1980 EVALUATION REQUIREMENTS

FOR THE

HEALTH DEMONSTRATION PROJECT

OF THE

KOREA HEALTH DEVELOPMENT INSTITUTE (KHDI)

SEOUL, KOREA

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F O R E W O R D

For two years, from July 1976 to August 1978, I was the USAID Project Manager, and Management Systems Advisor to the Korea Health Development Institute on this project. (departing shortly after the mid-term Joint USAID/ROKG review of the project held in July 1978.)

Because of my prior involvement with the project, and background experience, KHDI and USAID/Korea requested me to coordinate the final USAID/ROKG joint evaluation of the project with the termination of USAID's assistance in 1980.

Unfortunately, due to my present assigned duties and commitments I am unable to devote the time and attention required for this activity. However, during this brief TDY, I have endeavored to identify the parameters for evaluation and assist KHDI and USAID in formulating the evaluation strategy.

USAID/Seoul, Korea

21-26 February 1980

SUMMARY OF RECOMMENDATIONS

1. First priority should be given to obtaining the services of several specialized consultants who can individually review and evaluate KHDI's experiences and progress to date in their particular specialty, then provide further short-term technical assistance for the further development of Korea's Health Demonstration Project. This is deemed most important because although AID's participation is scheduled to end in 1980, the actual project will not terminate, but will continue under Korean and possibly other auspices. The innovative concepts in rural health delivery, introduced with AID's assistance, can be reinforced by this type of review, evaluation and consultancy. The areas of prime concern are:-

to develop sustainability

- -- Health Project Implementation
- -- Indicators for management, and data management systems
- -- Health Education and Training of various categories of health-workers, particularly at the rural clinic and village level.
- -- Health Insurance systems for rural residents

These consultants should be obtained as soon as possible.

2. Following the above consultations, attention should be directed toward a formal evaluation of project implementation experience and what was accomplished (i.e. the "outputs" and "purpose" attainments) by the AID project assistance. This type of review and appraisal is most important to AID because it summarizes the lessons learned in this "case study" and documents them for the AID system, providing a reference point for possible similar project activities by AID in other countries. The Korean Government would also benefit from such an evaluation. An "external" appraisal focusses high level Korean ministry attention on the KHDI project, and by highlighting weaknesses as well as strengths, can provide additional guidance, enhancing Korea's ability to obtain other, follow-on donor funding and/or technical assistance to complete the task that AID's initial assistance stimulated. For this type of evaluation, it would be most appropriate to gather together several consultants who have had prior experience with the Korean health scene and preferably the KHDI project. Some of the participants at the project's 1978 mid-term review would be desirable, if available. The timing for this evaluation would be late summer, early fall. In view of theproposed phase-out of AID presence in Korea beginning this summer, it would be highly desirable for an AID/W Asia Bureau direct-hire officer to assume the coordinator role for this evaluation, and visit Korea as soon as possible for orientation and familiarity with the project and principal counterparts.

Note of this is really evaluation rather review + T.A.

3. I recommend that the proposed 'Bennet Impact Evaluation', tentatively scheduled for the summer of 1980, be deferred. It is not

Ken says combine with their end of project eval — May/Sept

appropriate at this time within its current terms of reference, because the project has not yet progressed to the point where significant impact has occurred or can be readily identified. The project is still in the stage of "testing concepts".

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Background

A formal request for assistance in December 1972, to establish Gun (county) Health Care centers, made by the Korean delegation at the International Economic Commission for Korea conference, culminated in the signing of a $5 million loan agreement between the U.S. Agency for International Development and the Republic of Korea Government in September 1975.

The purpose of the loan was two-fold:

1) Institution Building to establish the capability within the Republic of Korea Government to plan, conduct, and evaluate low-cost, integrated health delivery projects directed primarily towards low-income families; and

2) Research & Development to demonstrate successfully at least one multi-gun (county) low-cost, integrated health delivery system that is replicable in other parts of Korea.

The USAID loan was for a period of five years, and is due to terminate in September 1980.

A formal, collaborative[1] evaluation of the progress of the project towards these purposes during the USAID-assisted period is required under the terms of the loan agreement, and is tentatively scheduled for August/September 1980.

In addition, an "impact evaluation"[2] of the project has been proposed by AID/Washington during the summer of 1980, as part of a program of selected internal project evaluations, world-wide, by AID/Washington personnel.

This paper outlines the thrust of these evaluations, and makes recommendations for conducting them.

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1 Collaborative -- Project participants as well as external consultants of both the US and ROK governments.

2 Impact Evaluation -- An evaluation of theproject's effect (particularly in terms of achieving the "purpose" and reaching intended beneficiaries), as opposed to simply the effectiveness or efficiency in delivering inputs or attaining outputs.

EVALUATION OF GOAL ATTAINMENT

1. The primary goal of the project was to "improve the health status of the Republic of Korea".

During the planning of the project, it was determined that the most significant indicators of a change in national health status would be reductions in the incidence of tuberculosis, ascaris, infant mortality, and a lowering of the crude death rate.

