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Evaluation of the Health Management Appraisal Project

and

Comments on AID's Priority Health Management Needs

John S. Alden

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The following report is presented in three parts. Part 1 is a summary of the AID Management Appraisal Project. Part 2 discusses some of the major project issues in more detail. Part 3 presents from the writer's perspective the agency's priority health management needs using the new Health Strategy Statement as a point of departure.

The report covered eleven days work over a six week period. The work took place entirely in Washington hence the conclusions reached regarding the field reactions and utilization of the Management Appraisal Systems project were necessarily drawn from secondary sources. A listing of the individuals contacted during the process of preparing this report along with a copy of the scope of work is appendend.

Part I - Project Summary

AID's four year involvement in health management appraisal with the Association of University Programs in Health Administration (AUPHA: 1977-1981) stems from the agency's overall interest in and policy committment to sector analysis. In the mid 1970's AID decided that the central instrument of AID analysis would be the sector assessment and that the findings and recommendations of these assessments would be the basis for assistance programming. Subject matter specialist units were formed and an ambitious agency-wide analytical effort was launched. The sector assessment process was envisioned to be both collaborative and continuous and looked toward eventually institutionalizing this capacity in the countries where AID worked.

When it came to health it became clear to the Health Sector Assessment (HSA) organizers and advocates in the Technical Assistance Bureau's Health Office that they had to have a better methodology for appraising the management of health sector institutions. They felt this was required to accurately and reliably analyze the health management situation in cooperating countries and to decide on recommendations and feasible solutions to key management problems.

Thus the Health Management Appraisal Project was born- a classic four step methodology develpment project starting with a literature search, followed by the design and field test of a new appraisal methodology and ending with the application of this new methodology in a Health Sector

Assesment. (AID's effort in Health Sector Analysis paralleled a similar approach in WHO called Country Health Programming (CHP) which attempted to analyze an entire health system and from that effort draw priorities for national health planning and international assistance). The actual design of the Health Management Appraisal project was a collaborative effort of the health and development administration offices. The Association of University Programs in Health Administration (AUPHA) was non-competitively selected to undertake this task because of its direct access to the best academic based U.S. resources in health administration and its network of international affiliates concerned with this issue. A $482.000 two year contract between AID and AUPHA was signed in September 1977. The contract stipulated that the AUPHA deliver the following products:

Within 4 months:

1. An annotated bibliography on the state of the art of Health Management Appraisals.
2. A list of countries where the methodology field test could be conducted.

Within 9 months:

3. A new methodology design plus details on host country testing arrangements. This requirement included overall analytical work on design of appraisals plus 10 topical papers (organizational behavior, health management information systems, accounting auditing, logistics, facilities and equipment etc.)

Within 14 months:

4. A completed, field tested methodology.

Within 19 months:

5. Written results and evaluation of methodology tested.

Within 23 months:

6. An edited methodology document.

The success of the management project rested on the following assumptions:

- that sector analysis would continue to be an agency priority pivotal to the approval of health assistance.
- that countries would collaborate or at least acquiesce in the HSA process
- that a satisfactory field site would be found to test the new management methodology being developed under this project.

Within the first twelve months of the implementation of the AUPHA project it became clear that the fundamental assumptions upon which the success of this project rested would not hold. Health Sector Analysis had turned out to be such a lengthy, complicated and expensive undertaking that it became impractical to tie this process to the approval of health project assistance. Only in the Latin American Bureau did an active HSA program emerge. Countries saw little near term payoff - and hence had little interest - in committing their scarce executive time to a broad assessment process. This view became more intense as it became clear that AID was willing to support only a narrow segment of the potential range of health activities. Finally, despite the optimism expressed in the

approved project design document it was not possible to nail down a field site where the new project methodology could be tested.

As if this were not enough there were 3 other totally unforseen developments that negatively affected the prospects for this project. First the AUPHA literature search did not uncover (as anticipated in the design) U.S. materials and approaches to health management assessment that could be readily adapted to LDC conditions. The contractor was thus faced with "inventing" new approaches for each of the topical reports (Leadership, Organizational Behavior, Logistics, Accounting etc.) covered in the contract. This added significantly to an already overloaded scope of work. Second, a shift in AID internal organization moved project backstopping from the Technical Assistance Bureau to the new Development Support Bureau(DSB). This reorganization stressed the need to make AID's new Bureau's work more relevant to today's field problems and lowered the priority of projects, such as this one, that were involved exclusively in new methodology development. Third, the three principal in-house AID advocates of this project were lost to retirement and transfer.

During the first eighteen months work under the contract was heavily involved in preparing a State of the Art Report and in the analysis and development of drafts of the health management modules. This task combined the skills of the AUPHA core staff and those of consultants drawn from the national membership. In April, 1979 the AID office managing this project (Rural

Development/Development Administration) sought unsuccessfully to transfer it to the Development Support Bureau's Health Office. (Later they were successful in securing some joint funding to wind down the contract.)

In November, 1979 it became clear that the contractor was experiencing great difficulty in achieving the project objectives, and that more time and money would have to be invested in this contract to approach a project output close to the one originally contemplated. A brief external evaluation was comissioned in July, 1980. This review concluded that despite a highly skilled and dedicated contractor and consultant staff the project faced insurmoutable problems and could not come close to achieving the objectives envisioned in the project design. The principal difficulties cited were:

- the link between the project and the fading health sector analysis initiative.

