outside?) technical assistance in lieu of Honduran, grass-roots impetus - it risks being implemented as a "top-down" mandate. It might then be perceived as merely a ploy to encourage rural campesinos to pay for services that heretofore have been free of charge.

The Bravo report, while detailed and descriptive, does not appear to take into account in its recommendations the wealth of information and experience available on community participation in hundreds of similar primary health care programs. Interviews with MOH personnel reinforce the conclusion of the evaluation team: in this component, above all, Honduran employees of the Ministry should take the lead. Community participation should be an indigenously-promoted concept that builds on existing local organizations. It is therefore recommended that this component be redesigned to include less TA, and that it focus on activities e., f., and g. (selection of communities, supervision by higher-level health workers, and training of promotores, nurse auxiliaries, and other, possibly non-health-related, community development workers). Further, a critical determinant of success in this component will be the selection of a dynamic, Honduran community development specialist/mid-level health professional (the National Coordinator). He or she should be assisted by at least one full-time, permanent health promoter/trainer.

It is recommended that the budget for this subcomponent be reallocated to fund training (for village-level health workers), training materials, a modest amount of community education materials, and a more modest village-level rotating fund (i.e., less than L 1000 at the beginning). The mission would benefit greatly from a review of other AID-funded community participation in PHC programs.

Recommendations:

1. Establish a short-term work group to develop an experimental approach to community financing, support for VHWs, and participation in health care. No long-term TA is required.
2. The work group should work closely with a permanent 2 or 3 person community action unit in the MOH which is responsible for instituting the experimental program.
3. The revolving fund should be used for medicines only. The community should be responsible for paying VHWs directly, according to general guidelines promulgated by the MOH. Traditional practitioners, including parteras, should be compensated in customary fashion. Direct payment of VHWs has several advantages: it will be clear that VHWs are not salaried MOH employees and they will not expect GOH salaries and benefits; the size (and potential for mismanagement) of the revolving fund will be minimized, and it will be more likely that funds for medicine purchase will be available; and VHWs will be responsive to the community's needs, since their payment will depend on community satisfaction.
4. Medicines should be purchased by a community committee through whatever means available, rather than depending on the MOH for distribution. Supplies will undoubtedly be more reliable, but some "depot" or source of medicines must be established beforehand.
5. To best implement this activity, the MOH should consider cooperating with the community development branch of some other GOH ministry. (Agriculture?)

Before proceeding with this subcomponent, AID should review the experience of community participation/financing in other AID-funded projects. APHA's "Community Participation" reviews experience through 1981. More recent information can be obtained from LAC/DR, S&T/Health and PPC.

19. Science and Technology Unit/Operations Research

As mentioned in Section III above, operations research has de facto become a new subcomponent of the project. The Reprogramming Document proposes two different budgets for increasing the activities of the Science and Technology Unit in support of operations research: one budget, for a total of \$784,500 (\$680,000 grant; \$184,500 loan) is stated on p. 27; a second budget of \$848,700 (\$664,000 grant; 184,700 loan) is included in the full discussion on p. 43. These two budgets must be reconciled.

As mentioned above (in the section on MCH/Family Planning) this component has a very high level of funding for technical assistance, long-term and short-term, especially when combined with the TA proposed under MCH/FP, with

which the Operations Research effort is linked. It is not at all clear that this intensive level of TA can be used effectively. The objectives and activities proposed under this subcomponent are technically sound. For example, the scholarships for training personnel in epidemiology and research will probably be extremely useful to the MOH in helping create a core group of people trained in applied research methodologies. However, the exact function of the Unit must be clarified in practice, as it has been on paper in the Ministerial Resolution that created the Unit. That is, is this Unit to be primarily a coordinating body for research conducted under the aegis of other, normative divisions of the Ministry, or is the Unit to actually conduct research? The inclusion of \$50,000 in the budget of the Unit for fieldwork and data analysis does not clarify the matter.

There is a real question about the capacity of the limited personnel in the Unit to coordinate and carry out the existing research load, let alone additional studies that might be developed through the project. The loan budget (3 years' salaries for field supervisors and interviewers) indicates that indeed additional research is contemplated under the project. The MOH will provide counterpart for this subcomponent in the form of the current Unit Director, 3 newly graduated physicians doing their "servicio social", part-time participation by regional epidemiologists and nurses, and a new, full-time secretary. No mention is made of continuing the services of one or more full-time, experienced researchers, such as the physician currently occupying the second position in the Unit. The mission states that 2 persons are being trained in biostatistics and in social survey research, and will join the Unit, but the team could not verify that these people will have positions and funding. It is the team's assessment that at least one or more full-time, permanent, experienced researchers are necessary for the Unit to effectively coordinate and conduct the research anticipated. This issue should be resolved before funding for this subcomponent is approved.

20. Continuing Education for Nurse Auxiliaries (Educacion a Distancia)

The objective of this component is to provide in-service retraining for nurse auxiliaries, the backbone of the rural health system. The Reprogramming Document does not describe how this training is different from, and might complement training in various technical areas already proposed under those subcomponents, and in the continuing education subcomponent. The list of activities for this subcomponent merely states that health personnel (5000 of them, categories not specified) will be trained "in aspects related to priority areas and those which support health policies at the various levels of attention." It is difficult to assess this component without knowing what types of personnel will be trained in what subject matter. However, in general, nurse auxiliaries will require continuing training, and they are already so burdened with responsibilities for service delivery and supervision on village health workers that "educacion a distancia" is probably the only realistic training approach.

However, the evaluation team believes that this subcomponent will involve an enormous level of effort, which might be realizable, but only at the expense of other project subcomponents. We note that this new activity will require 12 full-time counterparts (all support personnel - secretaries, drivers, etc.), in addition the personnel who will actually do the training. The salaries of these 12 individuals will be loan financed, raising the question of transition, over the life of project, from externally financed personnel to long-term, permanent MOH staffing for this activity. Since continuing education of nurse auxiliaries will undoubtedly be a permanent responsibility of the MOH, this issue should be addressed satisfactorily before this subcomponent is approved.

21. Oral Health

Oral health is indisputably related to comprehensive health care. However, the mission and the MOH should carefully weigh the implications of embarking on this new area of activity. Considerations should include the additional technical assistance and expertise required to adequately support this new subcomponent (including host-country counterpart), and the desirability of using scarce project resources for an entirely new activity versus consolidating the hard-won gains in ongoing project activities. While this issue is discussed more fully below (Issues), the evaluation team believes that this element merely adds to the proliferation of project activities and should be excluded in favor of greater effort in existing subcomponents.

22. Extension of Technical Assistance

This subcomponent refers to the general TA pool supporting the project, not to activity-specific TA. For example, not included in the proposal for increased funding under this topic are the two part-time positions funded under Maternal and Child Health/Operations Research, the full-time mass media position, or the long-term malaria advisor, which taken together with the 7 positions listed bring the total full-time, long-term TA to 10 1/2 persons through the life of the project. It is the conclusion of the evaluation team that all of the long-term technical assistance provided by the various contractors in this project has been of extremely high quality. However, any further expansion beyond the individuals listed here would further heighten the very serious question of the MOH's absorptive capacity. (See "Issues" below)

The Reprogramming Document does not specify the type of short-term TA anticipated, but this is absolutely essential. In the course of reviewing the progress in the different subcomponents it has become clear that specialized assistance of a variety of types is needed to reinforce the generalized TA being provided. Examples include short-term assistance by a malariologist (possibly another visit by a CDC expert) to review the overall program and assist the entomologist currently

employed; more TA in supervision to accelerate progress beyond the development of manuals; and in specialized maintenance functions (such as medical equipment, vehicles and industrial equipment) that the long-term maintenance advisor could not be expected to provide. (In the earlier discussion of maintenance it was noted that in order to provide the specialized TA contemplated under the maintenance component in this project, the Ministry has been soliciting advisors from other donor organizations.)

23. Strengthening the Project Coordination Unit

Obviously the Project Coordination Unit must continue to function effectively to complete the implementation of this project. It is not clear however, whether what is requested is an additional controller, or if this position has already been filled. Similarly, has the clerk (conserje) position already been filled? The paperwork of the PCU is overwhelming, and the unit has had to beg and borrow photocopying assistance. If possible, AID should consider seriously the Unit's request to purchase a photocopier to alleviate this dilemma.

The Reprogramming Document does not address a major issue concerning project coordination in general. That is the question of technical, rather than administrative (financial) coordination. As described in earlier sections, the PCU is functioning exclusively as the financial and logistics coordination arm of the project. Complementary coordination at a technical level has not been adequate to fully integrate the project into the ongoing functional units of the Ministry. The evaluation of administration and management of the project (Section IV of this report) substantiates the need for some unit - preferably a unit in the MOH, rather than another person in the PCU - to be the PCU's counterpart for technical coordination, that is to have the responsibility for communicating, on a regular basis, between the PCU and the multiple normative divisions and special workgroups involved in project-funded activities.

VII. ISSUES

Issues in the implementation of Health Sector I and its proposed reprogramming center on seven major themes. Before discussing the issues that have emerged from the evaluation and reprogramming review, it is important to note several "non-issues". First, as discussed below, the general orientation of the project is sound. There are some concerns in this regard raised by the reprogramming document, and these are mentioned where appropriate. However, the overall direction of the project, as it has evolved since the Project Paper, is sound. Second, with some exceptions, the overall pace of implementation is acceptable, particularly in view of the many external factors that have slowed implementation progress considerably. Finally, the personnel currently working in the project in all institutions directly involved, and as advisors to the project, are technically capable, dedicated, and enthusiastic.

1. Problems of Coordination and Communication

One of the more vexing issues arising from the evaluation is the lack of effective, systematic communication within the MOH, and between the MOH and AID. The team uncovered numerous instances in which staff-level and Division Chief level MOH personnel alleged not to be aware of the resources available to them under the project, and the strategy of the project. We agree with the Mission that it is not necessary, and probably not desirable, for MOH personnel to distinguish the project as a project. Rather, since the objective of the project is to strengthen the support systems and programs of the functional divisions of the Ministry, it is merely necessary that MOH staff comprehend the new resources available for improving the effectiveness of their programs.

However, in spite of the several annual meetings to discuss the project, and earnest attempts by the PCU and MSH, the evaluation team encountered misunderstanding and even mistrust. This may be due in part to transition in both AID and the MOH, and in part to the fact that the project's scope has evolved to fit changing circumstances. This may be a difficult finding for all parties concerned, because efforts at communication have been sincere, but the fact remains that there is a pressing need to increase and systematize communications and reporting, particularly at the functional level.

The evaluation also identified the need to install some systematic means of coordinating at a technical level the efforts of disparate MOH entities involved in project activity. This technical coordination would complement the administrative (financial and logistical) coordination role of the PCU. This issue is discussed in Section IV and again in Section VIII.

2. Centralization Versus Regionalization

This issue, which is just beginning to emerge, refers to a tension inherent in the process of decentralization, supported in part through the "local programming" activities of the project. Most of the project accomplishments to date have been in the areas of normative development, which necessarily has to be centralized. However, there is a point at which implementation has to be decentralized. The organizational structure of the MOH is such that Area Levels have neither the administrative mechanisms, nor the authority or budgets necessary to independently solve some of their problems. Though the regions have a certain autonomy, metas are still developed from the top down.

On the other hand, intensive effort is expended to develop programming capacity from the bottom up. This will become a serious contradiction once local programming is institutionalized. Because of the downward thrust of the program, metas, and training mandates, people

interviewed at the regional levels are rightfully skeptical about the willingness of the Central office to relinquish its control. This is reinforced by the disfaces in training and the provision of training support materials and the delay in the production of detailed manuals (particularly in Supervision) that are now functional on the operational level. Somehow, fairly soon, the MOH and A.I.D. must address these issues. A balance between central control and decentralized authority must be achieved for decentralization to be successful.

