Evaluation report

Final version

Evaluated project: Development of the Home Care CASMED II

Ordered by: Diakonie ECCB - Center of Relief and Development, Prague

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Executive summary

Evaluation purpose and scope

The evaluation of the project "Development of the Home Care CASMED II" was carried out based on the request of Diaconia ECCB - Center of Relief and Development (DECCB – CRD).

The aim of the evaluation is to obtain independent and consistent findings, conclusions and recommendations for DECCB – CRD decision making about the future focus of the cooperation with Moldova partners in the area of home care for elderly and disadvantaged people.

The main objectives of the evaluation include:

1. Assessment of whether the project achieved its objectives using criteria of relevance, efficiency, effectiveness, impact, sustainability, and cross cutting principles.
2. Proposal of recommendations for DECCB - CRD cooperation with CASMED in the area of home care and for further CASMED's development.

The evaluation of the project is based on information from project stakeholders gathered during evaluation mission, available project documentation and strategic documents of project partners, Moldova government and the Czech Ministry of Foreign Affairs.

Brief description of the project

The project has been implemented in north Moldova during 2014 – 2016 by CASMED NGO in cooperation with Hilfswerk der Evangelischen Kirchen Schweiz (HEKS), Switzerland Red Cross (SRC), and DECCB – CRD. The project focuses on improving community services by providing home care services (HCS) to support elderly people. Besides that CASMED has been strengthening the civil society by cooperation with local authorities (LA), family doctors, NGOs and state institutions related to social and health care. The secondary beneficiaries are social workers, nurses volunteers, and family members of the elderly people.

The overall project goal is to improve quality of life and well-being of elderly people in Northern part of Moldova. The project objectives contain:

1. Social and medical HCS are provided to existing and new clients in high quality and sustainable manner.
2. CASMED organisation and NGOs network are strengthened personally, financially and through cooperation with stakeholders on district and local level.
3. Integration of HCS issues to national legal, institutional and financial framework for medical and social care is enlarged.

The funding was ensured from three main sources: HEKS, SRC, and Czech Development Agency (CZDA). The total CZDA contribution amounts to 210 127 EUR. The overall project funding including contribution from National Health Insurance Company, LA, beneficiaries, fundraising and other local sources amount to 1,48 million EUR[1].

Key conclusions

Relevance

The relevance of the project to CDC Programme, Moldova national strategies and legislation and beneficiaries needs is high as well as the complementarity of CASMED HCS to other HCS providers in north Moldova.

[1] *The figure includes the budget for 2016, but the real funding is expected to increase till the end of the year.*

Effectiveness

- The main project indicators related to number of communities and districts with available HCS, clients benefited from HCS, HCS provided to clients, CASMED partner NGOs are fulfilled.
- The equal access to CASMED HCS is ensured by non-discriminating and transparent selecting procedure.
- The existing locations and beneficiaries are maintained thanks to proactive CASMED's approach and high quality of provided HCS.
- Cooperation with volunteers and caretakers has strengthen.
- The model of cooperation with local NGOs proved to be effective.
- CASMED organizational structure is suitable and sustainable.
- The funds from HEKS, LA, NHIC, beneficiaries and fundraising have been growing since the beginning of the project.
- Project visibility was ensured in line with CZDA requirements.
- CASMED could not be certified for providing the social HCS since the accreditation process did not started on the national level.

The overall effectiveness of the contribution of project activities and outputs to attaining the planned indicators, objectives and overall project goal is assessed as rather high.

Efficiency

- The costs for project implementation are reasonable, nevertheless the DECCB – CRD support and office cost shall be optimised.
- HEKS and SRC are stable and reliable donners. DECCB – CRD supports CASMED in professional issues related to HCS provision, though big part of the training is organised by CASMED itself.
- The coordination of project management and supervision between partners is ensured by the Steering Committee, but DECCB – CRD is not its member. DECCB – CRD relies on HEKS project coordination unit and on direct communication with CASMED.
- The cooperation with national home care related institutions has extended.
- The four main changes in project activities did not have any negative affect.

The overall efficiency of the project activities and results in relation to overall project financial sources is assessed as medium because there are delays with CZDA funding, there has been higher increase in DECCB – CRD support and office cost compared to the increase of CZDA funds used for HCS and trainings, the coordination of yearly project planning between project partners is difficult, and several activities were not completed.

Key impacts

- Over 3000 beneficiaries from 30 locations received medical and/or social HCS.
- The network of partner NGOs expanded to 18 member NGOs.
- Quality of provided medical and social HCS has increased which resulted in higher demand for provision of HCS in the existing and new locations.
- Number of CASMED staff grew from 43 to 75 (i.e. new nurses and social workers obtained work).
- The system of co-financing HCS from beneficiaries and LA proved to be functional and effective.
- Awareness raising and fundraising events attracted new volunteers and are efficient in raising funds.

Impacts are evaluated as high taking into account that the key indicators related to beneficiaries and geographical scope were exceeded even half year before the end of the project period.

Sustainability and follow up activities

- The project results are to big extent sustainable and are very likely to be sustainable in next four years since both key international donors (HEKS and SRC) plan to support CASMED in long term.
- Fundraising activities on local level are successful.

- Needs of elderly people for providing HCS are growing.
- Cooperation with local and districts authorities, local NGOs, NHIC, HomeCare Association, Ministry of health, Ministry of family, social protection and labour is developing towards long term partnership.
- CASMED strategic plan for 2016 – 2020 includes providing existing HCS, widening the scope of its activities and developing new activities (e.g. social entrepreneurship).

The level of sustainability is evaluated as high thanks to ensured midterm funding, developing possibilities for increase of local funding, stable demand for HCS and CASMED's strategic planning.

Cross-cutting issues

- The equal access to health HCS is ensured.
- The partnership with LA, district and state institutions is based on proactive CASMED's approach, and support of local NGOs to community development.
- The project activities do not have any direct impact on environment and climate change.
- The transparency of using CZDA funds is not complete, because the budget breakdown (and corresponding financial report) does not correspond to project outputs and activities.

Project management

- The logframe was not used during the project and there are some insufficiencies in the project logic. Although the project proposal specifies the scope of DECCB – CRD involvement, the DECCB – CRD reports do not relate to this specification and mostly lack the explanation about which activities and outputs were funded from CZDA sources.
- The monitoring carried out by CASMED, HEKS and DECCB – CRD is sufficient.
- Each foreign donor has specific reporting requirements therefore it is not possible to harmonise the reporting activities at CASMED level.

The DECCB – CRD project management can be evaluated as medium to rather low but the overall project management is relatively strong thanks to robust project management of HEKS and SRC and very good management of CASMED organisation and its partner NGOs. The overall project management can be evaluated as rather high.

Summary evaluation

Evaluation criteria		**Summary evaluation**
Relevance		High
Effectiveness		Rather high
Efficiency		Medium
Impacts		High
Sustainability and follow up activities		High
Cross cutting principles	Equal access of beneficiaries	High
	Good governance	High – rather high
	Environment & climate	Not relevant
	Transparency	Medium
Overall project management		Rather high

Key recommendations

For CASMED

- Decrease the cost for office rental by developing social business.
- Offering the training for nurses and social workers to other HCS providers as paid service.

- Sharing the printed instructions about diseases with other HCS provides and finding common sources for developing and printing instructions on more diseases.

For all project partners (DECCB-CRD, CASMED, HEKS, SRC)

- When preparing the project plan define key indicators with clear specification.
- Harmonize the project plans and project indicators to eliminate differences in reported results.
- Invite DECCB – CRD into the project steering committee or find other coordination mechanism for project planning with CASMED and HEKS.
- Enhance sharing SRC and HEKS long term experience in advocacy and lobbying and train relevant CASMED staff in effective advocacy and lobbying on local, district and national level.

For CZDA

- Require the budget break down according to the project outputs or activities in order to simplify the review of the relevance of cost and real expenses.
- Review the reporting requirements in order to cover period with available funding unless pre-funding is agreed.
- Improve the communication with project partners concerning the dates of possible availability of funds to improve project planning.

For DECCB – CRD

- Strengthen cooperation with HEKS project coordination unit and optimise the support and office cost.
- The project coordinator shall be able to communicate in Russian or Romanian.
- When drafting the project budget, relate the budget to project activities or outputs; the yearly plan shall contain activities related to DECCB – CRD support or funding.
- Include the risks and assumptions assessment, assessment of the indicators achievement and information about DECCB - CRD PR and fundraising activities in interim and annual reports.

Ideas for DECCB – CRD to further support CASMED in three strategic directions:

1) Developing functional model of community health and social services and promoting active aging in community:

- Support of local communities, authorities and NGOs providing HCS in selected villages by contribution to fulfil their needs related to HCS and community development including development of strategic planning and fundraising.
- Reinforce volunteering activities development.

2) Developing of organisational capacities:

Support CASMED's capacities development by training of CASMED staff in areas identified based on training needs assessment e.g. psychology training to increase of mental endurance of social workers and nurses.

3) Development of income generating activities:

Support in development of social entrepreneurship – based on the CASMED Strategic plan and Diaconia experience.

Content

List of Annexes

(note for electronic version – annexes are in separate file)

1 Introduction - evaluation objectives and scope

The evaluation was carried out based on the request of Diakonie ECCB - Center of Relief and Development (DECCB – CRD) and its Terms of Reference of the Evaluation Mission of the three years project "Development of the Home Care CASMED II" (further only CASMED project). The history of the project is described in chapter 2.2 and the project objectives are contained in chapter 2.3.

The aim of the evaluation is to obtain independent, evidence based and consistent findings, conclusions and recommendations for DECCB – CRD decision making about the future focus and scope of the cooperation with Moldova partners in the area of home care for elderly and disadvantaged people.

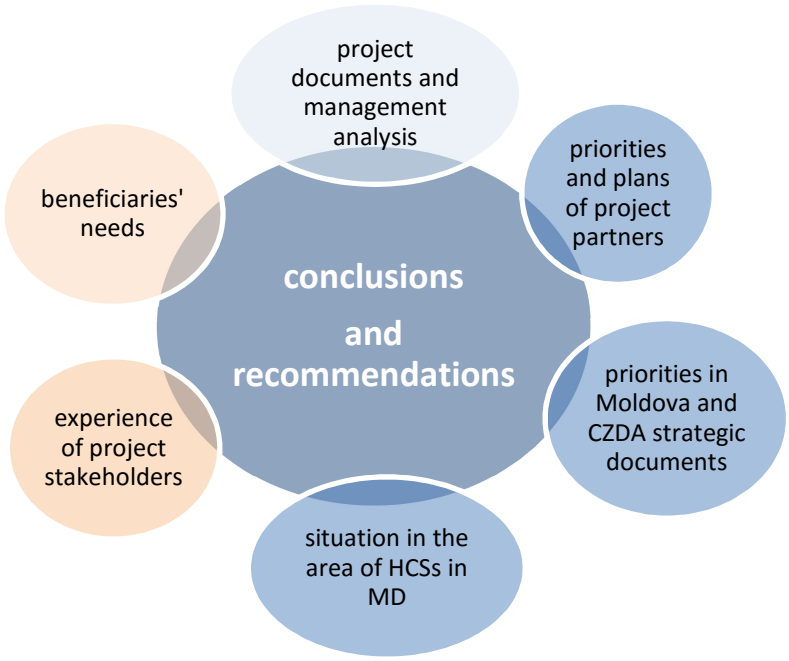
The main objectives of the evaluation include:

1. Assessment of whether the project achieved its objectives including determination of the relevance of objectives, development efficiency, effectiveness, impact and sustainability;
2. Proposal of recommendations for DECCB-CRD cooperation with CASMED in the area of home care and for further CASMED's development.

The evaluation results and lessons learned can be utilized also for improving management of the development projects in the social sector area in Moldova.

Evaluation scope

The evaluation of the CASMED II project and recommendation for further cooperation of DECCB-CRD with CASMED and other partners is based on information from project stakeholders gathered during evaluation mission, available project documentation and strategic documents of project partners, Moldova government and Czech Ministry of Foreign Affairs.



Scheme 1: Evaluation scope

The evaluation methodology and the list of questions are described in the work plan from 26. 7.2016. The questions are formulated based on following **evaluation criteria**: relevance, effectiveness, efficiency, impact, sustainability, visibility, cross-cutting principles and project management. The evaluation methodology is in compliance with the OECD/DAC Quality Standards for Development Evaluation[2].

[2] http://www.oecd.org/dac/evaluation/qualitystandardsfordevelopmentevaluation.htm

The information about experience of project stakeholders and beneficiaries' needs were gathered during evaluation mission, which took place from 17 to 24 August in Moldova. Detailed itinerary of the evaluation mission is listed in Annex 2.

2 Project background

2.1 Situation in the health and social sector in Moldova

The situation of the elderly people in Moldova according to the Ministry of Labour, Social Protection and Family[3]can be characterised as follows:

- Elderly persons constitute 15,7 % of the population of the Republic of Moldova. Elderly are disproportionately affected by economic emigration as they often have to bear the burden of caring for their grandchildren or other relatives on an already overstretched minimal pension.
- Many elderly persons living in rural areas do not have adequate access to water and sanitation, heating, flooring or roofing, sometimes even to health care.
- If current trends continue, in 2050 elderly will represent 33% from total population.
- Pensions in rural area amount to 700 – 900[4] MDL/person/month and the yearly increase is about 5% which the inflation during last 3 years fluctuate around 10 % per year.
- The elderly people who are left on their own without help of their family members can hardly cover basic needs without savings on health care (medication) in case they become ill, or house repair.

In 2014 the Moldova Government approved the Action Plan on implementation of the Road Map for mainstreaming ageing in policies for 2014 – 2016. One of the 13 actions listed in the Plan is "Health and well-being of older persons", which is specified as "**Strengthen the volunteer groups that provide home care**, including the extension of HelpAge experience".

Health care

- Since 2004 all citizens who take part in compulsory health insurance (including retired and disabled people)are entitled to basic health care[5].
- There is lack of family doctors who provide the basic health care in rural areas; one doctor have in average 1500 – 1800 patients and the village doctors are in majority over 60 years old[6].
- Family doctors in majority carry out home visits to patients who cannot come to their health centre; some of the family doctors' nurses also make home visits in addition to their obligation in the health centre.
- The home care services (HCS) started in Moldova in 1994. Since then there has been a number of projects supporting establishment of HCS in different parts of Moldova.
- The national Healthcare System Development Strategy for the period 2008 - 2017 contains action plan with concrete measures. One of these measures includes Developing community and home based care (measure 3.1.6).
- The home health care service was included in the legislation by the Gov. Decision 159-A from 15.9.2008. Since 2008 the National Health Insurance Company (NHIC) started to pay limited amount of HCSs to their providers based on agreed contract. Thanks to limited budget of NHIC the criteria for selecting patients to be included in the scheme paid by NHIC are very

[3] Presentation on the ACTION PLAN on implementation of Road Map on mainstreaming ageing in policies (2014-2016), 12/2014

[4] Exchange rate of the Czech National bank on 31.8.2016 MDL/CZK 1,236

[5] Presentation of the deputy minister of health, Mihai Ciocanu, about Health policy reform, 2014

[6] From meeting with the Ministry of health representative, discussion with family doctors in Falesti district

strict and the number of visits of one patient is also limited. Thus the current system cannot satisfy the patients' needs.

