

PROJECT EVALUATION SUMMARY (PES) - PART I

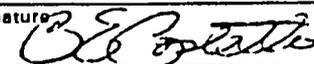
Report Control
Symbol U-447

1. PROJECT TITLE Community-Based Health and Nutrition Systems			2. PROJECT NUMBER 520-0251	3. MISSION/AID/W OFFICE USAID/Guatemala 75
5. KEY PROJECT IMPLEMENTATION DATES			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) 84-02	
A. First PRO-AG or Equivalent FY 80	B. Final Obligation Expected FY 83	C. Final Input Delivery FY 85	7. PERIOD COVERED BY EVALUATION From (month/yr.) June 1980 To (month/yr.) August 1983 Date of Evaluation Review February 2, 1984	
6. ESTIMATED PROJECT FUNDING			7. PERIOD COVERED BY EVALUATION	
A. Total \$ 12,719,000			From (month/yr.) June 1980	
B. U.S. \$ 5,800,000			To (month/yr.) August 1983	
			Date of Evaluation Review February 2, 1984	

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. Given the complexity of project design and continuously demonstrated implementation weaknesses in carrying out the project, the decision is made to focus project activities exclusively on the environmental sanitation component.	C. Costello	February 1984
2. Integrate all training activities of rural sanitation promoters into environmental sanitation implementation plan.	P. Cohn	April 1984
3. Eliminate all housing improvements both as models and as loans and re-direct the funds thus available for the construction of water supply and latrine systems.	P. Cohn L. Odle	April 1984
4. Delete the budget items for health posts rehabilitation and renovations.	P. Cohn L. Odle	April 1984
5. Discussions with the Minister of Health, the MOH and GOG commitments necessary for the MOH to meet its obligations agreed to in the amended schedule and budget as set forth in USAID-prepared agendas for those discussions.	P. Kolar P. Cohn	March 1984
6. Contract technical assistance to determine whether the regional concept continues viable; analyze the operation of the water system revolving fund and maintenance; and provide, as required, the necessary assistance in implementation.	P. Cohn L. Odle	April 1984

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS	10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT
<input type="checkbox"/> Project Paper <input checked="" type="checkbox"/> Financial Plan <input type="checkbox"/> Logical Framework <input type="checkbox"/> Project Agreement <input checked="" type="checkbox"/> Implementation Plan e.g., CPI Network <input type="checkbox"/> PIO/T <input type="checkbox"/> PIO/C <input type="checkbox"/> PIO/P <input checked="" type="checkbox"/> Other (Specify) Annex I to Proj Agreement <input type="checkbox"/> Other (Specify) _____	A. <input type="checkbox"/> Continue Project Without Change B. <input checked="" type="checkbox"/> Change Project Design and/or <input type="checkbox"/> Change Implementation Plan C. <input type="checkbox"/> Discontinue Project

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)	12. Mission/AID/W Office Director Approval
Paul Cohn, Health Development Officer, USAID/Guatemala Dr. Oswaldo Chinchilla A., Director General, MOH Dr. Luis Alonso, Chief, Community-Based Health and Nutrition Systems	Signature:  Typed Name: Charles E. Costello Date: February 8, 1984

13. Summary

Although the project agreements were signed in September 1980, they were not approved by the Congress of Guatemala until June 1981. The first loan-funded activities commenced in October 1982 with the initiation of the construction of eight water supply and latrine systems, the first training courses for health promoters and midwives, and the initial remodeling of a building to serve as the regional headquarters. Project progress has been excruciatingly slow due to the inability of the central grant-funded staff to plan and manage the actions necessary for implementation of a complex project. Major personnel changes at all levels led to the neglect of the project at the policy making level which consequently produced a sporadic and unpredictable cash flow and an uneven flow of materials to technical people in the field. Two key project staff funded by the grant were unable to handle their responsibilities exacerbating the delays.

Construction activities can be accelerated with the timely provision of the necessary materiel to the project sites. Training is on schedule but in and of itself will not be sufficient to meet overall purposes without the strengthening of supervision and information systems to support the trained personnel. The logistic support systems need to be evaluated to improve the efficiency and support of field personnel. The evaluators found that the project purpose could be achieved within the originally programmed project period if certain administrative policies were adopted and the institutionalization of the support systems was accelerated.