Base-line rates (1975) and projections for 1985 were as follows:

		1975	1985
1.	Tuberculosis prevalence	3.2 %	below 1 %
2.	Ascaris infection	44 %	below 10 %
3.	Crude death rate	8 / 1000	below 6 / 1000
4.	Infant mortality	36 / 1000	below 20 / 1000

Means of Verification KHDI should track each of the above indicators nationally and in the demonstration project areas on an annual basis for at least ten year period, beginning with 1975, using annual health statistics reports and population reports published by the Ministry of Health & Social Affairs, and the Economic Planning Board.

why only then ?

Comment The KHDI Health Demonstration Project began actual field implementation demonstration activities in late 1978, and full field implementation demonstration in mid-1979. Thus, 1980 is much too early to detect any impact or even progress towards the above goal. The above data should be tracked systematically by KHDI for time series purposes and future evaluations; however any discernible improvements to date cannot be imputed to KHDI activities.

2. A secondary goal of the project was to institutionalize successful models of integrated, low-cost, health delivery systems.

Comment Since the field implementation and testing of various health delivery system models is still under way, and are not ready for evaluation of effectiveness at this time, evaluation of "institutionalization is also premature.

PURPOSE

The overall KHDI project had two purposes -- Institution Building, and Research and Development. Each of these should be evaluated separately, as follows:

who all this planned to happen so late in project? What did they do 1975-78?

Institution Building KHDI was accorded permanent status in December 1979, as the official research institute exclusively in charge of health-related studies for the ROK Government. Thus, its hoped for de jure status has been attained.

From a Progress Evaluation standpoint, KHDI's de facto capability to function as previously envisaged should now be reviewed and evaluated in light of its experiences during the past four years, and recommendations made for appropriate budgetary support and staffing to continue to perform its assigned roles, in health planning, implementation of research/demonstration projects, and project analysis & evaluation.

This review should be undertaken by a team with backgrounds in health planning, health project management, and project evaluation. The team should review the formal professional training, experiences and skills of KHDI personnel, and render a technical judgement as to their competence, sufficiency, and needs for further training and/or staffing support. This can be done as a group effort in Seoul in a relatively short period of time - one to two weeks.

Impact Evaluation of this aspect would be marginal at this time; to trace the growing awareness and acceptance within the ROKG and the health sector of the need for this type of health planning and operational research. The results, replication if warranted, and consequent major impact are yet to occur.

2) Research & Development Originally, KHDI established three distinct R & D Health delivery system sub-project models in three different areas, with the intention of comparing these approaches for their relative efficacy in providing for, and improving the health status of the targetted populations. However, during the 1978 mid-term review it was noted that the various Gun models seemed to be converging spontaneously as service models evolved and such convergence and ad-hoc improvisation in project design would create difficulty in making clear comparisons between the three Gun models at the end of the project. The Mid-Term Review team therefore advised that the most meaningful assessment of impact should be based on specific project components rather than a total "model".

sensible but contrast to Mich. economist

These components include

a) Construction, equipping and establishment of a permanent, village-based, live-in clinics, to service rural residents.

b) Training and deployment of Nurse-Practitioners (Community Health Practitioners), to provide limited medical treatment and preventive health service to rural residents.

c) Retraining, reorganization and redeployment of existing single-purpose Nurse Aides as multi-purpose workers in the areas of Tuberculosis control, Maternal & Child Health, and Family Planning, to improve effectiveness and efficiency in treatment and preventive health service to rural residents.

d) Training of volunteer Village Health Workers as the initial point of contact in the village for identification, promotion and referral of health needs; and for provision of elementary first aid to local residents.

e) Reorientation of Physicians in nearby towns to shift attention from clinic-based treatment to a public health preventive approach, as well as supervision of the Community Health Practitioners.

f) Development and pilot testing of rural-based health insurance/prepayment systems and health cooperatives.

good

PROJECT IMPLEMENTATION

Most of the time under the AID loan has been spent in construction of facilities, preparation of the various categories of health worker, and developing conceptual programs (Outputs). Actual full implementation experience has been limited to the past year. Consequently, while some activity and progress can, and should be observed in the field and some impact may be evident, awareness of this relatively new approach to health delivery is still growing, and an impact appraisal of the project at this time would be premature.

For an ideal progress appraisal, it would be most appropriate for the evaluation team to be composed of individuals who were familiar with the baseline situation in rural Korea, or those who participated in the mid-term review. Such a group could be supplemented by other individuals with particular expertise in various aspects of health project development and evaluation in other developing countries.

∴ IMPACT TEAM (MUST) SPEND TIME IN US INTERVIEWING PPL WHOVE BEEN INVOLVED

Although US assistance to the health demonstration project is scheduled to terminate in 1980, from the Korean standpoint the project is still in its early stages of development and implementation, and

will continue with regular Korean government budgetary support and hopefully more foreign donor assistance. Thus the viewpoint has been expressed by the Korean Government's Ministry of Health and Social Affairs that any Joint US/ROKG evaluation provide expert consultancy, technical assistance and recommendations to serve the need of "looking forward" to continuing and future project development, and not be confined to reviewing what has been done to date.