- Thanks to lobbying of the Association of Home Care providers the payment for one visit of a nurse was increased from 7 MDL/visit in 2008 to 92 MDL/visit in 2016.
- National standards for medical services in the field of home care were approved by the regulation no. 851 on 29.7.2013. The new regulation contributes to the improvement of health care for seniors and people with disabilities and their families. And it represents the transition from institutional care to HCSs.
- In 2014 the NHIC contracted 150 providers of palliative care and home care[7].

Social care

- Law No. 123 on Social Services entered into force 3 March 2011. The law sets the general framework for creation and operation of the integrated social service system determining the tasks and responsibilities of central and local public authorities, other legal entities and individuals authorised to provide social services, as well as the protection of the rights of social service beneficiaries. (It allows NGOs to provided social services upon obtained authorisation Art. 7/3).
- Social HCS are provided by district and municipal authorities, but the budget for social workers is limited thus only small amount of elderly and disabled in need can access the services of state social workers or social assistant.
- Some municipalities (usually in bigger towns) operate social centres; a few of them also serve as day care centres or exceptionally as residential centres for elderly or disabled people.
- Many municipalities provide some form of social canteen or delivery of subsidised lunches to elderly people.
- The current legislation doesn't allow municipalities or district authorities to buy social HCS from NGOs.
- Standards of social HCS were approved by the government at the end of 2014.
- The ministry of Labour, Social Protection and Family is currently developing mechanism for calculation of payments for providing social HCS.
- Also the accreditation[8] system for providers of Social home care is being finalized by the ministry in cooperation with the special working group. Key member of the working group is the HomeCare Association.

Nongovernmental organisation "HomeCare Association" was established in 2005 with the aim to increase awareness about the problems of socially vulnerable persons, carrying out and defending civil rights, social, and other legitimate rights and freedoms of elderly and disabled people, children and other socially unprotected persons etc. The association established eight day care centres for elderly people through financial support of the CZDA. It plays important role in advocating and lobbying at the national level for improving condition for providing HCS.
The association has over 35 member organisations. CASMED, the Association of palliative care NGOs and nursing association belong to most active members. Also CASMED is one of the biggest organisations.

2.2 History of CASMED projects

In 2006 HEKS started to develop HCS in five villages in north Moldova. Since the demand for social and health care including HCS has grown, the Centre for Social and Medical Home Assistance (CASMED) was established in Balti in 2006. Thanks to the increased funding, CASMED extended its

[7] Presentation of the deputy minister of health, Mihai Ciocanu, about Health policy reform, 2014
[8] The accreditation for social HCS shall allow CASMED to have possibility to apply for state funding of social HCS similarly like in case of health HCS funded by NHIC.

services to 16 localities in 2013 and further to 30 localities in 2016. During this period CASMED created its network with 18 local NGOs which provide the social and/or health HCS in their localities. CASMED has organized the provision of services by involving local NGOs (where available) in providing the services in order to involve and utilize the local nurses and social workers in which the clients and LA have a trust. This also minimizes the organisational and transportation cost. Since the medical HCS can be provided only by accredited organisations in this field and it would be difficult and expensive for the local NGO to comply with all the medical accreditation requirements, the nurses are officially employed by CASMED which obtained the accreditation. In the daily work both nurses and social workers are coordinated by the local NGO manager. On the expert and education level they are coordinated by CASMED's medical coordinator and by CASMED's social services coordinator.

DECCB-CRD started to cooperate with HEKS and CASMED in 2013 through the first project funded by CZDA. Thanks to this support and cooperation CASMED managed to start providing HCS in three new localities.

CASMED provides the local NGOs support, capacity building, mentoring and financing. The homecare is co-financed partly by local authorities (LA) halls and by beneficiaries themselves. Apart from this model, some medical HCS (namely in Balti) are financed from the NHIC.

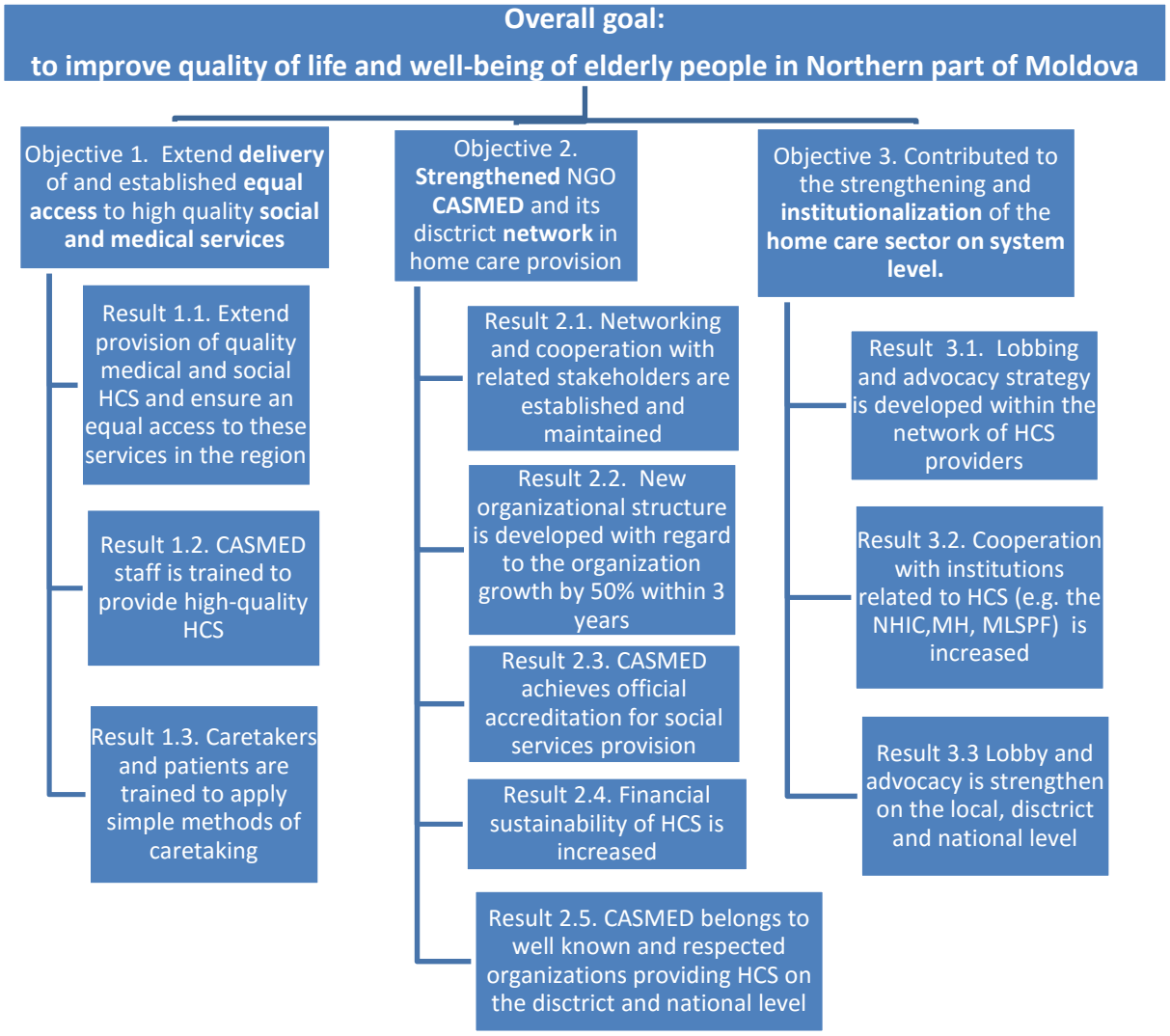
2.3 Project goal and objectives

The project CASMED II has been implemented in north Moldova during 2014 – 2016 by the NGO: CASMED in cooperation with DECCB – CRD. The project is focussed on improving community services by providing home care (HCS) to support elderly people from rural and urban areas (the primary target group). Besides that CASMED has been strengthening the civil society by cooperation with local authorities (LA), health centres, state institutions related to social and health care, NGOs and public. The secondary target group are social workers, nurses, volunteers, family members and/or neighbours of the primary target group, who has been involved in trainings and awareness raising activities.

The project under evaluation is extending the scope of activities by building the capacity of CASMED and the whole network of NGOs among other through training. Thanks to this CASMED can lobby for strengthening and institutionalisation of homecare in Moldova. Lately CASMED also focus on fundraising and volunteers activities.

The original project logic can be presented in the following scheme[9].

[9] *According to Logframe from 4.3. 2014*



The funding was ensured from three main sources: Hilfswerk der Evangelischen Kirchen Schweiz (HEKS), Switzerland, Switzerland Red Cross (SRC), and Czech Development Agency (CZDA).
The total CZDA contribution is envisaged in the amount of 210 127 EUR.[10] The following table gives overview of funding sources and amounts in individual years of the project. Local funding includes contribution from NHIC, LA, beneficiaries, fundraising and other local sources.

	2014	2015	2016 (plan)
Funding from CZDA	66 413 €	70 254 €	73 664 €
Funding from HEKS and SRC	304 831 €	388 450 €	485 570 €
Total project funding from foreign donors	**371 244 €**	**458 704 €**	**559 234 €**
Local funding	50 294 €	37 535 €	*5 447 €* *
Total project funding	421 538 €	496 239 €	564 681 €

** funds collected and approved by June 2016*

Table 1: overview of project funding[11]

[10] *the funding for 2016 is approved by CZDA but the funds has not been not transferred yet*

[11] Sources: DECCB-CRD and CASMED financial reports and budgets

2.4 Theory of change

The project logic presented in the logframe was reconstructed through the model of theory of change in order to:

- clarify the relations between activities, results, objectives and the goal (impact),
- reformulate some results in order to correspond to activities,
- reformulate outcomes in order to correspond the results and activities.

The resulting scheme is shown in the annex 3. The main changes in the project logic include:

- Adding the activity "continue to provide HCS in the existing locations", which was missing the in the list of activities and which uses the biggest portion of the budget for the CASMED staff.
- Reformulating majority of results in order to be more specific (i.e. contain the indicators) and relevant to the activities leading to each result.
- Reformulating specific objectives (outcomes) to be more concrete (e.g. outcome 1 "Social and medical HCS are provided to beneficiaries in high quality and sustainable manner").

2.5 Key assumptions and risks

The following main assumptions and risks are listed in the Logframe from 4.3.2014 related to fulfilling the objectives:

- Communities are willing to cooperate and are able to co-finance the HCSs.
- There are no natural disasters which affect the health of the population.
- Government, LA and communities are willing to cooperate in project implementation.

Further there are listed additional assumptions and risks related to reaching the expected results:

- CASMED staff is motivated to participate in the trainings increasing their qualification.
- Caretaker and patients are willing to cooperate.
- Public institutions (Family Doctor's Centers, municipalities) as well as local NGOs are willing to cooperate.
- Young people are motivated to be involved as volunteers in CASMED activities.
- Trust between patients and volunteers.
- The implementation mechanism of the "Law of social services" and "Law of social services providers accreditation" are developed in due time to allow the accreditation procedure.
- NHIC has been slowly increasing the funds for HCSs provision.
- The donors are willing to co-fund CASMED.
- People are able to pay for high quality services
- Increased confidence of population of the Northern districts of Moldova in quality and range of care available.
- Home care providers and national home care related institutions are willing to cooperate.
- The state bodies and the civil society is…[12]

In the project proposal form 3.3.2014 are listed the following additional risks, related assumptions and some mitigation measures:

- Harsh winters may hamper volunteers to make home visits to the beneficiaries whose health deteriorates during weather fluctuations.

[12] *unfinished formulation*

RISK	MITIGATION
People refuse to pay for HCSs, being used to receive medical assistance free of charge. People are not able to pay for the HCS due to low income. No or few paying clients.	Meetings and discussions with beneficiaries. Extension of the geographical area. Diversification of clients segment and price system. Continuous promotion of the services; Assurance of organization's visibility through publicity.
Local authorities are willing to cooperate but not able to co-finance the service in a substantial way due to lack of funds.	Signing of collaboration memorandum with LPAs in order to look for and apply together to alternative/additional funding sources.
NHIC does not have sufficient funds to contract and finance the services.	Looking for alternative/additional funding sources from other donors.
New home care providers appear. Competition increases.	Diversification of services; Analysis of clients' preferences and adapting the services to their needs and requests; Continuous analysis of other suppliers' offers Expansion to new regions with existing services (mobile teams); Development of new services.
Inflation – prices increase for medical materials, consumables, equipment, electricity etc.	Increase the prices for the services provided, proportionally to the inflation.

Table 2: Risks and mitigation strategies listed in project proposal

The identified risk and assumption are very elaborated, nevertheless there is one additional risk that is late availability the funds from donors. This appeared in case of funds from the CZDA especially in 2016, where the funds were received by DECCB – CRD only on 19.8.2016. Thanks to flexibility of HEKS the funding of activities planned from CZDA sources are pre-financed by HEKS funds.
From all the listed risks two following appeared:

- The implementation mechanism social services providers' accreditation was not approved on time and thus the accreditation procedure is not likely to be finished before the end of 2016.
- Some (3) LA are willing to cooperate but not able to co-finance the service in 2016 due to lack of funds. As a consequence of the lack of funding the HCS provision was stopped in these localities.

The absence of regular assessment of risks and assumptions in any of the regular report to CZDA is a shortcoming of the project management which can also effect the cooperation between project partners and beneficiaries.

3 Evaluation findings

3.1 Relevance

3.1.1 Relevance in relation to fulfilling the goals of Czech Development Cooperation programme

Development Cooperation Programme (CDC) Moldova for the period 2011 - 2017 states as one of the priority sector the education and other social infrastructure and services. The main goals of the CDC in this sector include:

- Support of programmes for socially disadvantaged groups.
- Cooperation in creating a connection between education, social programmes and employment policy.
- Support of home assistance as an effective tool of providing social care services (support of Moldovan organizations and institutions aiming to develop home care on the national scale and to reform the relevant legislation).

The evaluated project contribute to fulfilling namely the third of the above listed goals, nevertheless it partially contributes also to accomplish support for socially disadvantages groups through support of elderly and handicapped people and also to support in connection with education and employments as the CASMED staff undertake continuous training and the organisation manages to employ people in the rural areas.

3.1.2 Relevance in relation to meeting needs of the target group

The target group of beneficiaries are elderly persons from rural and urban areas which include isolated people in poor living conditions, people with reduced mobility, people who need post-hospital treatment, people with chronical health problems and people in terminal stages of life.
Based on the discussion with twelve CASMED clients, family doctors, representatives of LA including mayors, managers from social care departments of the district authorities, CASMED social workers and nurses and volunteers the following needs of the beneficiaries were identified:

- Regular health care especially in case of long term illness and recovery after injury
- Help with accompanying to health centres/doctors in case of absence of the doctors in the place of living.
- Social care including help with hygiene, bringing water, cleaning the house, cooking, washing clothes, shopping, brining community meal if available, communication.
- Financial contribution for heating (buying wood and coal), medical aid (e.g. walker), food, medication.

Some representatives of LA, social care departments and CASMED NGOs listed also needs for some kind of community centres (e.g. daily centres at least for meetings, washing and showering or residential centres for elderly people to stay over winter period) and additional funding for social care on local level.
The project activities under the first project objective (Extended delivery of and established equal access to high quality social and medical services) **meet needs of beneficiaries from big extent**. Nevertheless due to lack of funds on local level the scope of the HCS has to be sometimes limited to one or two social workers/nurses even if the need for the services in the location is higher. The needs for financial contribution to beneficiaries can be met only from small portion since it is very difficult to obtain the state contribution (due to lack of funds and strict criteria). Nevertheless CASMED is trying to obtain money for the contribution on medical aid through fundraising activities.