14. Evaluation Methodology

Given the slow rate of implementation, the Mission sponsored an outside evaluation to measure project progress. It was anticipated that a team of evaluators would conduct the evaluation, but the second primary health care evaluator cancelled at the last minute. Therefore, the scope of work was curtailed and the following project activities were evaluated: construction, primary health care training, and coordination and administration. The PES is based on the findings of the three evaluators.

Financed by project grant funds, Lic. Juan Valle Garido, a Guatemalan expert in administration, undertook an analysis of project administration and coordination during the month of June 1983. Lic. Valle interviewed central MOH and field personnel responsible for administering project activities as well as carrying out a survey of the personnel working in the administrative financial unit. His analysis was presented in a final report dated July 6, 1983.

Dr. Henry Van, funded by the Water and Sanitation for Health (WASH) Project, and Dr. Petra Reyes, funded by the Accelerated Delivery System Support (ADSS) project, reviewed construction and primary health care activities respectively, during the period July 24 to August 12, 1983. The evaluators reviewed project documents, interviewed Mission and Ministry of Health (MOH) personnel knowledgeable about the project, collected statistical reports, visited project sites to review actual progress, interviewed field personnel, and discussed their findings with representatives of the Mission and the MOH. These findings were presented in two separate reports submitted to the MOH and the Mission in August 1983. During their stay in Guatemala, Lic. Valle worked with the two team members.

The evaluation team recommended that the immunization and oral rehydration programs be evaluated as well as the fixed-facility service delivery system. The Project Committee was disappointed that the evaluators did not review the upward linkages between outputs and purpose and goal, the continued viability of the end of project status, and the feasibility of the regional fixed facility concept. All of the above mentioned areas should be addressed in subsequent evaluations.

15. External Factors

Two governmental coups during the period of project implementation resulted in major personnel changes in the MOH. Following the first coup, most MOH senior staff were replaced, partly by young and relatively inexperienced personnel, with the rest released or transferred to other MOH activities. In addition, a PAHO-supported program to restructure and decentralize the MOH created operational vagaries in project implementation. At the time of the evaluation, the MOH, under the government which took power on August 3, 1983, had not yet enunciated its policies concerning health priorities.

During 1982 the general decline in Guatemala's balance of payments situation forced the government to undertake an austerity program. In order to limit the central government deficits and conform to IMF strictures, the MOH among other social service ministries was forced to decrease their budget by 26%. This austerity measure impacted on project implementation through a delay in the establishment of new governmental positions for both permanent and contract employees. Six key project employees, who were to be placed on the MOH rolls at the beginning of CY 1983, had not had their positions approved as of July 1983. Currently the hiring process takes approximately 8 months, although in the case mentioned above it has exceeded that timeframe.

16. Inputs

AID financial inputs were provided on a timely basis through loan and grant agreements (signed in September 1980) and subsequent grant amendments. The GOG ratified the loan agreement in May 1981. Given the scarcity of funds in the DGSS (Dirección General de Servicios de Salud) to cover personnel costs associated with satisfying conditions precedent of the loan, AID authorized the use of grant funds for this purpose beginning CY 1981. Five persons, some of whom had other responsibilities, undertook the initial actions (programming, budgeting, requesting approval of positions, and meetings with other public sector institutions) to explain the program. Although the conditions precedent to initial disbursement of the loan were met in June 1981, none of the programmed activities were carried out in 1981.

The administrative organization as originally contemplated never functioned well. The DGSS had the responsibility to carry out the project and the structure that could adapt to a program with outside financing and did not have the required personnel to permit the efficient and timely execution of the program. The assumption that management development assistance to the central MOH organization, supported by PAHO and CDC, would complement regional management development and serve to strengthen central level capability to run the program was not realized. The project administrative unit is neither an executive unit nor an ordinary program of DGSS, it functions as an office added to the DGSS administration requiring compliance with all the bureaucratic requirements and organization of the Directorate General and creating a duplication of procedures due to procedural requirements by AID which affect negatively the project activities. Lic. Valle recommended a reorganization which emphasizes decentralization of decision making and the assignment of responsibilities to maintain strict control of the activities as well as placing the Financial Management Unit in a line position so that all project components are supported efficiently and timely.

