Primary Health Care Financing

Project Evaluation

USAID/Bolivia

Resources for Child Health Project

REACH
PRIMARY HEALTH CARE FINANCING PROJECT EVALUATION

USAID/Bolivia

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Alfredo Solari, MD, DPH
Gerald Rosenthal, PhD
Kevin Driesen, MPH

The Resources for Child Health Project
1100 Wilson Boulevard
Ninth Floor
Arlington, VA 22209

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EXECUTIVE SUMMARY

I. Background and Main Findings

A. The original project design of the Primary Health Care Self-Financing Program was incomplete. The conflicting interests and irreconcilable differences among participating cooperatives, between themselves and with the eventually autonomous Management Support Unit (MSU) were not fully addressed in the project design. These differences relate to ownership and control of the health services delivery modules (assets, personnel and operation). Most of these problems were recognized in the revision of the PID and contained in the cable of the DAEC Committee of February 1983. Regrettably, no appropriate corrective measures were included in the Project Paper of August 1983.

B. After 18 months of a power struggle which began between participating cooperatives, and later involved the emerging MSU, USAID/B temporarily assumed direct responsibility for project management. At that time USAID/B took action to replace the original participating cooperatives and strengthened the MSU, which became a discrete legal entity.

As of September 1985, USAID/B de-obligated and re-obligated the project through a cooperative agreement with Management Sciences for Health (MSH). The completion date was extended from August 1986 to April 1987.

C. The re-obligation and the Cooperative Agreement of September 1985 retained the main goal of the original project, which was to determine the feasibility of establishing self-sustained primary health care services through private providers. Nevertheless, important changes in the functions and responsibilities of key project components were introduced. These changes concentrated power in the MSU and opened-up the participation to almost any type of community organization. However, the inherent issues concerning ownership and control of the health service modules project were maintained for future resolution in the September/85 agreement.

D. Moreover, because of the urgent need to affect de-obligation/re-obligation actions, the Cooperative Agreement of September 1985 kept many formal elements of the original design (of 1983). As a result, the document specified tasks that had already proved to be infeasible or inappropriate, such as working in the San Julian and Minero areas. Most of these activities were identified in the MSH Semester Report of March 1986. For example, during phases II, III and IV (3 consecutive semesters starting in October 1985), the project was to develop three modules of primary care services in the geographical areas where the members of the original participating cooperatives live. However, as the original cooperatives were replaced with other participating institutions, these modules were developed elsewhere. Thus, MSU, already in charge of implementing the project under the name of Proteccion a la Salud or PROSALUD, began work with other cooperative-based or geographically-based communities. Subsequently, the evaluation could not be based upon the originally proposed benchmarks.
E. Finally, although the Cooperative Agreement was essential to the pursuit of self-financing primary health care services, it failed to address many conceptual problems. While some of these problems had not been adequately solved in the original design, others were created by the new nature of the project. Among the newer problem areas were the specification of responsibility and the identification of resources for marketing activities and the inclusion of research components in the project to assess feasibility of potential sites and to measure impact of services. Additional difficulties included the long-term nature of PROSALUD vis à vis the delivery of primary care services through project-developed modules; the long-term nature of the relationship(s) between PROSALUD and community organizations; and the decisions reflecting preferred or acceptable types of community financing in terms of fee-for-service, prepayment, and community subsidy.

F. The failure to adequately reconceptualize the project between February and August 1986 was probably unavoidable given the previous experience of the project and the following circumstances: the change of two key USAID/B officers directly related to the project (January 1985); the lack of project experience by the MSU staff (hired in November 1984); and the ever increasing demands on time and effort posed by the challenges to find new partners without a clear definition of granting capabilities by the MSU. Despite these difficulties, MSH, PROSALUD and USAID/B observed that an informal reconceptualization did take place. However, this process was not made explicit in the September/85 Cooperative Agreement.

G. Notwithstanding this undocumented conceptualization and the operational problems created by deteriorating economic circumstances throughout Bolivia, PROSALUD was able to develop and, since February 1985, screen several community organizations with positive results. Several attempts were made to associate with cooperatives and trade organizations, and approximately six out of twenty odd attempts were completed with geographically-based community organizations.

In March-April 1986, PROSALUD had already started delivering primary care services in two level III facilities: El Pailon (rural) and Villa Pillin (periurban). Also, a level II Center was being restored and prepared for operation sometime in May.

H. Although many problems remain to be solved, particularly of an operational nature, the second 18 months of the project have clearly been more productive than the first. Progress has been made in terms of testing the communities for their capability and willingness to finance and participate in the organization of primary health care services. But, if the reference is April 1987, it is evident that the project is far from reaching its goals.
II. Project Rationale

A. Current economic conditions have limited the ability of the Ministry of Health (MOH) to provide primary health care services for most of the Bolivian population. Although the economic stabilization policies adopted in late August 1985 are slowly showing positive results, the availability of public sector funds for social programs may be even more scarce today than in the early 80's when the project was originally conceived. Nevertheless, given the poor health status of the periurban and rural populations, the need for primary care is extremely high. This implies that if any of these needs for services are to be met in the foreseeable future, community and/or user-based funding need to be developed.

B. Current economic conditions are inducing the MOH and other public agencies active in the health field to divest themselves or the responsibility for managing the lower levels of the health care pyramid (up to level IV). This trend supports the Project's goal to determine the feasibility of developing alternative organizational forms to deliver primary health care services.

C. Observations made by the evaluation team or other experiences (Health Centers of Santa Rosita and Saavedra) and of initial successes within the project demonstrate the capacity and willingness of communities to organize and to finance, to varying degrees, the costs of health care services.

D. Under current circumstances, the project cannot fulfill its objectives of demonstrating the feasibility of self-financed primary health care services by the completion date of 1987. The development of community financing and administration strategies are contingent upon community organization and development. Similarly, the determination and establishment of the capacity of a community to organize and finance primary health care services is a slow process that will take the project well beyond its current termination date.

III. Main Recommendations

A. Redefinition of Project

The Evaluation Team recommends that several key aspects of the project be redefined based on a more coherent conceptual framework, on the project's past experience, and on more realistic expectations. The result of this redefinition should constitute a revision to the P.P. of 1983 and as an amendment to the Cooperative Agreement of September 1985. The following are some of the essential areas that need to be analyzed and defined.

1) Within the overall goal of the project, there is a need to distinguish between the economic self-sufficiency of Primary Health Care Delivery Modules and the self-financing capacity of PROSALUD. The self-sufficiency of the Health Care Modules should be tested first since, if the modules are not able to produce the minimum resources, the financial viability of PROSALUD may not deserve further consideration. In effect, if most Health Care Modules are unable to cover even their current operating

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expenditures, they cannot contemplate a contribution of any kind to PROSALUD to cover its costs. Furthermore, even if most Health Care Modules generate some revenue over their operating costs, there is still the question of the number of modules needed to demonstrate the financial viability of PROSALUD.

In view of these considerations, the Evaluation Team (ET) recommends that the project be extended in two stages - an initial stage to determine the organizational and financial feasibility of the community based, primary health care modules, and a second stage, contingent upon the results of the first, to determine the financial viability of PROSALUD.

2) There is a need to analyze and determine the long-term role(s) of PROSALUD in order to clarify and facilitate the types of partnerships it will be seeking with different community organizations. PROSALUD can potentially play several roles: direct provider of primary care services, support and management agency for health care modules that belong to cooperatives or community organizations, consulting/advisory firm that develops and manages primary care services, networking firm that co-sponsors and co-manages primary care modules with community organizations, etc. These diverse roles have important implications, in terms of ownership and control, for the relationship of PROSALUD with the communities it intends to serve.

The ET believes, on the basis of PROSALUD's experience, that these roles are not necessarily exclusive. Furthermore, the nature of the community organizations may influence which roles PROSALUD is able to play most effectively. Although the ET has a preference for enhancing the participation and responsibility of the communities, this may not be feasible in many communities until considerable community development has occurred.

The long-term roles of PROSALUD have important implications for the degree of financial support the PROSALUD may need to provide to different types of organizations during the initial stages of development and operations. If the long-term role of PROSALUD vis a vis cooperatives is of the support/advisory nature, then initial investments and subsidy requirements should be clearly stated as loans. On the other hand, if the long-term role of PROSALUD vis a vis a community organization is that of a management agency or, even more, a direct provider of services, then its initial investment and subsidies may be more properly considered as grants to that community.

Finally, the long-term nature of PROSALUD in relation to MSH must be analyzed and reconsidered. If it is envisioned as an independent, self sustaining entity, then a schedule for gradual disengagement should be contemplated.

3) This is a pilot project that should demonstrate the feasibility of self-financed medical services. Therefore, the research components of the project should be implemented, and PROSALUD should take over this responsibility directly. The major areas of research, according to the ET are: a) development and testing of the community screening criteria and the specification
of a typology of communities associated with different levels of self-financing; b) identification of epidemiological characteristics of the populations to be served and the assessment of potential service impacts on community health status and c) tests of the effectiveness and replication of the management and administrative systems used by the project. It is essential that the redefinition takes into consideration the financial and human resources needed by PROSALUD to accomplish these research tasks.