3.1.3 Complementarity to other providers of HCS for elderly in north Moldova

Overview of other main organisations providing HCS in north Moldova:

- Family doctor's centres / Family doctors' offices,
- District departments of Social assistance and family protection,
- Local departments of Social assistance (e.g. Balti State Department),
- Med Life NGO,
- Caritas Moldova NGO,
- HomeCare Association NGO – which supported establishment of day care centres combined with HCS,
- Second Breath for the North of Moldova NGO,
- CASMED NGO.

In addition there are a few formerly state centres where the elderly people can live on temporary or permanent basis funded from district or local authorities' budgets (e.g. protected accommodation in Balti).

Based on the discussion with representatives of district or local authorities, family doctors and HomeCare Association, the existing capacity of all organisations and authorities is not sufficient mainly due to lack of funding and lack of regulatory basis in the area of social HCS (see chapter 2.4).

Characteristics of HCS provided by district and local departments of social assistance:

- One social worker has to take care about 13 – 20 clients,
- Lack of funds for staff training,
- Low salaries and thus high turnover of staff,
- Some representatives of LA and district authorities mentioned that the quality of their services is lower than CASMED's or other NGOs,
- Free of charge for clients.

Characteristics of medical HCS provided by Family doctors and their centres:

- The doctors and their nurses can provide medical HCS only after regular opening hours.
- Since the doctors have in average over 1500 patients, they do not have time to carry out any longer care, e.g. rehabilitation exercise and the nurses often have time just to deliver the medication.
- Usually they do not have a car and thus rely on public transport.

CASMED is exceptional in comparison with other NGOs providing HCS in the following ways:

- Clients and LA contribution for HCS,
- High quality of provided services (*based on information obtained from clients, representatives of LA, RA, caretakes, volunteers),*
- Local staff – thanks to the model of local NGOs network,
- Involvement of volunteers,
- Provision of information materials about how to cope with common illnesses,
- Training of caretakes.

There were not identified any overlaps between CASMED activities and activities of other HCS providers. In case of Falesti region there was expressed wish for extending the cooperation and coordination in providing the social services. In case on Rebeca day care centre in Balti (funded by CZDA through Caritas CR project), nurses of Rebeca centre took part in several trainings for nurses organised by CASMED.

3.1.4 Relevance to the priorities of Moldova strategic documents

Key national strategies and legislation:

- The national Healthcare System Development Strategy for the period 2008 - 2017 contains action plan with concrete measures; measure 3.1.6 includes "Developing community and home based care".
- National standards for medical services in the field of HCS were approved by the regulation no. 851 on 29.7.2013. The new regulation contributes to the improvement of health care for seniors and people with disabilities and their families.
- Law No. 123 from 2011 on Social Services allows NGOs to provided social services upon obtained authorisation (Art. 7/3).
- Standards of social HCSs were approved by the government at the end of 2014
- The national Action plan on implementation of the Road Map for mainstreaming ageing in policies for 2014 – 2016 lists as one of the 13 actions "Strengthen the volunteer groups that provide home care, including the extension of HelpAge experience".

3.2 Effectiveness

The aim of this section is to find to what extent have the main activities and outputs contributed to attaining the planned indicators, objectives and overall project goal.

3.2.1 How are the new locations/beneficiaries for HCS selected?

New locations (villages/towns) are selected based on the interest of LA, elderly and disabled people needs and willingness of LA to contribute for the payment of provided services. LA representatives are informed about the CASMED possibilities to provide HCS on the meetings of district authorities related to social and health issues, via health centres, NGOs which cooperate with CASMED or directly by CASMED representatives. When some new LA agrees to cooperate with CASMED, they decide whether to form a new local NGO or utilize existing local NGO or use CASMED staff to provide HCS.

New beneficiaries are identified in cooperation with LA (in case of social services) and local doctors (in case of medical services). The identified potential beneficiary needs to fulfil selection criteria and fill in the introductory questionnaire. The criteria include their social status, pension level, health problems, communication possibilities, etc. The questionnaire contains also list of possible provided services for the beneficiary to select. (see Annex 4). The filled questionnaire with description of the needs and selection criteria is reviewed by commission which consist of local representatives (e.g. local doctor, representative of the LA) and CASMED representative. If the beneficiary fulfils the criteria, CASMED local staff has capacity to provide the needed services and LA and the beneficiary agree to contribute for the HCS costs, then the contract with the beneficiary is signed and the service provision can start.

At the beginning of the project CASMED provided services in 16 locations (villages and towns) and in August 2016 the number of location increased to 30 and there is a plan to widen the scope to several new locations by the end of the year. The list of current locations is in Annex 5.

3.2.2 How is the number of serviced locations/beneficiaries maintained?

Locations, where the HCS is provided, are maintained through regular communication and cooperation with the local NGO, authorities and doctors. CASMED takes part on the meetings of the local councils where presents the results about provided HCS and discuss problematic issues (e.g. increased demand on services) and possibilities for raising funds from various sources. The representative of LA regularly checks with the CASMED clients how they are satisfied.

The number of CASMED beneficiaries (clients) has increased steadily and already reached the planned indicator of 3000 over 3 years. Half year before the end of the project CASMED served 3803

patients. The yearly figures listed in the following table include both the existing and new patients receiving both medical and social HCS. The high numbers of patients is maintained thanks to high quality of provided serviced, regular monitoring and assessment of provided services and regular communication with caretakers (for more details see next subchapter). Nevertheless one of the limiting factor for increase of visits provided by one nurse or social worker is absence of transportation means (cars/bicycles) in majority of the CASMED's locations.

Indicators	*plan*	2014	2015	½ 2016	Updated plan for 2016
Locations with available HCS	*24*	22	33	30	7 new communities
Patients benefit from HCS	*3.000*	1709 only HEKS + DECCB – CRD	Total 3873 for all donors	Total 2853 for all donors	Maintain the number and increase where capacities of nurses and social workers allow

Table 3: overview of locations, districts and patients with provided HCS

There are three villages where the HCS stopped to be provided in 2016. These are villages where the LA could not afford to financially contribute for providing of HCS although they were satisfied with CASMED HCS in 2015. The only reason for stopping the services is the lower budget in these villages. Based on the information from the manager of the local NGO of two of these villages they hope that they will be able to afford to contribute and continue in cooperation next year.

Beneficiaries terminate the participation in the HCS either in line with their agreement (e.g. social services are provided for max. one year) or because they die, or some family member comes to help temporarily, or they move to live with their family members, or they agree with their neighbours to help them with taking care about the household.

3.2.3 How has the scope and quality of HCS developed since 2014?

The number of HCS provided yearly has increased to over 87.000 medical and social HCS. The total number of provided HCS for the 2,5 years exceeded the plan by 21 % and further increase is expected as listed in the following table. The social workers take care usually about 10 - 20 clients depending on the number of potential beneficiaries in every location, available funds from LA and the patient, and mainly on the scope of agreed services for each client under active contract. The nurses take care about 15 – 30 patients depending on the needs and scope of provided treatments.

Indicator	*plan*	2014	2015	½ 2016	Plan for 2016	Total reached for 3 years (planned)
Number of HCS provided to patients	160.000	59.626	87.001	47.598	at least 88.000	194.225 (234.627)

Table 4: overview of number of provided HCS

The quality of the provided services is regularly monitored in the following way:

- Medical HCS are monitored based on medical records from every visit. Depending on the state of the patients the nurse communicates with the relevant family doctor in order to adjust the provided services and applied medication. In case the health conditions improve and the patient is able to maintain himself/herself in good state, the medical care is stopped based on recommendation of the doctor.
- Monitoring of the medical services which are financed from the NHIC is also carried out by the state health inspection.
- Further the CASMED nurses take part in regular monthly meetings to exchange their experience with various diseased and applied treatments.
- The provision of social services is monitored by the CASMED social services coordinator through physical visits (once in half year), where the patient fills in the quality satisfaction

questionnaire or by phone (once per month), where he/she is asked the list of standard questions. The results of the questionnaires are analyses and discussed with the relevant staff.

- New more detailed questionnaire was introduced in February 2016 and its results will be described in the yearly report for 2016.

In 2015 96% of the questioned beneficiaries were satisfied with the services; 4% of the beneficiaries were less satisfied with the received services. The reasons for less satisfaction are requests for more time to be spent by social workers or requests for additional services or provision of medical aids, food, etc. The following graph shows the scope of provided social services.

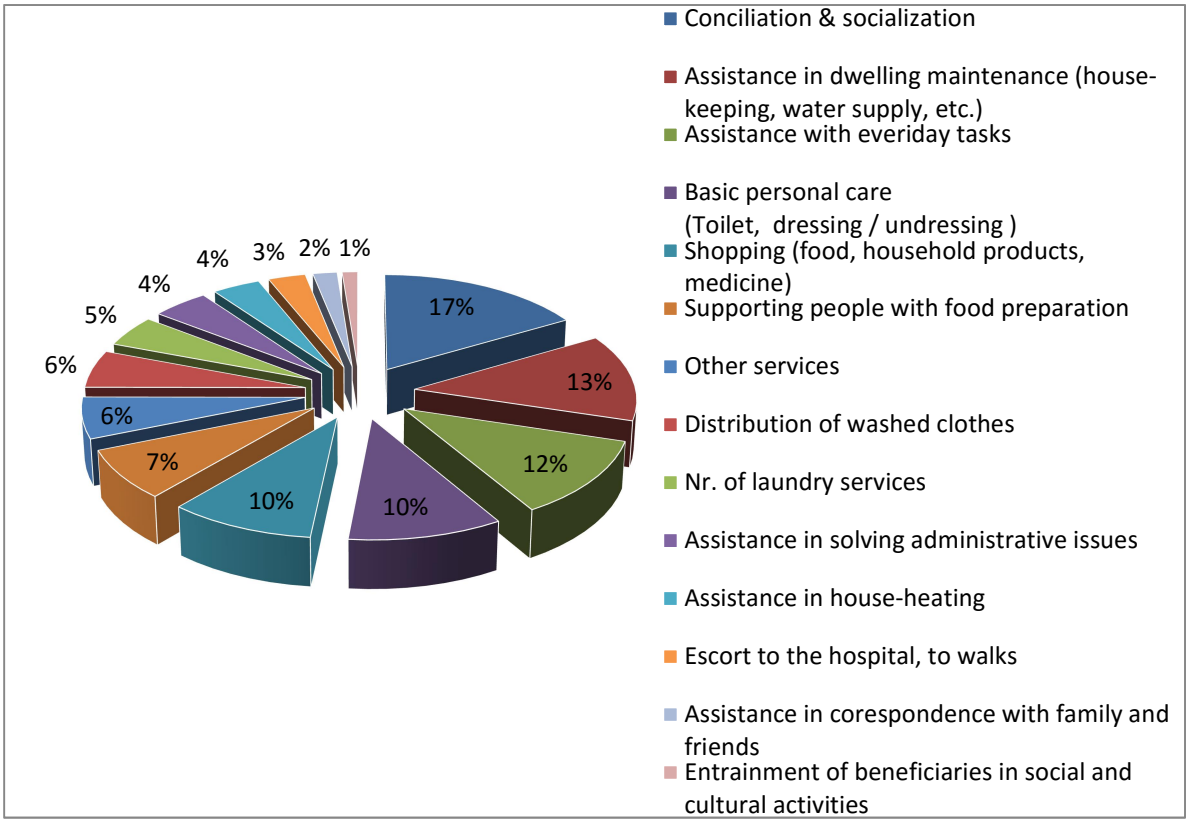


Diagram 1: Types of most requested social services[13]

3.2.4 How CASMED staff, volunteers and partner NGOs' staff utilize the knowledge gained in trainings and study visits?

CASMED provides training to all staff based on their needs and knowledge. The following part describes training of the main groups of staff and partner NGO representatives.

Training of nurses

Biggest requirements for training are for the nurses, who are required to undertake mandatory state-provided long-term courses for the qualification degree examination. Upon passing the mandatory courses they can obtain the certification which is valid for 5 years. The related project indicators require nurses to undertake in average 2 long term courses per year. As of June 2016 there were 18 nurses which undertook the courses for qualification degree certificate and in 2014 there was one nurse who undertook this course, in 2015 there were 5 nurses and in 2016 there are 12 nurses undertaking the course.

[13] Source: Annual Project Narrative Report for 2015, HEKS

Concerning the certification – 18 out of 26 nurses are certified, that is 70 % (the indicator is 80 %). According to the discussion with the medical coordinator, the reason for the lower percentage is that there are about 15 % of new nurses which were hired during last 12 months and they plan to undertake the courses in near future and also not all the nurses need the certification.
During the evaluation mission there was carried out the questionnaire research in which 46 % of nurses took part. Based on the questionnaire the nurse undertook in average 39h of training per year (in 2014 and 2015), in 2016 the average figure is about 15,6 h, but there are still many trainings planned for the second half of 2016.
Also all nurses have been taking part in the monthly coordinating meetings, on which they together identify new topics for trainings.
Nurses, who took part in the questionnaire research, highly appreciated the obtained trainings. They identified the following most useful topics:

- kinaesthetic methods,
- preventive diagnostic methods,
- care for patients after stroke,
- care about bed-ridden patients.

Concerning the utilisation of the gained knowledge the nurse selected many various applications. The most frequent are:

- Manipulation with bed-ridden patients.
- Mutual understanding with patients and caretakers.
- Recommendation on suitable diet for diabetes patients.
- How to recognize the symptoms of stroke.

Nurses also stated that they share the gained knowledge with their colleagues, caretakers, patients' family members, patients and doctors. This was confirmed during meetings representatives of LA, doctors, patients and caretakers in three villages and Falesti town.
The patients and care takers appreciate the following instructions obtained from nurses:

- How to take care about bed-ridden patients (manipulation, basis hygiene).
- Recommendation on diet for diabetes patients.
- How to take medications.

CASMED management team
There are 12 CASMED managers, coordinator, accountant and assistants (management team) employed in 2016. 75 % of them filled in the questionnaire for training utilisation research. The results of the questionnaire show, that they undertook in average 38 training hours in 2014, 51 training hours in 2015 and 18 training hours in 2016, and there are more training planned for the second half of 2016. The training indicator requires min. 25 training hours for each staff, which has been fulfilled.
Concerning the utilisation of the gained knowledge the management team selected the most beneficial trainings and study visits and the most frequent topics include:

- Advocacy and communication with LA,
- Human resources management,
- Study visit to CR and Romania,
- Fundraising.

Three members of CASMED management and coordination team took part in exchange visit to CR and Romania and all of them have used the gained information and experience in various ways. The most common ways are:

- Developing ideas (project proposal) for active aging centre.
- Implementation of coaching the medical assistants in the field and peer to peer support between nurses.

- Developing ideas for social entrepreneurship.

The knowledge from other trainings was most commonly utilized in more effective communication with LA.

CASMED's members of NGO network

CASMED NGOs' network has 18 members. Managers of 72 % of them filled the questionnaire for training utilisation research. Based on the questionnaire they undertook in average 13 training hours in 2014, 25 training hours in 2015 and 22 training hours in 2016, and there are more trainings planned for the second half of 2016. The training indicator requires min. 25 training hours for each staff, which was fulfilled in 2015 and it is most likely to be fulfilled in 2016.

Concerning the utilisation of the gained knowledge the NGO managers selected the most beneficial trainings and study visits and the most frequent topics include:

- Fundraising,
- Communication with clients and LA,
- Social service accreditation,
- Study visit to CR.