- the large amount of "deliverables" that were beyond the capacity of the contract team to produce in the time remaining under the contract.

- the quality and focus of most of the work available at the time of the review appeared to the evaluators to be abstract and academic and of little value to health decision makers.

- the project design did not give sufficient weight to the site specific nature of health management problems. The evaluators found it difficult to see how this project could develop materials that would be both broadly applicable and also relevant to specific problem situations.

- regional bureau staff expressed great skepticism (to the evaluators) that the completed project would fulfill any of their needs.

The evaluators recommended that the scope of work be sharply cut back and that AUPHA should be told to stop work on some of the draft modules. The evaluators felt that the time and resources available under the existing contract could be used most profitably to both complete the two modules that showed the greatest promise (Financial Management; Materials/Equipment Logistics) and to servicing the field consulting needs in health management that bureaus and missions were requesting. The substance of the evaluators' recommendations were accepted by both the AID project management committee and the bureau management which scaled back and refocussed the project to:

- deliver a reduced number of modules (after considerable discussion AID settled on seven modules)
- continue and expand the technical assistance relationships (where there was a market for AUPHA services)
- present the project's analytical product at evaluative seminars in the U.S. and overseas
- circulate the materials produced under the project to relevant institutions worldwide

An amended contract was signed on September 29, 1980 extending the contract for an additional year to complete the revised product. An additional $140,000 was provided for this purpose

In April, 1981 the AID project manager became concerned

with the apparently slow pace at which the modules were being produced and called in a consultant (who was involved in the original project design) to evaluate progress. The AID project manager credits this consultancy with stimulating both a greater sense of urgency in completing the analytical work and more relevance and utility to the final product.

The seven completed methodological papers were completed and formally presented to AID in September, 1981.[1] Evaluative seminars were held in Washington, D.C. for U.S. participants in May, 1981 and Lisbon, Portugal in June 1981 for AUPHA members. The Lisbon session included a number of specialists from developing countries. The methodological papers have been widely circulated both bv AUPHA and AID. The contract was concluded on September 30, 1981. The total effort cost AID about $750,000.

Part II Project Issues

1. How did the perception of technical assistance needs change in the course of this project from that of the original design to those of the redesigned project, and why did the perceptions change?

The best way to understand how and why the Health Methodology Assessment project was developed is to describe the organizational and policy context of AID in the mid 1970's. The so-called New Directions legislation was enacted in 1973. Responding to this, AID replaced the existing system of country macro-economic analysis with a policy if intensive analysis of the key

1. Earlier versions were available for the evaluation seminars in Washington and Lisbon.

"new directions" sectors where AID had a programming interest. Sector analysis programming units were formed throughout the agency and external resources-mostly from universities - were mobilized behind the new system. The large and powerful central Technical Assistance Bureau(TAB) saw sector analysis as the key action that would set the framework for decisions on project assistance. TAB took the lead in developing the methodology and mobilizing the resources for studies in the technical areas. In health, a staff of more than ten professionals were recruited at the HHS Office of International Health under an AID intergovernmental contract. While this staff had substantial analytical strength in health systems it lacked expertise and practical experience in health management - a key component in the sector analysis process. To bridge this gap AID sought outside help to develop a methodology for management assessment which led to the design of the Health Management Systems Appraisal Project. Thus the Health Management Systems Appraisal Project was not directly rooted in an analysis of the management development needs of health systems in developing countries, but was primarily directed to satisfying the internal analytical needs of AID programming. At the time this project was developed regional bureaus expressed a broad general interest in the problems of health management. But no one offered up a specific site for the field test of the new methodology.

More than a year elapsed between the design of the project and fielding the contractor survey teams. During this period

there were important changes in AID that influenced the course of the project:

1) The sector analysis initiative (to which this project was conceptually tied) had bogged down. This analytical process had turned out to be so complicated and time consuming that it had to be abandoned as the vehicle for project decision making. Furthermore very few countries had shown much interest in another broad and lengthy analytical excercise particularly at a time when the AID legislation had narrowed AID's programming focus.

2) The volume of TAB research projects were proving to be a great burden on the recently slimmed down field missions and were said to threaten the success of the bi-lateral AID project activities. The AID regional bureaus became more vocal in expressing their priority for less research and more field support from TAB.

3) The Technical Assistance Bureau was disbanded. The Development Support Bureau which inherited most of TAB's personnel and projects proclaimed a field support bias. Methodology development projects lost priority.

4) Health planners and managers became more aware that management issues were of great importance to project design and implementation. There was a growing market for health management technical assistance.

Thus the AUPHA as project contractor, was faced with implementing a project which was designed to produce a product to support a sector analysis system that was on the wane, in an

organizational climate where technical assistance methodology development had become less important and in an AID system which ultimately could not deliver to the contractor a field site to test his product.