3. MOH Absorptive Capacity

This concern refers to the ability of the MOH to utilize effectively the large quantity of technical assistance provided through the project, and, in particular, the ability of the MOH to assign sufficient numbers of competent personnel (initially as counterparts, and, during 1984, as permanent MOH employees ultimately fully-funded by the Ministry) and obtain adequate funding for the recurrent costs generated by the project. The issue of permanent positions has been deferred repeatedly, but must be confronted squarely before the level of project activity is increased with the reprogramming.

The major investment in this project is in people and systems. To institutionalize the hardwon changes brought about by this project, the Ministry must be able to guarantee that the people whose skills have been upgraded and the systems that have been put in place can be supported over the long term.

4. Institutionalization of Changes

Discussions with the Ministry have demonstrated that, with the exception of the local programming workgroup, all "temporary" workgroups are directly affiliated with some existing Ministry unit. There is therefore a good indication that structures exist to perpetuate the improvements effected by the project. However, a lingering concern exists over the staffing of these units. The subcomponent review consistently identified units where the current staffing (two people in "Health Education", two people in the "Science and Technology Unit", several key positions unfilled), is simply too weak to perpetuate the level of activity generated by the project. Once again, the crux of the project is improving management by working with people. Although improving systems (warehousing protocols, training curricula) are also essential program elements, the long-term success of the project depends on transfer of skills to people. Unless the required people are in place, on a permanent basis, the project's impact will be temporary. (See 6 below.)

5. Consolidation of Systems or Expansion of Technical and Service Programs?

This issue concerns the Reprogramming Document. The decision confronting AID and the MOH is whether to use the reprogramming as an opportunity to strengthen the early progress made in some critical support systems,

particularly maintenance, logistics and supervision, or channel resources (as proposed) into a plethora of new activities. The choice between consolidation and expansion is a question of balance. But in view of the conclusions about absorptive capacity and institutionalization, the evaluation team strongly recommends placing first priority on consolidation of incipient systems improvements rather than expansion into new program activities. The new project would concentrate on the MOH's four primary health programs (immunization, TB, diarrheal disease, and malaria) and on major health support systems (maintenance, logistics, supervision, management, with limited training of VHW and MOH employees).

6. Human Resource Constraints

Although this issue was broached above, it deserves mention as a separate issue because of its far-reaching implications for continued implementation of the project, as well as the proposed extension of project activities.

The Departments and Working Groups responsible for developing and implementing the essential systems components at the Central Level are too understaffed at present to implement effectively national programs.

Insofar as the technical advisors work as team members, the technical and managerial capacity of these groups has been amplified. There appears to be a "critical mass" of no more than 16 persons who are carrying out the development and implementation of the critical systems. This does not include the scarcity of human resources at the operational level. Given the MOH's inability to assume additional recurrent costs, the human resources situation is precarious enough without contemplating further expansion of program areas.

7. Measuring Change: Reporting and Evaluation

This evaluation is the first systematic attempt to assess the progress of the Health Sector I Project. More regular process evaluations are needed to aid in project monitoring. In addition, it is AID and the MOH who should have laid the groundwork for an impact evaluation a long time ago. It is surprising that evaluation has not been adopted as a management tool in this kind of project with its management and planning focus. Annual evaluations were planned in the Project Paper, and evaluations currently planned in the next phase, should be carried out.

This evaluation has revealed that evaluations are not routinely conducted within the Ministry of Health, and moreover that evaluations are generally viewed not as management tools in a continuing feedback process, but rather to judge (and punish accordingly) people who have not complied with established, quantitative norms. The evaluation team strongly recommends that part of the TA pool be dedicated to instilling an understanding of evaluations, and that a separate line item fund an objective, external evaluation within two years (process) and a more comprehensive (impact) evaluation towards the end of the extended life of project.

VIII. CONCLUSIONS

This section seeks to answer some elementary questions about the project the evaluation was designed to address. The answers are based on the findings of the evaluation and the review of the reprogramming document.

1. Is the Project still valid and necessary?

Yes, the Project design is still valid, as are the institutional and systems changes sought by the project. The Project has had a fluid evolution, and this has helped contour its activities to the needs of the MOH. In many respects, the proposals in the Reprogramming Document merely formalize this evolution. Is the Reprogramming Document valid and necessary? A formalized course alteration is definitely called for, if only so that plans and expectations can be brought up to date with ongoing project activities. However, as we have seen in the detailed review of the proposed Reprogramming Document and the "Issues" section, not all elements in that document are valid.

2. Do A.I.D.'s objectives coincide with those of the MOH?

In many respects, yes. But this statement would have to be qualified to specify distinct levels and branches within the MOH. Clearly there is harmony between A.I.D.'s objectives and those of the MOH unit most directly responsible for the project implementation, the Director-General's Office. However, it is important to keep in mind that the project is only one form of external assistance to the Ministry, and that the Ministry has a host of other goals and objectives - such as the continuing operation of hospital-based services, and the execution of national programs - which operate with or without project inputs. To the extent that this project diverts resources (human resources and operating expenses) from other activities, and to the extent that there is competition for these scarce resources, tensions arise. Some people interviewed saw the project as a means of subsidizing the operating expenses of the Ministry, and demonstrated no comprehension of the systems support objectives. To the extent that the objectives and resources of the project and how the project is meant to support ongoing activities are not fully understood throughout the Ministry, some cognitive dissonance is to be expected. Hopefully one result of this evaluation will be improved communication and coordination among operating units and levels on the nature of the project.

3. Is the Project headed in the direction originally intended?

Yes and no. In a broad sense, the Project continues to aim at the institutionalization of improved systems, and strengthened capacity to execute priority technical programs. On the other hand, the Project has

broadened its scope, particularly in the proposed Reprogramming Document, and serious questions remain about whether systemic changes will have a chance to be consolidated if project activities diversify further.

4. Is the Project administratively sound?

Again, yes and no. There have been major improvements in at least one area of project administration, namely the financial mechanism (the size of the rotating fund and the reconciliation of accounts between AID and the Project Coordinating Unit). On the other hand, in two other important areas - AID project monitoring and project coordination within MOH - there is considerable room for improvement.

In the first instance, AID project monitoring, we noted (in Section V) that AID does not have an explicit management planning approach. AID has not identified critical goals and objectives and dates by which they must be achieved in order to ensure timely project implementation and coordination among diverse project inputs. Thus there is no standard against which actual project implementation is measured. A critical path approach to project implementation, for instance, might have alerted AID to the continuing delay in processing titles to land the MOH was trying to acquire for building construction. Instead, delays wore on and only recently has a recommendation been made (by A.I.D.) to employ an attorney to resolve the situation. Impending problems such as this should be identified early on, and AID should move swiftly either to resolve them directly, or, alternatively, to encourage the appropriate party to resolve them.

With regard to the second area, coordination within the MOH, the evaluation noted that while the administrative aspects of project implementation are effectively carried out by the Project Coordination Unit, there is no central mechanism for planning and coordinating the technical aspects of the project. This coordination cannot be done largely through yearly meetings, and periodic verbal communication with normative division chiefs, but must be done on a more systematic basis. While this function was originally assigned to the GCEDI¹, we noted (Section IV) that this group instead has been assigned a series of technical tasks, and that the coordinating function has fallen by the wayside. A means must be found to place responsibility - and authority - for coordinating between the project and the MOH's ongoing line and staff offices in the hands of a person or unit within the Ministry.

In addition, the team found various instances of poor communication/misunderstanding within the MOH that worked to the project's detriment. Poor communication and resentment over the visit of the Community Participation consultant; general - not isolated - ignorance of the

1 This information, collected from various MOH officials, conflicts with the understanding of A.I.D. staff.

Reprogramming Document; widespread misunderstanding about the role and remuneration of MSH consultants indicate that at levels other than the Directorate-General (A.I.D.'s principal point of contact) the project is not as well understood and supported as it should be. An objective evaluation team was able to collect these opinions and views, which, for obvious reasons, are not readily accessible to A.I.D.'s staff.

5. Is the Project based on viable GOH-wide structures?

If we interpret "GOH-wide structures" to denote Proveeduría, Hacienda y Tesoro, and Crédito Público, we have to question the burden that these structures are placing not only on this health project, but on projects in all sectors. The evaluation described the lengthy, convoluted paths for procurement and reimbursement of expenditures. Clearly these requirements impede implementation progress.

6. Are mid-course changes indicated in:

a.) Project design: Yes. The rationale underlying the decision to reprogram is sound. The mission, in consultation with the MOH, must determine, based on the findings of the evaluation, which of the proposed changes in the Reprogramming Document are warranted.

b.) Project organization: Yes. See 4. above.

c.) Project implementation: Yes. The review of the subcomponents, project administration, and institutional participation contain numerous recommendations designed to encourage more effective project implementation.

d.) Project management: Yes. See 4. above.

e.) Probable end of project status: With or without the proposed reprogramming, a review of the end of project status is in order. Obviously, the changes will depend on which activities proposed in the Reprogramming Document are adopted. In general, however, the outcomes assumed in the original Project Paper were optimistic. A good example is the area of logistics, where the PP assumed that a whole series of conditions would be met prior to disbursement, but which conditions were eased progressively as it became apparent that they would only result from the activities funded under the project itself.

7. What are the most serious bottlenecks impeding project implementation?

Lack of sufficient counterpart personnel and repeated postponement of the creation of permanent positions for the full complement of personnel required to institutionalize the project; tortuous procurement procedures and requirements (GOH and AID); a logistics system that shows promise, but is still a major impediment; less than perfect communication and coordination

within and among AID, staff levels in the MOH and other parties directly and indirectly involved in the project (MSH, Hacienda y Tesoro); and the "desface" among project activities that has resulted from a combination of the above. A prime example of the latter is the poor coordination among various project inputs resulting from the MOH's slow pace of warehouse construction.

8. Is there adequate institutional support for the project?

Basically yes, although high level decisions are needed in the Ministry of Health to a.) ensure better coordination between the project and regular functions of the Ministry, and b.) fill some critical positions (identified in the subcomponents review) so that project activities have a better prospect of being absorbed into the MOH's ongoing operations. AID should use its resources to help the MOH acquire the additional personnel (permanent positions) it needs to reinforce the project.

9. What has been the effect of macro-economic/political factors on project implementation? What does this auger for the future?

The fiscal austerity that the GOH has imposed will continue to deleteriously affect project implementation, and will take a heavier toll in the future if the reprogramming goes ahead with its ambitious plan to expand into new areas of activity. This is due to the MOH's inability to commit itself to absorbing the new, permanent employees funded as counterparts under the current project, and the increasing difficulty that can be expected with regard to meeting operating expenses (to cover the costs of increased supervision, maintenance, etc.). As the Mission reviews the Reprogramming Document, the overall state of Honduras' economy should be weighed seriously against the level of intensity and diversity of project activity proposed.