The knowledge from the trainings was mostly used in:

- Sharing knowledge with colleagues from NGOs,
- Improved cooperation of social workers with clients,
- Organizing successful fundraising,
- Preparation of the accreditation documentations for social services.

Based on group discussion with six **social workers** the most useful trainings for them include: communication with clients, introduction to palliative care and care for bed-ridden patients (e.g. hygiene). The social workers agreed that they received in average 4 trainings per year with duration of one to two days each.

Based on group discussion with 11 **volunteers** the most useful trainings for them include fundraising, project writing and team building. Detailed results of the questionnaire research are listed in Annex 6.

3.2.5 How has the cooperation with volunteers and caretakers developed?

Since the beginning of the project the number of volunteers involved in CASMEDs activities increased from 8 in 2014 to 22 in 2016. In addition each NGO from CASMED's network cooperated with at least three local volunteers. So the indicator related to number of volunteers (30 in total) is exceeded. The CASMED volunteers are in majority young people, who are attracted on various fundraising and awareness raising events.

The volunteer coordinator V. Gorobet was hired in the middle of 2015 and since the third quarter of 2015 there have been organised 2 – 3 volunteering activities per month mostly in Balti. These activities include fundraising and awareness raising events, children's program, visiting children in hospitals, visiting clients, helping to CASMED's social workers and distributing food packages bought from fundraising funds.

In CASMED NGOs locations the number of older volunteers is higher. They often help with taking care about clients, driving clients who can hardly move to medical centres or just only visiting clients to talk with them. In Izvoare village even the local priest Alexander is involved in volunteering and recruiting local youth to help with taking care about older citizens.

Caretakers are mostly relatives and neighbours, who have close or very good relation to the elderly person who needs care. Based on the discussion with several clients and their caretakers in four locations and based on information from LA representatives and CASMED staff, the caretakers of CASMED's clients are very satisfied with the provided HCS. The caretakers appreciate especially the nurses' advices and explanations how to better care about the elderly especially concerning diet in case of diabetes, taking care about bed-ridden persons, etc.

3.2.6 How the caretakers and patients utilize the knowledge gained in trainings and written instructions?

As mentioned in the previous subchapter, caretakers appreciate the nurses' advices and explanations how to better care about the elderly. Upon discussion with 12 patients and 5 caretakers during the evaluation mission, both caretakers as well as patients appreciate printed instructions on how to cope with diabetes and other diseases. These instructions are also appreciated by family doctors who do not have available any written instructions for patients. CASMED medical coordinator estimates that more than 70 % patients and/or their caretakers obtain every year the written instruction related to their diseases.

All patients and caretakers appreciate all the care and instructions as in most cases the patients do not have anybody else to talk about their health and social needs. Some of the patients and caretakers experience improvement in health after applying instruction on:

- How to properly take medications.
- Recommendation on diet especially for diabetes patients.
- Recommendation on basic hygiene namely for the bed-ridden patients.

The additional added value of the provided HCS is in many cases improved patients mood.

The indicator how many caretakers follow training on methods of caretaking cannot be objectively monitored as CASMED does not keep the list of caretakers and they are not always available for monitoring (e.g. they may work during the day out of the village).

3.2.7 How the CASMED network developed throughout the project?

Since the beginning of the project the territorial coverage of providing HCS by CASMED in north Moldova grew significantly as presented in the following table.

Indicators	2013	Target at the end of 2016	2014	2015	½ 2016	Updated plan till end of 2016
CASMED partner NGOs	9	13	12	19	18	At least 2 new local NGOs
Locations where CASMED provides HCS	16	24	22	33	30	7 new locations
Districts where CASMED provides HCS	6	8	7	9	9	Keep the existing districts

Table 5: Overview of territorial coverage development

Concerning the explanation of the decrease of locations between 2015 and 2016 see subchapter 3.2.2. The list of CASMED network members and localities is in Annex 5.

Organisation of CASMED NGO network

The aim of CASMED is to provide the HCS by developing the capacity of local community actors. In every new location there is the aim to find local nurses, social workers and coordinator which will be in direct contact with beneficiaries and LA. If the local people have capacity to provide the services, CASMED helps them to form NGO and support them by relevant trainings and agreed funds.

3.2.8 How is ensured interest of LA and local doctors to cooperate with CASMED network?

The interest of LA to social and health HCS for elderly and disabled people is related to the increasing number of senior citizens in their territories. Senior citizens forms 10 - 30 % of the population in north Moldova[14]. The percentage is higher in small villages. For example in Glinjeni the seniors makes 30 % of the population. The trend of the adults (working force) to work abroad still continues, thus the portion of people in need grows while the income of the LA is getting smaller, since there are only a few or no income generating organisations (common in small villages).

[14] Based on data from project proposal (2013) and figures from locations visited during evaluation mission.

Thus LA are seeking support in providing social and health care especially when bigger portion of services costs is covered by other than LA sources. They are also interest in cooperation with CASMED as it is an opportunity for a few local citizens (nurses, social workers, coordinator) to find a job. The most difficult decision for the LA is about the financial contribution on HCS provided by CASMED. But as there is very limited opportunity to obtain any other funding for providing medical and social service in local level, most of LA who participate in the CASMED network decide on yearly basis to contribute by less than 1 % of the LA budget. The difficulty is in the budget structure, which does not contain any compulsory line to be spent for social and medical services, thus they usually take the funds from emergency line.
CASMED representatives or their NGO partners take part in LA council's meetings where they present the achieved results in provided HCS, plans for the next period and seek agreement with LA on financial contribution (details about funding structure is listed in the following subchapter). The agreement is signed with LA for one to three year with yearly amendment related to the allocated budget.

Family doctors and health centres are in majority interested in cooperation with CASMED nurses. The doctors have often more than 1500 patients under their responsibility and thus they have very limited time to make home visits. Concerning their nurses, some of them do not make home visits, depending on the amount of work and their capacities. In some villages there is no permanent doctors' office and there is agreement with the doctor from nearby village/town to visit the village once or twice per week. Also majority of family doctors are senior people around the retirement age. As explained above, the cooperation with local doctors is crucial when determining the scope of medical HCS and for the regular check of the patients' health state, which is ensured by CASMED nurses in consultation with the doctor.
Out of 26 respondents of the questionnaire survey (CASMED staff and NGOs managers) 73 % assess the cooperation with doctors as good and 17 % as very good.
The project indicator required to have at least 7 mutual agreements with doctors. In 2014 CASMED made 12 mutual agreements, in 2015 already 22 and in 2016 mutual agreements are established with almost all district family doctors. Some reluctance for collaboration with CASMED is currently from doctors in Bocani, Răuțel, Mărăndeni[15].

3.2.9 How does the organizational structure respond to the increase of serviced communities and clients?

In 2013 all management and coordination was ensured by the director which was hardly feasible. As the organisation expanded to more locations, the need for management and coordination capacity increased. It was necessary to delegate some of the managerial and coordination activities to other staff members. The current team of CASMED head office consist of 10 personnel:

- Postolachi Natalia, Executive Director,
- Pricop Ana, Finance Manager,
- Moraru Olga, Accountant,
- Mortean Antonina, Chief medical assistant,
- Bolfosu Livia, Project Coordinator responsible for monitoring and reporting to and other to HEKS and DECCB – CRD,
- Buga Andrian, Project Coordinator responsible for monitoring and reporting to SRC,
- Parea Alexandr, Assistant Manager,
- Gorobeţ Viorica, Volunteers Coordinator,
- Chistruga Alexandru, Coordinator for social services,
- Fillip Alexandru, Fundraiser.

[15] Base on information from CASMED staff.

The current organisational structure is listed in Annex 8.
Based on discussion with the executive director and other head office staff members the current structure functions well, although they are searching for monitoring and evaluation specialist, PR specialist and fundraiser on fulltime basis.
There was established very good practice of monthly meetings of all nurses in order to exchange the experience, learn from each other and discuss the training needs.
Based on the discussion with three NGO managers and some social workers, they would appreciate also regular meetings for exchanging of experience. Currently they meet only during trainings which takes place 3 – 4 times per year.
The current management structure is suitable and sustainable considering the legal requirements for NGOs, requirements of the national standards for medical and social HCS, donors' requirements for monitoring and reporting, requirements for communication with local and district authorities, needs for fundraising and development on local and national level the current management structure is suitable and sustainable.

3.2.10 How the funding structure of HCS has developed?

The structure of CASMED's funding in 2014 – 2016 is presented in the following table. The table shows that the funds from HEKS, LA, NHIC, beneficiaries and fundraising have been growing.

Income sources	2014		2015		Figures till June 2016	
	MDL	%	MDL	%	MDL	%
1. International sources						
1.1 HEKS	2 099 860	36	3 767 717	41	5 586 158	56
1.2 SRC	2 376 021	40	3 635 104	40	3 169 466	32
1.3 Diaconia **	815 248	14	1 000 935	11	887 859	9
1.4 FHI (USAID)	327 119	6	227 379	2	207 200	2
Subtotal (1)	**5 618 248**	95	**8 631 135**	95	**9 643 483**	97
2. Local sources						
2.1 LA	7 040	0,1	11 865	0,1	23 972	0,2
2.2. NHIC	52 761	0,9	62 545	0,7	62 545	0,6
2.3 Economic agents	1 200	0,0	39 000	0,4		0
2.4. Individual donations	5 755	0,1	100	0,0	320	0,0
Subtotal (2)	**66 756**	1,1	**113 510**	1,2	**86 837**	0,9
3. Income generating activities (local)						
3.1 Membership fees	200	0,0	700	0,0		0
3.2 Medical services - beneficiaries	211463	3,6	301 114	3,3	144 040	1,5
3.3 Social services - beneficiaries		0	2 250	0	10 045	0,1
3.4 Fundraising	5725	0,1	68 958	0,8	12 089	0,1
Subtotal (3)	**217 388**	3,7	**373 022**	4,1	**166 174**	1,7
Total	**5 902 392**	**100**	**9 117 667**	**100**	**9 896 494**	**100**

** the USAID project is described below in the box.*
*** it includes funds transferred to Moldova and funds for trainings and study visits paid directly by DECCB-CRD*
Table 6: Structure of CASMED's funding in 2014 – 2016[16]

[16] Sources: DECCB-CRD and CASMED financial reports and budgets

Methodology for national and local co-funding of HCS is presented in the following table:

Type of HCS and source of funding	**Rate or proportion of funding/ HCS visit**	**Limitations**
Medical HCS funded from NHIC	91,5 MDL/visit	Limited by the contract with NHIC which covers only HCS provided in Balti
Other medical HCS funded by international donors and beneficiaries.	international donors (90%) – about 90 MDL/visit + beneficiaries (10 %) – usually 10 MDL/visit	Limited by the international donors funds for HCS
Social HCS funded by international donors, LA and beneficiaries.	international donors (60%) + LA (30 %) + beneficiary (10 %) - usually 25 MDL/month/beneficiary	Limited by the international donors and LA funds for HCS; in case of lack of funds from beneficiaries or LA sometimes some local private people help financially

Table 7: Methodology for national and local co-funding of HCS

The model for co-funding the social HCS by beneficiaries started in 2015. The experience with beneficiary's contributions shows that patients value and care about the paid services more than if the service is provided by free. There have been some cases when the beneficiary could not afford to contribute. In some of these cases the local NGOs help to find a local sponsor and in a few cases the HCS was stopped.

Based on the information from the CASMED financial manager the real cost for HCS including CASMED overhead cost are as follows:

- Medical HCS cost in average 130 MDL in 2014 as well as in 2015
- Social HCS cost 110 MDL in 2014 and 112 MDL in 2015

FHI 360 Project: Rural Civil Society Organizations as Proactive Actors in the provision and development of community services and promotion of European Integration

The project is funded by the US Agency for International Development (USAID) through the program "Partnership for a Sustainable Civil Society in Moldova", managed by FHI 360. The duration of the project is 36 months, starting from 01.08.2014 until 30.07.2017. The total project budget is 30'000 $. The project aims at strengthening the network among the NGOs providers of community services in the North of the country. Thanks to the gained skills and developed tools, these organizations will be able to respond more effectively to community needs and attract resources to support social projects, to initiate partnerships with LA for the effective management of local resources.

Box 1: Summary of the FHI360 community support project

Fundraising activities started to be more successful with the new volunteer coordinator, fundraiser and increased number of volunteers. The fundraising activities include mainly cultural events e.g. concerts and awareness raising events such as activities on the day of diabetes, on the seniors' day. CASMED developed Fundraising strategy for 2016 which aims to increase the CASMED funds by 3,5 million MDL through several fundraising way including grands from international donors, bank loan, crowdfunding and other traditional fundraising actions.

The indicators for national, local and beneficiaries co-funding are not correctly formulated as the planned percentage increase of national, local, beneficiaries co-funding does not specify what is the basis of the percentage (e.g. total budget, subtotal of local/national budget, or price/cost for one HCS

visit). Similarly the fundraising indicator is not clear as it related to local funding, but there is no specification what constitutes local funding (see table 6 above).

3.2.11 How was the project visibility ensured?

The project visibility is ensured by the following communication tools: newsletters, leaflets, website, signboards, backdrops, articles/interviews in district newspapers, participation on activities of the HomeCare Association, meetings with local and district authorities, awareness raising and cultural (fundraising) activities.
The CZDA logo is used in line with the contract requirements – on printed materials, medical tools and other tangible asset as car or furniture, on signboards of the NGOs offices financed from CZDA funding. For example see picture 1. Apart from that the logo is used on the website http://casmed.md/ and the CASMED signboard and backdrops used during awareness raising campaigns.

Picture 1: signboards of the NGOs Nufarul ALB offices in Glinjeni

The indicators related to visibility:

- 5000 newsletters and leaflets distributed quarterly in project area – the figure was reached on yearly basis and not on quarterly basis in line with the budget allocated for the printed materials. According to the CASMED director, this indicator is in HEKS logframe formulated as "2000 newsletters and 3000 leaflets distributed in the project area per year".
- People access CASMED web-site - min 500 per year – the monitoring started at the end of 2015 and till June 30 there were 1154 views.
- 3 articles or interviews about the service published in a regional newspaper – it was reached in all project years. For details see Annex 9.

3.2.12 Did CASMED obtain the certification for provision of social services?

Although the standards of social HCS were approved by the government at the end of 2014 and CASMED has been adapting the services to the standards and preparing for the certification, the accreditation system has not been finalized by the Ministry of labour, social protection and family.
The start of the accreditation process is expected in the first half of 2017.

3.2.13 How the strategy for lobby and advocacy work was utilized?

The Strategic advocacy plans were prepared for 2015 and 2015. They contain set of goals, outputs/strategies and activities. The goals for both years are the same:

1. Increase funding for HCS from local fund
2. Increase funding for HCS from NHIC
3. Network has capacity to advocate for HCS
4. Strengthening and institutionalization of home care sector on system level

Most of these goals are the same or similar with objectives and expected results from the project Logframe. The plans do not contain concrete responsibilities and schedule for implementing activities. Many of the outputs are formulated as activities (e.g. "meet with district and local municipalities") and do not specify concrete results. Thus it is not clear how such a plan can be practically utilized and how to measure its fulfilment.

Based on the information from CASMED's director, she ensures majority of lobby and advocacy activities. In 2016 the CASMED director takes part in the meetings of the national HomeCare Association, National working group on HCS for the Ministry of Family, social protection and labour, and National Council for Accreditation and Evaluation of social services. Thanks to her long term experience with HCS she can influence development of the relevant and needed strategical documents and legislation on national level.