The project record does not clearly explain or document how the project product was changed from a methodology for external assessment (in connection with sector analysis) to a methodology for "self-assessment". The contract documents do not reflect this change. There are a number of possible speculative explanations. There was a practical need for this project to distance itself from the health sector analysis initiative that was going nowhere. There was a need to make the assessment project more directly responsive to field needs. There was a growing recognition that external assessment of LDC health management issues was so complex, culture specific and politically sensitive that it could not be undertaken effectively by outsiders to the system. The AUPHA project managers probably also realized that for the assessment to have lasting development value collaborating countries would have to feel that it was theirs, and that decisions on content and coverage were not being stage-managed by outside consultants.

The self-assessment product seemed to satisfy all of above requirements by delivering a self-standing product (the MAPS modules) which could be managed, staffed and administered by interested health institutions in collaborating countries. This thinking presumed that the full range of MAPS modules could in

fact be produced, that there was a market for the health system self-assessment approach and that the modules as delivered by AUPHA could be used effectively without extensive adaptation to country situations.[1] Unfortunately, none of these assumptions turned out to be true.

In September 1979 it became clear that the contractor was experiencing great difficulty in fulfilling the terms of the contract and the original purpose of the contract (to produce a methodology for health management appraisal to be used in connection with health sector assessment) was no longer valid. The June 1980 evaluation elaborated the extent of these difficulties commenting on both the approach and prospects for implementation. The evaluation recommended that the contract outputs be scaled back and the project phased out.

The final year of the contract was directed to winding down the project in the most productive fashion by:

a) completing the MAPS modules that showed the greatest potential. (The evaluation cited two; the total number was in fact reduced after some negotiation from ten to seven).

b) making available the AUPHA staff for field consultation to meet the growing need expressed by regional bureaus.

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1. The project made no provision for the people and resources needed for the extensive adaptation of the materials to local conditions. Some AUPHA people felt this adaptation was an essential step in translating the modules into practical use.

c) disseminating the results of the AUPHA work through seminars in the United States and Portugal.

The Health Systems Management Appraisal project started as a methodology project primarily to support an AID programming initiative in sector analysis. It did not enjoy much support outside TAB but as a pure Technical Assistance methodology project this was not of itself a critical design defect. A serious problem arose when TAB could not find a country setting to test the new methodology.

When interest in health sector analysis slackened the project seems to have attempted to convert from "methodology" to "service", to meet the growing field interest in health management matters. The contractor's capable staff was made available to provide short term help to field missions while efforts continued to produce health management problem solving modules that would hopefully have wide application. Beyond providing needed management consultant help to missions, the AUPHA and AID hoped that this field exposure of the project staff would contribute to the reality and practicality of the assessment modules.

In the wind-down phase of the project the contractor completed work on the seven modules that were considered to be the most relevant, continued to provide short term consultant assistance and disseminated the project's findings through two conferences.

2. <u>How have the project outputs been used by missions and LDCs and what problems have arisen in their use. Focus on the Management Problems Solving Manuals, case studies</u>

on the Management Problems Solving Manuals, case studies and consultancies

The seven methodological papers - the MAPS Health Management Problem Solving Modules - have been widely distributed both to USAID, international agencies some private voluntary insititutions and some developing country institutions. AID has received and continues to recieve numerous follow up request for additional copies of these documents from both USAID's and outside agencies. The limitations of this study preclude reaching solid conclusions regarding the degree to which these materials have been effectively used. We do know, however, that outside of Jordan and Ecuador (where a long standing relationship existed between AUPHA and the field missions) no USAID mission has reported that the AUPHA materials have either stimulated an interest in or contributed to an ongoing self assessment or have been used in AID health project design. While the absence of positive word from USAID is far from definitive, chances are that had these materials have found an important or extensive AID program related use, the health people in AID would be aware of it.

Some international institutions have secured additional copies of the modules for use in upcoming training activities but here too we are in the dark as to the success with which they were used. The Aga Khan Foundation - a private health agency that operates hospitals and health clinics in a number of developing countries - has reported a very positive result when they worked with the modules at a management training seminar for health managers. This positive evaluation is an important plus because the Aga Khan Health Director is a seasoned,

international health professional. The USAID Sudan mission has also reported that the AUPHA materials were effectively used in a health training program.

In canvassing the perspectives of the AID/Washington health program managers on the documents the consensus view is that the product represents a useful contribution to the body of literature on health management, that the quality of the work is entirely respectable (although somewhat sterile, academic and theoretical; many thought the modules would never be used outside the classroom), and that their most probable constructive use will be as a teaching resource for training health managers. There is a continuing need for good teaching materials of this kind. The AID health managers felt the modules missed the mark as a practical resource for problem solving in health systems because of their level of generality - and that perhaps this was the unfortunate but unavoidable tradeoff that had to be made to secure a wide potential applicability. Most doubted that the modules could have been made more relevant without adapting them specifically to each management situation. Some observers felt that the quality of the AUPHA work was uneven and in some respects superficial. Some modules appeared to presume that the users knew relatively little about health organization and management. For this reason they seemed better adapted to teaching than practice. The evaluator shares this general view.

Outside AID some technical assistance managers who examined the AUPHA materials were quite critical. They felt the modules had badly missed the mark and were a waste of AID's money. They

contended that the much of management technology contained in the MAPS manuals was out of date and the assessment approach to management problem solving had little prospect of success.