4) Even in the original design of 1983, when recruitment of members was entrusted to the participating cooperatives, the absence of a clear marketing plan, strategy, activities and budget represented a deficiency of the project. This handicap became more important once the project was opened and geographically-based/community organizations were invited to participate. PROSALUD needs human and financial resources to develop and implement marketing plans which will vary according to the types of long-term roles as well as to the kinds of relationships that the organization establishes with its cosponsor agencies.

B. Strengthen Project Management

The ET strongly recommends that several areas of project management be reinforced. The appointment of an Executive Director who can provide conceptual as well as operational leadership on a permanent basis is important for the long-term success of PROSALUD. The extension of the project makes this more feasible but also more essential. The evaluation team recognizes the value of a team approach to decision-making, particularly in the initial stages of institutional development. However, we believe there is presently a need for a clearer assignment of duties and responsibilities to individuals, coupled with stronger leadership and delegation of authority with less consensual decision-making.

The ET believes that project management will be strengthened and assisted by:

1) Development of an Advisory Board with representatives from community organizations, regional development and health authorities and persons of prominent leadership position in the community.

2) Reinforcement of the personnel recruitment procedures, in particular, for field staff to be placed in isolated rural areas; the development of support procedures that can counteract potential weaknesses or disorderly behavior of personnel under the pressure of isolation.

3) More strict management or time and tasks or both main office and field staff through careful planning and periodic review.

4) Testing and adjusting the management information systems to local realities, particularly with respect to data acquisition from field personnel.
C. Improve Marketing

In addition to the analysis of the role of marketing, which needs to be designed as part of the reconceptualization process, the ET recommends that the promotion of the primary care modules and PROSALUD systems be assigned high priority. The validity of the self-financing strategy can only be demonstrated if it is supported by a strong marketing effort. To this end, we recommend that the present marketing plan be revised and further refined, adjusting its application in each particular community or cooperative to the distinct relationship between PROSALUD and each organization. Furthermore, the ET recommends that the responsibility for marketing, both planning and implementation, should be concentrated in a single individual with sufficient available time for this task and with strong back up from the Executive Director. To facilitate these changes, a reasonable amount of resources have to be included in the budget.

D. Reinforce Health Promotion at Community Level

The ET recommends that immediate steps be taken to reinforce the health promotion and preventive components of the health benefit package and its orientation towards detecting health problems by working outside the centers and in the community. Although the program contains most of the elements of the primary care approach, there is a need in our view, to emphasize the outreach orientation of the health services module.

The ET agrees with current project policy related to the use or community-based health promoters as a fundamental element of the primary health care strategy embodied in the PROSALUD system. The development in the community or voluntary health care personnel should serve to reinforce the community development and marketing strategies essential to the goal of self-financing. Although we believe that the promoters should represent primarily a community contribution or subsidy to the system, it is possible to provide some inducements without undue economic impact on the system. Such inducements might include: free enrollment in the delivery system and the use of PROSALUD's bicycles while working as promoters. However, the ET strongly recommends that the training of the promoters and their introduction into the delivery system be simultaneous with the development and implementation of the other components of the primary health care module.

E. Extension of the Project

As stated earlier in this section (A.1) the ET recommends that the project be extended in two stages: each dealing with one of the aspects of economic viability. The first stage is to determine the feasibility of self-financed primary care modules and the second is to explore the financial viability of PROSALUD. The observations that follow refer only to the first stage of the extension:

1) The ET believes that, once the positions included in the current organization chart are filled with the corresponding appointments on a permanent basis, the size of the staff or PROSALUD in the main office should not be increased. We also believe that the
current personnel should not be overextended in new areas of development until previous ones are consolidated.

2) The Primary Care Modules (or semi-autonomous Centers, levels II and III) require strong initial support from central PROSALUD staff during the developmental and early implementation periods. We estimate the duration of these two stages at about 12 months after initial screening is completed and a community selected.

3) Therefore, PROSALUD should target for development only one Primary Care Module (PCM) or 3 to 4 centers, levels II or III, per year.

4) The stabilized operation of a PCM or its corresponding centers, indicating it has achieved its potential development, will take at least two years after initial establishment.

5) Definitive results regarding the self-financing capabilities of PCM or its corresponding centers, require some minimum number or example observations. The ET have set this number arbitrarily as three modules or twelve centers.

6) Therefore, considering that the development of the first PCM or set of Centers has been initiated and can be consolidated in 1986, two more years will be required to complete the necessary minimum number of observations: 1987 and 1988.

7) Finally, given the research nature of the project, the ET recommends that a third additional year be granted for the purposes of analyzing the data, writing research reports, documenting results of management techniques and systems and preparing the rationale for a decision regarding the second stage, if needed.

In view of the foregoing, the ET recommends that given an adequate redefinition of the project and with the objectives indicated above, the project be extended, as a first stage, until April 30, 1990.

F. Funding

The ET has reached some highly tentative figures in relation to the level of funding needed for this extension. It assumes that current project costs are covered until April 30, 1987, although we recognize that a thorough redefinition of the project will require some additional resources.

The budget categories are self-explanatory and follow the same pattern as the budget in the September 1985 cooperative agreement, with the addition of two items: Research and Marketing. These preliminary figures are based on the proposed schedule of PCM development and implementation schedule, as stated previously in (E.6) and (E.7) of this section.

Technical assistance does not include the cost of a permanent technical advisor to the project since the ET believes this would not be needed on a permanent basis beyond April 1987. However, it includes four months per year of a technical supervisor to monitor the continuous development of the project. All other short-term
consultants are scheduled for two visits of one month each, during year 1 and one visit of one month each during years 2 and 3.

The tentative nature of these figures should be emphasized. The ET did not have time to evaluate in a more precise fashion the costs of several items included in it. Furthermore, this budget does not take into consideration project revenue that will originate from the provision or services through the PCM or the health centers. These revenues have not been estimated at present and are highly uncertain in terms of volume and timing. The reconceptualization of the project recommended in this section (E.2) should include a more precise estimation of the budget needed for the first extension, its sources of revenue and the different categories or expenditures.
### SUGGESTED TENTATIVE BUDGET (5/1/87 - 4/30/90)

*(In thousands of US $)*

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*Sub-total in parentheses.*
PROJECT BACKGROUND

I. Introduction

A. The self-financing primary health care (SFPHC) project was designed to improve the delivery/availability of basic health services to low-income rural and semi-urban persons in the department of Santa Cruz, through the participation of local community organizations. Services provided under the project were to be established on a self-financing basis to help ensure their continuation beyond the life of the project. The SFPHC project was approved by USAID/Bolivia in August, 1983, but did not begin substantive activities until a "Management Support Unit" (MSU) was organized within the project grantee, la Merced Cooperative in Santa Cruz. La Merced was one of three cooperatives - the others being two largely rural organizations in San Julian and Mineros - which had originally agreed to participate in the project. However, serious inter-organizational differences between the three cooperatives eventually caused the dissolution of their working agreement. The withdrawal of the San Julian cooperative from the project in mid-late 1984 left La Merced, Mineros, and its MSU as the institutional participants in the project. The situation deteriorated further in the face of unrealistic demands and expectations which La Merced presented to USAID in late 1984. In January, 1985 a resident Management Sciences for Health (MSH) advisor to the MSU arrived in-country. That same month, USAID concluded that implementation of the project with La Merced was not possible but continued project development with the now autonomous MSU. In August-September, 1985, USAID terminated the La Merced grant and executed a cooperative agreement with MSH to continue the project. MSH's institutional counterpart was/is Proteccion de Salud (PROSALUD), essentially the original MSU (now operating independently of La Merced under its own articles of incorporation (personeria juricica). Since the arrival of the MSH representative nearly 1985, the MSU/PROSALUD has been staffed and re-organized and has completed virtually all pre-operational aspects of the project. Several community organizations have been screened and a number of them have been invited to participate in the project as sponsors of PHC service delivery modules. The project began its operational phase in two communities, one semi-urban (Villa Pillin) and one rural (El Pailon) in February-March, 1985.

B. Because of this lengthy and difficult start, it is important for the purposes of the evaluation to present a more detailed historical account of this project. Somewhat arbitrarily, the Evaluation Team (ET) has divided the project's history into two periods: its initial development and first phase of implementation (December 1982 to January 1985) and its second phase of implementation and current status (January 1985 to present). The major events which occurred in these two periods will be presented in the next two sections of this chapter.
II. Project Development And First Phase Of Implementation

The main events during this period, extracted from USAID/B Project Activity Log were the following:

A. PID completed (12/31/82); PID reviewed in AID/W DEAC meeting in January 1983; Guidance Cable issued with objections/recommendations by DEAC (2/2/83); development of background components to the PP, which is completed at 8/19/83.

B. Project authorized by USAID/B Mission Director on 8/19/83 with preconditions to be met by grantee prior to disbursement of funds for project implementation and prior to disbursement of funds for inauguration of health services modules; Cooperative Agreement signed with La Merced cooperative as grantee.


D. During the first nine months of 1984 serious intercooperative differences occurred causing the dissolution of the working agreement, and major changes were introduced in the operational structures of the Project by USAID/B on 9/18/84. Some of the most important events leading to these major changes were:

1) After 6 months of reviewing candidates for LT-TA position, Mr. Lewis (Ridge) Applegate arrived for 3 weeks assignment. He did not return to the project, literally dropped out (5/84).

2) L. Hougen and R. Indaburu interviewed candidates for LT-TA position and found lack of administrative capacity in La Merced.