Based on the discussion with representatives of SRC and HEKS offices in Chisinau, they also contribute to lobbing and advocacy in order to strengthen and institutionalize HCS on system level. The lobbing and advocacy efforts of SRC, HEKS and CASMED are more or less coordinated. Nevertheless it would be helpful for CASMED management to strengthen the cooperation with SRC, and HEKS in the lobbing and advocacy activities on national level and utilize their experience in this area. The CASMED support by HEKS and SRC in lobbing would be useful also due to time demands for traveling (CASMED is located in Balti) and big workload of the CASMED's director, which is the only CASMED representative involved in lobbing on national level.

Based on the information from the SRC representative, SRC is lobbying at the Ministry of Health for increasing the funds for NGOs providing HCS in order to cover the administrative cost since these cost are covered from national budget to public institutions which provide HCS.

Concerning the achievements related to the goals:

1. The Increase of funding for HCS from local fund in 2015 compared to 2014 is 69% and comparison of ½ 2016 with 2015 is 102 %.
2. Increase funding for HCS from NHIC in 2015 compared to 2014 is 19 % and the agreed funding for 2016 is the same as in 2015, but it is expected that some small additional increase can be additionally approved in the second half of the year.
3. Network has capacity to advocate for HCS – the advocate capacity is visible in very good relations with representatives of district social protection departments, many LA and some medical centres and family doctors.
4. Strengthening and institutionalization of home care sector on system level – this is a joint effort of organisations united under the umbrella of HomeCare Association. As explained in the chapter 2.1, the strengthening and institutionalisation is a long process, but it is developing in the desired directing (based on the information from the director of HomeCare Association).

3.2.14 What factors influenced attaining project outputs and goals?

List of main supporting factors:

- Communities and LA are willing to cooperate and are able to co-finance HCS.
- Caretaker and clients are willing to cooperate - trust between CASMED staff (nurses/social workers) and patients.
- Local NGOs and family doctors are willing to cooperate.

- CASMED staff and partner NGOs' staff is interested in the trainings and in the application of the gained knowledge in practice.
- Young people are motivated to be involved as volunteers.
- The donors are willing to co-fund CASMED – flexibility of HEKS to pre-fund activities planned to be co-financed by CZDA.
- Clients are able to contribute for HCS.
- NHIC continues to funds for medical HCS provision and the price for one medical visit has increased in 2014 and since then it has been stable.
- New organisational structure, which allows the director to delegate some managerial and coordination tasks, contributes to bigger efficiency of the organisation as a whole.

Limiting factors include:

- The approval of implementation mechanism for social HCS providers' accreditation has taken longer time then envisaged and thus the accreditation procedure has not started till September 2016; also the calculation of the fee for providing social HCS is not finalized on the national level and there is so far no mechanism how to allocate state funding for social HCS.
- The LA budgets do not contain special item for social services, which would allow purchasing HCS from any HCS provider.
- The agreed funds from CZDA have been slightly delayed (in 2016 the funds were received at the end of August), which influence the planning and utilisation of the funds.
- CASMED does not own any property (building) thus some of the project cost are allocated to cover rent of offices and meeting/training room and not to provision of HCS.
- Different requirement of donors on monitoring and reporting requires work of two project coordinators; moreover the list of project indicators differs between donors although they fund in majority the same activities;
- Some of the project coordinators in donors and partner offices changes (DECCB – CRD/HEKS/CZDA) so the current coordinators do not always know the background of why something was planned, how to obtain data for checking the fulfilment of some of the indicators.
- The structure of the DECCB – CRD budget does not correspond to project outputs or activities, so the reporting on utilisation of funds is complicated.

3.3 Efficiency

3.3.1 Were project implementation costs reasonable in relation to achieving the results?

The efficiency assessment is made by calculation of:

- cost for providing one HCS,
- salaries of social and medical staff,
- cost for training and study visits, and
- cost for coordinating and support offices.

Cost for providing HCS

The following table presents the average cost for providing one HCS by CASMED in comparison with the official state rate from the NHIC. Unfortunately the other providers of HCS (e.g. Caritas) did not share the information about cost per one HCS.

Cost for one HCS	2014	2015	½ 2016
CASMED's cost for one HCS visit	5,29 €	5,01 €	5,04 €
State payment for one medical HCS (NHIC)*	5,18 €	4,43 €	4,13 €
Inflation rate in Moldova	*5 %*	*13 %*	*7 %*

** the rate is the same for last three years (91,5 MDL/HCS); the difference is caused by the development of the exchange rate.* Exchange rate for 2016[17]

Table 8: Average cost for providing one HCS

Based on the discussion with CASMED's financial manager the average cost for medical HCS are 18 % higher compared to the social HCS. The figures for CASMED cost in 2016 are preliminary estimation since the number of provided HCS can differ at the end of the year as well as the total income.
The comparison of state rates and CASMED rates show difference between 8 - 12 % in 2014 and 2015. In the evaluator's opinion the higher cost are relevant since they cover also training, transport and equipment for the nurse and social workers as well as the overheads for coordination and management of the organisation and NGOs network. The NHIC rate covers only the actual provision of medical HCS without transport, trainings, equipment or overhead costs.

Nurses and social workers salaries

The level of salaries of CASMED's social and medical staff can be compared with state nurses and nurses working in Rebeca centre in Balti (established by Caritas CR financed CZDA)[18]:

- CASMED nurse: 249 EUR/month (max. salary depending on the number of visits)
- Rebeca nurse: 226 EUR/ month
- State nurse: 190 EUR/month
- CASMED social worker: 120 EUR/month (can differ +/- 10 % depending on the number of clients and the clients contribution)
- State social worker: 100 EUR/month depending on the number of clients

The salary of CASMED nurses is about 30 % higher compared to state nurses and about 10 % higher compared to Rebeca nurse. The higher salary shall motivate the nurses to dedicate to the work the whole day (as most of Moldavian people are trying to find second or third job and/or work on their yard in afternoons) and also to ensure long term engagement of the nurses.

[17] http://www.exchangerates.org.uk/EUR-MDL-exchange-rate-history.html
[18] the minimum salary is 41 EUR/month

Cost for training and study visits

Cost	2014	2015	2016 - plan
Average cost for training for one staff member	223 €	162 €	330 €
Cost for study visits to CR per person per day	77 €	85 €	141 €
Study visit to Romania per person per day	137 €	-	-

Table 9: Cost for trainings and study visits

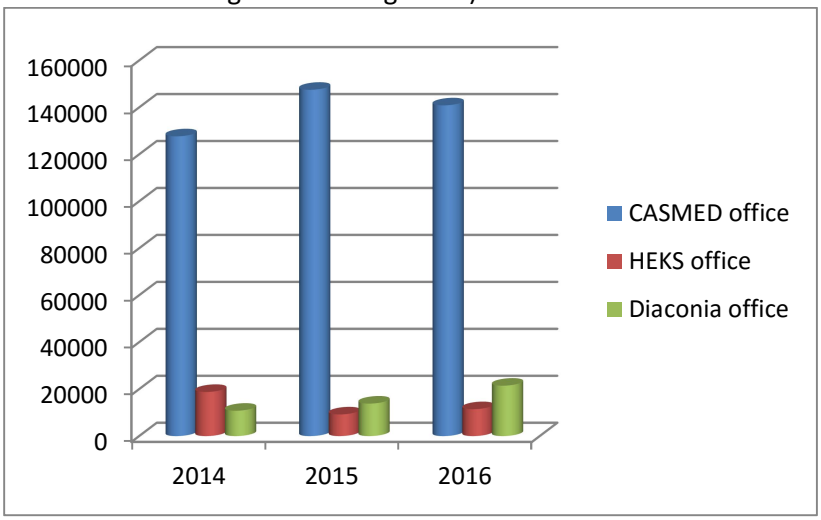
The costs for training are difficult to analyse since different groups of staff obtain different trainings. As described above in subchapter 3.2.4, the majority of CASMED staff obtains 35 – 40h of training per year and all the staff receives min. 20h of trainings. Majority of the training is provided by Moldavian experts, while the foreign (Czech) experts carry out 1 – 2 trainings per year apart from study visits. Thus the training cost can be considered reasonable.

The cost of the study visits are incomparable since it depends on the number of people, the transport means and on the program. The study visits to CR in 2014 and 2015 included 9 – 14 people, while the study visit in 2016 and study visit to Romania included 4 – 6 people.

Based on the discussion with CASMED staff and NGOs coordinators and managers, and the responses listed in the questionnaires, the study visits are useful in the way that the visitors can see how different models of HCS works in practice. And when they return to Moldova, most of the coordinators and managers utilize the gained knowledge for developing their services (e.g. establishing community centres) or developing CASMED's activities – ideas about social entrepreneurship, active aging, etc.

Cost for coordinating and support offices

The review of coordination, managerial and other overhead cost (further only office cost) shows that these costs have formed 42 – 31 % of the total project cost. The highest portion of the office cost are logically consumed by the CASMED office, which grew in number of employees, office equipment, coordination needs along with the increase of the locations and number of offices (in 2015 was rented new training and meeting room).



Graph 2: Office cost in EUR

HEKS office cost presented in the budget consist of only portion of the overall office cost of HEKS office in Chisinau since HEKS Moldova they coordinate at least three projects. The cost listed in the CASMED's project budget for 2016 represent only about 10 % of the overall HEKS cost for office operation in Chisinau and related capacity building.

Figures related to HEKS office cost, presented in the following table and graph, include the CZDA contribution which makes about 25 – 50 % of the overall HEKS office cost presented in the project budget.

Cost	2014	2015	2016
CASMED office incl. coordination of NGOs	34%	32%	25%
HEKS office	5%	2%	2%
DECCB – CRD office	2,9%	3,0%	3,8%
Total office cost/total project cost	42%	37%	31%

Table 10: Office cost

DECCB – CRD office cost represent 2,9 – 3,8 % of the overall project cost, but they grew in the time compared to CASMEDs office costs which are declining. The personal cost represents the highest portion of DECCB – CRD costs (68 – 79 %).

DECCB – CRD staff in 2014	*DECCB – CRD staff in 2015 and 2016*
1. Coordinator	1. Project Coordinator
2. PR expert	2. PR (project visibility)
3. Administrative personnel - accountant	3. Accountant
4. Administrative personnel - assistant	4. Assistant
	5. Office manager
	6. Supervisor
	7. Financial manager

Table 11: DECCB – CRD project related staff

The nature and scope of the services ensured by DECCB – CRD in the frame the project has not significantly changed during the course of the project except for widening the PR activities and starting with fundraising activities. But the increase of PR and fundraising activities does not explain the overall growth of personal and support cost. Based on the discussion with DECCB – CRD coordinator and the supervisor the responsibilities and activities carried out by DECCB – CRD office include:

- Monitoring and reporting based on CZDA requirements (two reports per year and preparation of project proposal for the subsequent years),
- Communication with CZDA, HEKS, CASMED and related institutions,
- Financial management (accounting and reporting),
- Organisation of one study visit to the CR per year,
- Organisation of several trainings (incl. discussing training needs and finding the relevant experts),
- Ensuring translation of project related documents and information,
- Publishing information about the project on DECCB – CRD website[19] and Facebook,
- Other PR activities such as presentations of the project in the Global development education framework, within Diaconia network and to public.
- Fundraising activities.[20]

In the view of the evaluator the above listed responsibilities can be ensured by three to four staff members as it was in the beginning of the project (2014). Considering the changes of the project coordinator during the project period, the supervisor's contribution is reasonable for limited time. The involvement of office manager, assistant and financial manager can be decreased. And PR and fundraising activities shall be part of the project activities planning and reporting to enable review of the activities and their impact.

[19] e.g.: http://diakoniespolu.cz/stories/za-projekty-je-radost-konkretnich-lidi/

[20] The fundraising is carried out above the scope of project activities agreed in the project plan. Neither Diaconia fundraising or PR activities are mentioned in the project reports.

Summary:

- Cost for providing one HCS are reasonable in relation to achieving the results and in comparison with state regulated rates paid by NHIC.
- Salaries of CASMED social and medical staff are higher compared to state nurses and Rebeca nurses, but their level is reasonable for motivation of the staff to dedicate to the work the whole working day and to ensure long term engagement of the nurses.
- Cost for training and study visits are also reasonable and represent good investment in developing high quality of HCS and the experience from study visits are utilized in ideas for CASMED and its NGOs development.
- Cost for coordinating and support offices represent relatively big portion of the overall project cost 31 – 42 %. While the CASMED's office cost decreases in the time, the DECCB – CRD office cost has grown. The DECCB – CRD support and office cost shall be optimised by decreasing the involvement of office support staff, planning the PR and fundraising activities and reporting about these activities in reports for CZDA.

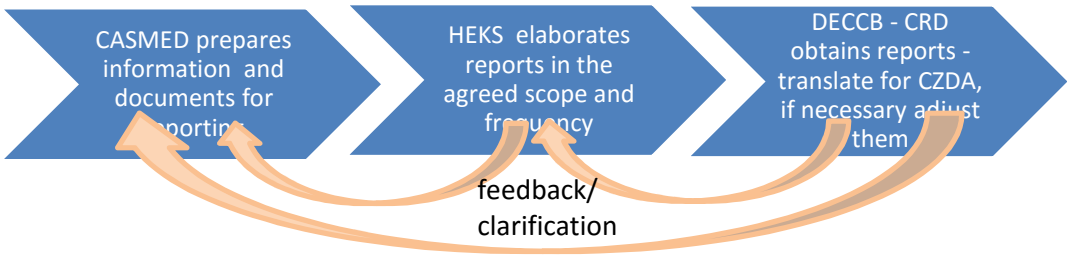
3.3.2 How efficient was the cooperation between project partners?

The partners' cooperation is based on the following agreements:

1. Cooperation agreement from December 2013 signed by CASMED, SRC and HelpAge International in Moldova (predecessor of HEKS Moldova).
2. Cooperation agreement from June 2014 signed by all project partners (CASMED, DECCB – CRD ECCB-CHDA, HEKS Moldova and HEKS Switzerland).
3. Cooperation agreement from July 2015 signed by all project partners (CASMED, DECCB – CRD ECCB-CHDA, HEKS Moldova and HEKS Switzerland).

The agreement for 2016 is under preparation during preparing the evaluation report.

All the above agreements contain division of responsibilities for funding, financial management, reporting, coordination, and visibility.
In the agreement between DECCB – CRD and other partners for 2014 there are specified the responsibilities for report preparation and related deadlines. The agreed reporting procedure for annual reports is presented in the following scheme. Monthly reports were prepared by CASMED and sent directly to HEKS and DECCB – CRD. In 2014 DECCB – CRD obtained six monthly reports, one quarterly and one annual report.
DECCB – CRD prepared for CZDA the interim report and the final report. The utilisation of the monthly reports in the second quarter is unclear since the CZDA requires interim and final reporting.



Scheme 3: Reporting procedure

In 2015 the list of agreed reports contained two quarterly reports, interim report and annual report. The available project documentation contained report for the 1st quarter, interim report and annual report. The second quarterly report is missing in the project file directory. Although the cooperation agreement was sign in the middle of July 2015, it contained requirement for the 1st quarterly report to be submitted on 5.7.2015. This retroactivity is probably related to CZDA requirements.
In 2016 the reporting cooperation continues regardless the absence of the agreement. In addition the HEKS Programme Officer of Social Projects sent to DECCB – CRD also three monitoring reports.
Based on the discussion with representatives of HEKS PCU and CASMED, the main difficulty in the cooperation is the uncertainty and delay of the agreed funding from CZDA. This negatively influences the project planning and its implementation especially in the first half of the year.
The cooperation agreement from 2013 between CASMED, SRC and HelpAge International in Moldova (later HEKS Moldova) specified the establishment of the project steering committee lead by SRC, which shall meet on quarterly basis. It also contain article on mutual support of partners in strengthening and managing local capacities as well as liaise with governmental institutions on national, regional and local level. The agreement also specifies the midterm evaluation which was carried out by SRC. SRC does not share the results of monitoring or evaluation with HEKS or DECCB – CRD.