TABLE 1

CRITICAL DATES: HEALTH SECTOR I PROJECT

Project Number : 522-0153

Loan Number : 522-U-042

Grant Funding : \$4,426,000

Loan Funding : \$10,965,000 Subtotal (A.I.D.): \$5,391,000

Government of Honduras Counterpart: \$17,000,000 Total Value of Project: \$32,391,000

Life of Project: 4 years

Project Assistance Completion Date : July 17, 1984

Project Paper Signed : June 30, 1980

Project Agreement Signed : July 31, 1981

Initial Conditions Precedent Met : February 27, 1981

Project Coordinator Employed : April 1981

Technical Assistance Contract Signed (MSH): January 22, 1982

Table/Cuadro 2-

UNIDAD DE COORDINACION (HEALTH SECTOR I)

	1980	1981	1982	1983
COORDINADOR DE PROYECTOS 522-0153		Dr. R. Gómez	Dr. R. Gómez	Dr. R. Gómez
OFICIAL DE PRESUPUESTO ADMINISTRADOR		Lic. Felipe S. Paredes	Lic. F. Paredes Lic. G. Botilla (Vacante 4-8/82)	Lic. Germán Escilla P.N. Vilma Padilla
OFICIAL DE COMPRAS		P.N. Joel Ortiz Lanza	P.N. Joel Ortiz Lanza	P.N. Joel Ortiz Lanza
SECRETARIA IV		Sra. Rosmaría de Aguilar	Sra. Rosmaría de Aguilar	Sra. Rosmaría de Aguilar
CONTADOR IV I				P.N. Rosario de Helaya P.N. Yolanda Aviles
CONSERJE				Sra. Milagro Carbajal
SECRETARIA I				Marcia Zambrano

3. ESTRUCTURA ORGANIZATIVA DE LA AID

	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>
JEFE DE DIVISION	John Oleson	John Oleson	Ronald L. Nicholson	Anthony J. Cauterscoi
DIRECTOR DE RECURSOS HUMANOS	Jimmie Stone	Jimmie Stone	Ronald Witherell	Ronald Witherell
OFICIAL DE SALUD	John Massey	John Massey	John Massey (vacant 6-12/82)	Tom Park
JEFE DE PROYECTO	John Massey	John Massey	Barry Smith	Barry Smith
ENLACE DE PROYECTO	Barry Smith	Barry Smith	Barry Smith	Barry Smith
ADMINISTRADOR DEL PROYECTO			Scott Taylor (de 7/82)	Scott Taylor

F-3

4. ESTRUCTURA A NIVEL REGIONAL

<u>REGION EMITARIA</u>	<u>NOMBRES</u>			
1	Dra. M. del Carmen Miranda	Dra. María del C. Miranda	Julio Cesár Arita	Franklin Cerrato
2	Dr. Justo Pastor Ramírez	Dr. Justo Pastor Ramírez	Dr. Alejandro Melara	Dr. Próspero Cáliz
3	Dr. Jacobo Beltrán	Dr. Laudelino Cibrian	Dr. Hernán Galeano	Dr. Hernán Galeano
4	Dr. Mauricio Pérez	Dr. J. Antonio Burgos	Dr. Guillermo Salgado	Dr. Arturo Ferguson
5	Dr. Alberto Hernández	Dr. Arnulfo Bueso	Dr. Arnulfo Bueso	Dr. Arnulfo Bueso
6	Dr. Rafael Rodríguez	Dr. Rafael Rodríguez	Dr. Rafael Rodríguez	Dr. Rafael Rodríguez
7	Dr. Obencio Cáliz	Dr. Obencio Cáliz	Dr. Roberto Brevé M.	Dr. Carlos Sierra A.

ESTRUCTURA ORGANIZATIVA DE LAS DEPENDENCIAS DEL GOBIERNO DE HONDURAS

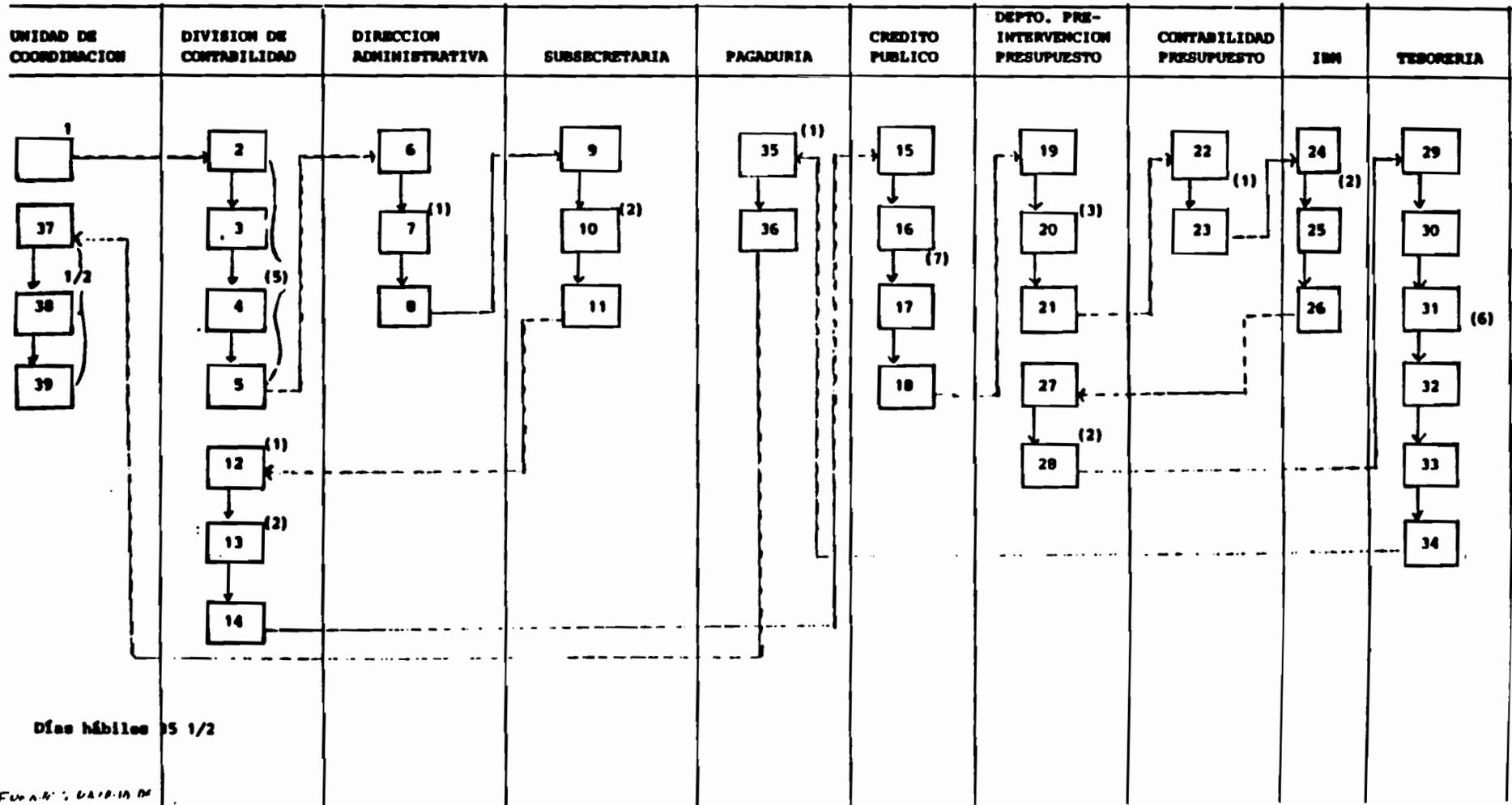
<u>CARGOS</u>	<u>AÑO / TITULAR</u>			
	<u>1980</u>	<u>1981</u>	<u>1982</u>	<u>1983</u>
MINISTRO DE SALUD	Dr. Luis Cousin	Dr. Juan Andonie P.	Dr. Gonzalo Rodríguez	Dr. Ruben F. García M.
VICE MINISTRO DE SALUD	Dr. Manuel O. Suazo	Dr. Jorge Rápalo	Dr. Rubén F. García	Dr. Rigoberto López L.
DIRECTOR GENL. DE SALUD	Dr. Alberto Guemán	Dr. Anibal Villatoro	Dr. Gustavo Corrales	Dr. Gustavo Corrales
SUBDIRECTOR DE SALUD	Dr. María Fernández	Dr. Juan de Dios Paredes	Dr. Juan de Dios Paredes	Dr. Juan de D. Paredes
MINISTRO DE HACIENDA Y CREDITO PUBLICO	Lic. Valentín Mendoza	Lic. Benjamín Villanueva	Lic. Arturo Corlato	Lic. Arturo Corlato
DIRECTOR GENERAL DE PRESUPUESTO	Lic. Napoleón Pereira	Lic. Napoleón J. Pereira	P.M. Néctor Medina	P.M. Hector Medina
DIRECTOR GENERAL DE CREDITO PUBLICO	Lic. Angéi R. Ordoñez	Lic. Angel R. Ordoñez	Lic. María A. Domínguez	Lic. María A. Domínguez
DIRECTOR GENERAL DE SERVICIO CIVIL	Lic. Roberto Lagos	Lic. Roberto Lagos	Lic. Max Gil Santos	Lic. Max Gil Santos
PROCURADURIA GENL DE LA REPUBLICA	Lic. Serapio Hernández	Lic. Serapio Hernández	Lic. Elizabeth Chius S.	Lic. Elizabeth Chius S.
PROVEEDURIA GENL DE LA REPUBLICA	Lic. Italo Tugliane	Lic. Italo Tugliane	P.M. Julio C. Castillo	P.M. Julio C. Castillo
CONSUPLANE	Lic. Efraín Reconco M.	Lic. Efraín Reconco M.	Lic. Luis A. Flores	Lic. Luis A. Flores

7-1

Tabla/Cuadro 5

FLUJO DE TRAMITE ORDEN DE PAGO

MINISTERIO DE SALUD



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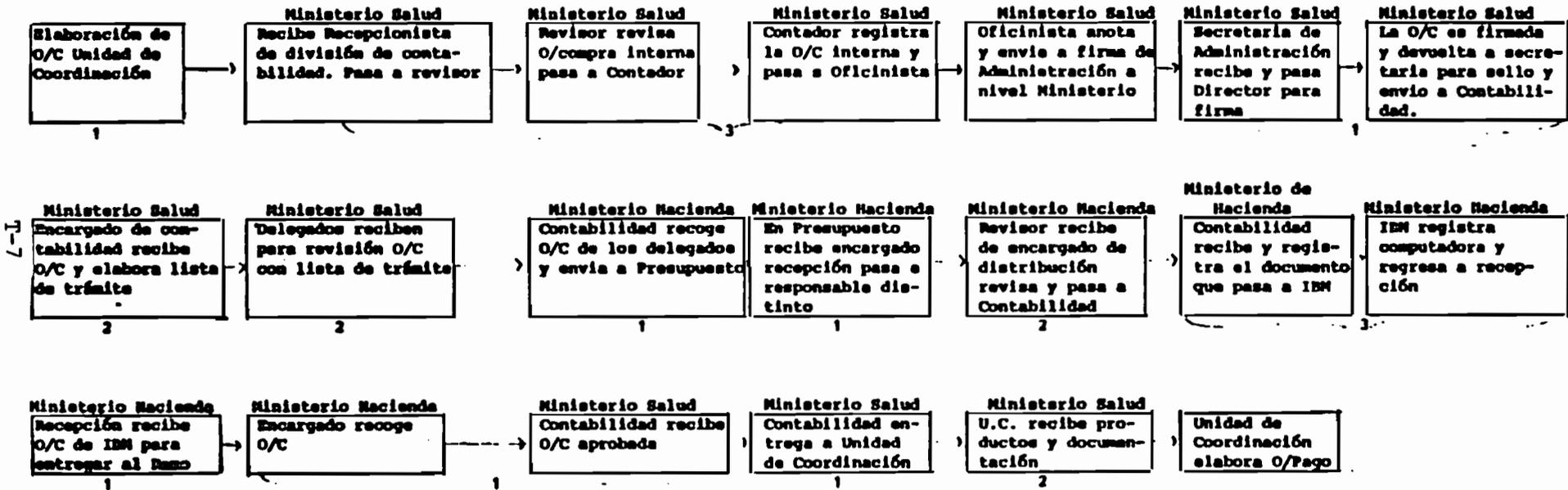
T-5

CODIGO DEL FLUJO DE TRAMITE ORDEN DE PAGO (MSP)