3) There was a blow-up at Intercooperative Board Meeting between Adalberto Tercerps (La Merced) and Ramiro Monje (San Julian); the relationship among cooperatives deteriorated and total mistrust prevailed among them (6/30).

San Julian sent a letter asking an apology from La Merced, otherwise they would quit attending board meetings (6/30/84).

4) An implementation plan was approved by all three cooperatives after conciliatory meetings (7/13/84).

5) La Merced presented its own implementation procedure scheme (bipartit and vertical) (7/20/84) warning that if not accepted they would be out of project.

6) La Merced refused to attend the board meeting in Minero where meeting was held. San Julian and Minero decided to go ahead and a detailed implementation plan was approved. To establish the necessary institutional umbrella, both cooperatives decided San Julian could lend its "Personeria Juridica" to the project (7/21/84).
USAID/B assessed the evolution of the project and decided that the project needed to go ahead with a totally new entity, either through FIDES or with the creation of a new organization.

Dr. L. Vasquez suggested the constitution of a "Sociedad Civil" "Minuta de Constitucion". The statutes were prepared and discussed with all three cooperatives. An Acta was signed by La Merced, San Julian and Minero, committing themselves to the new "Sociedad Civil", whose statutes and "Minuta de Constitucion" were to be prepared by La Merced's legal advisor (8/17/84).

USAID's Regional Legal Advisor pointed out required de-ob/re-ob authorization of grant monies if the "Sociedad Civil" alternative were to be approved (8/20/84).

La Merced sent a letter backing off from its previous commitment to participate in a "Sociedad Civil" and promised to fulfill the projects expectation if it is allowed to run the project by itself (8/29/84).

San Julian and Minero sent, for USAID's approval, the constitution of a new entity. This action followed La Merced's non-attendance at the meeting set for developing such a constitution together (8/27/84).

The failure to reach a workable compromise among the three cooperatives, which had already caused one year delay in the implementation of the project, led to the adoption of major decisions by the Mission Director in agreement with its staff (9/18/84). Taken from the "Memorandum of Decisions made on September 18th about the SFPHC project", the most important decisions were:

1) USAID will take an active role in managing the project, including the selection and contracting of MSU personnel, technical assistance and procurement of medical equipment and pharmaceuticals.

2) All cooperatives within the Santa Cruz region will be eligible to receive health services provided by the project under the concept of an HMO health insurance program.

3) La Merced will remain as project grantee and the Project Agreement will remain in full effect.

4) La Merced will use its existing Health Committee to serve as the Board of Directors for the project. The Board of Directors will include an ex-officio member from USAID/Bolivia who will also be the USAID project manager. The Project Board of Directors will serve until such time as a new legal entity for the MSU is established.

5) The Board of Directors will authorize the Mission to hire the MSU staff, other technical assistance, and to approve the initiation of all procurement and training programs. MSU personnel selected by AID will be contracted and paid for in accordance with Mission employment policies.
The Board of Directors will authorize MSU executive personnel to hire all support personnel required under the project.

The Board of Directors will authorize USAID/Bolivia to disburse funds directly to the MSU to cover project expenses incurred by the MSU. A system of advance payments and voucher reimbursements will be established.

6) The following personnel are being considered for key positions with the MSU:

- Lic. Waldo Gardia, Administrator/Acting Director (pending interview by USAID Mission Director)
- Ing. Emilio Medina, Cooperative Coordinator/Promoter
- Dra. Maria Elena Zabala, project physician (Level III)

Other key positions within the MSU that must be filled in the near future are:

- Director, Assistant Director of Health Services, Financial
- Analyst/Accountant, personnel administrator,
- Logistics/Procurement Specialist, head of training program.

7) A representative of the MSU and the USAID Project Committee will initiate the technical review of proposals for technical assistance on Wednesday September 26, as established in the R.F.P.

F. La Merced and Mineros decided to accept the new rules established by AID in relation to the management of the project and its opening to all community based organizations in the Santa Cruz area. On the contrary, San Julian cooperative decided to withdraw from the project arguing that it had lost its participatory nature, jeopardizing the self-managing concept of the service delivery modules.

G. During October 1984, USAID/B staff, La Merced, and Mineros tried to reorganize the project under the new directives. New areas of disagreement emerged between La Merced and USAID/B in the following months regarding the definition of areas of responsibility and control in project management. Meanwhile, USAID/B organized the MSU outside the control of La Merced and evaluated and made a decision in relation to the Technical Assistance component of the project (granted to MSH).

H. In January 1985 La Merced withdrew definitively from the project arguing that USAID/B had not met its obligations under the terms of the Cooperative Agreement. Meanwhile, USAID/B reached the decision that the participation of La Merced in the project had to be terminated after an assessment made by Mr. Bowers (new Director of HHR - USAID/B) and Mr. Mejia (long-term technical advisor from MSH). Mr. Bowers and Mr. Mejia occupied their respective positions in January 1985 and from then on, became the most important decision-makers in the (badly needed) reorganization of the project. This was a turning point for the project.
III. Second Phase Of Implementation

A. February 1985 marked a second birth for the project. The decisions of September 1984 to initiate direct management by USAID/B and open up the possibility of participation to all types of community organizations in the Santa Cruz area were maintained. The departure of La Merced led to a third important change; although ultimate management responsibility remained in USAID/B, there was ample delegation of authority for implementation and day to day management to the nascent MSU (4 persons) supported by the resident, long-term technical advisor of MSH.

B. During February and March of 1985 the project nucleus (MSU-MSH and HHR-USAID/B) reconceptualized the project in terms of objectives and design since what had been proposed in the PP of 1983 was no longer operative. As will be seen later in this report, this reconceptualization process and its ensuing redesign was not as complete and thorough as it should have been. In addition to the project's failures and frustrations of the previous 18 months, other factors related to the severity of the political, social, and economic crisis of Bolivia, also played a significant role.

C. The seeking of new institutions that might be willing to participate in the project as cosponsors of the primary health care services and marketing partners for the self-financing initiatives became a high priority of the MSU-MSH-USAID/B project nucleus. A large number of organizations were approached and invited to participate: several saving and loans and consumer cooperatives (San Martin de Porras, Jesus de Nazareno, Guapay); some large trade associations (Federation of Sugar Cane Growers); large employers and unions (Municipality and Municipal Employees), etc. The first priority of the project became to establish an agreement with a cosponsoring agency and get some modules of primary care services under way.

D. Another important area, during the period February-August 1985, was the development of the MSU until it evolved into Proteccion a la Salud or PROSALUD. Two items are of significance in this regard: PROSALUD obtained its Personeria Juridica, enabling it to enter into agreements with other institutions as a full-fledged legal entity; and, it made important efforts to recruit the necessary personnel to meet its staffing plan. In the effort, PROSALUD was not entirely successful, since some important positions remain vacant or are occupied in an interim basis. However, it should be noted that, despite serious setbacks, PROSALUD has been able to hire and develop a competent staff.

E. In September 1985 the transformation of the project was completed when USAID/B de-obligated La Merced and re-obligated the project to MSH after a Cooperative Agreement with this institution was reached. Since then, MSH has played a dual role in relation to this project: it is the grantee as well as the organization in charge of providing technical assistance. The Cooperative Agreement will be analyzed in detail later in this report. Although it ensured the survival of the project as a viable idea, it failed to address adequately some
important issues of conceptual design. With the reobligation, many characteristics of the project were changes. The achievement of its main goal, demonstrating the viability of self-financing PHC, required the development of a conceptual framework.

F. Since October 1985, under the Cooperative Agreement of MSH with USAID/B, the project continues to develop on the basis of a close collaboration between MSH and PROSALUD. The pace of development, increasing since February, gathered momentum after the signing of the Cooperative Agreement in September 1985. Among the most important achievements during this last period are:

1) The completion of the development of management and logistical systems designed to support the operation of the primary care service modules.

2) The authorization obtained from the Unidad Sanitaria (local office of the Ministry of Health) to organize and operate primary health services in the department of Santa Cruz. This authorization includes a provision by which the U.S. can delegate the operation of some of its own facilities to PROSALUD under a self-financing arrangement.

3) The completion of negotiations with several geographically-based, community organizations and the initiation of service delivery in two areas: one in El Pailon, a rural town located about 60 kms. from the city of Santa Cruz and one in the periurban neighborhood of Villa Pillin.
I. **Objective**

To review the implementation of the project in order to make specific recommendations, concerning project design, funding and scheduling as well as to extract lessons for future projects of a similar nature.

II. **Scope Of Work**

A. To evaluate the appropriateness of project design in terms of the proposed relationship between PROSALUD and the community organizations responsible for delivery and financing of services.

B. To assess the role of USAID/Bolivia in supporting the project in terms of project conceptualization and design, logistical support and any other aspect of importance to implementation of the project.

C. To review the difficulties encountered in identifying suitable community organizations as participants in the project; to assess the appropriateness and effectiveness of the corrective actions taken by PROSALUD, and to make recommendations for future action and for other projects.

D. To evaluate the marketing strategy and efforts made by PROSALUD and the community organizations to ensure the incorporation of rural and marginal urban populations in the financing/delivery systems.

E. To review the logistic and management support systems developed during the pre-operational phase of the project in order to determine their consistency with each other, the likelihood of their effective implementation, and their potential contribution towards the achievement of the overall objectives of the project.