A major delay encountered in carrying out the project activities was the failure to meet the condition precedent for the first disbursement for the construction of the environmental sanitation subprojects until January 1982. All activities under the environmental sanitation component were paralyzed until this condition was met resulting in no recruitment of personnel until August 1982, and commodity purchases (primarily vehicles) originally scheduled for 1981 not being programmed within the GOG budget in 1982. The GOG revolving fund for per diem and petty cash which was set up in January 1982 is fraught with bureaucratic requirements which divert the employees' time to process the paperwork. In order to accelerate

construction under the environmental sanitation component, AID initiated a system of advances to provide funds for the purchasing of the required materials. Up to now the MOH has been unable to present receipts within the 30 days required to liquidate the advance.

Personnel shortages exacerbated project implementation as well as lack of coordination among all administrative levels of the project. Project administration has not been continuous due to the two unexpected changes in government and consequent changes in the Ministry of Health. Following the March 1982 coup, the Deputy Director General resigned causing problems in the administrative structure as he had been the Project Director. The succeeding Deputy Director General did not have the experience necessary to be the Project Director nor did he take responsibility for the project. The DGSS would not agree to hire a top level experienced Project Director to assist the deputy Director General, thereby continuing inadequate administrative support. Assignment of personnel to project areas did not preclude their diversion to other MOH activities outside of the project nor did principal field personnel (area medical chief and area engineer) coordinate the establishment of priorities in the field. As the present organizational structure in the field is inadequate to meet the outputs expected, organizational and administrative responsibilities should be defined and the central project administrative unit should be the catalyst for coordination at all levels.

The environmental sanitation construction component has suffered substantial delays due to the lack of equipment, tools and construction materials. To date, in order to make progress, the Environmental Sanitation Unit has had to improvise tools and borrow equipment and materials. Technical assistance should be provided to assist the MOH Procurement Department to recommend an appropriate management system to facilitate efficient procurement procedures. As a stop-gap measure, AID should procure materials and equipment to build up a good supply while the MOH institutes its management system. Dr. Van has also recommended that the possibilities of using a bidding process to purchase materials should be explored.

Community participation has been excellent in the project. Communities have done, in many cases, work beyond their responsibility when the project failed to provide the requisite material, i.e., paid for the transportation of materials or purchased certain items that were lacking to keep the project going.

Nearly two-thirds of the projected required institutional personnel under the primary health care component have received

the initial training for their functions. Training support continues to be inadequate and has not received sufficient attention from the MOH. It has been reported that physicians at the area and district levels demonstrate lack of understanding of the program and their responsibilities and functions for its support. The communication flow among project levels is inadequate. A training management plan must be developed concurrently with the program implementation plan. Training should be decentralized in accordance with the systems management plan. Area medical chiefs and district level physicians must have clear definitions of their responsibilities and functions. Analysis of the management information system should be routinely communicated to the decentralized levels and serve as a basis for site visits by project personnel.

17. Outputs

The project was far behind output targets at the time of the evaluation. None of the programmed activities to be carried out in 1981 were implemented. In 1982, project activities were concentrated on potable water and latrine systems construction, training institutional personnel, completion of the first phase rehabilitation of the regional complex, primary health care training of community personnel, and training of community and institutional personnel for environmental sanitation. In the first six months of 1983 under the environmental sanitation component, 13.3% of the aqueducts programmed were constructed, 53.8% of the latrines provided, 100% of community personnel and 39.6% of institutional personnel were trained. The above statistics reflect an accelerated pace in carrying out the project activities during the first half of calendar year 1983. Table I shows the outputs programmed, completion as of July 30, 1983, and the percentages completed as of that date according to the evaluator's findings.