The evaluator had great difficulty in securing views on the case studies as almost no one had read them. There is no evidence available that they are being used in either AID or other programs. This is a shame particularly in the case of the Jordan study which is exceptionally well written and would serve as a first-rate teaching resource.

The AUPHA received very high marks for its technical consultation work in Jordan from the Near East Bureau. An examination of the record by the evaluator supports this judgement. More than 250 days - representing about three fourths of the total project field consultation - was involved in the Jordan health program. Here a fortunate combination of circumstances meshed to achieve a technical assistance success, much along the lines forseen in "self-assessment" phase of the project design. These included a new Health minister anxious to improve ministry management and interested in the self assessment approach, competent and well liked AUPHA consultant staff who provided intermittent but sustained support to the ministry management reform program and strong teaching and analytic materials adapted to the Jordan situation.

It was not possible to secure an independent assessment of the effectiveness of the consultancies in the Dominican Republic, Somalia and Mali. The AUPHA Comparative Case

study document describing these consultancies suggests the MAPS modules were not relevant to much of the work. The assignments covered a wide range of management topics (from advice on establishing a management information system to evaluating a ongoing primary health project at mid-term). There is every evidence that the AUPHA provided creditable short-term assistance. This document attempts to integrate and compare four very different short term consultancies. It might possibly be useful for teaching purposes.

The AUPHA's short paper on institutional analysis - prepared as an aid to AID project planners and designers - is quite disappointing. The treatment is shallow and procedural and dwells on the methodology of organizing an institutional analysis. As such it goes little beyond the existing AID guidelines contained in AID Handbook 3 and common sense. How much more useful would have been a document that highlighted the substantive experience on what makes health projects fail or succeed and described in some detail the critical financial and management issues that needed to be considered in the project design. In fairness to the AUPHA this document was produced hurriedly and was not a part of the original or revised scope of work. The evaluator saw no need to attempt a wide distribution of this document.

3. <u>What can the project experience tell us about current TA needs in health management? What are the lessons learned? What are the major constraints?</u>

Part III of this report will deal broadly with the technical assistance needs in health management. What AID should learn or perhaps relearn - from this project experience is that the global approach to improving LDC Health management represented by the Health Management Appraisal Project does not work. There continues to be a need for good assessment tools for use in teaching and practice. But the fact remains that few countries are interested in tackling health management issues on a system wide basis. There is a strong situation specific content in any management problem and AID's management assistance strategy in countries should build from an understanding of country specific problems and a technical engagement with country leadership. The capacity for effective interaction on a person-to-person basis is as important as technical competence. Effective personal relations often becomes the key variable in achieving change. It is just not enough for AID to produce globally applicable modules for management analysis and expect these will result in management change. It is not surprising that the distributed field manuals have produced little field reaction. In the one case (Jordan) where the modular materials were effectively used they were adapted locally and combined with competent technical consultation in a hospitable ministry setting. In the absence of an "on the ground" advocate the best that the manual for assessment can hope to produce is a reference tool for local adaptation or a classroom document. Even the able and dedicated contractor staff could not remedy these fundamental defects in the project design.

The trouble with this is that AID is well aware of all that has been said above. This leads this evaluator to conclude 1) that AID could have done a much better job with this project than it did 2) that the management appraisal effort was a casualty to shifts in policy organization and personnel within AID and 3) that overextended AID management was particularly damaging during the project's early stages.

Ideally this project should have been cancelled or at least redesigned when it became clear that Health Sector Analysis would not gain broad acceptance. The fact that AID and the contractor could not find a country that was willing to test the appraisal methodology was further ample warning that the project would not be able to deliver the product contemplated in the original contract. In restrospect, the Contractor would have been well advised to initiate program redesign discussions with AID at this stage. AID management gets high marks for insisting on an evaluation before approving additional funding or extending the life of the project. This appraisal highlighted the project's difficulties and lead to an orderly phase down. Once the decision had been taken AID acted capably and responsibly to assure the maximum productive project output. It should be noted that the life of this relatively short project spanned three AID bureau backstopping organizations, three project managers, and four principal contact points in the central health office.

There is one other observation worth making about the

Health Management Appraisal technology development experience. Despite the low level of confidence in the feasibility of the project design regional bureaus continued to support an extension of this contract. This reflects a recognition of the growing importance of management issues, a reluctance to move against the only centrally funded management oriented investment in AID's portfolio,and a desire to gain continued access to the contractor's able project and consultant staff for short term work.

Most all concerned feel that the Management Appraisal Project was a technically disappointing,and from a cost/product standpoint expensive,debut for the central technical bureau in health management. Granting this there is still a growing recognition that effective management is pivotal to realizing AID's health objectives. For this reason AID needs to continue to be concerned and give high priority to feasible management improvement interventions.

Part III AID Health Management Needs and Priorities

The most relevant point of departure from which to consider AID's health management needs and priorities is the recently completed Health Strategy Statement(10/15/82). This paper describes AID's health priorities and spells out fairly explicitly the policies and programs AID will pursue. Broadly speaking AID intends to do four things in the policy management area.