F. To review the proposed health services delivery model and the primary health care programs; to review the changes introduced to this model in terms of staff functions and strategy of implementation in order to determine their consistency with the overall objective of the project.

G. To ascertain the operations research requirements of the project and to assess the external and internal human resources and information needed to satisfy those requirements.

H. To assess the feasibility of the project's attainment of the following objectives by the termination date of the project:

   - Service-delivery self-sufficiency under various institutional and payment schemes;

   - Development, through research and project experience, of the information needed to draw conclusions concerning alternative models for potential replication elsewhere in Bolivia;

And in view of the foregoing assessment, the evaluation will make recommendations concerning changes, if necessary, in project duration and funding needed to achieve the above objectives.
I. **Evolution**

Since its original conception, this project has undergone considerable changes in both design and structure. While these changes have often been described to the ET as reflecting problems of personality, bad faith, and poor judgement, we believe that they also reflect unclear and changing views of the goals and objectives of the program. Since form must follow function, the appropriateness of the design of this project can only be evaluated in terms of its ability to support the accomplishment of project goals and facilitate the implementation of project activities. The comments of the evaluation team are directed towards this end.

Basically, the project consists of two operational activities:

- The development of primary health care delivery systems integrating Levels I - III.
- The marketing of these PHC delivery systems in a manner which can lead to their financial self-sufficiency.

One of the critical influences on project design is the relative importance attached to each of these functions in terms of the use of project resources, both financial and human, the role of the community organization, and the role of the MSU. It is the interaction among these three factors, the MSU-PROSALUD, the community organizations, and project resources, which is defined by the project design.

In the earlier designs, the decision to work with the cooperatives reflected a view that they represented a special marketing opportunity. The links of the cooperatives to their membership were seen as representing a "captive audience" for the prepayment for PHC services and an excellent setting for testing the viability of this financing strategy.

While no specific documents exist to verify this observation, it seems to the ET that the initial decision was probably made to initiate this activity as a result of the interest of La Merced cooperative. La Merced is an organization in the business of marketing credit, insurance, and various other financial and service "products" to its customers who become members specifically to avail themselves of its services. (Ed. note: USAID/B has stated that the project was established pursuant to an AID Health Assistance Policy calling for greater reliance on the private sector and cost-recovery mechanisms, and not on prior interest on the part of La Merced.)

In this conceptualization, the role of "PROSALUD" was to organize and produce the PHC services which the cooperatives were going to market. The project was seen as a test of the marketability of the product, but that function, central in the design, was subsumed almost entirely into the role of the cooperatives. The administrative decision to award the grant to one of the cooperatives inevitably served to reinforce their centrality in the process and their perception of the PHC service development function as a subservient element of the project, notwithstanding its need for the major part of project resources.
These early perceptions and decisions reinforced the ambiguity of the role of the MSU in the management and implementation of the project. Almost all of the discussions the ET had with members of the project and AID personnel clearly indicate that in their view, the role of the MSU was central and independent of any particular community organizational relationship. But the conceptual basis for that view was not clearly presented in the documentation of the project (PP, PID, or award). The combination of the logistic and administrative needs of USAID, the lack of clarity in the role of the MSU and the delegation of the critical marketing functions almost totally to the cooperatives all led to a high degree of potential conflict between the community organizations (cooperatives) and the MSU-AID, with its inevitable cost in time, good will, and project performance.

The problems were exacerbated when the decision was made to incorporate the two rural cooperatives, Mineros and San Julian, into the project. The role of La Merced as the official grant recipient (and, therefore, officially responsible for the money) gave it a special relationship to the project not shared by the other cooperatives and placed them in a position of potential subordination in which differences would be emphasized and areas of conflict made more important and destructive. The conflict between the urban focus of La Merced and the rural focus of the other cooperatives together with ethnic and personality differences all served to obscure the role of the cooperatives and the MSU and the lack of a clear set of project goals.

While the decision to fund the project through La Merced was presented to the evaluation team as a matter of administrative convenience for AID, it seems clear that the view of a marginal role for La Merced was probably not ever shared by the cooperative itself. As a marketing organization, this project represented an important opportunity to expand its "product line" without the up-front expense of product development. Even though these costs were to be provided by AID, La Merced would inevitably view the MSU that operated the services as a supplier and not a controller of the services. Differences in view as to the role of the MSU continue to permeate the project but, in the dealings with the cooperatives, their political need to be identified as the source of the services they "bring" to their members was, and will always be, reflected in a need to control, and eventually to own, the service providing entities. This general observation would apply equally to cooperatives, sindicatos, gremiales, and many other membership based, as opposed to geographically based, organizations.

II. MSU - Community Relationship

With the formal establishment of an independent MSU and the shift of the grant to MSH, the problem of fiscal control and responsibility was eliminated as a source of operational conflict but other aspects of project design are potentially problematic. With the move away from cooperatives to a focus on geographically based community groups, the marketing function has been recognized as a major responsibility of the MSU (PROSALUD). Yet even so, the marketing strategy is community based and produced as a result of a special relationship established for each community. The community remains a "marketing partner" and, in the convenio which establishes the agreement to develop a PHC center, expectations for community "assurance" of a given level of service coverage are included. While the cable from
USAID/B which requested this evaluation described the community as sponsors of the PHC service delivery modules, their role is still not well defined.

At the present, each center has a board made up of three members from the community and three members from PROSALUD. Nevertheless, in both Villa Pillin and El Pailon, community members of the board indicate that they expected the sharing of control to be a temporary situation. In Villa Pillin, board members simply said that the whole board would eventually be from the community. In El Pailon, board members indicated that they expected to "pay back the PROSALUD investment within five years" implying that, after that time, the relationship between the community and PROSALUD would change. While anecdotal, such comments indicate the possibility of multiple notions of the appropriate current and ultimate role of the community and obligations of both the community and PROSALUD. The absence of a clear project statement of responsibilities and eventual rights and obligations around issues such as ownership of community constructed (or partly contributed) facilities, the authority to hire and fire, and failure to achieve financial self-sufficiency indicates that a specific resolution of the roles of the community "sponsors" is not yet well defined.

III. Research Design

The relationships between the MSU and the community groups noted above are only one aspect of the inadequate conceptualization of the project design. Within the operating structure of project implementation activities, other design problems remain potentially limiting. In the original project design, responsibility for analytic activities central to the entire feasibility study was not incorporated into the central structure of the project nor supported within the project budget. The community economic studies, critical for the assessment of the potential for communities to generate sufficient revenue to make self-financing a possibility, the development of cost, revenue, and utilization projections, and the overall management of project resources, was treated as a "research" element entrusted to FIDES, an independent institution; and therefore, this facet was organized, funded, and technically supported outside of the project structure and not subject to its own timing and oversight. The evaluation committee believes that this decision seriously compromised the ability of the project to accomplish its goals of testing the feasibility of developing self-financing community based PHC systems. The separation in the management of these functions and the treatment of the community baseline analysis as research, rather than the critical central element in the community selection and project management process that it is, has led to the current state where the community survey has not been done for any of the settings in which services are now being provided! However, alternative plans prepared by the PROSALUD staff are underway to do such studies in the areas (Cotoca, etc.) where new services are being developed. This means that service and financing experiences are being generated without financial projections, without utilization projections, and without the ability to assess the community selection and marketing activities being developed and tested as a central effort of the project.

By treating these activities as distinct, or even distinguishable, from the overall design and management of the project, their importance has been obscured. At the present time, the community economic feasibility study is not "on the critical path" for any PROSALUD activity. Neither are the specific skills necessary to undertake these studies available among
the PROSALUD staff, nor are plans underway for extensive technical assistance. Yet their absence severely limits the reproducibility of any project experiences to date.

With the termination of the FIDES-PRICOR project, the existence of a separate project is no longer a problem. Nevertheless, no real response has been made to the loss of what is a central operational activity in the entire project. Its absence in the PROSALUD structure and operating system is an unfortunate result of history and inadequate project conceptualization but its continued absence is a serious design flaw which needs remedy. The design and testing of community assessment methods are critical for the interpretation and application of the experience being developed in this project. This activity needs to be integrated in the PROSALUD operating model and sufficient technical support needs to be integrated into the PROSALUD resources to assure its development and implementation. Additional project funding will be needed to finance these research costs.

As a final comment on overall project design, the ET recognizes the historical chronology and administrative constraints which have led to the current administrative structure of the project. Nevertheless, it feels compelled to note that ability to foster and assess the viability of PROSALUD may be constrained, or at least made ambiguous, by the fact that it is a fiscal "child" of the organization which provides it technical assistance. Staff of PROSALUD describe themselves as employees of MSH, a circumstance which obscures the need and potential for developing financial self-sufficiency for PROSALUD as well as for the individual PHC systems/modules. The team has no recommendation to make regarding this issue. The observation is made to reflect the team's view that this relationship merits rethinking as part of the recommended reconceptualization and formalization of the overall project which is clearly essential to its continued success.

IV. Selection Of Community Organizations

Because the original project was based on the participation of three already identified cooperatives, the issue of community selection was not specifically addressed in its design. When it was decided that the project should continue without the participation of the cooperatives, the issue of identifying suitable "sponsors" for the PHC modules became a central consideration of the project.

While its importance was recognized by both AID and PROSALUD as a new operational demand on project resources and timing, the conceptual issues involved in this decision were neither thought through adequately nor reflected in a new project design.