Health Services Delivery System

KHDI has, with AID urging and assistance, embarked upon a unique and innovative approach to rural health services delivery (preventive and curative), using "para-medical" personnel, village health workers and other intermediaries, and attempting to establish a referral system within the context of an existing government health field service structure. It has met with several setbacks, as well as successes in this endeavor. At this time, in addition to appraising the state of development, it would be most appropriate to provide further technical consultative guidance for future development.

Indicators and Health MIS Development

For meaningful progress evaluation, KHDI needs to focus attention on developing indicators to measure the preventive aspects of health delivery, and to institute a regular system of data gathering and analysis for project implementation management purposes. The former will be crucial for the 1980 evaluation, while the latter will be helpful for subsequent ROKG project implementation.

Although KHDI has made some incremental improvements in its data gathering and development of indicators since the July 1978 Review, and the Korea Development Institute (KDI) is also conducting surveys and analyzing data to evaluate the effectiveness and efficiency of the project they could both benefit from some short-term consultant assistance to strengthen this area, prior to formally convening the 1980 evaluation team.

Training

A major thrust of the KHDI project has been in reorientation, and training new categories of health workers to serve the rural populations in both preventive as well as curative aspects. KHDI benefitted somewhat in its early development from experiences shared by staff members of the Lampang Project in Thailand, as well as observations and discussions with other organizations in the Third World, and the United States.

The mid-term review in 1978 observed that the emphasis of health services and activities of the project should be redirected from curative to

preventive, focussing on women of child-bearing age, infants and pre-school children. As pointed out in the 1978 Review, the emphasis was initially placed on Community Health Practitioner training, and primarily in a curative role. Since then, some attempts have been made to broaden the training to include preventive aspects for the CHPs as well as other categories of workers, but much still remains to be done, particularly at the Village Worker level. Also, audio-visual aids and reference materials need to be developed further.

It is highly desirable at this time for a specialized, indepth assessment of various aspects of KHDI's training program, with recommendations for future development and technical assistance, in anticipation of replication.

Health Insurance This aspect of the KHDI project was a late starter, due to both the complexity of the subject, and emerging schemes from other organizations of the Ministry of Health which made it difficult to delineate a separate geographic area for pilot testing of different approaches. A scheme has now been outlined and is in the early stages of implementation/testing, with operational problems beginning to emerge. KHDI could therefore benefit from some expert technical advice as soon as possible, from someone who could review their program, observe its effects and make recommendations for further development.

IMPACT & PROGRESS EVALUATION

At this time, although an "end of project" progress evaluation is warranted, it does not appear that the implementation activities of the project have proceeded a sufficient time for the results to be widely disseminated or an impact evaluation to be expected to obtain much worthwhile information.

TIMING OF EVALUATION

The foregoing specialized reviews of indicators, health MIS formulation, training, and insurance, are required as soon as possible, and should be conducted independent of any progress evaluation held by USAID and the ROKG.

In reviewing the proposed timing for the 1980 formal Joint Team Evaluation with various Korean government officials, it is their consensus that September or October 1980 would be the most appropriate time. In addition to providing more time for field implementation activities and experiences, more lead time will be available between the development work of the specialized reviews and preparation for the evaluation team's arrival, orientation and logistical support arrangements. Because of other programmed activities, as well as anticipated travel and accomodation difficulties, the summer period

(June, July & August) have been ruled out of practical consideration by the ROKG. Furthermore, an evaluation team visit prior to June is considered entirely too premature as well as impractical.

* From USAID/Korea's standpoint, late August would be preferable. Furthermore if specialized consultants for review, technical assistance and evaluation are to be provided to KHDI in the near future, and if the team evaluation is to be held later than May 1980, as seems most probable, a full-time liaison officer should be assigned on temporary duty or consultancy as soon as possible, to work with KHDI, the Ministry of Health & Social Affairs as well as USAID/Korea and the US Embassy to become acquainted with the project and its principal personnel. This is necessary because of the imminent close-out of the USAID/Korea mission, and the scheduled departure of its remaining contingent of three personnel beginning June 1980. Priority mission phase-out plans preclude continuing involvement in KHDI on-going activity support and/or evaluation.

Therefore a coordinator should provide such administrative and supporting backstop continuity during AID's final technical and financial contribution to the Health Demonstration Project, and bridge the transition to final phase-out.

Ideally, the coordinator should be a direct-hire officer experienced in both health development activities in Korea, as well as backstopping support of such activities within AID/Washington. Failing this, someone familiar with health development activities in other developing countries should be assigned and become familiar with the Korean scene/situation immediately, so that he/she can respond effectively to KHDI's, ROKG's and AID's continuing needs.