CLASSIFICATION

PROJECT EVALUATION SUMMARY (PES) — PART I

Report Symbol U-447

1. PROJECT TITLE	2. PROJECT NUMBER	3. MISSION/AID/W OFFICE
RURAL HEALTH DELIVERY SYSTEMS	511-0453	HHA - USAID/B

4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) 78-7

☒ REGULAR EVALUATION ☐ SPECIAL EVALUATION

5. KEY PROJECT IMPLEMENTATION DATES			6. ESTIMATED PROJECT FUNDING	7. PERIOD COVERED BY EVALUATION
A. First PRO-AG or Equivalent FY 1976	B. Final Obligation Expected FY 1979	C. Final Input Delivery FY 1979	A. Total $ 1,356,500 B. U.S. $ 914,000	From (month/yr.) June 1976 To (month/yr.) August 1978 Date of Evaluation Review

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

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. To establish a bank account for the rotation fund from sales of medicines.	MSW/PH	December 1978
2. To determine the need for accounting personnel at the Regional Level, and to insure the implementation of the approved accounting procedures.	MSW/PH	December 1978
3. Future expansion of project activities outside the Montero area, i.e. the San Julián area.	MSW/PH NIC	November 1978
4. Construction of the project warehouse in Montero for storing project stock.	CORDECRUZ	December 1978
5. To hire a person for filling the position of Project Administrative Officer in Santa Cruz in a permanent basis.	MSW/PH	November 1978

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9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS

- ☐ Project Paper
- ☐ Financial Plan
- ☐ Logical Framework
- ☐ Project Agreement
- ☒ Implementation Plan e.g., CPI Network
- ☐ PIO/T
- ☐ PIO/C
- ☐ PIO/P
- ☐ Other (Specify) _____
- ☐ Other (Specify) _____

10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT

- A. ☐ Continue Project Without Change
- B. ☐ Change Project Design and/or ☐ Change Implementation Plan
- C. ☐ Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)

Edward L. Kadunc
Acting Chief Health & Humanitarian Assistance Division

12. Mission Director Approval

Signature

Typed Name Frank B. Kimball

Date 5/17/79

AID 1330-15 (3-78)

13. SUMMARY.- The project, currently operating within the proposed area, has proven to be based upon a sound design, although it still encounters certain administrative problems at all levels. Within the near future, Project activities will be expanded into the San Julian area, which will aid in testing the applicability of all systems and instruments. The Ministry of Social Welfare and Public Health is giving serious consideration to using the Montero Project as a model for providing rural health services to other parts of the country under the proposed Rural Health Loan.

14. EVALUATION METHODOLOGY.- This evaluation focussed on the tendencies that are clear from project experience to date which indicate the potential for improving service utilization and coverage by using the rural health model developed in this project. Since service delivery began in late 1977, this evaluation did not focus on completely evaluating accomplishments in these critical areas.

- the evaluation describes the various sub-systems or components of the systems as they function within the project's overall structure. The sub-systems are: (1) service delivery; (2) human resources (3) community organization; (4) facilities and logistic support; (5) Administration; (6) Information and evaluation; and (7) Planning. It also discusses the population coverage achieved under initial full system operation.

- include evaluation methodology and costs.

- identify agencies and key individuals (host, other donor, public, AID) participating and contributing.

15. EXTERNAL FACTORS

The major change with respect to project design has been a shift in the emphasis of the project from the broad health research efforts to one that is expected to be more useful in the long run, i.e., to design and implement specific pilot projects in the systematic delivery of health services in a limited rural area of Bolivia.

This shift and extension of 18 months, which have been supported by two additional funding amendments approved by AID/W ($250,000 in FY 1976 and $230,000 in FY 1977), have enabled the Mission and the MSW/PH to design and gain experience in the management of each of the components and of the system as a whole. Such experience has been valuable to the GOB in designing an expanded rural health activities.

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This last MOH effort on a national basis also confirms one of the major assumptions considered in the logical framework of this project, which was "that the MOH will expand the effective health coverage of the rural population".

16. INPUTS.- Looking at the project in terms of the personnel currently in place, the personnel required according to the logical framework, and the personnel currently required for adequate functioning of the project, two significant facts arise. First, the original project design underestimated the number of personnel required to design and initiate the integrated system of health service delivery envisioned. Despite this underestimation, the MSW/PH has responded positively in most cases by providing additional personnel as required.

Second, the community participation mechanism and number of persons involved at the community level was not foreseen in the original project design. Despite lack of specific funding to secure this participation, the Project has both developed this mechanism and assured the full participation of 92 persons who are members of the community committee.

Also, as a result of further analysis of the community level and the mechanism for securing full community participation in health services provided by the MSW/PH, the Community Organization project component had to be significantly increased over the initial project design. The narrative of the PP called for strong community participation in terms of community elections and payment of the health promoter, payment by community member for individual health services and supplies, and joint community promoter health service programming with MSW/PH supervision. In order to achieve such community participation the Project has designed a four-step methodology to enable the communities to organize themselves for these purposes, and has already begun implementing health activities with the MSW/PH under this scheme.

Despite the variations from the Logical Framework and the difficulties in carrying out the training activities, the project has trained nearly twice as many people as planned; the only two elements that have not been completed are the course for empirical midwives and the two national seminars.