- to engage in a policy dialogue with governments with respect to their health goals and the way in which they use their health resources

- to select, plan, manage and evaluate project investments that expand the coverage of certain primary health care services

- to help start and to strengthen LDC institutions that will expand local, self-sustained capacities in planning and management

- to broaden the knowledge base regarding health policy and health organizational alternatives available to planners and managers

In addition to setting AID strategy the paper also highlights some specific management concerns. These are:

- the adequacy of project planning and design, particularly in the areas of financial and economic analysis

- the major impediment poor management is proving to the effective delivery of health services

- the need for a more creative engagement of the private sector in the delivery of health services.

The AID objectives are appropriate. AID managers should feel confident that they are working on the right problems. At the same time these goals are very ambitious and an effective program involvement at this level of sophistication requires a cadre of very skilled technical people within AID and access to best there is technically from the public, private and university sectors. The technical component of this effort is far more important than the money. AID has correcly chosen not be involved in subsidizing the direct delivery of service. Where AID funds can best be used is in transferring proven technology, building self-sustained local institutions and in

narrowing the knowledge gap regarding feasible policy and organizational alternatives. There is definitely a shortage of proven solutions to many of the most pressing policy and organizational issues in LDC health today. AID can make a major contribution by helping countries work through the best situation-specific answers to their health delivery problems that can be sustained with local technical and financial resorces.

This report treats a few areas of both priority and concern that are central to the achievement of AID objectives and where policy/management initiatives can and should be undertaken as an AID health priority.

Maintaining an Effective Policy Dialogue with Collaborating Countries on Health Issues.

The most important aspect of AID's health relationship with collaborating countries is the technical dialogue on health issues. The USAID field missions are charged with this responsibility which generally devolves to the mission health officers. They are responsible for analyzing the local health situation, building the range of contacts in the public and private sector and maintaining the policy dialogue on health matters. The mission health officer serves for AID as the generator of new project ideas, assures their relevance to the local situation, guarantees their organizational, financial and economic adequacy and provides AID with the assurance of host country support.

The AID health officer serves as the gatekeeper who controls the entry of external technical expertise, clears

off on country participation in AID sponsored research activities and host-country participation in AID sponsored training seminars and international conferences.

Most important, the AID health officer serves as the filter through which all host country ideas must pass before they are considered by other elements in the agency.

The system that makes the field mission the central programming point is a good one and provides AID with a strong comparative advantage over other donors who must rely on intermittent technical visists from the home office. However, for this approach to work it is essential that the field technical officer have broad technical competence, a wide range or contacts and is sufficiently analytical and persuasive to identify opportunities and exploit them. The nature of the dialogue AID is seeking to engage is sophisticated. It requires a very broad knowledge of health systems,the trade-offs in the alternate uses of health resources the potential role of the private sector and the possibilities for quasi-governmental approaches to health delivery systems. Since resources allocation issues are often decided at Ministries of Planning or Finance the Health Officer needs to have enough grounding to deal interministerially on these points.

The point of this discussion is that the mission health officer post is both sophisticated and demanding. It needs to deal with health's big league problems. The range of skills required to handle it adequately include but go considerably beyond a narrow definition of public health.

Unfortunately in a dangerously large number of situations the AID health officer position is staffed by a relatively junior officer both in terms of health skills and technical assistance experience. (In some cases the health interest is covered by a population officer with little or no health training). It is just unrealistic to expect these people to initiate a policy dialogue on national health strategy, to exercise mature judgement in selecting the best programming opportunities, to call forward and exploit the most appropriate external technical help or to compete effectively for resources within the AID system.

As a result AID is obviously missing opportunities for a dialogue on policy, and program interventions are often not well enough thought through. It should not be surprising that the inexperienced or relatively untrained health officer has often little that is innovative to propose.

The best single measure that AID can take to broaden the possibilities for a productive health policy dialogue and develop a greater number of better quality health projects is to vigourously work toward improving the capacities of the AID health staff in the field. This, in the writers judgement, is AID's highest health management priority and a almost prerequisite to effective engagement on policy/management issues.

Conversely, if this is not done there is a danger that much that is proposed or generated at the Washington end will be only marginally productive. It is probably not realistic to

expect that AID will be able to add significantly to the Health field staff. All the same there are good opportunities to upgrade the capacities, provide better backup and demand more from the people presently on board. AID provides little or no support to the field in policy analysis and project selection. AID does almost nothing to provide continuing education or inservice training for the staff. (This would be particularly useful in exposing the staff to the key health issues where AID has a program interest). AID has done next to nothing in cultivating long-term consultant relationships with the best outside health expertise - either on a country specific or a subject specific basis.

Much can be done to upgrade the health analytical capacities in the field with a relatively modest level of resources that will provide a quick program payoff. Failing some enhancement of field capacity AID will need to either rethink a strategy that depends so heavily on a field generated program dialogue or perhaps modify the programming relationships between Washington and the field.