The evaluators found that the input/output coordination problems were a result of problems with the central administration unit and its relationship to field activities. None of the evaluations revealed any changes needed in the outputs to achieve the project purpose. Specific findings on the environmental sanitation and primary health care training activities follow.

A. Environmental Sanitation Activities

Dr. Van found that the MOH personnel responsible for the studies and designs of the water supply and latrine systems have lacked the requisite drafting and topographic equipment, but using borrowed equipment they have made good progress on the designs for the water supply and latrine systems and the

renovations of health posts. Selection of candidates for housing improvements has been slow and practically nothing has been done to provide subloans for housing improvements. The environmental sanitation unit has been short of personnel and the construction has had serious problems with materials and transportation. The construction activities are far behind schedule with construction and renovation of health posts not yet begun. The housing improvements programmed appear to be insufficient to satisfy the communities since they would be constructed on a model basis, thus giving some community members free improvements while others would have to borrow in order to effect the change. Two alternatives should be considered: (1) delete the housing improvements and construct four more water supply and latrine systems or (2) supply all community members with a Lorena-type stove.

The present organizational structure is inadequate to meet the outputs expected. The rural sanitation technicians (TSR) work mainly with the project's medical staff on activities outside the program and are not functioning as planned to gather preliminary information to initiate water supply and latrine systems. The lack of coordination between the area physicians and the area engineers has prevented the establishment of priorities regarding environmental sanitation and primary health care activities. To achieve better coordination central project administration should conduct an information seminar at least every three months with regional personnel to know the project and learn how the various components integrate with one another.

B. Primary Health Care Training Activities

Training activities started slowly and have gained momentum during the past six months. All of the institutional personnel in the program and at all levels of participating health facilities were oriented to the program and trained. However, the evaluators encountered problems and/or misunderstandings concerning the functions of the TSRs. In December 1982, the first groups of community-based personnel entered training and assumed responsibilities in March/April 1983. More than 60% of the targeted midwives have been trained. The percentage of promoters trained is considerably smaller than that of the midwives. Irrespective of the program delay in initiating training activities, the numerical output of personnel trained is adequate and acceptable as a mid-project accomplishment and a functional training system is in place.

Since the functioning supervision/information system was not in place to help evaluate the training quality and effectiveness subjective impressions of quality were reported by

Dr. Reyes. A major accomplishment of the program has been a complete reorientation of the training methods from theoretically oriented didactic classroom methods to a functional task-oriented approach. Of all training levels reviewed, only the auxiliary nurses appeared to be less skilled in their approach, thus requiring further on-the-job and in-service training. Trainee satisfaction and enthusiasm were overwhelming in the first of five training units. The promoters are making community contact, but the time available for this contact is limited by their work. Senior project staff report that there has been an increase in service demands and output in those areas where the community-based workers are operating. A severe problem in assessing the effectiveness and quality of the training is that information is currently based on self reports. Until the supervision-information system is sufficiently in place, neither the TSRs nor auxiliary nurses have a firm base to verify activities on the family level.

The key elements in the project design are the dual functions of institutional personnel in training and supervision. At the end of 1983 with the completion of the training of the third group of promoters, both San Marcos and Sololá will have reached their capacity with given institutional personnel. In fact, the standards for supervision may have to be modified according to locality, taking into consideration the dispersion of the population, difficulty in access posed by the terrain, and the logistical support system. Effectiveness of training can only be gauged through an effective supervision system. To reach the targets, institutional personnel have already been shifted from other areas in the program. Following the third cycle of trained promoters, additional trainers will be required for further training output. This situation does not take into account the time required to effectively put an information system into place. A practical analysis of supervisory output can be made only after the supervision/information systems have been fully implemented.