1. Elaboración O/Pago (Unidad Coordinación)
2. O/Pago recibida por Recepcionista Contabilidad Salud
3. O/Pago es pasada al Revisor (Salud)
4. O/Pago es pasada al Contador (Registro)
5. O/Pago es pasada a firma por oficinista
6. O/Pago es recibida en Administración por secretaria
7. O/Pago es pasada al Director o Subdirector Administrativo
8. O/Pago a la secretaria, sella, anota y envía a Subsecretaría
9. O/Pago es recibida por secretaria
10. Es pasada a Subsecretario
11. Secretaria encargada sella, anota y envía a Contabilidad
12. Recibe encargada en Contabilidad (oficinista)
13. Separa y elabora lista de trámite
14. Pasa a delegados Presupuesto
15. O/Pago es recibida por recepcionista
16. Pasa a Subdirección de Crédito Público
17. Pasa O/Pago a revisor
18. O/Pago pasa a encargado de enviar a Presupuesto
19. O/Pago es recibida por recepcionista en Presupuesto
20. O/Pago es pasada a encargado de distribución
21. O/Pago pasa a revisor
22. O/Pago pasa a Contabilidad
23. O/Pago es procesada por encargado
24. O/Pago pasa a IBM
25. O/Pago es operada en computadora
26. O/Pago es entregada para enviar a Información Presupuesto
27. O/Pago es entregada a encargado de Información
28. O/Pago pasa a encargado de enviar a Tesorería
29. O/Pago es recibida por encargado en Tesorería
30. Pasa a autorización del pago
31. Regresa a encargado para registro y envío para elaboración cheque
32. Elabora cheque
33. Pasa a la máquina para registro
34. Regresa a elaboración cheque para facturar y entregar a encargado Pagaduría
35. Recibe encargado Pagaduría
36. Elabora factura cheque en Pagaduría
37. Unidad de Coordinación recibe y elabora depósito
38. Depósito enviado al Banco Central de Honduras
39. Posteo del depósito

Tabla/Cuadro 6

FLUJO DE TRAMITE DE O/COMPRA INTERNA

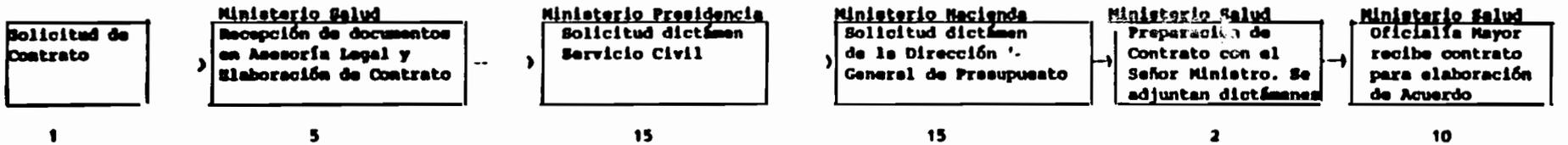


Trámite de Cancelación igual al cuadro Flujo de O/Pago.

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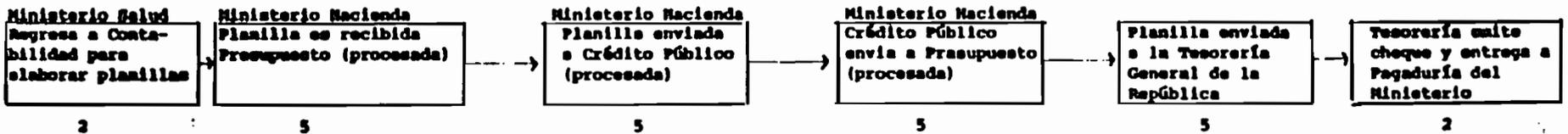
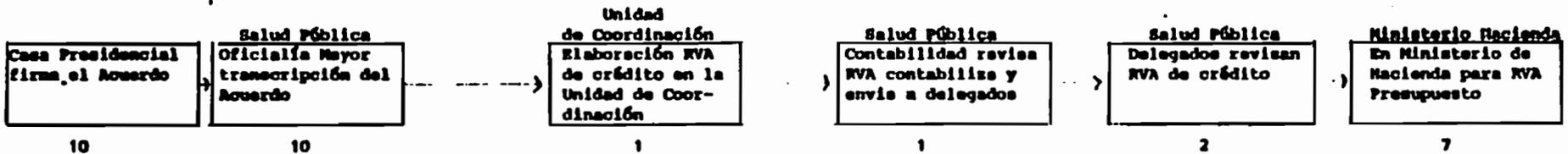
Tabla/Cuadro 7

FLUJO DE TRAMITE CONTRATACION PERSONAL



8-I

Solicitud Carta de Ejecución AID por parte Unidad Coordinación

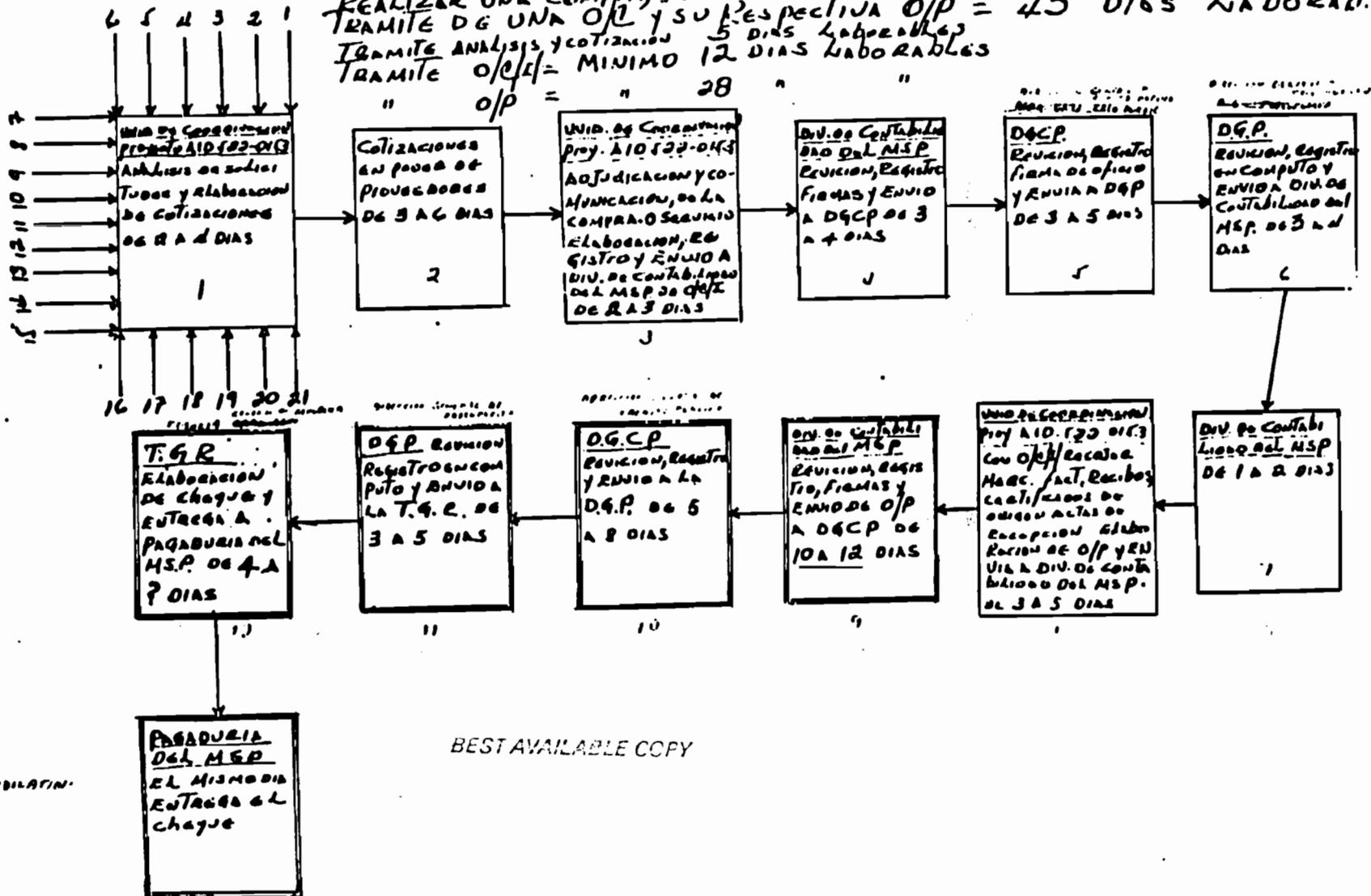


Pagaduría entrega a Unidad de Coordinación para que entregue al beneficiario

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Table 8

CUADRO DEMOSTRATIVO DEL TIEMPO MINIMO APROXIMADO PARA REALIZAR UNA COMPRA, Y DEL TRAMITE DE UNA O/P Y SU RESPECTIVA O/P = 45 DIAS LABORABLES
 TRAMITE ANALISIS Y COTIZACION 5 DIAS LABORABLES
 TRAMITE O/C/E = MINIMO 12 DIAS LABORABLES
 " O/P = " 28 " " " " " " " " " " " "



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Source: Project Coordination...

APPENDIX A
SCOPE OF WORK

ARTICLE I. FIRST MID TERM EVALUATION OF HEALTH SECTOR I

This scope of work is to carry out the first external evaluation of the A.I.D./Ministry of Health Project 522-0153, Health Sector I.

The Health Sector I Project (A.I.D. No. 522-0153) is a four year country-wide project directly affecting most of the Ministry of Health normative divisions and all eight of the regional health offices. It is composed of a loan of \$ 10,965,000 a grant of \$ 4,426,000, and a Honduran counterpart contribution of approximately \$ 17,000,000. The purpose of the project is to increase the effectiveness, efficiency, coverage and use of the health care system. More specifically, the Project will assist the Ministry of Health to develop and improve its human and institutional resources thereby enabling it to adequately plan and execute its program of extending the primary health care system throughout the country, particularly into rural areas.

The Project Agreement was signed by representatives of the Ministry of Finance, the Ministry of Health, and A.I.D. on July 31, 1980. One day after signing a new Minister of Health was sworn in and the entire top level management at the MOH changed over the ensuing six months. Within two months after signing, the A.I.D. team which had developed the Project were all transferred as well. The result was that those responsible for Project design, both on the A.I.D. and MOH side, were gone when the time came to begin Project implementation. The consequence was a delay in implementation start-up, particularly in personnel contracting.

The initial CP's which should have been met by October 29, 1980, were not met until February 27, 1981 and a Project Coordinator was not identified until April 1981 and his contract was not signed until August, 1981. Implementation really dates from that time.

In September, 1982, at both A.I.D. and MOH instigation, a commission was formed to suggest reprogramming of HSI funds and to propose what new funds and activities should be included if the Project were extended and additional funding provided. The first draft of a revised Project Description was presented in March 1983. That document is currently under review within the Mission and GOH.

Funding mechanism problems have plagued the implementation of this Project since its onset. This led the A.I.D. Mission Director to request a careful analysis of those problems. Such an analysis was conducted from January through March 1983 and a final report submitted to the Mission Director in early April.

ARTICLE II. OBJECTIVE

Evaluation Results

The results of this evaluation will enable A.I.D. and the GOH to know if the project is still valid and necessary. The evaluation results will indicate whether the real objectives of A.I.D. and the GOH coincide, with respect to the project. They will enable A.I.D. and the GOH to know what mid-course corrections in project design, organization, and management ought to be made and what the expected changes in EOPS would be. The results will validate the Project's recent internal reprogramming evaluation, in terms of both content and process.

Evaluation Determinations

In order to arrive at these results, the evaluation will determine if the Project is headed in the direction originally intended. It will determine if the project internally is administratively sound, and if it is based externally on viable organizational structures within the GOH. It will determine if there are bottlenecks in implementation and reasons for them. It will examine linkages between inputs and outputs to determine if there are changes in the scheduling of inputs, outputs and EOPS.

Evaluation Focus

In order to make these determinations, the evaluation will focus on implementation issues rather than impact issues. It will focus on the Project's organizational structure rather than outcome. It will look at the Project's financial mechanism, its information system, its decision-making and institutional capacity to act upon decisions made. Moreover, it will make a brief component by component review of progress to date, with special attention on those components showing lack of progress, analyzing why and recommending solutions. The adequacy of integration and coordination between components will also be addressed. The evaluation will focus on the management performance of USAID, the MSH team, the GOH relevant ministries, and other consultants/contractors.