Nevertheless, it was quickly recognized that the overall existence of the project depended on the identification of new organizational partners with whom agreements could be reached and PROSALUD responded by initiating discussions with numerous organizations, ranging from other cooperatives to geographically based communities. Each of these different types of organizations implies a different set of PROSALUD responsibilities and roles with regard to membership recruitment, community development, and management and control. The absence of a well defined set of ultimate objectives for the project (and, as well, for PROSALUD) essentially left
the community selection process without project based criteria beyond the need for some agreements to assure project survival.

It should be emphasized that the project has always recognized at some level, the importance of the ability of the partner to produce a volume of use sufficient to meet the self-financing needs of the PHC services. However, in the original design, this ability was presumed to be part of the inherent characteristics of the cooperatives. With the change in partners to geographically based groups, the issue of potential financial viability of the relationship was addressed as a "research" issue and "farmed out" as noted earlier.

The operational responses of PROSALUD have led to initial implementation activities in a number of communities where services which are being delivered in two level-III centers at the current time. The ET believes that many of the difficulties encountered in selecting and reaching agreement with suitable community organizations reflect the earlier noted problems of inadequate conceptualization of appropriate relationships and the lack of well-defined ultimate objectives. While the corrective actions of PROSALUD clearly responded effectively to the immediate need for implementing the project, they need, in addition, to formalize the conceptual constructs which can then serve as a guide for implementation and evaluation of further program developments.

It is interesting to note that while discussions have been held with many types of organizations, positive responses have come, thus far, from geographic, rather than membership based, organizations. As noted earlier, membership based organizations have different political and organizational needs which imply a different relationship with PROSALUD. It seems to the ET that it will be important for PROSALUD to build on its experience, particularly if it continues to seek to develop relationships with different types of organizations. The continuing negotiations with FEDECAN, for example, imply a very different role for PROSALUD than it currently has or anticipates with the geographically based communities. While drawing on the same resources, the relationships and responsibilities of PROSALUD to the health centers and to FEDECAN will, of necessity, be very different. These differences need to be systematically understood if they are to provide guidance for similar developments in the future, by other organizations of by PROSALUD itself.

PROSALUD has rightly recognized that the community selection process occurs in two stages: a general feasibility assessment to identify communities in which a successful self-financed PHC might be established and a more rigorous assessment of communities which look feasible, specifically to evaluate the actual likelihood of a successful project by: 1) estimating potential demand, 2) projecting expected operating and investment costs, and 3) producing a plan for development and implementation which indicates potential viability and can serve as a guide for the progress of the program if it is initiated.

PROSALUD has developed a comprehensive list of general attributes to be considered in the prefeasibility phase. These criteria need to be further specified in two dimensions: 1) The indicators which can be used to describe each of the general attributes and a scale for their measurement. 2) The relative weights to be assigned to each attribute. As PROSALUD gains more experience in developing new community relationships, these dimensions can be tested and replicated in other settings.
The ET sees the initial survey that PROSALUD is doing with the community as a community development instrument and values it highly in this regard. However, the survey, in its present format, does not yield either the qualitative or quantitative data needed for a feasibility assessment. A more extensive survey with the characteristics noted above needs to be developed and undertaken by PROSALUD as part of the process of community selections. This material should form the basis for the negotiations of an agreement based on the specific characteristics of each community.

The ET has already noted that this activity is central to the implementation process if the self-financing goal is to be retained for the project. We also believe that it should not be managed outside of the main activities of PROSALUD although we recognize that some of the specific skills essential for this process do not now exist within the staff. The development of appropriate instruments and the algorithms to analyze these data and produce the needed estimates should be of the highest priority in the technical assistance made available over the next year of the project.

It is important to note that the process described above is not simply applicable to the selection of geographically based communities. A similar process of assessment and development of economic projections needs to occur, as well, for cooperatives and other membership "communities". The critical role of these activities in the management and eventual evaluation and reproducibility of the project's experience should not be ignored in the pressure to move to operational stages. The effort to establish clear expectations with respect to both shared roles and responsibilities and prospective economic performance will prove to be highly cost-effective.

As a final issue, the ET believes that a protocol for terminating a relationship when it proves to be infeasible should be developed. Once such a procedure has been initiated, there should be agreement on the stages and timing of the activities as well as a sharing of the criteria which will be used to make the judgement. The ET has observed that relationships between PROSALUD and community groups with which it has not been able to reach agreement have been somewhat indefinite. In particular, the UCC and CCAM have been left for months without a formal response from PROSALUD in relation to pending business. The open-endedness of the activity reflects its current ad hoc nature and, to the ET provides further evidence of need for systematizing and formalizing the overall community selection process.
RESEARCH REQUIREMENTS OF THE PROJECT

I. Overview

Operations research (OR) under the FIDES/PRICOR COMPONENT was acknowledged in the MSH Technical Proposal as the process of "activist monitoring and continuing integrated evaluation" of program activities. The need for an effective research component integrated through all aspects of PROSALUD is apparent given:

- The innovative nature of prepaid health services in Bolivia. Since no previous experience exists, the lessons from the experience become important for developing alternative medical care delivery systems.

- The continuous need for information upon which to measure progress and/or execute necessary mid course corrections.

- The pilot nature of PROSALUD. USAID will want to extrapolate a series of lessons learned from this project and, if appropriate, develop similar models in other regions. This requires that basic assumptions, hypotheses, and data collection methods be structured in a formal and systematic manner.

The ET believes that OR is, within the context of this project, a fundamental element and should be recognized as essential to the success of PROSALUD. However, we also believe that research activities will only be effective to the degree that they are applied appropriately and within the technological constraints inherent in Bolivia. The management information system that currently exists is quite sophisticated and may be too cumbersome to process data effectively from multiple and extremely isolated rural sites.

The viability of PROSALUD's research components is greatly dependent on which operational questions need to be asked. Thus, a clear understanding of program goals and objectives is needed to articulate these questions. This will, we believe, help to structure the applied operations research component. Within this content, it is essential that PROSALUD's management, administrative, and selected program staff be involved in the planning and implementation of research activities. However, specific responsibilities should be delegated to ensure that research activities are carefully documented, especially in relation to those areas that will need to be replicated in other USAID projects.

II. General issues

The ET also recognizes that a strong research effort is contingent upon specific program and service expectations. We have noted in previous chapters the need for a clearer conceptualization of the whole program and each of its subsystem parts. All of the suggestions that the ET has made with respect to more precise goals and objectives, more systematic operational monitoring of performance, and more specific criteria for decision-making should be viewed as examples of opportunities for OR for this project.
The timing of the design, implementation and analysis of research activities is quite important and should be of particular concern to PROSALUD. In particular, in order to complete an impact evaluation, it is necessary to collect baseline epidemiologic data in the communities targeted for medical service. Without this information, it will be difficult to measure the impact of medical intervention. Other areas of community research are currently needed to develop an appropriate marketing strategy (see following chapter). The ET is concerned about the immediate necessity to begin research activities in support of future evaluation needs and current program activities.

PROSALUD staff members are currently designing a series of staff training modules for local centers. Within these modules, training should be developed for the systematic and reliable collection of epidemiologic data. The ET was impressed with the overall process of these modules, in particular with the specification of appropriate collection methods to be used by local promoters. In addition, we also believe that some of these educational modules could be distributed and used within other USAID public health programs in Latin America.

III. Research Concepts in The Project Proposal

The original project proposal did not offer a clear rationale, plan, or strategy for developing research activities. In fact, it placed a series of distinct functions under a general umbrella called operations research. Financial planning, management information systems, program evaluation, and community analysis were identified as part of the OR strategy under the FIDES/FENACRE component. Unfortunately, discrete goals or objectives were never specified. This ambiguity in the FIDES/PRICOR project has persisted to form a gap between the concept and its practical implementation.

One major deficiency in the project's conceptualization and design was the assignment of the major research functions to an independent organization. As previously mentioned, FENACRE/FIDES were to have assumed responsibility for a series of data collection, analysis and projection tasks called research but fundamental to the operation of the project. The relationships between PRICOR/FENACRE/FIDES appear too unclear from the beginning. This problem was increased by the need for long distance communication and coordination. FENACRE withdrew from the Project leaving FIDES with a series of responsibilities which they did not appear to have the technical ability to complete. Furthermore, due to the unstable operating model between the three original cooperatives and the MSU, FIDES did not have a counterpart within the operating element of the project and, as a result, did not receive adequate direction. They also did not receive necessary and requested technical assistance. While many of these problems were operational in nature, it is clear the FIDES was contracted to complete work which was outside of its domain (e.g. develop service package and cost estimates).
PROSALUD began their operations phase without the benefit of essential baseline data. They also did not possess the technical capability to collect this information and were placed in a position of having to make initial decisions without the necessary data foundation. That process has evolved and PROSALUD continues to have an information deficit that impedes its operational capabilities. It further limits greatly the degree to which the experience of this project can be evaluated and reproduced.

IV. **Specific Research Issues And Recommendations**

A. The ET has noted a general need for better conceptual and operational models for projecting expectations, monitoring performance, and evaluating program effectiveness. All of these activities can appropriately be served by effective application of OR concepts and methods. All of the suggestions that the ET has made in respect to more precise goals and objectives, more systematic operational monitoring of performance, and more specific criteria for decision-making should be viewed as examples of opportunities for operation research in this project.