Broadening the Knowledge Base Available to Health Planners and Managers Regarding Health Policy and Organizational Alternatives

When the developing world embarked - with developed world encouragement - on the worldwide "Health for All" initiative the planning was far from complete. Most "Health for All" plans envisioned a broad expansion of public sector services - often at minimal or no cost to the user. The financial and management strategies to support these programs were in many

cases not resolved before attempts at expansion of services started. Now, quite predictably, unresolved concerns (many evident at the planning stage) are becoming highly visible and justifiably threaten the confidence in the primary care movement. The principal difficulties have little to do with medical care technology but deal with money and organization. There is a major resources problem that is impeding the extension of services for which there is no public sector solution in sight. There is also a growing recognition that in many countries even if the resources were available governments lack the managerial and organizational capacity to effectively deliver primary health care services. The financial problem is complicated in some countries by constitutionally enshrined provisions guaranteeing "free" health services to the people. These guarantees were often promulgated at the time of independence and are thus associated in the minds of the citizens and politicians as benefits resulting from the release from colonialism. Realistically, these theoretical "free" services have in many cases been translated into no "active" services, and many citizens of modest means have elected to bypass the overextended government system to secure care from the private and voluntary sector.

The organizational problem deals with the capacity of government in the delivery of health services. Many LDC governments (not unlike those in developed countries) have great difficulty managing day by day operation of complicated

social services programs such as health and medical care. The front line is often manned by a poorly motivated and paid health care staff serving out some period of obligatory service to compensate for some government financed education. There is a discouragingly low level of productivity. This front line is backed by an administrative system that is just incapable of providing the resources and necessary logistical backing. There is often little administrative discipline. Working under these circumstances even the most efficient and dedicated people become quickly discouraged. In this administrative environment the problems are far greater than resources, and a recognition of this has caused some governments to start to rethink the role of the Ministries of Health in the direct delivery of services. (Should, for example, Ministries of Health be limited to policy planning, regulation, research and evaluation,with the direct delivery of personal health services provided in the private sector or in combination with quasi-government organizations on a self financing basis except for the very poor). What this examination is suggesting is that many public sector institutions that provide direct services delivery have so many disabling management and financing problems that it is not practical to try to fix them and expect a near term payoff in improved services. Efforts should be rather directed to looking at other models, adapting or creating new institutions with sounder management and financial foundations that could carry the health delivery function. This fundamental re-examination of the capacities of government to provide health services is not

limited to so called "capitalist" societies. In at least one major "socialist" country the raw, non-availability of resources combined with government in administrative capacities in health services delivery is forcing a reexamination of the foundations of health financing and organization. The writer anticipates that many other countries will soon arrive the same situation. Thus, an examination of alternatives for organization and financing of health services in LDC's is becoming increasingly urgent.

AID, the donor community, and the governments of the developing world have relatively little experience with non-governmental institutions and non-governmental solutions to health services problems. This has been understandable for AID since the program focus has been on public health and the target groups have been the very poor - both elements that are served principally by the public sector in the United States. In many countries where AID works health services are provided by government, the voluntary - largely church related - sector and the private sector. In a few countries quasi-governmental institutions deliver health services through health insurance. Generally these insurance systems serve employed individuals in the urban areas. The dependents are usually not covered. There is almost no experience with applying health insurance to the rural areas in developing countries. Some investigators have wondered whether it is possible to develop an analogue to the Health Maintenance Organization for developing countries,

perhaps linked in the rural areas with exisitng agricultural cooperatives, marketing or credit organizations.

There is even less experience in attempting to harness the private sector to serve more than the personal health care needs of the middle and upper class. Could, for example, more efficient arrangements be worked out to deliver on a contract basis through the private sector socially important public health services as well as personal health services for the poor as now takes place under some circumstances in the United States?

As the national government health systems management and financing crisis becomes more apparent governments and international donors will be grasping for realistic alternatives. If these are not forthcoming there is a clear danger that the broad intersectoral concern in health development that now exists will vanish and health as a development assistance topic will likely recede to the low level of interest that was present in the 1960's.

AID involvement in seeking alternatives approaches to financing and management is of high priority. AID can be a leader in thoughtfully examining this technical issue.

Improving the Project Design, Review and Implementation Process

The Health Strategy Statement has correctly identified improvement in the project design, review and implementation process as a priority management need. In project design and review much can be gained by applying what AID already knows. The Agency has labored intensively to gain a good understanding

of the issues and mechanics of project design and the need for a collaborative analysis and a sense of project ownership by the involved institutions. It would be particularly unproductive to embark on producing a new generation of guidelines and manuals for project design as long as AID does such an indifferent job of applying the tools that are presently available.

During the course of preparing this paper the writer encountered a major new health activity that had recently passed through the complex AID review system when it was unclear whether the health providers could legally deliver the services contemplated under the project. This issue is now presenting major implementation difficulties. The sponsoring mission is staffed with an experienced health officer. The program officer and AID director are AID career professionals. The review process in Washington approved the field presentation despite concerns raised to these and other related issues raised by the Washington technical people.

The specifics of this situation are not particularly important. What matters is that no system can prevent people from papering over issues and there are limits to which educational solutions, represented by "better guidelines", can be applied to what are ~~in~~ management/executive problems.

Within the various elements of the AID organization very different weight is given to the views of technical people about projects. In the Near East Bureau (NENA) the technicians are the managers which guide the project through the approval process. In Africa the technicians role is advisory. It would

seem that as a technical agency - at minimum - a technical project should not be approved without the strong technical endorsement of the sponsoring bureau's technical staff.

The design process must also assure that adequate weight is given to the financial and management issues and that provision is made to employ skilled management people to assist in implementation.