Based on the data and other information gathered in the previous section the evaluation will:

ARTICLE III. SCOPE OF WORK

- (1) Analyze the overall administrative system and identify bottlenecks to implementation and other problems. Describe bottlenecks and evaluate what the immediate and secondary causes and effects are and propose solutions.

- (2) Analyze the institutional and larger (economic/political) environment in which the Project is being carried out. Answer these questions: Is there proper institutional support? If not what are the immediate and secondary causes and effects and what are proposed solutions? Does the macro political/economic environment encourage or discourage implementation?
- (3) Analyze Project sub-components that are not progressing as planned, describing which of the above factors are most important and identifying additional factors not addressed above. Here it will be understood that the priority sub-components will be emphasized. (Priority sub-components are Malaria, Diarrhea Control, Logistics, Maintenance, Management and Planning, Supervision, and Continuing Education.) In this section the evaluation will also determine to what extent inputs are leading to planned outputs.
- (4) A summary analysis will then be prepared looking at the whole implementation process and prioritizing problems in terms of overall effect on implementation and recommending and prioritizing solutions in terms of positive impact on implementation and ease of effecting solutions.
- (5) Finally, the evaluation will apply the conclusions from the above to the reprogramming making judgement on its design and the reasonableness of its inputs and outputs, and suggest modifications which are believed necessary to maximize the possibilities of attaining EOPS.

ARTICLE IV. REPORTS

- A. Draft - A final draft report in Spanish and English (five copies (5) of each) will be submitted to USAID Project Manager and the MOH Project Coordinator prior to the end of the consultancy.
- B. A final report will be due 30 days after the in-country work is completed. Fifteen (15) copies in English and twenty (20) in Spanish will be sent to USAID/H. USAID/H will notify the contractor when the report has been accepted with MOH clearance. The USAID will have 21 days from receipt of the report to accept the report or notifying the contractor of any problems.

ARTICLE V. RELATIONSHIPS AND RESPONSIBILITIES

See Block 22.B and C; page 3.

A. Sub-component Review

The evaluator will analyze inputs for each sub-component using the guidelines presented below and Annex A of these terms of reference. The guidelines are intended as a general frame of reference and should be considered the minimum acceptable.

1. Technical Assistance

- a. was the TA provided called for in the Project Paper (PP);
- b. was the TA called for in the PP provided;
- c. was it provided in a timely manner (i.e., was it provided when planned and/or when the Ministry was best able to utilize it.);
- d. was the scope of work adequate;
- e. does the work plan;
 - (1) reflect the scope of work,
 - (2) appear to be adequate in terms of amount, achievability and orientation,
 - (3) appear to be implemented
- f. have counterparts been identified and were/are they being fully incorporated in the work; and
- g. has TA been effectively utilized (i.e. have recommendations been made and acted upon, has TA been called in for assistance that appears within its competence, but not necessarily specified in its scope of work?.

2. In-Country Training

- a. has the training called for in the Project been carried out;
- b. is there evidence that the courses fit into a well defined and well planned educational strategy;

- c. do courses have clear objectives and is the curriculum designed to meet those objectives;
- d. Are appropriate educational methodologies being utilized;
- e. is pre and post-testing carried out;
- f. are the level, content and tasks expected to be carried out appropriate for the personnel being trained;
- g. are the courses those called for in the Project Paper; and
- h. are persons trained using the knowledge/skills gained the from training program;

3. Overseas Training

- a. has the training called for in the Project been carried out;
- b. has the training carried out been called for in the Project;
- c. is the training part of an overall educational strategy;
- d. is the candidate selection process adequate; and
- e. are persons trained using knowledge/skills gained from training programs?

4. Construction

- a. has the construction called for been carried out;
- b. has the construction done been called for in the Project;
- c. has the construction occurred when needed and when the MOH has been in a position to adequately utilize it;
- d. has the design been done by competent personnel and carefully reviewed by A.I.D.; and
- e. has supervision been adequate?

5. Equipment (Commodities)

- a. have the planned commodities been purchased;

- b. have the commodities purchased been those called for in the Project Paper; and
- c. have specifications
 - (1) been technically elaborated;
 - (2) been according to the needs and available resources of the MOH;
- d. have purchases been timely; and
- e. is the system of receiving, registering, distributing, and monitoring equipment adequate?

6. Personnel

- a. have the personnel called for in the Project been hired;
- b. have the personnel financed by the Project been those called for in the Project;
- c. does the selection process optimize the possibilities of obtaining highly qualified and competent personnel; and
- d. are personnel being used as contemplated in the Project?

B. Administrative Systems (Focus on Project Coordination Unit (PCU))

1. Planning

- a. does planning of inputs occur (implementation and financial plans);
- b. does a system exist for identifying unanticipated problems;
- c. once identified are the relevant parties brought into the problem solving process; and
- d. are communications including reports and meetings adequate for monitoring implementation progress, and identifying and resolving problems?

2. Implementation

- a. are implementation plans and problem solutions developed carried out; and

- b. is the financial mechanism sound and secure so that loan, grant and counterpart funds are available when and where needed?

3. Evaluation

- a. is implementation monitored in a regular and reliable fashion so that delays are avoided to the extent possible?

4. Logistical Support

- a. are PCU personnel adequate in number, type, and capacity; and
- b. are equipment, supplies and space adequate in amount, type and quality?

C. Institutional Participation

1. MOH

a. Political Level

- (1) is the Project adequately supported at the policy level?

b. Normative Level

- (1) are the normative offices knowledgeable about the sub-components for which they are responsible;
- (2) do they participate in the elaboration of the implementation plans for their sub-components;
- (3) do they coordinate well with the PCU and are they knowledgeable of its procedures; and
- (4) do they feel adequately supported by the Project?

c. Operative (Regional Level)

- (1) are they knowledgeable about Project resources available from the Project; and
- (2) do they feel supported or assisted by the Project?

d. Staff offices (legal, purchasing, accounting)

- (1) are project documents processed by the established deadlines;
- (2) are counterpart funds made available when needed;
- (3) is assistance provided to the PCU in resolving problems or clarifying situations when required; and
- (4) is there knowledge of and support for the Project?

2. Ministry of Finance and Public Credit (MOF)

a. Budget Office

- (1) are Project documents processed within the established deadlines;
- (2) are counterpart funds made available when needed;
- (3) is assistance provided to the PCU in resolving problems or clarifying situations when required; and
- (4) is there knowledge of and support for this Project,

b. Public Credit Office

- (1) Are Project documents processed within the established deadlines;
- (2) Are procedures agreed upon by A.I.D., MOH, MOF followed for requesting and liquidating advance funds;
- (3) is assistance provided to the PCU in resolving problems or clarifying situations for the Project;
- (4) is their knowledge of and support for the Project.

3. A.I.D.

a. Planning

- (1) does A.I.D. participate in an effective and useful fashion in the PCU's planning process;

- (2) does a system exist for identifying unanticipated problems;
- (3) once identified are the relevant parties identified and brought into the problem solving process;
- (4) are communications, including reports and meetings adequate for monitoring implementation progress, identifying and resolving problems; and
- (5) does PCU and MOH feel A.I.D. planning and problem solving support is adequate?

b. Implementation

- (1) Are implementation actions (PIL's, PIO's, budgets, obligations, etc.) carried out according to plans and in a timely and accurate fashion; and
- (2) Is the A.I.D. side of the financial mechanism operating in such a manner that it does not interfere with Project implementation?

c. Evaluation

- (1) is implementation monitored in a regular, reliable and useful fashion so that problems are addressed in a timely fashion?

The evaluator will use but not be limited to the following information sources:

A. Project Documents

1. Project Paper
2. Project Agreement
3. Project Implementation Letters
4. PIO's
5. Implementation Plans
6. Financial Plans
7. Correspondence
8. TA Work Plans (MSH, AED, Stivers)

B. Project Reports

1. FCU Quarterly Reports
2. A.I.D. Quarterly Reports
3. MSH Monthly/Semi Annual Reports and Substantive Reports
4. Stivers (Entomologist) Quarterly Reports
5. AED Periodic Reports
6. Other Reports (e.g. Hacienda & Chrysler Vehicle Memo)
7. Quarterly Financial Reports (A.I.D. & MOH)

C. Interviews

1. MOH (Directorate General; Normative, Regional and Support offices)
2. PCU (Coordinator, Administrator, Accountant, Purchasing Officer)
3. A.I.D.

D. Field Trips

Project Inputs

1. Malaria

- a. Technical Assistance (TA)
 - 1. Vector Control Trainer (4 months)
 - 2. Entomologist (42 months)
 - 3. Bio Control Agent Inventory (1 month)
- b. In-country training
 - 1. Malaria Control course
 - 2. Regional seminars
 - 3. Training of ACV/s, Promotor II's and Supervisors
- c. Overseas Training
 - 1. Vector Control Course for Director (2-3 months)
 - 2. Observational Travel Director (2 weeks)
 - 3. MOH Entomologist (1 year)
- d. Construction
 - 1. 1 500 M² central insecticide warehouse
 - 2. 6 100 M² regional insecticide warehouse
- e. Commodities
 - 1. Insecticide
 - 2. See list Annex II, Exhibit C, Project Paper
- f. Personnel
 - 1. Vector Division Administrator (1)
 - 2. New Inspectors (4)
 - 3. New Promotors II's (26)
 - 4. ACV's (110)

2. Rabies

- a. TA - None
- b. In-country training
 - 1. regional workshops

- d. Construction - None
 - e. Commodities
 - 1. Electrolyte packages
 - 2. Other (see PIO's for equipment purchased but not contemplated in PP)
 - f. Personnel - None
 - g. Supervision - 1 person week/month
5. Tuberculosis
- a. TA
 - 1. Experts for National Seminar (4)
 - b. In-country Training
 - 1. National Seminar (1)
 - 2. Workshop for Med./Nurses School Instructors (1)
 - 3. Regional workshops (8)
 - c. Overseas Training
 - 1. Scholarships (12)
 - 2. observational visits (2 weeks)
 - d. Construction - None
 - e. Commodities
 - 1. See Annex II, Exhibit C. Project Paper
 - f. Personnel - None
 - g. Other
 - 1. Supervision (1 pers. week/months)
 - 2. Special Studies

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6. Sexually Transmitted Diseases

- a. TA
 - 1. 1 person month
- b. In-country Training
 - 1. National seminar (1)
 - 2. Regional seminars (8)
- c. Overseas Training
 - 1. International Conferences (2)
 - 2. Observational trips (5 pers./weeks)
- d. Construction - None
- e. Commodities
 - 1. See Annex II, Exhibit C of Project Paper
- f. Personnel - None
- g. Other
 - 1. Supervision (1 pers. week/month)

7. Maternal-Child Health

- a. TA
 - 1. Mass Media
- b. In-country training - None
- c. Overseas Training
 - 1. Long term (8)
 - 2. Cytotechnicians (12)
 - 3. Short courses (75)
 - 4. Observational visits (60)
- d. Construction - None
- e. Commodities
 - 1. Contraceptives
 - 2. Midwife kits (5,000)

- f. Personnel - None
 - g. Other - None..
8. Epidemiology Training
- a. TA
 - 1. Expert for surveillance seminar (6 weeks)
 - b. In-country Training
 - 1. In-country training (4)
 - 2. Surveillance seminar (1)
 - c. Overseas Training
 - 1. 3 months courses (3)
 - d. Construction - None
 - e. Commodities - None
 - f. Personnel - None
 - g. Other - None
9. Basic Medicine List
- a. TA
 - 1. 1 person (2 months)
 - b. In-country training - None
 - c. Overseas training
 - 1. Observational trip (2 weeks)
 - d. Construction - None
 - e. Commodities - None
 - f. Personnel - None
 - g. Other - None