B. As stated before, the research effort should be carried out within PROSALUD since only its personnel can identify the proper questions and potential responses. However, since PROSALUD does not have personnel for this purpose, outside technical assistance must become available.

C. The issue of determining the potential demand for and use of health services in the community is a central element in establishing the projected viability of the service and estimating its potential subsidy requirements. Therefore, particular attention needs to be directed towards developing a method for estimating this demand which makes maximum use of the project's ongoing contact with the community, its knowledge of the community's structure and living patterns, its technical competence, and the potential to generalize the methodology. Every strategy for estimating future demand incorporates a large measure of uncertainty. Therefore, estimates of demand for these services need to be constantly revised on the basis of ongoing project experience. There is a need to make an initial demand projection in the early stages of community discussions which do not involve large scale data acquisition by personnel not associated with the project. Due to the lack of previous experience with health services, and even more with health (or any other type of) insurance in the community, the estimation of demand curves for both has must be done indirectly through the analysis of other community behavioral characteristics like savings patterns, risk aversion, valuation of health status, community organization, etc.

D. The ET recognizes that the prepayment concept is an important element in the development of the self-financing capacity of primary care in the community. Nevertheless, it is clear that for the foreseeable future, fee-for-service will constitute the predominant form of community support. This latter observation reflects both the view that most families will wait for some experience with the service before considering a prepayment commitment and the belief that for many of the families in the service area, income limits almost preclude the deferment of current consumption for saving in the form of prepayment. This project provides an unique opportunity to identify
family and community characteristics associated with choice of payment mechanisms for a given set of services. This analysis should constitute an important research component of this project.

E. Community related research should allow the project to estimate whether its service interventions have had an impact on the target population's health status. Initial baseline data should be collected so that future assessments can be made regarding changes in basic morbidity and mortality. Periodic data analysis should be implemented for administrative (planning and evaluation) purposes as well as to help diagnose and control community health problems.
PROSALUD’S MARKETING STRATEGY

I. Overview

Marketing is essential to the economic viability of this project. The ET recognizes that PROSALUD is executing a variety of marketing related activities. However, there does not appear to exist a cohesive strategy with clearly articulated objectives nor is there a specific budget to finance marketing activities. A single individual with sufficient time available should have the delegated responsibility to coordinate a marketing strategy.

Within the PROSALUD context, it is difficult to conceive of marketing in isolation from other program activities such as community organization, outreach, and the delivery of medical care service. However, while it is a process that should be carefully orchestrated with these other activities, it needs to be planned to achieve independent outcome objectives. The need for active marketing becomes more apparent as:

- there does not appear to exist, within the current "cultural context", a high demand for either prepaid or preventive health services;
- targeted populations do not have a large amount of financial resources; the purchase of health services will have to compete with the purchase of other necessary and/or desired services or commodities;
- periurban health centers, such as Villa Pillin, will also have to compete with alternative medical care resources; and
- some people may not be accustomed to seeking medical care due to lack of financial and/or geographic accessibility. In this event, the demand for service will have to be stimulated.

PROSALUD’s current marketing strategy is closely associated with community organizing activities. The ET recognizes the critical nature of this relationship given that an organized and educated community is a necessary condition for the active participation in, and the co-management of, health care services. Currently, there appears to exist a lack of infrastructure, pockets of poverty, and a high degree of need for medical and preventive care within the communities targeted for service by PROSALUD. The original project paper accurately stated, "the limited sense of community and the fragility of social structures in the project areas present serious obstacles to achieving the required involvement."

Marketing will also be associated to other program activities at PROSALUD. A marketing strategy should be derived from a plan that recognizes it as a management function. The MSH technical proposal emphasized that marketing should provide the basis for coordinating decisions. Marketing activities are closely tied to decisions about the service package, estimating prepayment fees and projected utilization, and establishing criteria for community selection, as well as with general public relations.

A particularly important series of management and marketing decisions relates to the selection of target communities. PROSALUD has chosen to work within specific geographic areas after consultation with the Santa Cruz public health agency (Unidad Sanitaria). However, PROSALUD is
retaining the option to provide management and/or medical services to cooperatives throughout Santa Cruz. This flexibility to identify and work with different community and institutional organizations is an important source of strength. However, it should be recognized that marketing strategies and resource needs will vary in relation to the community or organization selected.

II. Impact of Model Changes On Marketing Strategy

A series of major changes throughout the history of the project (see chapter 2) have had a major impact by impeding the development of a marketing plan. In short, a comprehensive plan could not be developed without a thorough analysis of the target communities, service package, estimated demand and service costs. By the time these latter variables were more clearly defined, an ad hoc approach to marketing was already in operation.

Initially, the project was designed to function within three cooperatives, using their infrastructure to promote services and recruit membership. A marketing plan was not well articulated in the project proposal; each cooperative was supposed to establish a staff position to coordinate health program recruitment activities. The actual nature of the marketing partnership between the MSU and the cooperatives was never clearly defined. The technical proposal in response to RFP La Paz 84-011 indicated a much clearer understanding of an overall marketing orientation but it was not clear about specific objectives, activities or time lines. The ET believes that the initial project paper’s design of a marketing plan was rooted in questionable assumptions about membership size and the degree of member participation within the three cooperatives.

The original project coordinators delegated to FENACRE/FIDES through PRICOR a series of fundamental operational research functions. FENACRE was unable to accept implementation responsibilities and a contract was given to FIDES to:

- identify primary health care service packages that address the health needs in each of the target areas;
- identify financing alternatives for the primary health care service packages offered in the three areas; and
- analyze the capacity of the cooperatives and the communities to deliver and pay for the primary health care services.

FIDES worked on these objectives for over one year and amassed a significant amount of data related to the demography, epidemiology, local economy, medical care utilization and health behavior patterns in the communities served by the three cooperatives. Their data collection methods appeared to be systematic and rigorous. Unfortunately, due to poor communication, not having a counterpart during the beginning stages, lack of technical expertise, etc., the data was never analyzed in a manner useful to PROSALUD. In addition, the information was collected in areas that ultimately were not targeted for service by PROSALUD.
Besides other roles, FIDES was assigned the responsibility of analyzing the market for this project. Although they were not to deliver or promote services, they were assigned very significant premarketing activities that had tremendous implications for the management of PROSALUD. Furthermore, the information collected by FIDES would influence the service package, and pricing decisions necessary to begin program implementation.

FIDES submitted its report in August 1985. Most of its findings were not useful to PROSALUD. Contrary to expectations in the project plan, their data did not provide necessary premarketing information. A community analysis that could serve as a basis to estimate: 1) demand for medical services, 2) utilization patterns, demographics, or 3) health behavior, upon which to make price, product or promotion decisions still has not been completed.

During the past six months PROSALUD has been searching for and has identified several different service target areas. Level III modules have been established in Villa Pillin and El Pailon. A level II center should be completed by the end of May in Montero Hoyos. Criteria for the selection of these communities include, among others, the absence of alternative medical services, population size, and geographic accessibility. While these criteria are appropriate, the ET is concerned that they were not scaled or weighted and did not provide an adequate foundation upon which to base the decision to select a community. Moreover, while there appears to exist a strong demand for medical service within Villa Pillin, Montero Hoyos and El Pailon, this was not assessed on a manner that will allow PROSALUD to evaluate their decisions about community selection.

III. Current Marketing Activity

PROSALUD staff have performed well using a team approach although more direction is needed to implement a cohesive and planned strategy. Marketing is a time consuming process that requires following a critical path of events. A marketing plan should be developed that includes:

- a community survey that enables PROSALUD staff to identify community characteristics and areas of risk;

- projections about the future demand for services with benchmarks for evaluation; and

- promotion strategies that are targeted to specific audiences and that explain the service costs and benefits.

The current proposal for marketing strategy is actually a plan for basic community development within Villa Pillin, Cotoca and Portachuelo. Another plan specifies concrete marketing activities in Cotoca but does not identify the persons responsible to complete tasks nor provide a necessary time frame. Discussions have taken place regarding the recruitment of community marketing agents; however, the ET was unable to review any documented plan.

A series of promotional activities have been implemented throughout Santa Cruz. These activities were well performed and apparently effective.
Several newspaper articles have been published covering the grand opening of PROSALUD and the general need for primary care service in Santa Cruz. A slide show has been developed and will be used to educate communities about PROSALUD services. Numerous community forums have been held and have produced a vaccination campaign and a community awareness survey along with other activities.

Technical assistance has been provided to PROSALUD staff to help development marketing skills. This assistance has apparently increased the general understanding of marketing concepts and has been rated positively by PROSALUD staff. The reports submitted indicate that the information presented was both timely and relevant. Among other outcomes, a marketing and community organization plan was developed for a center in Cotoca as a prototype for other centers. Although the plan is well designed, it does not include a time frame nor does it delineate responsibilities.

It is evident that a great deal of work has been completed by PROSALUD staff on separate marketing related activities. However, many of these activities appear to have been completed in isolation from a comprehensive plan or overall strategy. The ET is also concerned that both marketing and program development activities have occurred without having thoroughly estimated the ability of the communities to self finance service and without a comprehensive analysis of community health needs.

IV. Specific Recommendations

A. Administrative

1) Identify a marketing section within the PROSALUD organizational structure and delegate responsibilities to a single person with sufficient time to develop a marketing strategy.

2) Designate budget for marketing activities.