The former has not been carried out because of a major restructuring of all material and child health programs which took over a year to

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complete. The latter has been postponed because the central MSW/PH officers under specific directions from the Ministry decided not to publicize the Project in a national Forum until services are being delivered as planned. At this moment, there is a greater chance that such seminar will take place soon, given the current project status and the recent GOB priorities regarding this sector.

17. OUTPUTS.- There has been delay in the design of the various sub-systems, which are presently being developed, together with the proposed manuals. Only 70% of the manuals have been prepared. The Project has organized health activities in 39 Rural Communities as compared with the original target of 44; in other words, it is approximately 89% of target. The Project surpassed its training targets: originally the Project planned on training 467 people in 47 courses, seminars and workshops. However, as of the middle of 1978, 741 people had been trained in 45 courses. Despite the delay in receiving the necessary financing for the training activities, the Project has been able to increase the output of persons-trained by increasing the number of participants per training activity. There are no foreseeable changes required for the outputs, although some systems manuals may be considered unnecessary.

18. PURPOSE.- The purpose of the project is to plan, organize and successfully implement a low cost rural health services delivery system (RHDS) in a pilot area - Montero, Santa Cruz Department.

The first EOPS condition that will indicate that this purpose has been achieved is that MSW/PH systems required for adequate functioning of the Montero RHDS service and support activities are organized and operating at the local, sub-district, district, departmental and national levels. At the national level there still remain some problems due to the inadequacy of the MSW/PH existing administrative system for the project. At all the other levels the systems are working 99% as planned. Given the recent GOB priorities within the health sector, however, adequate changes in the MSW/PH administrative and organizational systems are expected soon, which should have a positive impact in the RHDS Montero Project.

A second EOPS condition is that a training capacity would have to be established to meet the auxiliary and community level human resource development needs of the project and other departmental programs. Except for the empirical midwives training program which is still pending due to the delay of MSW/PH funding and the low priority given to this activity all the other programmed training activities under the project have been achieved 100%.

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The third MOH condition is to have an analytical base for the project adequate to determine its feasibility for wider application in Bolivia and to provide the basis for such decision. This MOH condition has been 100% achieved since the MOH is implementing an expanded system of rural health services based on the experience gained for the Montero MIDS project.

19. GOAL.- The overall goal of this project is to improve the health status of the approximately 120,000 rural people living in the northern Santa Cruz area. In doing so, the project should provide for achievement of the health sector goal of improving the health status of all rural Bolivians.

Excluding the urban center of Montero with its population of 30,000 from the Project's direct coverage area, the project is directly providing health services to 14,046 people in a family-by-family basis and indirectly to 38,125 additional persons; this is a total of 44% of the target group. According to the Health Sector Assessment (1974) the MSW/PH provides a sporadic service to approximately 15% of the total rural population. Under this project, however, the MSW/PH is providing continuous service to 31 of the total rural population in Northern Santa Cruz. If we were to include the on-going health services provided under the traditional MSW/PH scheme outside the project area, coverage would be about 50%.

According to the information available for the first four months of service activities in the project there is significantly greater utilization of services than on a national basis. While the national average of services provided at the health posts by the Auxiliary I is 16 visits per month, the average in Montero is 63 per month. Considering that in the project the Auxiliary I dedicates a maximum of 50% of his/her time to this activity while the other national group is dedicating 100%, this four-fold increase is impressive. In terms of the promoter, which is a harder level for delivering services and for which there is no national comparison, he/she averages 60 household visits per month.

20. BENEFICIARIES.-

The primary beneficiaries of the project are the estimated 35,000 rural people in the five nuclear communities and the 33 satellite communities plus a number of people from other surrounding communities as less direct beneficiaries, which make a total of approximately 120,000 people living in the Northern Santa Cruz area.

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Actually, the project is directly providing health services to 14,646 on a family-by-family basis and to 38,125 people less directly.

Originally 44 potential communities were selected to participate directly in the project. By June 1977, 31 were organized and ready to participate in project activities: these had a community committee elected and were ready to nominate a health promoter to be paid by them and to sign an agreement with the project outlining the mutual duties and rights. In January 1978, 24 communities were working with promoters and 17 were fully entered the service delivery system under the project's auspices. Thus, in the first six months of operations, the project had a 39% rate of full community participation and a 55% rate of partial participation. By January 1979, it is expected that project will achieve a full community participation rate of 70% due to the efforts of the District Outreach Team to reinforce the weaken community organizations.

From the 39 rural communities receiving health services in the Project area, 31 are classified as Coverage Units with an average population of 245 people each; and 8 communities are classified as Basic Health Units with an average population of 800 people each. The remaining population is located in four towns designated Area Centers with an average population of 6,000 people each. These classifications refer to the different types of service, personnel and infrastructure that should be found in each. The 30,000 people living in the Montero urban area are not included in the project's direct coverage area.

21. UNPLANNED EFFECTS.- The major unplanned effect of the Project has been in the area of community organization, including the training of community leaders and the creation and involvement of local Community Health Committees. This aspect has helped gain support for the Project, both within the Montero area as well as throughout the rest of the country.

22. LESSONS LEARNED.- A major lesson learned has been the need to assure that counterparts be assigned to the Project on a full-time basis and that they be competent in the respective fields. In addition, the time frames required, especially in order to establish the various sub-systems (information, logistics, etc.) should be studied more closely in relation to the technical assistance available and the disponibility of the present systems to adapt to the necessary changes.

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The evaluation methodology should be firmly established early in the life of the Project so that the information system can readily provide the required data. If the Project plans to expand into other areas the evaluation methodology should also take this into consideration.

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