10. Logistics

a. TA

1. Expert logistics (24 months)

b. In-country training

1. Courses (32)

c. Overseas Training - None

d. Construction

1. 2000 M² central warehouse (1)
2. 1000 M² regional warehouse SPS (1)
3. 500 M² regional warehouses (5)
4. Renovation central medical & transport workshops

e. Commodities

1. Cold chain - see Annex II, Exhibit C
2. Medical and Laboratory - see Annex II, Exhibit C
3. Pick-up trucks (5)
4. Radio communications equipment
5. Fuel, oil and tires

f. Personnel

1. Administrative Officials IV (3)
2. Warehousemen IV (2)
3. Warehousemen III (6)

g. Other - None

11. Maintenance

a. Technical Assistance

1. Maintenance Expert (24 months)

b. In-country Training

1. Regional training
2. Central training

c. Overseas training

1. 32 persons (1-3 months)

d. Construction - None

e. Commodities

1. Central, SPS and La Ceiba workshop tools
2. Regional workshop tools
3. Area workshop tools
4. Spare parts for medical and transport equipment (pre-project)
5. Spare parts for medical and transport equipment

f. Personnel

1. Administrative Official IV (1)
2. Mechanics (7)
3. Mechanic helpers (7)
4. Refrigeration technicians (7)
5. Artesans (25)
6. Other (5)

g. Other

1. Per diem for personnel

12. Management and Planning

a. Technical Assistance

1. TA in Integrated Human Resources, Integrated Logistics and Maintenance, Information Systems, Program Evaluation, and Program Planning and Evaluation (196 months)

b. In-country Training - None

c. Overseas Training

1. Courses for top level Civil Service personnel (60 months)

- d. Construction - None
 - e. Commodities
 - 1. Computer
 - 2. Other (see PIO's)
 - f. Personnel
 - 1. Additional to DG's office (5)
 - 2. Project Coordination Unit (3)
 - 3. Project Liaison Officer (1)
 - 4. Computer programmer
 - g. Other
 - 1. Evaluation of Project
 - 2. Nursing feasibility
13. Mass Media for Village Health Workers (VHW's)
- a. Technical Assistance
 - 1. Principal Advisor (24 months)
 - 2. Expert media technology (2 months)
 - b. In-country Training - None
 - c. Overseas Training - None
 - d. Construction - None
 - e. Commodities
 - 1. Production of 30 second spots (100)
 - 2. Purchase of radio airtime
 - 3. Production of posters and pamphlets
 - f. Personnel
 - 1. Technical Coordinator (36 months)
 - 2. Field Coordinators (2 - 72 months)
 - g. Other
 - 1. Pre program Research

14. Teacher Training

- a. Technical Assistance
See sub-component # 17)
- b. In-country Training
 - 1. One week courses (8)
- c. Overseas Training
- d. Construction - None
- e. Commodities
 - 1. Books
 - 2. Educational materials
- f. Personnel
 - 1. Coordinator (24 months)
 - 2. Instructors (2 - 48 months)
 - 3. Secretary (24 months)
- g. Other - None

15. Supervision

- a. Technical Assistance
 - 1. Expert Supervision (48 months)
- b. In-country Training
 - 1 Courses training supervisors
- c. Overseas Training
 - 1. See PIO/P's
- d. Construction - None
- e. Commodities
 - 1. 34 vehicles

- f. Personnel
 - 1. Coordinator (36 months)
 - g. Other
 - 1. Per diem for supervision
16. Continuing Education for Village Health Workers (VHW's)
- a. Technical Assistance
 - 1. See under sub-component # 17
 - b. In-country Training
 - 1. 4000 students per year
 - c. Overseas Training - None
 - d. Construction - None
 - e. Commodities - None
 - f. Personnel
 - 1. Regional Continuing Education Coordinators (8)
 - g. Other - None
17. Continuing Education for MOH Employees
- a. Technical Assistance
 - 1. Continuing Education Advisor (36 months)
 - 2. Information Center Advisor (6 months)
 - b. In-country Training
 - 1. See list Annex II, Exhibit E, pg. 53 of PP
 - c. Overseas Training - None
 - d. Construction
 - 1. Printshop (additional to PP)
 - 2. Information Center (additional to PP)

e. **Commodities**

1. Books for students
2. Books for Information Center
3. Equipment for continuing education magazine
4. Equipment for Information Center
5. Microscopes (20)
6. Materials for continuing education magazine

f. **Personnel**

1. Continuing Education Coordinator (48 months)
2. Information Center Coordinator (36 months)

g. **Other - None**

APPENDIX B

Amplified Project Description

ARTICLE A

The Project

Section A.1. The Project Goal. The goal of the Project is to improve the health status of Hondurans in terms of increased life expectancy at birth, decreased mortality of infants and mortality among children under age five and a decrease in general morbidity.

Section A.2. The Project Purpose. The Project purpose is to increase the effectiveness, efficiency, coverage and use of the services of the health care system in Honduras.

Section A.3. Summary Project Activities. The Project will finance: a) short or long term training for approximately 3,000 Ministry personnel in various subjects including malaria control, epidemiology, maternal child care, supervision of community health workers, continuing education of community health workers and other Ministry employees, logistics and maintenance; b) technical assistance to improve technology delivery systems in areas such as malaria, tuberculosis and diarrhea, develop policies, procedures and system manuals in administration, management, logistics and maintenance; c) commodities and equipment needed to support the Ministry's health services, supply and maintenance systems and the technology delivery systems cited earlier; and d) the construction of supply storage and equipment facilities in various parts of the country.

Section A.4. Financing. Project funds will include the A.I.D. Loan (\$10,965,000), the A.I.D. Grant (\$3,826,000) and a Government contribution of \$17,061,000. (The total A.I.D. contribution is subject to the conditions set forth in Section 2.2. (a) of the Project Agreement.)

ARTICLE B

Project Components

Section B.1. Component No. 1: Malaria Vector Control. To design and implement malaria and vector control activities, several steps will be undertaken as follows: a) training of health personnel who are directly or indirectly related to malaria control; b) field investigations to determine what combinations of activities are required for control; c) strengthening program administration, norms and procedures; d) investment in plant, equipment and commodities.

a) **Training.** Three types of training will be done: (i) formal courses and seminars, mainly in country, both basic and in service; (ii) some selected, specialized training abroad; (iii) field training closely supervised by specialists.

Basic courses of about one month each will be given to about 250 personnel who have malaria control as their primary responsibility i.e., regional promoter III's, area promoter II's and community based Auxiliaries of Vector Control (ACV's). The curricula for these courses will be developed by a short-term contract specialist in vector control from outside Honduras, in conjunction with an epidemiologist, an engineer and other medical personnel knowledgeable about malaria who are residents of Honduras. These courses will address various subjects, including methods of determining adult vector and larval numbers and habits, physical and biological control methods, mass drug use, community education, motivation for community involvement, insecticide safety and the training of community malaria collaborators. Supervised field training will consist of applying the techniques learned in the course in the students' area of assignment with frequent follow-up visits by professionals to assist in the proper application or redesign of procedures.

Following the first year of study and training, an evaluation of the basic training courses in relation to what the students actually did in the field will be done in order to revise the methodology used and contents of the course and to design mechanisms for follow-up instruction.

Seminars will be arranged by the Vector Control Division (VCD) for 65 regional health personnel i.e., regional directors, regional nurses, epidemiologists, laboratory technicians, and some area physicians and nurses to improve their understanding of the malaria problem and clarify their responsibilities for malaria control. Training materials will be supplied by the VCD itself and also will be financed through the Project.

To strengthen the professional capability of the VCD, the GOH entomologist in that office will receive 9 to 12 months of entomology training abroad with a vector control orientation. The VCD director will receive 2-3 months of malaria control training abroad with a vector control emphasis.

b) **Field Investigations.** The services of a long-term (four year) contract entomologist will be engaged to conduct field investigations which will be used to characterize the malaria vector and its environment through the changing seasons of the year. Based on the foregoing, the contractor will assist in developing improved, more cost effective combinations of vector control interventions. In the second year of the Project, the contract entomologist will serve as the VCD entomologist while the GOH entomologist is receiving long term training. To assist in the field studies, a biological control agent inventory will be done by a separate contractor.

c) Program Administration. Program administration in the malaria central component will be managed by an administrative assistant for the component who will act as liaison with the Division of Epidemiology and the Coordination Unit for the Project.

d) Investment in Plant, Equipment and Commodities. The spraying and mass medication approach presently being used will continue until the training and field study stage is completed and new interventions are designed. Project support for this stage will include vehicles to permit promoters and supervisors to work with ACV's; sprayers; equipment for field studies; construction of insecticide and equipment storage space in each region; and boats and motors.

The MOH will staff the field positions planned with four additional promoter III's, 26 more promoter II's and 130 more ACV's. The GOH will also improve the technical quality and salaries of ACV's to a point high enough to attract candidates with higher formal education.

e) New Malaria-Control Interventions. Prior to undertaking any newly-designed or additional malaria-control interventions under the Project. The GOH, together with the contract entomologist, will complete an evaluation assessing the environmental impact of such interventions. This evaluation must be reviewed and approved by AID before implementation of such interventions.

Section B.2. Component No. 2: Rabies. This component will provide training to 80 individuals in animal rabies control, and update the knowledge of rabies control practices, particularly those of regional rabies inspectors. It will also provide motorcycles for them, observation cages, transport containers, refrigerators and community education materials. This component will be the responsibility of the Division of Epidemiology with the collaboration of the Human Resources Division and Regional Offices.

Section B.3. Component No. 3: Immunization Programs. This component will assist the MOH in its efforts to establish integrated immunization program with services based and dispensed at health facilities, by providing a) training and b) the equipment necessary to assure the viability of vaccines.

a) Training will be provided in two ways: through workshops at the national and regional levels, and through in-service education sessions for auxiliary nurses and volunteers.

National and Regional level seminars will be held to provide detailed information to 270 members of Regional and Central staffs, concerning MOH immunization norms. Subject areas will include vaccine transportation, storage and preparation; and vaccine administration procedures, contra-indications and complications.

The curriculum for the basic training of auxiliary nurses and volunteers is already being strengthened by the MOH to provide the information noted in the above paragraph and required for this element. For the auxiliary nurses already in the field, this topic will be presented in special continuing education sessions to be held in following years. The continuing education sessions will include instruction on what vaccination information should be taught to volunteers during the monthly auxiliary nurse-Volunteer Health Workers (VHW) meetings.

A national level seminar dealing with immunopreventable disease and the MOH immunization program will be held for 30 participants including regional doctors, Medical School faculty and members of the MOH Epidemiology and Maternal Child Health Divisions.

b) Equipment. Equipment, including freezers, refrigerators, ice boxes, thermometers, plastic bottles and refrigerator maintenance kits will be procured to complete the cold chain. A vehicle will be provided at the central level to assist in supervision. Cold rooms will be built into central and regional warehouses.

The Division of Epidemiology together with the Human Resources Division and the Regional Offices will manage this component.

Section B.4. Component No. 4: Diarrhea Control. This component will support the training of 150 individuals through regional and national seminars and supervisory-evaluation visits of central level personnel to lower levels. It will also provide an initial supply of electrolyte packets for oral rehydration to be used by the MOH. The seminars will deal with the problem of diarrhea, and its causes, diagnosis, treatments, epidemiology and prevention, with emphasis on the use of oral rehydration instead of intravenous fluid. MOH employees, instructors from schools of nursing and medicine and selected individuals from other institutions will participate. Continuing education seminars for auxiliary nurses will be oriented almost entirely toward norms of diagnosis, referral and the use of oral rehydration. Training of the VHW's will concentrate on identification, rehydration and referral. The pediatric section of the MOH Division will have full responsibility for coordinating and implementing appropriate national level actions and assisting regions and others to implement the norms. The Human Resources Division will coordinate various training and educational efforts along with the Division of Health Education.