Summary on the cooperation results:

- HEKS and SRC are stable and reliable donners, who work on long term basis. SRC is now finalizing country program for 2017 – 2020 which will include CASMED support. Similarly HEKS has the Country program for 2016 – 2020 where the funds for CASMED are planned already.
- HEKS and SRC have offices in Chisinau which allows regular contact with the project, but they also support CASMED in lobbying for bigger support of HCS on national level. They are members of the HomeCare Association.
- DECCB – CRD supports CASMED in the professional issues related to HCS provision (study visits to CR, selecting trainers on the selected topics where the Czech experts have strong experience).
- Since the reporting requirements of donors differ, it is not possible to share the reports between SRC and HEKS/DECCB – CRD. But HEKS is sharing its reports with DECCB – CRD on regular basis in line with the yearly cooperation agreements.
- The delays in receiving CZDA funding are solved partly by pre-financing of the regular provision of HCS by HEKS and partly by changing the training plan, so that the trainings are carried out in the second half of the year.

3.3.3 How is ensured coordination of project activities between project partners?

The coordination of project activities between the HEKS, SRC and CASMED is ensured by the steering committee meetings (SC). DECCB – CRD is not member of the steering committee.
Since DECCB – CRD does not have the local office in Moldova, it cannot ensure regular participation on the SC meetings and thus the coordination of DECCB – CRD with project partners is ensured by communication with individual partners when necessary.
The planning of activities for the next project years is based on the agreed Logframe for the whole project period. Nevertheless the scope and focus of some activities (e.g. training, study visits) are discussed directly between DECCB – CRD and CASMED.
The deadlines for submitting project proposals/plans for next year are also different for each donor. For example the HEKS plan for the next year is approved at the end of the calendar year. Therefore it is difficult to precisely agree on the project plan before October, when is the deadline for submission of the application for trilateral projects to CZDA.
The coordination of project implementation is ensured by CASMED management and coordination team. HEKS and SRC are not directly involved in project implementation except support in lobbying on the national level. The lobbying and advocacy on the national level is coordinated by the HomeCare Association. The coordination of study visits to the CR and training financed from CZDA is

ensured by cooperation of CASMED coordinator L. Bolfosu and DECCB – CRD coordinator N. Krejcova based on the approved project plan.

3.3.4 How has the cooperation with national home care related institutions developed?

The lobbying and advocacy on the national level (with relevant ministries and NHIC) is coordinated by the HomeCare Association which unites over 35 NGOs providing HCS. CASMED belongs to the small group of the most active in members of HomeCare Association and participates in working group under the Ministry of labour, social protection and family. This working group helped with formulation of the standards of social HCS and during 2016 it has presented to the ministry proposals of the calculation methodology for pricing the social HCS.

Similarly CASMED participate on developing strategic and legal documents related to medical HCS with the Ministry of health. The tariffs for medical HCS are reviewed and approved by the Ministry of health on yearly basis. Ministry of health consults the draft tariffs or other draft documents related to HCS with HomeCare Association including CASMED.

The relations with the NHIC are relatively good, CASMED managed to negotiate the increase of the funding for 2014 and 2015. For the 2016 NHIC firstly agreed to provide the same funding as in 2015, but during August the negotiations continued and there is high probability of increase by about 10 %. According to the representative of SRC, NHIC is more interested in big providers of health HCS, who would cover big territory. So with the growth of CASMED organisation, the probability for good cooperation with NHIC can widen.

3.3.5 What major changes took place in the project compared to the plan?

Overview of changes:

- Activity 2.3.2 “To prepare and apply the dossier for accreditation procedure of the CASMED NGO as provider of social services” was not finished since the accreditation procedure did not started on the national level and is expected to start during 2017.
- Activity 3.2.3 “Signing the cooperation agreement with the social services responsible state institution” cannot take place because the national system for payment for social HCS by other than state providers is still under preparation.
- Activity 2.2.6. “To further develop and implement the mobile regional and municipality based HCSs” – the mobile services were stopped since LAs in the two villages (where the mobile HCS) was provided do not have sufficient funds for co-financing the mobile team in 2016. It is expected that the HCS in these villages will be provided again next year.
- Increase of the funding from international donors by about 10 % per year. The increase allowed fund more HCS and to buy and distribute more medical equipment and material for patients and nurses.

The impacts of the changes related to activities 2.3.2 and 3.2.3 resulted in lower portion of the contribution from state budget then planned. But the lack of state funding was compensated by increased funds from international donors.

The stop of the mobile team operation does not have any significant changes for the CASMED organisation and network (the car used by mobile team is used by the project and social services coordinators); but the lack of the HCS provision does impact the former clients who are now dependent on their neighbours or relatives, if any willing to help.

3.4 Impacts

3.4.1 What were the main impacts caused by the project implementation?

Main impacts include:

- Over 3000 beneficiaries from 30 villages and towns have received medical and/or social HCS.
- The network of partner NGOs expanded to 19 NGOs members.
- Quality of provided medical and social HCS has increased - measured by the satisfaction of beneficiaries, caretakers, doctors and representatives of LA; the result of the increased quality and satisfaction is higher demand for provision of HCS in the existing and new locations.
- Number of CASMED staff grew from 43 to 75, thus new local nurses and social workers obtained work, which is very hard to find in rural parts of Moldova.
- The system of co-financing HCS from beneficiaries and LA proved to be functional and effective as both clients and LA are more interested in checking the scope and quality of the provided services compared to HCS provided for free.
- Awareness raising and fundraising events attracted new volunteers which are capable and motivated to take part in more events as well as help with care for beneficiaries.
- The cooperation with HomCare Association in lobbying and cooperation with national institutions related to HCS contributed to the approval of the standards of social HCS by the government at the end of 2014.

3.4.2 What are the differences in the implementation, results and impacts of CASMED project in comparison with other projects?

The comparison can be made only generally with the project implemented by Caritas CZ and HomeCare Association called “Development of HCS in the North of Moldova 2013-2015”, which was fully financed from CZDA sources. The project aims included:

1. Development and institutionalization of professional and quality HCS in the North of Moldova.
2. Increase the awareness of home care as a part of health and social services among key actors, professionals and the public.

In practice the project created two centres in the Balti and Taul municipalities which provide mix of day care and home medical and social care services with trained staff (nurses and social workers). The aim was to provide care for 1250 patients in 3 years. The total project budget was nearly 400.000 EUR (10.948.230 CZK). More details about the project are listed on: http://svet.charita.cz/en/where-we-help/europe-and-former-ussr/moldova/home-care-in-the-north-of-moldova/.

At the end of the project the functional centres with trained staff and equipment for provision of medical and social care are transferred to relevant LAs who shall ensure the budget for further operation. The centre in Balti (newly called Rebeca centre) did not finish the legal transfer of the centre to LA till 2015 and thus CZDA co-finances the operation of the centre also in 2016. The Balti municipality plan to finance the centre completely from 2017 with yearly budget 300.000 MDL (13.544 EUR) with yearly budget increase 15 %.

The following table compares the main characteristics of CASMED approach and Caritas CZ approach.

Characteristics	*CASMED* *Czech partner: DECCB – CRD*	*Rebeca centre* *Czech partner: Caritas*
Provided services	Medical and social HCS Coordination and training for members of CASMED NGOs network, Doctor in case of locations without regular doctors service Awareness raising and fundraising activities Cooperation with LA on support of community development	Day care centre medical services, Laundry and shower Medical HCS Awareness raising through printed brochures
Sources of funding	SRC, HEKS, CZDA, clients, LA, local fundraising, NHIC. SRC and HEKS plan to support the project at least till 2020.	CZDA, LA From 2017 only LA, plan to apply for NHIC and search for additional sources,
Number of clients (direct beneficiaries)	Target for 3 years – 3000, Achieved by ½ 2016 - 3803 1709 – 3873 per year CZDA portion 415 – 431 per year	Target for 3 years – 1250 Centre in Balti 350/ year Plan to increase for 600/year
Clients characteristics	Wider criteria compared to the national vulnerable criteria (for details see annex 4)	Comply with national vulnerable criteria (lives alone, no relatives, small pension, specific disease)
Average cost for one client	Total yearly budget/number of clients/year = 164 EUR/client CZDA budget/clients funded by CZDA = 162 EUR/client	Total budget/target no. of clients = 319 EUR/client From 2017 plan 40 EUR/client plus about 5 EUR/client/medical HCS if paid from NHIC
Training of staff	Ongoing – highly appreciated by all stakeholders	Regular during the project implementation. From 2017 only compulsory state courses for the nurses
Clients trust to nurses and social workers	High - thanks to selection of local staff in every location. Satisfaction rate 96 %.	Centres operate in bigger towns, thus the staff is not always familiar to clients; very good satisfaction from LAs and clients which are visiting the day care program. Information about satisfaction with HCS – not available.
Involvement of volunteers	Increasing in all locations; thanks to employment of the volunteers' coordinator the number of volunteers activities grew (awareness raising and fundraising activities).	Several support volunteers, Details not available
Provision of instructions about illnesses	Printed instructions available for all relevant clients and caretakers; Training of caretakers by nurses.	Printed instructions available for all relevant clients.
Medical aid provision to clients	Needed funds are ensured from SRC or fundraising in urgent cases.	Non
Advantages	Diversification of funding sources Continuous training of all staff Possibilities for funding the most urgent medical equipment for clients Wide outreach thanks for awareness raising activities and cooperation with LAs.	Provision of day care services for seniors who are able to come to the centre. Lower operating cost after handing over to LA.
Disadvantages	Higher cost for coordination of HCS provision in wide range of locations.	No reserve sources for repair or replacement of medical equipment. Unclear funding in case of decrease of the budget from LA.

Summary: there were not identified any overlaps between CASMED activities and activities of Rebeca centre on the contrary the centres cooperate on training of nurses. The main difference between CASMED and Rebeca centre is in the sources of funding – CASMED applies diversified

funding and aims to increase the portion of local and national funding compared to Rebeca centre which was financed by CZDA and from 2017 will be financed only from LA budget.

3.5 Sustainability and follow up activities

3.5.1 To what extent are the project results sustainable and are likely to be in next few years?

Based on the assessment of the development of the main project indicators (number of HCS beneficiaries, provided HCS, locations and districts where CASMED provides HCS, and national and local funding) the majority of project results are sustainable. One of the planned project results (obtaining accreditation for social services provision) was not achieve due to slow development of the national legal framework in the area of social HCS. Nevertheless it is expected that the accreditation process will start in 2017.

The diversified sources of funding (strong long term Swiss partners, contributions from CZDA, NHIC, LA, beneficiaries and fundraising) represent unique sustainable model in Moldova.

CASMED developed strategic plan for 2016 – 2020 which include continuation with providing existing HCS and related activities and developing new activities or widening the scope of existing activities. The new activities include:

- Facilitating participation of older people in society through development of seniors' clubs and involvement in volunteering activities.
- Diversification of social and medical services (e.g. rehabilitation, occupational therapy and socialisation).
- Developing social entrepreneurship.

3.5.2 What are the needs of elderly in relation to home care/ other social and health care?

The portion of elderly people (retired) is in between 10 - 30 % of the total population in the two towns (Balti and Falesti) and three villages (Izvoare, Bocani and Glijeni) visited during the evaluation mission. Bigger towns provide more community services (e.g. health centres with specialists, water supply and sewage, social canteen). There is not so big demand for social services (although there are a few state social workers) and the medical service is sometimes extended to home visits of doctors and nurses. In villages there is higher need for medical services since having its own doctor is rate for villages with pollution under 2500 inhabitants. Also the need for social services is higher because 30 – 50 % of the population work abroad or in bigger towns and cannot commute on regular basis. The community services may include water supply of non-potable water, but even this water tap is outside the house. The drinking water is taken from wells about 10 m deep which can dry sometimes in summer. There is no sewage and mostly dry toilets (in Turkish style) usually outside the house. So for old people who have difficulty to walk even the basic hygiene is a problem.

The identified elderly needs for HCS and other social and health care services are listed in subchapter 3.1.2. Except the services which are provided by CASMED, the needs include:

- Financial contribution for heating (buying wood and coal), medical aid (e.g. walker), food, medication.
- Community centres (e.g. daily centres or residential centres for elderly people to stay over winter period).
- Access to drinking water at home.

No bigger changes in the needs of elderly people are expected in the near future. This is partly related to the process of decentralisation of the state administration which is very slow, and overall lack of public finance in Moldova.

3.5.3 What is the strategy/plans/needs of CASMED in short and midterm?

CASMED developed strategic plan for 2016 – 2020 which include continuation with providing existing HCS and related activities, and developing new activities or widening the scope of existing activities. The plan contains three strategic directions:

1. Developing of functional models of community health and social services and promotion of active aging in the community.
2. Developing organisational capacities (of the CASMED organisation, network of partner NGOs and LAs).
3. Development of income generating activities (social entrepreneurship).

Besides continuation with existing activities, there are several new activities. The main new activities include:

- Facilitating participation of older people in society through development of seniors' clubs and involvement in volunteering activities.
- Diversification of social and medical services (e.g. rehabilitation, occupational therapy and socialisation).
- Developing social entrepreneurship.

The last new activity is partly related to the need to buy its own office and training space, which will in long term save money which are now paid for office renting.
The needs of CASMED staff were also identified by the questionnaire search during evaluation mission. The most common listed needs in questionnaires related to DECCB – CRD include:

- Exchange of experience on social entrepreneurship, NGOs network management, and seniors volunteering.
- Trainings on various topics related to NGO management.

3.6 Cross-cutting issues

3.6.1 How is ensured equal access to HCS for beneficiaries?

The equal access to medical and social HCS beneficiaries is ensured by:

- Selection of beneficiaries for social HCS based on agreed selection criteria which are based on the real social conditions, capabilities, possibilities, needs and health state.
- Involving the representatives of LA, local NGO and local social workers to take part in the decision making on new clients.
- In case the candidate for HCS scores the highest in the needs and his/her only insufficiency is the lack of money for contribution on the service, the local partners try to find additional funds to cover the beneficiaries' contribution.
- Selection of beneficiaries for medical HCS based on the recommendation of the relevant family doctor and/or other local representatives (LA, local NGO, relatives, neighbours). But the scope and period of the medical care is always agreed with the doctor in line with the national standards for medical HCS.

The compliance with the standards for health HCS are monitored by the NHIC in the locations where NHIC finances the medical HCS.
There were no complains on unequal access to HCS from beneficiaries nor from LA.

3.6.2 How did the partnership with LA, district and state institution worked?

The partnership with LAs has worker based on agreement for co-financing HCS, regular communication with LA and local NGO, participation at council's meeting, cooperation in selecting clients, fundraising and awareness raising activities, and transparent funding on local level.
The cooperation with local and district authorities has been supported by FHI-USAID project.
More information about cooperation with LA is listed in subchapter 3.2.8.