B. Community Analysis

1) Design community survey that satisfies basic premarketing information needs: demographic, utilization patterns, service demands, community attitudes towards health care, etc. The initial survey instrument designed by FIDES should be assessed for relevance to this task. While it is a cumbersome tool, much of the information it solicits would be useful. It should also be noted that a 100% response rate is not necessary, rather an appropriate sampling procedure can be used.

2) Consistency is needed when following a marketing process. The timing of events is critical and should occur in a planned sequence or the effectiveness of a strategy can be lost. For example, the "agents" who completed the community development survey should continue to be involved in other promotion or education activities.

3) The community selection process should be more formalized. A clearer definition for indicators of both viable and non-viable communities is needed. Community development activities such as the current survey should not be completed unless it is relatively
clear that PROSALUD will be working in that area. Otherwise, if general awareness of health problems exists, expectations may be raised while no positive outcome will be forthcoming.

4) Focus groups may provide a good low cost alternative to assessing community health needs and perceptions. These groups of 8-12 randomly selected individuals can be very helpful by generating important qualitative data.

C. Marketing Strategies

1) Product: The logistics for prepayment should be clearly identified (who collects money during which periods may become an important issue). Level I care also needs to be specified and identified as a service product. Finally, the type of service given by physicians, nurses, auxiliaries, or other personnel is a critical issue. The evaluation team recognizes that most consumers want physician care and that the predominant method of payment will be fee-for-service until the clear advantages of prepayment can be demonstrated.

2) Price: The actual cost for prepayment should be determined using a more accurate formula. Research to estimate costs may include assessing prices and utilization rates observed at other health centers. Currently the financial capacity of the community is not well understood.

The ET was impressed with the current PROSALUD intention of providing service to those individuals who cannot afford to pay. This is consistent with the overall implicit social goals of the project. However, PROSALUD may want to consider some type of sliding scale for poorer people.

When assessing pricing issues, it may be helpful to consider the investments made by the community such as: providing building material, space, construction work, service volunteers (promoters), health committee involvement, Mothers Club’s involvement, etc. Strategies should be developed to maximize these indirect community subsidies.

3) Place: Level II and III centers have been placed in rural and periurban communities that appear to be in need of medical care services. However, the ET believes it imperative that additional efforts are made to deliver outreach services and education from the centers to different community groups. Natural locations for outreach activities would include schools and, perhaps, community markets. The promoter concept should also be refined and initiated during the first stages of center planning and implementation.

4) Promotion: Planned strategies urgently need to be developed to promote both PROSALUD and the local health centers. Health Committee members in El Pailon have expressed need for such material; this should be a major area of technical assistance from PROSALUD. Immediate micro level activities could include developing pamphlets, a poster, a bulletin announcing service hours and other community education events and the education of local PROSALUD agents (Mothers club, promoters, students, etc.). The
latter range of activities will have a marketing impact but is more accurately considered a community organization strategy.

A macro strategy that focuses on mass media and general public relations should be planned. These activities would be targeted to support the concepts of prepaid and primary care services.

The ET believes that promotion schemes will vary between communities (with many commonalities) and over time (directed at both first time and repeat consumers). We recommend that specific themes be generated from the targeted communities and that all promotion be related to these themes. Such themes might include consumer interest in child delivery services, cost issues, physician service, quality of care, advanced technology (laboratory), pharmacy services, etc.. These themes can be generated from focus group discussions.

The absence of promotion and education material is a problem that has been identified during the ET's site visits. The urgency of this problem is apparent; the costs of developing materials in terms of both time and finances can also be high.

The ET recommends that a long-term strategy be developed that identifies information needs, projected audiences and methods of communication. High quality and appropriate materials can be developed at a local level but should be pretested before wide scale reproduction.
I. Introduction

The ET reviewed not only the logistic and management support systems of the MSU/PROSALUD vis a vis the primary health care modules but also the internal organization and management of the project itself. This decision, and particularly the emphasis put on the latter area, was based on the concept that a coherent, well functioning project staff is essential to the adequate and effective application of the systems developed in the preoperational phase. These two areas of concern will be addressed in this section of the report.

II. PROSALUD's Organization And Management

A. The ET believes that the MSU and PROSALUD needed, as a nascent organization, strong leadership in the decision-making process coupled with effective delegation of authority. The lack of an Executive Director on a permanent basis and the uncertainties that have surrounded the project (in terms of clientele, timetable, economic environment, etc.) have led to a consensual style of decision-making that, although useful for strengthening the bonds of PROSALUD's team, may prove to be ineffective in terms of solving problems and using PROSALUD's human resources effectively.

In spite of this management style, it is recognized that PROSALUD's team has made considerable progress in the implementation of the project.

B. The evaluation team recognizes the value of a team approach and teamwork in the initial stages of development of an organization. However, the ET believes that, at present, there is a need for more clear assignment of duties and responsibilities to individuals coupled with stronger leadership and delegation with less consensual decision-making.

The success of PROSALUD needs, as well, the appointment of a permanent Executive Director who can provide conceptual as well as operational leadership. The extension of the project beyond April 1987 makes this more feasible but also more essential.

C. The placement of health care personnel in rural, semi-isolated communities is always a difficult process. Thus, the evaluation team recommends that the personnel selection/recruitment process be strengthened and formalized. Some procedures which warrant consideration include: develop a panel of physicians or other health personnel potentially available for long-term and/or short-term assignment; make arrangements with the School of Medicine to enlist physicians and nurses on their year of social service as long-term or back-up personnel; introduce screening procedures in the selection process to detect potential difficulties of adaptation to working and living in rural isolated communities; introduce procedures to detect early maladjustments to living in rural areas; and provide support in these events using periodic rotation, more frequent supervision, increased time for programmed public health activities.
III. Management Support Systems

A. The Scope of Work of the evaluation calls for an initial assessment of the logistical and management support systems developed during the pre-operational phase by the MSU/PROSALUD. The Cooperative Agreement between USAID/B/MSH of September 1985 called for the development of the following systems:

1) a financial/accounting management system with two separate components allowing to track the funds provided by the grant as well as those generated by the program;

2) a data-collection and management information system consisting also of two components: one to be developed by FIDES/PRICOR to produce demographic and economic profiles of the target populations and another, developed within PROSALUD and presumable coordinated with the former, identified as a Management Information System composed of service logs, financial records, supervisory reports and service delivery reports; and

3) a general services function with a variety of elements designed to provide logistical support for the primary health care modules including: commodity procurement (acquisition and distribution of all equipment, supplies and pharmaceuticals with special attention to drug packaging, distribution and storage), communications and transportation and maintenance of facilities and equipment.

B. Notwithstanding some reservations and comments that will be presented later, the ET has found this area to be the strongest sector of the project. Most of the tasks called for in the Cooperative Agreement have been done or are in the process of being completed. PROSALUD has paid special attention to the development of these systems and they are ready for operation and testing. Furthermore, since two centers have recently become operational, there is already some initial experience with their utilization as management and support mechanisms.

C. The assessment made by the ET and the comments that follow, should be taken as preliminary and limited observations, since the two centers that exist, whose logistical support is the final aim of these systems, have been functioning for less than two months and are only the first to be established. A more definitive assessment should be made in about one year when more centers and a longer experience will allow more definitive conclusions and recommendations in this crucial aspect of the project. The ET makes its observations and recommendations within these limitations.

D. The team noticed the absence of plans for the implementation of each primary care delivery module containing schedules of programmed activities (indicating person responsible and timetables); expected utilization rates of services, projected costs and revenues, estimates of membership growth and ultimately impact on health status. The contents of these implementation plans would serve, not only to provide guidance to field staff activities, but also as benchmarks against which progress could be checked by a monitoring system.
Moreover, the implementation plans and their monitoring counterpart for all primary care modules together with the projection of expected revenues and costs of PROSALUD's main office would constitute the overall financial plan of PROSALUD.

E. Without reviewing the management information systems in all details, the ET has reached the following conclusions:

1) the data regarding disease episodes, diagnosed and/or treated in the centre, and the coverage of population treated by the centre should be reinforce (i.e.: estimate prevalence of specific diseases through drug consumption);

2) a periodic assessment of main health problems in the population at large, including a measure of the impact of the primary care service, has not been contemplated and needs to be undertaken; and

3) some of the information systems (drug or pharmacy inventory, cash flow records) appear to be too complex for the capabilities or training of the field personnel.

F. The evaluation team was favorably impressed by both the design and the handling of the medical records, although as stated before, the experience with them is still very limited.
The Evaluation Team reviewed the primary health care model of services being developed by PROSALUD in several communities in terms of overall orientation and operational cohesiveness functions and forms. These observations are presented in the section "Model Orientation and Design". The ET made observations and recommendations as well, regarding some operational aspects that, in our view, need to be strengthened.

I. Model Orientation And Design

A. The PP of 1983 and the Cooperative Agreement of 1985 called for the development of networks of primary care services based on a model developed by the Bolivian MOH, with a 3 tiered hierarchical arrangement offering the least sophisticated services of the system. The basic level, Level I, emphasis would be on environmental sanitation and treatment and surveillance of common diseases and injuries. Health nutrition, education, ORT, and a supply of essential drugs are the basic components. In addition, the project is called to develop several, although fewer, level II facilities where emphasis would shift from basic promotion, treatment and surveillance to the management and treatment of patients referred from level I as well as the supervision of level I activities in their geographical area. Finally, the project would establish up to six level III outlets which form the apex of the system. Their main function would be to serve as referral points for cases which cannot be adequately diagnosed or treated at levels II or I. These centres would also assume a larger supervisory role, especially with regard to sanitation and MCH programs of level I and II outlets.