Section B.5. Component No. 5: Tuberculosis. Activities under this component will consist of a) training, b) equipment support and c) special study work.

a) Training. Several types of training are to be provided:

- a national seminar for regional directors, Chest Hospital personnel, Medical School faculty and personnel in the Division of Epidemiology. The seminar will cover topics such as diagnosis, treatment and follow-up care, new treatment regimens and the role of tuberculosis vaccination;
- a workshop for the teachers of the Nursing School and Medical School in epidemiology and control of tuberculosis;
- a regional workshop concerning epidemiology and control of tuberculosis for 160 persons from the sanitary regions;
- visits by the program director to observe tuberculosis programs in other countries;
- training of auxiliary nurses and VHM's practicing in the rural areas will be done through in-service education sessions (see In-service Training) and will include screening and diagnosis procedures, treatment norms, methods to encourage patients to continue long-term treatment, and the steps to be taken by those in close contact with TB patients;
- training in microbiology abroad for doctors, microbiologists, nurses and other personnel;
- mass media messages discussing T.B., its symptoms, and services provided by the MOH will be directed at the population through the newspapers and radio.

b) Equipment Microscopes and reagents will be supplied for diagnostic purposes at the CESAMO level. Vehicles will be provided to assist in patient follow-up in larger cities (where most of the reported TB is located, primarily among the poor). In addition, the National Director for this program will make monthly supervisory trips to visit each level of the service system in at least one sanitary district.

c) Special Studies studies related to tuberculosis epidemiology, treatment and clinical characteristics will be undertaken.

The Division of Epidemiology will execute this component with the assistance of the Division of Human Resources and Health Education and the regional offices.

Section B.6. Component No. 6: Sexually Transmitted Diseases. The Project will support continuing education in this area through national seminars and regional workshops and will provide the opportunity for key personnel to visit and observe successful programs in other countries. This education, combined with technical assistance, will be oriented toward improving program structure. The MOH will train students in the Medical School, Nursing School and in laboratory courses. This effort will be supported by supervisory trips from the central level and through mass media campaigns to educate the public.

The Project also will support the training of 127 directors, supervisors and service providers down to the area levels; will improve laboratory diagnosis and support supervisory visits of central level personnel to the field, and will finance attendance at international conferences, observation trips, and classroom presentations at the Medical School. The Division of Epidemiology will manage this subcomponent with assistance from the Divisions of Human Resources and Health Education and by the regional offices.

Section B.7. Component No. 7: Maternal Child Care. This component will provide assistance in the area of Maternal Child Health (MCH) in collaboration with efforts being made with other agencies. Specifically, assistance will consist of a) training, b) technical assistance, and c) equipment.

a) Training Long-term Training in specific subjects of MCH will be provided to 8 members of the MOH involved in the MCH program. Subjects to be addressed include general gynecological care, maternal and infant nutrition, pregnancy of the very young women, birth spacing and program administration. Training will also be provided to 12 cytotechnologists. Short training courses or seminars will be provided to about 130 people in the public and private sector who are concerned with MCH, in various aspects of MCH such as the health implications of frequent pregnancy, and indications for pregnancy avoidance. The opportunity to see effective MCH and family planning programs in other countries will be provided for this purpose.

b) Technical Assistance Technical assistance will be provided to assist the MOH in publicizing MCH services currently available in the Ministry, and to educate the public on the general subject of MCH.

c) Equipment Equipment in the form of 5,000 kits for traditional midwives will be provided in support of another donor supported training program designed to improve midwives skills. The Maternal-Child Health Division of the MOH will manage this sub-component with support from the Divisions of Human Resources and Health Education.

Section B.8. Component No. 8: Epidemiology Training. The Project will fund seminars which will include 25 central and regional epidemiologists, regional supervisors and medical faculty teachers. The content of the training activities will include epidemiological methods, the epidemiology of common illnesses in Honduras, statistical analysis and epidemiological programming. A special seminar related specifically to surveillance

techniques and methods of disease outbreak investigation is planned for 25 participants. This is to be supplemented by short courses abroad in epidemiology for three selected individuals. The Epidemiology Division with the assistance of the Human Resources Division will complement this training.

Section B.9. Component No. 9: Basic Medicine List. This component will provide technical assistance to carry out a study of pharmaceuticals and develop a final basic medicine list, develop the methods for data collection and analysis regarding drug utilization, and advise in the general organization of the MOH Pharmaceuticals Unit. The Director of the Pharmaceuticals Unit will be given an opportunity to observe functioning systems in other countries to aid her in determining how the list is kept current and responsive to new opportunities. Observing the dynamics of this process in other medical communities will be of primary importance to the success of this effort. The Pharmaceuticals Unit of the Hospital Division will be the responsible implementing unit.

Section B.10. Component No. 10: Logistics System. This component consists of a series of activities which will carry out some administrative reorganization, establish operating policies and procedures, provide training and renovate or construct workshops and supply warehouses throughout the country.

a) Administrative and Organizational Improvement. Technical assistance will be provided to assist in the design and implementation of a central logistics management system to serve the primary health care system, including volunteer workers, CESAR's, CESAMOS and hospitals. The system will be capable of recovering information on consumption of supplies and inventory on hand and forecasting supply requirements; it also will have improved arrangements for procurement of supplies at regional and central levels. The Directorate for Administrative Services will assume supervisory authority over all activities in the logistical process at all levels of the MOH, and will develop a complete set of policies and procedures, including manuals for each of the processes involved in the logistical system, including procurement, storage and distribution.

This effort together with the new supply facilities contemplated in this Project, will require additional personnel at various points in the system, including at least three specialists to develop norms for procurement, storage and supply control and distribution, and eight warehousemen or supply managers in the regional warehouses. Loan funding will finance 100% of the salaries of these new personnel in the first year of the Project and will decline on a graduated basis (100% first year, 75% the second year, and so on) until the GOH is paying 100% of the new salaries.

b) Training: Training courses will be given both to personnel working in the Directorate of Administrative Services and to MOH personnel who use the logistics system. Training will be provided through a combination of short-term technical assistance and institutional resources from within the Human Resources Division of the MOH, and possibly from INFOP, the Professional Training Institute. About eight courses will be given each year with up to 25 attendees in each class. By the end of the Project, approximately 200 people from the Directorate will have attended formal training courses or seminars on at least an annual basis. In order to minimize turnover of trained personnel under both the logistical and the maintenance systems, efforts will be made to hire and train personnel in the regions. In addition, in those cases requiring long-term or specialty training particularly for regional personnel, trainees will be required to sign contracts committing them to work with the MOH for appropriate periods of time following their training.

c) Construction, Equipment and Vehicles. A new central warehouse and six smaller regional warehouses will be constructed. Each of the warehouses will have cold storage rooms, refrigerators and freezers, storerooms for spare parts for medical equipment and vehicles, extra equipment, an office for a regional supply manager and, in the regional shops, small workshops for vehicle and medical equipment repair. Delivery of parts for maintenance purposes will be done by five trucks to be provided under the Project. Each warehouse also will be equipped with a shortwave radio which will enable the central office and regional warehouses to determine the needs of the regional facilities at any given time. Storage of perishable materials and supplies will be improved by the provision of air conditioners, freezers, small refrigerators, ice chests and accessories to CESAND's and CESAR's not so equipped at present. A number of CESAR's will be equipped with both general medical equipment and CESAND's will be provided with laboratory equipment. In accordance with the Condition Precedent outlined in Section 5.2 (b), however, construction of the warehouses and the purchase of vehicles or pertinent warehouse equipment will not proceed until both A.I.D. and the GOH have approved the administrative and management systems discussed earlier in this component.

Section B.11. Component No. 11: Maintenance System. Administration and Organizational Improvement. By the end of the Project, the Department of Maintenance will be operating with a complete new set of policies, procedures and manuals which will allow it to perform preventive maintenance and general repair duties more efficiently and on a much broader scale. The Department will be incorporated into the Directorate of Administrative Services and will work in close coordination with other units of that organization, including the MOH Procurement Office. Although the maintenance system is smaller in size than logistics systems managed by the Directorate of Administrative Services, the expansion of services contemplated for the Department is such that long-term technical assistance (approximately two man-years) is also planned here. The expansion in services will also increase the number

of personnel. By the end of the Project, the Department will have grown to include one administrative officer, seven mechanics, seven mechanic's helpers, seven electricians, seven cold chain repairmen, one secretary, 25 artisans, such as bricklayers and plumbers, and five drivers. Financing of the additional personnel will be carried out in the same manner as that discussed in Component No. 10.

a) Training. Training courses currently being given to Department of Maintenance personnel also will be expanded to ensure that all personnel within the Department receive in-service training (short-term or long-term, depending on the complexity of the equipment involved) with respect to their particular skills. Training also will be given to selected employees outside of the Department in preventive maintenance programs for vehicles, simple medical equipment and office machinery. Ministry employees will attend seminars in Tegucigalpa or in the regions. With respect to regional needs, small outreach teams or individuals will travel to the various regional facilities to train regional maintenance personnel and other employees in the areas mentioned above. Courses will be given on a monthly basis with about 20 persons attending each course, either in Tegucigalpa or in the region. Classes will be coordinated by MOH personnel from the Human Resources Department. Eight people will travel abroad each year to receive one to three months of training in technical subjects including the maintenance of refrigeration and X-ray machines. Approximately 1,000 people are expected to have been trained in equipment repair or preventive maintenance techniques by the end of the Project.

b) Equipment and Vehicles. As was noted in one of the foregoing components, regional workshops are to be constructed within the regional warehouses. By the end of the Project it is expected that all eight workshops will be fully equipped to deal with the maintenance and repair needs of medical equipment and vehicles. In order to make optimal use of the central workshop facilities in Tegucigalpa, both the medical equipment and vehicle workshops will be renovated. In addition to the vehicles mentioned in the Logistics System Component, the Department will have two other vehicles assigned specifically to it to assure that parts and needed equipment flow to the regional warehouses and workshops from the central warehouse on a timely basis. As with the warehouses mentioned previously, neither renovation of the workshops nor the purchase of vehicles will be effected until A.I.D. and the GOH have approved and implemented the administrative and management systems discussed in this Component.

Section B.12. Component No. 12: Reinforcement of Management and Planning. This Project component will reinforce Central Program planning and implementation capabilities in the MOH by increasing the staff of the General Directorate of Health from two to seven full-time national technicians. The five additional technicians will be responsible for specific integrated functional areas such as Human Resources, Administrative Services (including logistics and maintenance), Information Systems, Program Evaluation and Investigation, Program Planning, and Budgetary Analysis.

To support and complement these new personnel, A.I.D. will provide eight work years of technical assistance, computer equipment and programmers to facilitate studies and better accounting procedures, and scholarships for key staff personnel. The Project also will finance salaries of the new members of the Director General's staff on a declining scale as is described in earlier Components. The MOH gradually will take over the costs of national personnel, and provide computer programmers, supplies, and maintenance of the equipment.

The computer equipment to be provided, which will consist of an interactive computer system, compatible with other GOH computers, (for example, the WANG-VS, similar to that now used by the Census Bureau, and CONSUPLANE). The computer will be used for routine service statistics, morbidity and mortality data, special studies, budget control, inventory control, hospital cost control, and personnel management evaluation.

This component will produce periodic evaluation reports, semi-annual reports from automated service statistics and budgetary information systems, and should lead to improved overall coordination of the MOH as indicated by increased efficiency of program operation.

Section B.13. Component NO. 13: Mass Media for Village Health Workers. The purpose of this component is to provide both recognition and continuing education to Village Health Workers (VHW's) through mass media (radio) and to provide some related health education to the community. A potential side benefit is that the programs will reach many of the estimated 16,000 midwives and other traditional health practitioners not active in MOH programs. This purpose will be accomplished primarily through programs both from national radio networks and from small local stations. Pamphlets and posters also will be developed and used. A combination of short, pre-recorded spot broadcasts and longer (10 minute) live broadcasts on local stations will be employed. The content of the programs will include the following:

- Recognition of outstanding VHW's.
- Recognition of active community projects.
- Health education messages for the VHW covering problem areas such as TB, maternal child care, vaccination, oral-rehydration, sexually transmitted diseases, and rabies control.
- Announcements of local meetings and continuing education programs in which the VHW's should participate.