Partnership with district authorities (social affairs departments) has worked on the basis of exchanging information, regular participation on meetings with LA, cooperation in selecting locations, fundraising and awareness raising activities and support in lobbying on national level.
Partnership with relevant Ministries was based on cooperation with the HomeCare Association, through which CASMED has been involved in various advisory/consultation/working groups on issues related to legal and institutional framework for HCS. Cooperation with NHIC involves mainly negotiation on the scope of funded medical HCS on yearly basis. More information about cooperation with national HCs related institutions is listed in subchapter 3.3.4.

3.6.3 Did the project have any relationship with the protection of environment and climate change?

The project activities do not have any direct impact on environment and climate change. The only indirect minor impact to the quality of underground water can occur in case of using project washing machines by local NGOs when there is no waste water treatment. During the evaluation mission there was visited one village, in which the local NGO received washing machine, but it is not in operation since there is now sewage and waste water treatment. It would be useful to either deliver the washing machine with waste water treatment or to distribute the washing machines only to location where the treatment already exists.

3.6.4 Where the funds provided by CZDA been used transparently?

Requirements and rules for the use of CZDA funds are specified in the CZDA yearly decisions for providing the subsidy to DECCB-CRD. Based on the final financial reports for 2014 and 2015 the CZDA funds were used in line with the decisions requirements. The transparency of the CZDA funds utilization in Moldova is ensured by HEKS special account for the funds transferred from DECCB-CRD and by CASMED's accounting and reporting.
Nevertheless as the budget breakdown does not correspond to project outputs and activities, it is possible to demonstrate the use of the CZDA funds only for some project activities (e.g. study visits and trainings paid directly by DECCB-CRD, provision of HCS by CASMED nurses and social workers, which are listed in the budget). This shortcoming is caused by insufficient requirements of CZDA on relating budget to project activities and/or outputs.

3.7 Project management

3.7.1 To what extent is the project plan/Logframe used during project implementation?

The project plan (logframe) - common for all project donors - has been part of the project proposal in 2014. It was not part of any CZDA decision on the yearly funding. The compulsory part of the yearly CZDA decision is the table of outputs and activities for the given year. The table is derived from the logframe, but it does not contain the same project indicators, any assumptions and risks related to outputs and activities. The exception is the tables for 2015 and 2016 where are listed a few assumptions.
Also the activities listed in Logframe and the table of outputs and activities slightly differ – e.g. the table of outputs and activities for 2014 does not contain activity 2.2.6 "to further develop and implement the mobile regional and municipality based HCS".
It is not clear whether the Logframe document (indicators) is compulsory. The annual report for HEKS contains table with progress of activities and results with overview of the indicators achievements.
Furthermore the project proposal specifies on p. 21 **the role of DECCB – CRD in the project** as follows: DECCB-CRD promised to accept the role of guarantor of capacity building and education within the project. With respect to this role, DECCB-CRD will focus first of all on know-how exchange of DECCB – CRD experts as well as on preparing trainings in medical and social services provision and in different management skills. Besides that, DECCB-CRD will participate in some other important project activities, too, as shown in the following overview:

Expected result	DECCB – CRD involvement
Objective 1: To extend delivery of and establish equal access to high-quality social and medical services.	
1.1	Continuous support of services provision in 3 communities. Continuous support of mobile team.
1.2	Provision of trainings both to management and nurses.
1.3	Sharing know-how to implement a project of trainings for caregivers.
Objective 2: To strengthen NGO CASMED and its regional network in home care provision.	
2.1	Sharing know-how to cooperate with local and regional public authorities. Sharing know-how to establish different networks and associations.
2.2	Supporting new CASMED staff.
2.4	Provision of trainings on fundraising.
2.5	Participation on CASMED and local partner NGOs expertize development. Know-how sharing in PR.
Objective 3: To contribute to the strengthening and institutionalization of the home care sector on system level.	
3.1-3.3	Sharing know-how to organize lobby and advocacy. Sharing know-how to organizing awareness raising campaigns.

Table 11: DECCB – CRD scope of involvement as defined in the project proposal

This specification is not listed in any DECCB – CRD report and instead DECCB – CRD monitors and reports about all project activities and outputs.
Concerning the project indicators – they slightly differ between project partners. HEKS is setting yearly target values of all project indicators. DECCB - CRD defined some yearly target values of project indicators mostly without reference to the total project indicators' value and some key indicators e.g. number of patients and provided HCS are missing. In the yearly reports for CZDA there are listed only some figures related to monitored indicators, but they are not systematically presented and compared to the indicators figures. Also the interim reports for CZDA contains some of the key figures, but its presentation does not give overview how far are the indicators achieved. But DECCB plans to make the overall project assessment in the yearly report for 2016.
Yearly list of activities and outputs do not indicate which activities will be financed from CZDA funds.
Also the time schedule for project activities is not fully fulfilled, partly due to delay of the CZDA funding and partly the information about implementation period is missing in the reports (e.g. yearly report for 2015, activities no. 1.1.8, 1.1.9, 2.1.1, 2.1.3, 2.4.3). Many of the project activities are being implemented during the whole year or longer period, but the list of outputs and activities specify usually just one month.

Summary: the logframe document was not used or updated during the project; as explained in chapter 2.3 there are some insufficiencies in the project logic. Although the project proposal specifies the scope of DECCB – CRD involvement, which was to big extent fulfilled, neither the DECCB – CRD yearly list of activities and outputs nor the interim and annual reports do not related to this specification and do not explain which concrete activities and outputs were funded from CZDA sources (although the yearly report for 2015 gives some indications). The time table of activities specified in the yearly table of outputs and activities is not fulfilled in many cases due to various reasons (delay of CZDA funding, prolongation of activities, missing information about the implementation time in yearly reports).

3.7.2 How does the project implementation monitoring takes place?

Monitoring of the scope and quality of provided HCS as well as development of other project activities is ensured on monthly basis by CASMED staff based on the information from partner NGOs. During the review of project indicators achievements it was found that CASMED staff is not clear about the figures needed for monitoring a few indicators (e.g. people benefit (potentially) from access to HCS).

HEKS PCU monitors the use of funds for the implementation of the project activities, the compliance with the table of activities and timetable in line with the yearly cooperation agreements between HEKS, CASMED and DECCB – CRD. Representatives of HEKS PCU make also several monitoring visits per year in the project locations.

DECCB – CRD monitors the used of funds which are not transferred to Moldova (i.e. cost for selected trainings and exchanges visits, relevant DECCB – CRD staff and overhead) and utilizes CASMED's and HEKS's record keeping of transferred funds. DECCB – CRD coordinator carries out at least one monitoring visit per year in CASMED and locations financed from CZDA sources. Since the current project coordinator does not speak Russian or Romanian, her communication with local partners is depended on the translation, which is usually ensured by CASMED staff.

Also representatives of CZDA and Czech embassy can carry out monitoring visits. CZDA made one monitoring visit in 2015, nevertheless according to CZDA internal regulations the results were not communicated to DECCB – CRD. Based on the discussion with CZDA representatives the internal regulations specify, that the results are communicated only in case of bigger insufficiencies.

3.7.3 To what extent are the project's reporting requirements relevant to the needs of project partners/donors?

Reporting requirements of project partners and donors are specified in three cooperation agreements listed in subchapter 3.3.2. In the agreement between DECCB – CRD and other partners for 2014 and 2015 are specified responsibilities for monthly (only in 2014), quarterly and yearly reports' preparation and related deadlines. In 2016 the reporting cooperation continues regardless the absence of the agreement (till August 2016).

The CZDA requirement for interim report is hardly justified if no funding has not been available before the end of June. Detailed description of reporting procedure is listed in subchapter 3.2.2.

Based on the discussion about reporting requirements with representatives of SRC, HEKS and DECCB – CRD it is clear, that each of the foreign donor has specific requirements on the scope, content, frequency and deadlines for submission of reports and it is not possible to harmonize these requirements in order to simplify the reporting tasks for CASMED staff. Nevertheless it was confirmed that HEKS will continue to share its reports with DECCB – CRD in line with cooperation agreement for 2016 which is being finalized during September.

4 Conclusions

This chapter contains summary conclusions related to findings about all evaluation criteria. The overall evaluation is listed in the table at the end of the chapter.

4.1 Relevance

- The evaluated project contributes to fulfilling the Czech Development Cooperation Programme (CDC) Moldova for the period of 2011 - 2017 namely the main goals of the priority sector the education and other social infrastructure and services.
- Project activities and objectives are contributing to fulfilling the national Healthcare System Development Strategy for 2008 – 2017 and relevant strategies in the social sectors; they are also in compliance with relevant national legislation such as national standards for medical HCS and national standards for social HCSs.
- The project activities namely provision of HCS meet needs of beneficiaries from big extent. Due to lack of funds on local level the scope of the HCS has to be sometimes limited even if the needs for HCS in the location are higher. Concerning the needs for financial contribution to beneficiaries - CASMED is trying to raise funds for the contributions on medical aid through fundraising.
- The existing capacity of all other organisations and authorities providing HCS for elderly is insufficient mainly due to lack of funding and lack of regulatory basis in the area of social HCS, therefore the complementarity of CASMED's HCS is high. There were not identified any overlaps between CASMED activities and activities of other HCS providers.

Based on these conclusions **the relevance of the project** to CDC Programme, Moldova national strategies and legislation and beneficiaries needs **is high** as well as the complementarity of CASMED HCS to other HCS providers in north Moldova.

4.2 Effectiveness

- The new locations are selected in transparent way in cooperation with local stakeholders; new beneficiaries are selected based on assessment of transparent selection criteria; the assessment and decision on new clients is carried out by a local committee in cooperation with CASMED. The applied procedure does not allow for any discrimination of any vulnerable group of inhabitant, thus the equal access to CASMED HCS is ensured. The indicator of providing HCS in 24 locations at the end of the project is complied with since CASMED operates in 30 locations.
- The indicators related to number of serviced locations, districts and beneficiaries were reached and in the number of locations exceeded by 25 %. The existing and new locations and beneficiaries are maintained thanks to proactive CASMED's approach.
- The indicator related to number of provided HCS exceeded the plan by 21 % and further increase is expected till the end of 2016. The quality of provided services is high, based on the results of the monitoring assessment and based on information from doctors, representatives of LA, local NGOs, beneficiaries and caretakers.
- The project indicators related to staff and NGOs training are in majority fulfilled - majority of CASMED staff receive over 35 training hours/year; majority of CASMED's NGOs managers receive 25 training hours/year; 70 % of nurses are certified.
- Cooperation with volunteers and caretakers has strengthen during the project implementation; number of volunteers exceeded the planned figure 30; CASMED nurses and social workers help to make the care of caretakers easier by sharing knowledge and advice on proper care.
- Majority of patients and caretakers utilize the practical recommendations from nurses and social workers and written instructions. There is no complain about unclear or bad instructions. The indicator on the number of instructions on how to better cope with illness distributed to patients (in total 3000) was not reached due to limited budged on developing and printing instructions on more rare diseases.
- CASMED network expanded from 9 to 18 local NGOs, which means exceeding the plan by 38 %. The model of cooperation with local NGOs proved to be effective.

- CASMED's cooperation with LA and local doctors is ensured by proactive approach of CASMED staff and partner NGOs and by high quality of provided HCS. The indicator of number of mutual agreements with doctors was exceeded twice.
- The development of organizational structure responded to the increase of serviced communities and clients in adequate way; current management structure is suitable and sustainable
- The funds from HEKS, LA, NHIC, beneficiaries and fundraising have been growing since the beginning of the project. Co-funding of social services from the state did not started since the national institutions have not approved the payment system yet. Approximately 10 % of the medical services visits are covered by patients. Other indicators related to funding cannot be assessed as their definition is not clear.
- Project visibility was ensured in line with CZDA requirements, indicators related to visibility were fulfilled except from too ambitiously formulated indicator related to number of distributed newsletters and leaflets.
- CASMED could not be certified for providing the social HCS since the accreditation process did not started on the national level.
- CASMED's lobbing and advocacy activities are slowly brining the desired results. It is not clear how the brief Strategic Advocacy plans have been useful as most of the identified activities are listed in the project logframe/list of activities and the plans do not contain concrete outputs.

Based on these conclusions the effectiveness of the contribution of project activities and outputs to attaining the planned indicators, objectives and overall project goal is rather high.

4.3 Efficiency

- The costs for project implementation are reasonable in relation to achieving the results. Nevertheless the DECCB – CRD support and office cost shall be optimised.
- HEKS and SRC are stable and reliable donners, who work on long term basis. HEKS and SRC have offices in Chisinau which allow regular monitoring of the project and supporting CASMED in lobbying for strengthening HCS on national level. DECCB – CRD supports CASMED in the professional issues related to HCS provision, though big part of the training activities are organised by CASMED itself in cooperation with national experts.
- The delays in receiving CZDA funding are solved partly by pre-financing of the regular HCS by HEKS and partly by adjusting the training plan.
- The coordination of project management and supervision between partners is ensured by the Steering Committee (SC), but DECCB – CRD is not member of the SC. Since DECCB – CRD doesn't have any local coordinator, it partly relies on HEKS project coordination unit in Chisinau and partly on direct communication with CASMED. The coordination of project planning between donors' representatives (HEKS, SRC and DECCB – CRD) has not been ensured completely since the donors' deadlines for planning (submission of applications for funds for next year) differ.
- The cooperation with national home care related institutions has extended. The cooperation is ensured partly via participation in HomeCare Association and partly directly by CASMED director.
- The four main changes in project activities did not have overall negative affect, as one of them (increased donors' funding) was partly mitigation measure for some of the uncompleted activities. The changes caused the failure of reaching the result 2.3 "CASMED is officially accredited for provision of social services." The failure in achieving this result caused the incomplete achievement of 2 out of three indicators related objective 3.

Based on these conclusions the efficiency of the project activities and results in relation to overall project financial sources is medium as there has been higher increase in DECCB – CRD support and office cost compared to the increase of CZDA funds used for HCS and trainings, there are delays with CZDA funding, thanks to different donors' deadlines for submitting and approving plans it is difficult to coordinate yearly project planning and several activities could not be completed.

4.4 Impacts

Summary of key impacts:

- Over 3000 beneficiaries from 30 locations received medical and/or social HCS.
- The network of partner NGOs expanded to 18 member NGOs.
- Quality of provided medical and social HCS has increased which resulted in higher demand for provision of HCS in the existing and new locations.
- Number of CASMED staff grew from 43 to 75, thus new local nurses and social workers obtained work.
- The system of co-financing HCS from beneficiaries and LA proved to be functional and effective.
- Awareness raising and fundraising events attracted new volunteers and are efficient in raising funds.

Impacts are evaluated as high taking into account that the key indicators related to beneficiaries and geographical scope were exceeded even half year before the end of the project period.

4.5 Sustainability and follow up activities

- The project results are to big extent sustainable and are very likely to be sustainable in next four years since both key international donors plan to support CASMED in long term and the funding till 2020 is already approved in case of HEKS.
- Another strong factor effecting sustainability is the long term cooperation with local and districts authorities, local NGOs, NHIC, HomCare Association, Ministry of health, Ministry of family, social protection and labour and rising money from fundraising.
- Needs of elderly people include improving community services and those with health problems need medical as well as social HCS. Therefore there is no risk that the demand for HCS will stop or get smaller in the next four to ten years.
- CASMED strategic plan for 2016 – 2020 includes providing existing HCS and related activities, widening the scope of existing activities especially fundraising and developing new activities (e.g. social entrepreneurship).

The level of sustainability is evaluated as high thanks to ensured midterm funding, developing possibilities for increase of local funding, stable demand for HCS and CASMED's strategic planning.