By their very nature technical assistance projects will encounter suprises and unexpected changes in program direction. But AID can do a much better job of dealing with the forseeable by applying our existing knowledge and experience. To do this, AID needs to have ready a cadre of skilled management people available to help in project design and help USAIDs and host countries think through the implementation recommendations.

The adage that AID pays ten times the attention to design as to implementation is true. There is relatively little to help the AID health project manager in guiding projects in the implementation stage. Agency wide AID's most talented technical assistance people have not worked extensively on technical assistance implementation issues.

As a result the technical assistance concerns related to implementation have often been submerged to accomodate lending and procurement's procedural priorities.[1]

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1. Host country contracting for technical assistance is a good example of this phenomena.

There is little consistency in approach to health project implementation and the available guidance is weak. The principal substantive work in thinking through better approaches to project implementation is being carried out by AID's Development Administration office and their grantees and contractors.

A useful implementation initiative that is now being undertaken in agriculture through a USDA PASA may also be valuable to health. The USDA unit, the Development Project Management Center,specializes in supporting effective systems for project management and performance improvement in developing countries. It is sponsored by S & T's Multisectoral Development Division. Very recently this group was invited to assist in the first stages of implementation of an Africa Bureau health project where they made a valuable contribution. AID's health managers need to consider the possibility of investing in the development of a similar implementation capacity for their projects. This unit might combine field technical assistance, cataloging of the best practical experience and a modest research capacity directed to solving health implementation issues.

A word of warning. Health people tend to be put off very quickly by "management experts" who present their perspectives in language and concepts that are barely comprehensible to the uninitiated. This factor has probably contributed significantly to the "less than fair" consideration of the potential for the application of modern management practices to health technical assistance. It is therefore crucial that any such resource

employed to help health people seek as its first objective understanding and communicating with the health people being served.

AID also needs to identify and maintain links to competence in areas of specialized implementation need which can be used to back up field programs. Some important areas are logistics, pharmaceutical procurement distribution,and management and in health behavior change. The body of expertise and literature in these fields is growing. In all cases the approach that should be encouraged is one that builds from successful field experiences (which recognize the management and resources constraints). The "top down" strategy that seeks to evolve global approaches to health management improvement or pays inadequate attention to country specific issues and priorities will probably yield little that is useful.

Institutional Development for Health Planning and Management

This report does not identify institutional development for health planning and management as a priority for new initiatives. The writer agrees that this area is important but AID seems to have a reasonably good grasp on these issues. AID also has a number of ongoing investments which should provide a good test of the best current approaches.

There are collaborative projects underway in Indonesia and the West Indies that are testing the feasibility of building a self-sustained competence in planning and management in local institutions. AID is also associating itself with the WHO/AFRO

effort to help bolster selected institutes in the region to train better health managers. AID should continue to work with country based health management and planning institutions and evolve ways to best improve local competencies in a fashion that can be sustained.

Conclusions & Recommendations

AID's new Health Strategy is a realistic and ambitious approach to the most important health problems. However, in many cases AID does not now have the capacity to engage and carry forward the policy dialogue in health that this strategy implies. AID is still struggling to build an internal analytical capacity to assure that country situations are adequately understood and exploited. In a sense AID is still dealing with the same deficiencies in analytical capacity that prompted design in 1977 of the original Health Management Assessment Project. These issues remain at the core of an effective AID health program.

The growing problem of insufficient money and inefficient management of government health systems is causing an overdue re-examination of government's role both as a financier and manager in the direct delivery of health services. This is likely to be the highest priority concern in international health during the next few years. AID needs to take the lead in exploring alternate approaches to health delivery that better mesh with local capacities.

AID can improve its performance in project design and

project managment - in part by applying what it already knows and in part by some selective investments to improve AID project implementation.

The followings are the priority initiatives AID should take to address the most urgent management problems:

1. Elevate the quality of the policy dialogue between AID and LDC's on health issues through:

- providing more technical leadership and support to the field in health situation analysis and project selection
- a vigorous inservice training and continuing education program for field health staff.
- selecting better trained and more experienced people for field health positions.

2. Explore alternate financing and management arrangements for primary care health services particularly focussed on:

- health insurance
- private sector

3. Improve health project design and implementation through:

- application of AID's extensive experience and competence
- a broader role for health people in project decision making
- exploring the possibilities of acquiring a specialized "health implementation" competence to support field projects.
- Acquiring a cadre of "on call" specialized skills in management situation, organization and finance to assist in situation analysis, project design and implementation.

Persons Contaced During the Course of Preparing this Report

Jarret Clinton, M.D., Agency Director for Health and Population S & T Bureau, A.I.D.

Gary Filerman PhD, President, Association of University Programs in Health Administration

Jerome French, Director Office of Multi-Sectoral Development, S & T Bureau, A.I.D.

Rachel Hines, Program Assistant, Office of Development Administration, S & T Bureau, A.I.D.

Marcus D. Ingle, Development Program Management Center, U.S. Dept. of Agriculture

Kenneth Kohrner PhD, Chief, Development Administration Division, S & T Bureau, A.I.D.

Jeanne North, Project Manager, AUPHA Project Multi Sectoral Development Division, S & T Bureau, A.I.D.