The ET believes that the organization of a Board for each health centre, regardless of its level of complexity, has created inconsistencies with the provisions of technical, financial and operational interdependence between levels II and III as envisioned in the original MOH model, adopted by the project. In particular, the team is concerned about the arrangement between a centre level III and the centers level II located in its catchment area that PROSALUD will have to develop in order to cover the functions of supervision and sharing of the doctor's time. The team is also concerned with the difficulties with cross communities subsidies raised by this independent approach. Although speculative, it seems easier to consider that a relatively large, wealthier community will move from level III to a level IV health centre rather than to redistribute some of its excess resources to the level II centres in its catchment area.

B. Given the strong "a priori" preference in the communities for the presence of curative oriented providers, namely physicians, the development of a three level, community based, primary health care system remains a strong challenge to the project. The delay in incorporating the promoters in the current operating systems indicates that this problem is not satisfactorily solved. Moreover, it is not clear to this team that the functions originally assigned to the promoters (community outreach, health promotion, surveillance of health problems at the community level) have been temporarily but effectively transferred to other providers in the system. The ET
believes that the outreach attitude of the centres should be strongly strengthened through public health preventive and promotion activities delivered directly at the community level in Mother’s Club, school and homes. Particular emphasis should be put on health education, environmental sanitation and safe water supply, health nutrition and, for those couples that approve it, family planning services.

Conversely the development of a fee schedule in which preventive services are provided free of charge represents a positive commitment to this component of primary health services in the community.

C. The evaluation committee thinks that the use of community based health promoters is a fundamental element of the primary health care strategy embodied in the PROSALUD system, particularly with its commitment to public health and health promotion focus.

The development in the community of voluntary health personnel serves to reinforce the community development and marketing strategies that are essential to the goal of self-financing. Although we believe that the promoters should represent primarily a community contribution or subsidy to the system, it is possible to provide some inducements without undue economic impact on the system such as: free enrollment in the delivery system and utilization of health centre bicycles while promoters. The development of the promoters and their introduction into the delivery system should be simultaneous with the development and implementation of the other components of the primary health care module.

II. Operational Aspects

A. In the absence of a baseline assessment of the health problems in the communities, the primary care modules are being developed under the guidance of generalized diagnosis of health status. This estimate, while possibly unreliable because of incompleteness and inaccuracies, may also prove to be invalid for the specific communities in which PROSALUD works. Differences in health problems between urban and rural settings are, therefore, not reflected in their respective health programs. Furthermore, severe scarcity of resources means that epidemiological data are needed to prioritize problems and activities.

B. In the early stages of implementation of the health services modules, the health care personnel, particularly the physicians, should spend relatively more effort on community development and public health activities given that clinical activities may not use all of their available time.

C. While negotiations are currently underway to reduce fee-for-services costs for hospital-based services for insured patients, the general issue of access to hospital services and its financial implications for the populations served by PROSALUD’s Centros de Salud needs further conceptualization.
SUPPORTIVE ROLE OF USAID/B

The scope of work of the ET calls for an assessment of the role played by USAID/B in supporting the project in terms of conceptualization and design, logistical support, and any other aspect of importance to its implementation. The ET believes that, notwithstanding the difficulties and setbacks that this project has experienced, USAID/B should be recognized for conceiving and promoting this initiative. At times of economic crisis, when most governments in developing countries have been forced to face economic realities and scale down their allocation of resources to the health sector, particularly to primary care, USAID/B decided to try an alternative approach that was full of uncertainties. It rightly perceived that a pragmatic answer involved what is described in the PP of 1983 as "a conceptual framework that makes use of "three main concepts:"

- "emphasis on primary health care delivery, where the focus will be on preventive services and the use of community-based health workers supervised by a professional staff;"
- "minimum new infrastructure requirements..." and
- "self-help mechanisms where health services to be offered must be fully integrated in the sponsoring cooperatives (community organizations), address major health problems faced by cooperative (community) members, and financed by the membership"

The ET values highly the courage to take this initiative by members of USAID/B, particularly its Mission Director (Mr. H. Basford) and the Director of Health and Human Resources (Mr. Lee Houghan).

The supportive role of USAID/B, in the conceptualization and design of this project, both in 1982/83 and in 1985, are included in the analysis contained in Chapter IV of this report. However, some more specific remarks are presented here. The logistical support provided by USAID/B during the implementation will also be assessed.

I. Conceptualization And Design

A. During our interviews with the leaders of the three cooperatives originally invited to participate in the project and with current senior project staff, the ET was told several times that one of the major flaws of the conceptualization of the project was the lack of direct involvement and in depth participation by the cooperative leaders and membership. The initiative emerged apparently from USAID/B and the cooperative leaders did not play a significant role in the development of the PID and of the PP. The most important issues that blocked the effective implementation of the project during its initial 18 months could have been prevented, to some extent at least, if this cooperative participation had taken place. Negotiations between the cooperatives, among themselves, and with AID prior to project authorization could have avoided or mitigated at least part of the power struggle that occurred from August 1983 until January 1985. Furthermore, greater involvement of the participating cooperatives, particularly of San Julian and Mineros, in the pre-authorization phase would have helped to identify, and clarify, and perhaps, even solve some of the conceptual and operational issues that remain unclear or
undefined in the PP. This ambiguity proved later to be an unsurmountable obstacle that brought the project to a halt.

B. Similarly, the ET faults USAID/B in its lack of responsiveness to the issues raised by the DAEC in its assessment of the PID in February 1983. The DAEC questioned in particular, the formal and informal relationship between La Merced Cooperative (as grantee but also as equal participant) and the other two cooperatives, rural-based and of a more participatory, activist nature. It also questioned the lack of a definition of the ownership and control of the health services and/or its contradictory nature with an eventually independent, autonomous MSU. Regrettably, the PP did not provide an adequate solution to these issues, as it should have done.

C. It has already been mentioned in Chapter IV, but it is important to repeat and expand upon the following idea here: that during February-August 1985 the project was reconceptualized, albeit in an imperfect way. There were four major areas in which USAID/B should have established clearer concepts which, in turn, would have provided guidance to the project in its development and implementation. New personnel in USAID/B and in the project, the social/economic and political instability of the country, and a high degree of uncertainty of project feasibility the short and mid-term may explain some of these imperfections. This need to reconceptualize the project with a more global approach was quickly recognized by HHR/USAID/B by its decision to call for an external evaluation. In effect, its quarterly report of October 1985 states: "an evaluation of the project is scheduled for March-April 1986, after which USAID will decide on revisions, as necessary, to project funding and scheduling."

Furthermore, the statement of the general objective of the evaluation calls for a "review of the implementation of the project in order to make specific recommendations, concerning project design, funding and scheduling as well as to extract lessons for future projects of a similar nature." In the opinion of the ET, the four areas referenced above are:

1) a clear redefinition of the target population(s) taking into consideration that, at that point, the three cooperatives that had been members of the project had disengaged from it and were unlikely to return to it;

2) a more precise and explicit redefinition of the nature and role(s) expected from the MSU/PROSALUD. The MSU had always been envisioned as an independent entity but the types of relationships and roles that the MSU should have pursued with its co-sponsoring agencies (of primary health services) were not specified;

3) the original design of 1983 left essential areas of research, which were germane to the test of feasibility of the project, to be the responsibility of an outside agency (FIDES). This arrangement was already proving to be difficult to manage as uncertainties and continuous changes were occurring in the project. Furthermore, the key research design was not reassessed to incorporate the new orientation of the project in terms of the characteristics of the institutions and communities that were being approached and invited to participate in the project; and
4) finally, the withdrawal of the original cooperatives, the autonomy of the MSU and the nature of the new (potential) co-sponsoring agencies called for a profound assessment of the implications of these changes upon the marketing aspects of the project. A new marketing plan and strategies were needed as part of the new design since the project lacked, from that point on, the "captive" membership provided by the three original cooperatives.

Therefore, for the reasons presented in Chapter IV and because of the lack of adequate conceptualization summarized above the ET recommends that, prior to an extension of the project, these and other issues of project design be analyzed and clearly defined. Furthermore, the ET believes that it should be the responsibility of USAID/B, as a granting agency ultimately responsible, and as beneficiary of the project, to undertake a major role in its reconceptualization.

II. Logistical Support

A. USAID/B has provided the SFPHC project an inordinate amount of supervision and support. Given the implementation problems which occurred between September 1983 and January 1985, particularly the failure of the participating cooperatives to reach and maintain a working inter-agency agreement, USAID/B has shown a high degree of commitment to supporting the project by:

- the direct hiring of personnel to staff the MSU;
- the direct involvement in the negotiations between the cooperatives and in the management of the project itself; and
- timely supervision and decision-making; although, in this later aspect, USAID/B performance improved sharply after January 1985.

B. There have been some minor problems in terms of logistical support, e.g. in the timely procurement of pharmaceuticals (delayed for 9 months) and in the purchase of vehicles not totally suitable for Bolivian conditions (unleaded cars when in Bolivia unleaded gasoline is not available). These minor problems have not had a negative impact, in the opinion of this team, on the performance of the project.