4.6 Cross-cutting issues

- The equal access to health HCS is ensured by the set of national health HCS standards and consultations with relevant family doctors; CASMED's selection criteria for inclusion to social HCS are in line with the national standards for social HCS and the decision about new client for social HCS is made by local committee.
- The partnership with LA, district and state institutions is based on proactive CASMED's approach, support of local NGOs to contribute to community development and cooperation with HomeCare Association.
- The project activities do not have any direct impact on environment and climate change.
- The funds provided by CZDA been used according to the agreed budget break down. The transparency of the CZDA funds utilization in Moldova is ensured by HEKS special account for the DECCB-CRD funds transferred and by CASMED's record keeping. Nevertheless the budget breakdown does not correspond to project outputs and activities, and thus it is possible to demonstrate the use of the CZDA funds only for some project activities, which are listed in the budget. Therefore the transparency of using CZDA funds is not complete.

4.7 Project management

- The logframe was not used or updated during the project and there are some insufficiencies in the project logic. Although the project proposal specifies the scope of DECCB – CRD involvement, which was to big extent fulfilled, neither the yearly list of activities and outputs nor the DECCB –

CRD regular reports relate to this specification and mostly do not explain which concrete activities and outputs were funded from CZDA sources.

- The monitoring carried out by CASMED, HEKS and DECCB – CRD is sufficient concerning the scope and frequency. The CZDA internal rules for limited communication of monitoring results do not contribute to mutual trust and cooperation.
- The reporting is carried out in line with the valid cooperation agreements; each foreign donor has specific reporting requirements therefore it is not possible to harmonise the reporting activities at CASMED level. HEKS shares its reports with DECCB – CRD.

Based on the above conclusions the DECCB – CRD project management can be evaluated as medium to rather low but the overall project management is better thanks to robust project management of HEKS and SRC and very good management of CASMED organisation and its partner NGOs. Thus the overall project management can be evaluated as rather high.

4.8 Summary evaluation

Evaluation criteria		Summary evaluation
Relevance		**High**
Effectiveness		**Rather high**
Efficiency		**Medium**
Impacts		**High**
Sustainability and follow up activities		**High**
Cross cutting principles	Equal access of beneficiaries	**High**
	Good governance	**High – rather high**
	Environment & climate	Not relevant
	Transparency	**Medium**
Overall project management		**Rather high**

5 Lessons learned

Beneficiaries needs

Moldova is affected by the phenomena of an aging society and migration of young and middle age people for work abroad. There is an increasing need to develop programs for supporting the social group of elderly people. In Moldova, as in other countries, there is an increasing desire of the elderly to stay in their own homes for as long as possible. For this reason, the number of people who want to be served at home is increasing. Home care services represent a good alternative to the stationary systems (hospitals, asylums), offering services that are flexible to be adapted to the changing needs of the elderly, ill people, based on an individual approach.

Reform of health and social care, decentralisation

The ongoing health care reform includes decentralization of primary health care with the aim of increasing the autonomy of the primary health care sector and support of palliative care and home care providers. The system of covering medical HCS from NHIC is developing in order to enable increased access of medical HCS to people in need.

The reform of the social care is slower in respect to establishing legal and institutional framework for supporting social HCS provided by NGOs. Nevertheless the development during last three years confirms, that the government is willing to establish a system for funding social HCS from NGO providers. The lobbying, consultation and advocacy with Ministry of health and the Ministry of labour, social protection and family show that intensive interest and support of the government institutions bring the desired outcomes e.g. approval of the national standards for social HCS at the end of 2014.

The process of state administration decentralisation is very slow and advanced only in delegation of responsibilities to district and local authorities, but without necessary funds. Thus the local authorities shall take care about social needs of their inhabitants, but the compulsory budget structure does not contain any special line for social care or support.

Interconnection of HCS and community development

The provision of social HCS brings benefits to beneficiaries and to local communities. The services allows elderly people to be cared in a familiar environment and to be part of their communities, while strengthening the role of NGOs in the social life of the community and their integration in the local strategic plans. Moreover CASMED's activities focus also on strengthening the LA in supporting social care by sharing information and inviting LA into various awareness raising and community development activities.

Funding sources and fundraising

Apart from funding from strong international donors, the co-financing of the services by NHIC, LAs and the beneficiaries is vital for the long term sustainability. The experience with co-financing from LAs and beneficiaries shows that their initial uncertain approach is developing to trust and appreciation. Thus the co-financing proves to be a good steering tool for demand and need oriented services, fostering quality of the provided services and a good argument for seeking other funding partners.

Thanks to a multi-stakeholder approach in the realization of the project the local NGOs got experience and know-how in the implementation of social projects, which lead to improved communication and relationships between LPAs and NGOs. Also CASMED has been developing various fundraising activities and passing the experience over to partner NGOs who apply the fundraising activities in their communities. In such a way the role of the NGOs in the life of communities becomes more and more important.

Development of additional activities
During the project period CASMED has developed beside high quality HCS also other activities:

- Volunteering for young and senior people in awareness raising events, taking care about children and support of social workers in project locations.
- Developing ideas for active aging and starting with involving seniors in community life, physical exercise, participation on awareness raising events related to disease prevention.
- Various fundraising activities on local and district level.
- Sharing the knowledge gained in trainings, practice and exchange visits to foreign countries.

The experience of providing HCS in 30 locations, developing the above listed activities and cooperation with local and district authorities enable CASMED to more deeply understand the needs of the seniors, disabled people, but also of the surrounding society. This understanding and the knowledge about the experience with various foreign models of NGOs providing medical and social HCS motivate CASMED for further development of its activities in two areas:

- Diversification of social and medical services (e.g. rehabilitation, occupational therapy and socialisation).
- Developing social entrepreneurship.

Training and experience sharing
The focus on ongoing training of all CASMED staff brings benefits in the form of increased demand for HCS, satisfaction with provided services, stable staff, volunteers' interest and cooperation with LA and NGOs on local level. The training of nurses in various medical methods and special care for various diseases has been very much appreciated based on feedback from project stakeholders on local, district and national level. Similarly are appreciated the experience sharing meeting of the nurses carried out on monthly basis. There is interest of nurses from other organisations to take part in the training or to work for CASMED.

Project and organisational management
The stability of the management and coordination team is crucial for keeping up with the organisational development which has happened in CASMED. The CASMED organisational structure has developed to support the growth of the CASMED NGO network. The coordination of NGOs and its social workers, CASMED medical staff and other team members is functional and effective.

The project management of the two main donors HEKS/SRC is systematic based on robust and practical project management tools (e.g. project cycle operational manuals, training of CASMED staff on applying the new/updated project management tools).

The DECCB – CRD project management and coordination are very flexible. In comparison with HEKS and SRC it is using only CZDA instructions for monitoring and reporting and it does not apply some special project management tools for Moldova project partners. The project coordinators have changed several times during the project period. Although the DECCB – management tried to ensure passing over the experience from the previous coordinator to the new coordinator and the project supervisor has been involved, some information were not recorded and thus the current coordinator does not know the complete project background, including the data needed for checking achievement of some project indicators.

Models for further cooperation in HCS in Moldova
Based on the review of the project reports and discussion with project stakeholders and representatives of other HCS providers, the evaluator suggests three possible models of further cooperation of DECCB – CRD in developing HCS in Moldova:

1. **Continue in the current model of trilateral project with emphasis on sharing experience** in the social entrepreneurship, active aging and other areas of CASMED's development. This would include also providing training and funds for regular provision of HCS.
2. **Support of community development in selected villages or municipalities**. This model focuses on overall community and social services needs in the specific location. This means that the CZDA funds would be used not only for provision of medical and social HCS, but also for some of the following areas:

- Developing fundraising plan for social and medical care in the location.
- Contribution on building/reconstruction of community centre and equipment of the centre.
- Contribution to small scale waste water treatment plant in case of need for washing machine and showers, but no available waste water treatment.
- Contribution to medical aids and medical materials needed by the CASMED's patients.
- Ensuring training of the local NGO and its nurses and social workers.
- Contribution to bicycles for the NGO's social workers and nurses in the villages where the terrain allows to use them.
- Developing plan for ensuring supply of heating wood for socially weak inhabitants of the village in cooperation with DECCB - CRD agricultural specialist *(e.g. test of planting fast-growing poplars).*

3. **Cooperation with CASMED and other provider of medical and social HCS** (e.g. Caritas CZ). Such a model can benefit from experience of two strong Czech (or foreign) organisations in providing medical and social care in the Czech Republic and abroad and CASMED's capability to transfer the experience and develop stable and high quality HCS in Moldova. Such project could combine the tested Caritas model of building a daily care centre with combination of HCS, CASMED's provision of HCS and supporting local NGOs in community development. It would also allow CASMED to benefit from the experience of Diaconia and Caritas CZ. Nevertheless this model is dependent on the interest of the new project partners to cooperate and possibilities of CZDA to financially support such a bilateral project. In the evaluator's opinion, such a model can save the coordination cost of the Czech partners since Caritas has a local representative in Moldova.

The recommendations contain combination of the first and second model for further DECCB – CRD cooperation with support CASMED.

6 Recommendations

For CASMED

- Decrease the cost for office rental either by negotiating with the LA in Balti to contribute for the rent/providing premises for free or discounted price, or buying CASMED's own premises and develop social business.
- Offering the training for nurses and social workers to other HCS providers as paid service
- Sharing the printed instructions about diseases with other HCS provides (e.g. Rebeca centre) and finding common sources for developing and printing instructions on more diseases if there is interest from patients and doctors
- Sending the quarterly newsletter by email to representatives of the Czech embassy to ease the information sharing about project development.
- Recommend partner NGOs to take part in the tender of the Czech embassy for small local projects which is opened once per year in the autumn (available funds max 15.000 EUR)
- In case of washing machines are allocated to partner NGOs within CASMED network, it is necessary to ensure water supply and waste water collection and ideally also treatment - it shall be responsibility of local NGOs and LA.

For all project partners (DECCB-CRD, CASMED, HEKS, SRC)

- When preparing project plan (lograme, list of activities and outputs) define key indicators, with clear specification in order to understand what will have to be monitored for making assessment of the indicators' achievements.
- Harmonize the project plans and project indicators to eliminate difference in reported results
- Invite DECCB – CRD into the project steering committee or find other coordination mechanism for project planning with CASMED and HEKS. Unless it is possible to invite DECCB – CRD to the SC, share information about the steering committee meetings with DECCB – CRD
- As SRC and HEKS have long term experience in advocacy and lobbying it can be mutually beneficial to enhance sharing the experience on advocacy and lobbying and train CASMED managers and coordinators and NGOs managers in effective advocacy and lobbying on local, district and national level.
- As the social and health care systems are under the development is it necessary to continue with the advocacy and lobbying activities by all Moldavian partners.

For CZDA

- In the project proposal require the budget break down based on the project outputs or activities in order to simplify the review of the cost and expenses relevance.
- Review the reporting requirements in order to cover period with available funding unless pre-funding is agreed and required.
- Improve the communication with project partners (e.g. Diaconia) concerning the dates of possible availability/transfer of funds to allow better project activities planning.
- It would be useful to inform the project partners about the conclusions from the monitoring visits.

For DECCB – CRD

- Consider establishing office for project coordination in Moldova (relevant in more than 2 running projects on the territory of Moldova) or strengthen cooperation with HEKS project coordination unit.
- In case of no local office, utilize more the HEKS PCU.
- The project coordinator shall be able to communicate in Russian or Romanian.

- When drafting the project plan and budget, relate the budget to project activities or outputs so it is clear, what are the costs for various project activities. Also the yearly plan does not need to contain activities which are not related to DECCB – CRD support or funding.
- Clarify with CZDA at the beginning of the project which documents and figures are compulsory (e.g. are the Logframe indicators compulsory if they are not annexed to the contract with CZDA?) and then refer to the agreed project plan in the reports.
- Include the risks and assumptions assessment as well as assessment of the indicators achievement in interim and annual reports (for example in table form similar to HEKS table of progress of activities and results).
- Transferring funds to CASMED on quarterly basis in order to simplify the CASMED's reporting to local authorities.
- Optimise the DECCB – CRD support and office cost by decreasing the involvement of office support staff, planning the PR and fundraising activities as part of the yearly project activities plan.
- In case of doing additional activities related to the project, e.g. fundraising and promotion- include the information about its results and experience in the project reports.

Ideas for DECCB – CRD to further support CASMED

The ideas are related to the strategic directions specified in the Strategic plan for 2016 – 2020.

1st direction: developing functional model of community health and social services and promoting active aging in community:

1. Support of local communities, authorities and NGOs providing HCS to develop strategic planning and fundraising – e.g. training and assistance in planning, projects writing, searching for donors, project management, training of LA in lobby and advocacy in order to increase the local budgets and include special line on social support in the LA budget.
2. Reinforcement of volunteering activities development – e.g. active aging (involvement of older people in community life), fundraising, awareness raising about prevention to various diseases, involvement of university students of the social affairs to cooperate with CASMED on internship basis.
3. Support the local community and NGO providing HCS in selected villages *(2 – 4 depending on the budget – e.g. Izvoare, Bocani)* in some of the following ways based on needs:
    - Contribution to rebuild or equip community centre (where the LA and NGO already stared with reconstruction) – the equipment can include for example solar or photovoltaic panels, washing machine, small scale waste water treatment plant(WWTP[21]), car
    - Contribution to small scale WWTP in case where the washing machine is used, but the waste water is not treated.
    - Contribution to medical aids and medical material needed by the CASMED's patients
    - Contribution to bicycles for the NGO's social workers and nurses in the villages where the terrain allows to use them
    - Contribution to providing medical and social HCS
    - Developing plan for ensuring supply of heating wood for socially weak inhabitants of the village in cooperation with Diaconia agricultural specialist *(e.g. test of planting fast-growing poplars)*

[21] Such WWTP is produced in the CR and tested by the Czech Water research institute, it treats water for house with about 8 people in discontinual basis, cost are about 40.000 CZK for the whole WWTP.

2nd direction: developing of organisational capacities

Support in developing CASMED's capacities by:

- Training of CASMED staff in knowledge management[22], project proposal writing, training of trainers
- Psychology training – for NGOs managers/coordinators, social workers and nurses (e.g. increase of mental endurance of social workers and nurses, care for old people in depression)
- Training in palliative care for nurses and social workers and other special topics based on actual needs.

3rd direction: development of income generating activities

Support in development of social entrepreneurship – based on the CASMED Strategic plan, CASMED fundraising strategy and Diaconia experience in the Czech Republic (e.g. offering training and education to wide range of target groups related to care for old, ill and disabled people) – through the exchange of experience between Diaconia CR and CASMED mangers/coordinators, fundraisers, including partner NGOs managers/coordinators.

[22] This topic was listed in the questionnaire of the CASMED director.

Abbreviations

CASMED	Centre for Social and Medical Home Assistance
CASMED project	Project “Development of the Home Care CASMED II”
CDC	Development Cooperation Programme Moldova for the period 2011 - 2017
CZDA	Czech Development Agency
DECCB – CRD	Diaconia ECCB - Centre of Relief and Development
HCS	Home care service
HEKS	Hilfswerk der Evangelischen Kirchen Schweiz
LA	Local authorities
Logframe	Logical framework
NGO	Nongovernmental organisation
NHIC	National Health Insurance Company
PCU	Project coordination unit
SC	Steering committee meetings
SRC	Switzerland Red Cross
USAID	United States Agency for International Development
WWTP	Waste water treatment plant

Note annexes are listed in separated file