These activities will be coordinated through a technical advisor provided by A.I.D., and a technical coordinator and two field coordinators to be provided by the Health Education Division of GOH. The technical advisor will help design and coordinate pre-program research for selected messages, develop guidelines for written or pictorial messages (used to reinforce or supplement media messages) and local live programming, and assist counterparts in the supervision of the commercial production of pre-recorded broadcasts. This advisor will spend about half his time working in continuing education related to mass media for GOH personnel in the health sector.

The MOH technical coordinator will supervise the commercial production and the broadcasting of messages, assure the timely logistical and administrative support of the activity, acquire new skills needed to conduct pre-program research, and perform other duties in concert with the technical advisor. The field coordinators will work under the supervision of the technical coordinator to facilitate effective programming of live broadcasts from local stations.

Pre-recorded messages will be prepared commercially on a contract basis. Cassette recorders will be provided to facilitate preparation of local broadcasts. Airtime will include national networks (about two thirds of the spot budget) and local stations.

This component will produce 900 live 10-minute broadcasts, 175,000 short (30 second) radio spots, and will distribute 200,000 pamphlets and posters.

Section B.14. Component No. 14: Teacher Training. This component will provide both long-term academic training (12 person years) and a series of short seminars. Long-term academic training will be financed for the faculty of the Medical and Nursing schools in the areas of general public health, epidemiology, bio-statistics, and nurse-midwifery. The GOI agency employing the participants will pay international travel and salary as needed. AID will pay other costs such as enrollment and per diem.

In-Country courses will be scheduled so that each participant will receive a one week course each quarter for two years; courses will be given continuously to facilitate flexible scheduling and continuity among courses. The USAID has agreed informally to participate with the MOH in giving these courses, and will provide academic credit to participants.

The MOH will provide a classroom, an office, a full time coordinator, a secretary and required instructors, and will develop a detailed plan for the use of funds for course materials and books to be purchased under this Project. Technical assistance for this component will be provided by the advisor to the Continuing Education component of the Project (Section B. 16.).

Section B.15. Component No. 15: Extension of Supervision. This component is designed to extend the supervision system of the MOH to meet the need for supervision created by the recent expansion in the number of auxiliary health workers, VHM's and auxiliary nurses. Supervision is understood to include one-to-one continuing education done at the employee's normal place of work and, to a lesser extent, evaluation of the employee's efforts.

The principal factors limiting effective supervision at this time are funds for transportation and per diem. Supervision guidelines recently have been developed under an AID contract, and these will be applied to the new supervision system. Training of supervisors will also be financed under this component. The principal outputs of this component will be supervisors trained and supervisory visits carried out.

The Project will finance the services of a technical coordinator whose role will be to coordinate training in supervision, and to monitor and evaluate supervision activities. However, the coordinator will not serve as a general technical supervisor, but rather as a monitor of supervision activities. The Project also will provide two years of technical assistance for management level training in supervision, and to support the coordinator. A.I.D. will provide per diem and materials, and the GOH will provide salaries, transportation, classrooms, and instructors to support the training of supervisors. A.I.D. initially will subsidize per diem for supervisors, but these costs gradually will be assumed by the GOH on an increasing basis similar to that used for new GOH employees under this Project; that is, Project funds will pay 100% of the per diems the first year, 75% the second year, and so on, until the GOH is paying 100% in the first year after the end of the Project. A.I.D. also will provide 32 vehicles for supervision, while the MOH will provide drivers, fuel, and maintenance.

Given the importance of supervision to the effectiveness and efficiency of the Extension of Coverage Programs of the MOH, it is essential that these efforts be coherent and well directed. Therefore, the MOH will make supervision a program level activity at either the national or regional level with its own budget and coordinating staff.

This component will produce an operating system of supervision which will effectively increase the efficiency of the MOH by providing 261,000 person days of VHW meetings with the auxiliary nurse from their CESAR, 154,000 person days of supervision of VHWs in their villages, 36,000 person-days of supervision of auxiliary nurses in their area supervisor's office, 21,000 person-days of supervision of auxiliary nurses in their CESAR work sites, and 18,000 person-days of supervision of Promoter I's in their work sites by Promoter II's, and 770 persons trained in supervision activities.

Section B.16 Component No. 16 Continuing Education for Village Health Workers. This component will be supported by the Extension of Supervision and Mass Media for Village Health Worker components.

The purpose of this component is to increase the number of village volunteers actively working. This in turn will increase health service coverage at the community level, and increase the number of services provided through MOH programs. The component will retrain most VHW's annually. The training will be based upon the existing program and problems which will have been identified. A study of current VHW activities and abilities to provide a basis for this training will be funded under the A.I.D.-financed Health Planning Project No. 522-0148.

A.I.D. will provide initial funding for a coordinator at the national level and per diem for the volunteers. The MOH will assume these costs gradually over the life of the Project in the same manner discussed in several of the earlier components. A.I.D. will finance some materials, and the MOH will provide instructors' salaries.

This component will produce 96,000 person-days of courses for VHW's actively working in the MDH extension of coverage program.

Section B.17. Component No. 17: Continuing Education for MDH Employees. The purpose of this component is to increase the efficiency and effectiveness of both auxiliary and professional employees working primarily at the CESAR and CESAM levels, through continuing education. This component includes continuing education in a formal classroom setting, by the Division of Human Resources. The training will be for auxiliary nurses, health promoters, maintenance workers, administrators, malaria workers, and laboratory technicians. Also, doctors and nurses working at the regional and clinic levels will receive training. The content of training will be designed to facilitate effective execution of the extension-of-coverage program, with emphasis on effective communicable disease control, mother-child health, cultural distance factors and other basic health services.

Several additional activities will be undertaken to support the training. A monthly continuing education newsletter for the MDH staff will be produced and distributed on a trial basis by the Human Resources Division. A national planning and continuing education information center will be established either with regional branches or with a system for circulating documents to the regional level. This will be based on an existing A.I.D. financed feasibility study. Finally, the MDH training center for auxiliary health workers in San Pedro Sula will be expanded to provide increased classroom space.

A.I.D. initially will finance per diem for students. The MDH gradually will assume these costs. A.I.D. also will provide three years of TA to support this and other continuing education activities, as well as materials, equipment, and construction costs. The MDH will provide instructors' and students' salaries, and coordinators' salaries, along with the items already mentioned.

This component will result in an output of 7,200 person weeks of short courses in the fields specified in the budget tables, the distribution of 25,000 copies of different Continuing Education Magazines, and the establishment of a national system for the distribution of health sector information.

ARTICLE C

Project Implementation

Section C.1. Project Coordination. Overall Project coordination will be the responsibility of the Project Administration and Coordination Unit located in, and responsible to the Office of the Director General of Health. The Unit will be the focal point for coordinating all administrative or managerial activities required under the Project description, and will be the main GOH liason or contact point between the MDH, CONSUPLANE, and A.I.D. with respect to Project implementation matters.

The Coordination Unit will consist of three people, to be financed with loan funds, including a Project Coordinator/Program Officer, a Budget Officer and a Procurement Officer.

The Project Coordinator will have the specific responsibility of keeping the Director General of Health, and through him, the Minister of Health, informed as to Project progress. The Coordinator will bring any implementation problems of a policy nature to the attention of the Director General for resolution. The Coordinator will be responsible for monitoring Project progress against stated goals and for maintaining liaison with the various component coordinators, consultants and heads of offices charged with specific implementation responsibilities. He will also be responsible for the development of a time phased implementation plan for the execution of the Project.

The Budget officer will be responsible for control of Project costs and, through the Project Coordinator, communications with the Ministry of Finance and Public Credit and A.I.D. on matters pertaining to reimbursements of Project expenditures. He will also work with the heads of various participating offices in the preparation of any budgets or financial reports required within the framework of the Project.

The Procurement Officer will concentrate on matters related to the procurement of goods and services, and will prepare and forward for approval (through the Project Coordinator) to A.I.D. all procurement actions and pertinent documents proposed or produced by participating offices, such as bidding documents, personal services contracts and so forth. The Procurement Officer will also be responsible for maintaining liaison with the Proveduria General and the Ministry of Finance with respect to procurement matters.

Project Grant funds will be used to contract an individual responsible to A.I.D. to act as an A.I.D. liaison representative, to assist the Coordination Unit and the MDH in complying with A.I.D. regulations and other provisions of the Project Agreement.

Section C.2. Project Evaluations. Project evaluations will be carried out on an annual basis beginning with the first anniversary of the signature of the Project Agreement. The evaluations will be conducted jointly by A.I.D. and the MDH and will involve CONSUPLANE participation and that of the Ministry of Finance. Project funding will be used to finance related expenses such as surveys, data processing, analytic work and possibly short term technical assistance if the need arises.

Project progress will be monitored on a continuous basis by A.I.D. and the Coordination Unit and will be the subject of Quarterly reports to be coordinated between the MDH, CONSUPLANE and A.I.D.

Section C.3. Cost Sharing Study. To comply with the special covenant contained in Section 6.3 of the Agreement regarding a study of means for cost sharing, the MOH will submit to A.I.D. a plan showing the scope of the study and the resources necessary to complete the study. In the event additional resources beyond those already available to the Borrower/Grantee are needed to complete the study, Grant funds may be reprogrammed for this purpose by mutual agreement.

Section C.4. Financial Plan. The following attachments represent the Project Financial Plan in the following manner: Attachment A shows the Project budget by funding agency (A.I.D./GOH and applications or input e.g. technical assistance, and so on). Attachment B shows the Budget by Component and calendar year and Attachment C shows the budget by Component and project year.

LIST OF PERSONS INTERVIEWED

AID:

Dr. Barry Smith, Project Officer
Thomas Park, Health and Nutrition Officer
Scott Taylor, Project Assistant
Cynthia Giusti, Project Support Officer
Ron Witherell, Chief, Human Resources Office
Ron Nicholson, Deputy Mission Director

PROJECT COORDINATION UNIT:

Dr. Reinaldo Gomez Urtelho, Project Coordinator
Ulhma Padilla, Project Administrator
Joel Ortiz Lanza, Procurement Officer

MOH CENTRAL OFFICES:

Dr. Carlos Pineda, Chief, Vector Control Division
Dra. Anarda Estrada, Chief, Human Resources Division
Lic. Guillermo Consuegra, Human Resources Division
Dr. Omar Gonzalez, Vector Control Division
Arq. Emilio Rivera Rios, Chief of Maintenance, GCEDI
Dr. Richard Molina, Supervision Working Group
Dra. Beatriz Fonseca, Supervision Working Group
Dra. Yolanda I. Morales de Ponce, Coordinator of the Information Center
Marina de Bhaday, Chief of Purchasing and Supplies, CONAME
Dra. Maria Huguet M. De Portillo, Unidad de Medicamentos, CONAME
Carlos Nelson Peralta, Sub-Director de Administracion, CONAME
Lesbia de Lorenzana, Chief of Warehousing, CONAME
Melida de Duron, Encargada, Central Warehouse
Dr. Alberto Guzman, Chief of Epidemiology Division
Dr. Escota, Chief of Tuberculosis Program
Dr. Danilo Velasquez, Chief, Maternal and Child Health Division

Sr. Fausto Carcamo, Chief of Transport, Administration Division
Dr. Yanuario Garcia, Chief, Science and Technology Unit
Dr. Alefando Melara-Croup Coordinacion Ejecutive y Desarrollo Institucional (GCEDI)
Dr. Jose Annibal Funes-GCEDI
Dr. Alfredo Leon Padilla-GCEDI
Lic. Joselina Paz-GCEDI
Dr. Elio Sierra-Chief Planning Division
Dr. Anibal Mejia-Advisor Administrative Division
Lic. Luis Sarminto, Acting Chief, Health Education Unit
Lic. Maria Rosa Bonanno, Diarrheal Disease Unit
Lic. Maria Teresa Cerella, Diarrheal Disease Unit

OTHER:

Dr. Jeff Stivers, Malaria Advisor