Clifford Pease, M.D. Acting Director, Office of Health, S & T Bureau, A.I.D.

Barbara Sandoval, Former Chief, Health and Nutrition Latin America Bureau, A.I.D. (now with USDA)

James Sheppard, M.D., Chief Health Advisor, Africa Bureau, A.I.D.

Anne Tinker, Deputy Chief Field Operations Division, Office of Health, S&T Bureau, A.I.D.

Barbara Turner, Acting Chief, Office of Health Nutrition and Population, Near East Bureau, A.I.D.

Scope of Work

Project: Appraisal of Health Management Systems Project 931-1016

Contractor: Association of University Programs in Public Health Administration (AUPHA)

Purpose of Evaluation: To examine the project's performance and outputs in relation to present health management needs and those perceived during the life of the project in order to identify areas for future planning.

Evaluator:

Dates: October 12 - 26, 1982

Cost:	Evaluator - 11 days @ $215	$2,365.00
	Clerical Services - (up to) $135.00	135.00
	USDA Overhead @ 25%	625.00
	Total	$3,125.00

Project Evaluation Background: As originally designed in 1977, the project was to develop and test a methodology for the appraisal of the management of health sector institutions. The direction and scope of the project changed over time to focus on two areas:

1) technical assistance in health management to USAIDs and host country governments, and 2) the preparation of papers to be used as tools to promote health management program self-assessment and planning.

These changes are reflected in evaluations and evaluative papers:

1) A team evaluation completed in June, 1980, focused on the progress of the project, the major problems in achieving output goals, and the effectiveness of the process. The evaluation also discussed the relevance and validity of the original project goal and purpose.

2) The Project Committee periodically reviewed the progress of the project and reassessed the goals. Of particular note is the Committee meeting of January, 1981.

3) A review of the material produced by AUPHA was done by Edward Rizzo in April, 1981. He reviewed five sets of draft papers and evaluated their usefulness.

4) Evaluative seminars were held in Washington for U.S. participants, and in Portugal with AUPHA members. No record of these exist, but a report on the seminar in Portugal is contained in J. North's trip report of June-July, 1981.

None of the above evaluations attempted to measure the impact of the project in the field.

Project Progress: AUPHA has completed seven methodological papers for management self-assessment and problem-solving in LDC health programs. These papers are called Management Problem Solving Manuals (MPAS) and include separate reports on:

- Materials and Facilities Management
- Personnel and Human Resources Management
- Patient Services
- Financial Management
- Organizational Design
- Community and External Relations
- Options Analysis and Implementation

Four additional documents include:

- A case study in Jordan with a supplement of the Management Division Exercises used in the study
- A case study in Ecuador
- A comparative case study of Health Management consultancies in Jordan, Ecuador, Dominican Republic, Somalia, and Mali.

These outputs, significantly different from those originally proposed, reflect the change in the perception of research and technical assistance needs to which the redesigned project responded.

The principal consultative activity was long term technical assistance to the Kingdom of Jordan.

Problems and Issues to be Addressed by the Evaluator:

A. Project Issues

1. How did the perception of technical assistance needs change in the course of this project from that of the original design to those of the redesigned project, and why did the perceptions change.
2. How have the project outputs been used by Missions and LDCs and what problems have arisen in their use. Focus on:
   a. the Management Problem Solving Manuals
   b. case studies
   c. consultancies
3. What can the project experience tell us about current technical assistance needs in health management in LDCs. What are the primary lessons learned? What were the major constraints?

4. How do the lessons learned from the project relate to current A.I.D. and S&T policy. Take into account:
   a. the Institutional Development Policy Paper
   b. ST/MD Management Strategy Paper
   c. Administrator's cable of 5/25/82 on health care assistance
   d. A.I.D.'s general health care goals and international committment.

B. General Issues

1. What general recommendations can the evaluation make concerning A.I.D.'s /TA's research needs into the 1980's, in terms of:
   a. R&D areas for exploration
   b. intervention methodologies
2. What general recommendations can the evaluation make (based on the project evaluation and the evaluator's experience and research) for future health management programs, in terms of:
   a. present technical assistance needs in health management
   b. the general goals of health management programs, taking into account A.I.D. and ST general policies
   c. the administration of health management programs

Output of the Evaluation: A report of not more than 50 pages which discusses these recommendations and describes the relationship between the changing perceptions of health management needs and the consulting services and methodological paper outputs during the life of the project.

Annexes to the Evaluation:

1. Of what recommend use are the following materials produced under Project 931-1016, based on the discussed needs and direction of LDC health delivery systems management
   a. the MAPS modules, noting the use of and requests for this material.
   b. the case studies, particularly Jordan and Ecuador.
   c. the paper on institutional analysis
2. OPTIONAL Comments on:
   a. the process through which projects change to meet shifting perceptions of needs
   b. the usefulness of AUPHA consultilng services to USAID missions.
   c. the usefulness of the LDC experience and research in the information base within the network of university programs affiliated with AUPHA.

Documents available for the evaluator:

- chronological file of project contracts and amendments
- projet papers
- evaluation reports
- field reports
- correspondence, including a tally of materials sent out and responses received
- publications resulting from the project

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