TABLE I

<u>Activity</u>	<u>Sched- uled LOP</u>	<u>07-30-83 per Eval- uators</u>	<u>Actual Percent- age Com- pleted</u>
<u>A. Environmental Sanitation</u>			
i. Water Systems	114	8	13.0
ii. Latrines	7,000	582	23.0
iii. Housing Improvements	1,500	0	
<u>B. Primary Care Component</u>			
i. Promoters Trained	1,500	577	38.5
ii. Promoters Retrained	600	0	
iii. Midwives Trained	950	610	62.1
iv. Trainers Trained			
- TSRs (Rural Health Technicians)	75	48	64.0
- Auxiliary Nurses	95	60	63.2
v. Health Posts Constructed	13	0	0.0
vi. Health Posts Renovated	44	0	0.0
vii. Health Posts Equipped	123	0	0.0
<u>C. Support Component</u>			
i. Regional Service Center in Totonicapán			
- First Phase Renovation	1	1	100.0
- Second Phase Renovation	1	0	0.0
ii. Information System	1	0	0.0
- Complete Baseline Surveys	1	1	50.0

iii. Maintenance System Initiated	1	0	0.0
- Purchase of Maintenance Equipment for Regional Service Center	1	0	0.0
iv. Achieve Improved Medications Supply System	1	0	0.0

18. Purpose

The project purpose is to develop the institutional capacity of the MOH to increase the coverage and effectiveness of a fully integrated rural health delivery system in the target area. Given the absence of a supervision/information system, specific progress towards the end of project status (EOPS) cannot be measured at the present time. As described in the Outputs Section, progress in meeting the EOPS has been minimal due to implementation delays. However, all three evaluators reported that project purpose could be achieved within the originally programmed project period if certain administrative policies were adopted and institutionalization of support systems were accelerated.

19. Goal

The goal of the project is to improve the health and nutritional status and overall welfare of the rural poor in the target area. Due to the delay in realizing the outputs, it is premature to evaluate whether this project is contributing to the goal. However, the increased demand for services in those areas where the community-based workers are operating would indicate that the project will contribute significantly to achieving the goal. There is no information at present which indicates the goal cannot be achieved if the inputs are provided on a timely and appropriate basis.

20. Beneficiaries

The direct beneficiaries of the project are the rural population within the three health area/departments of Sololá, Totonicapán and San Marcos (population 695,000 people) with special emphasis given to the major at-risk groups: rural children under 5 and women of child-bearing age (132,000 and 167,000 respectively). Communities have responded very well to the community participation concept when the villagers have seen a tangible reward for their labor. Some communities have waited up to eight years to get a water supply and their commitment has been demonstrated in assisting project personnel in overcoming material and transportation shortages. Community members trained by construction engineers in the operation and maintenance of the water supply and latrine systems seem to understand their duties and responsibilities regarding operation and maintenance of the systems as well as the collection of maintenance fees. The Rural Health Promoters have demonstrated their grasp of their responsibilities and their own and community objectives by attempting to balance this volunteer work with earning a livelihood. Frustrations expressed by the promoters dealt with the drug supply system inadequately working and in one case the difficulty in getting referral cases managed at the fixed facilities.

21. UNPLANNED EFFECTS

Not pertinent at this time.

22. LESSONS LEARNED

1. The project was originally developed for more than double the amount of AID funding finally approved. The activities of this project were scaled down but the complexity of the project was not reduced. This project has been shown to have so many components, activities, and subactivities that it is a very difficult project both for the MOH and the Mission to manage. Any one of the three major components would have been a project by itself without the complexity resulting from integration of activities made necessary by the design.

2. The Ministry of Health and the Mission both clearly underestimated the need for an experienced central MOH administrative unit capable of coordinating, integrating and managing these activities. In addition, the Ministry of Health does not number among its employees administrators capable of managing the central administrative component either on the administrative side nor on the technical side. The Ministry was very loath to hire technical assistance to assist and train the core staff originally hired and approved by both the MOH and the Mission who were inadequately trained and prepared for the complexity of the task.

3. Three evaluators, each one obtained from and funded through a different source, participated in this evaluation of a complex and difficult project. As a result of not having appointed a team leader charged with coordinating and synthesizing the three reports and as a result of having received the draft and final reports months later, the Mission project staff found itself in the position of assuming this task after the fact. It was not clear to the Mission until the receipt and review of the reports that the continuing viability of the EOPS had not been closely reviewed although this had been clearly in the written scope of work and the entrance briefing.