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9. ABSTRACT

A strategy paper on organization of resources for meeting health needs of disadvantaged populations. Health care delivery projects should be community-centered. They need to be carefully designed to assure that populations in rural areas are served. PASITAM can assist in this by drawing up models of alternative patterns of project organization. If such models are to be useful to practitioners, they must include information about key issues faced in designing, implementing, and evaluating projects, including (1) project-client interfaces and community involvement in provision of services, (2) integration of health services and of these with other development efforts, and (3) evaluation of impact to learn what works best under what conditions. Such PASITAM and MUCIA services might serve several user groups: first, MUCIA participants who undertake overseas health projects on a contract basis; second, major donor organizations such as USAID, the World Bank, and WHO; third, numerous private voluntary organizations. Some 25 such organizations have received development program grants. The first task of PASITAM is to develop models and tools. Some relevant work has already been done. A two-week analytical skills training program has been developed for AID and host country program personnel. With appropriate adaptations, elements of this course are likely to be appropriate to training in the health area. The second task is choosing and implementing the mode of delivery of models, tools, and knowledge. PASITAM is producing Design Notes and Design Studies in keeping with that task, and can organize workshops and training activities in collaboration with clients.

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Design, Implementation, and Evaluation of Health Delivery Projects-- 1975  
A PASITAM Strategy Paper.

The health needs of disadvantaged populations, and the problems of meeting them, have recently been re-examined by the World Health Organization and the World Bank.<sup>1</sup> The problems are not only insufficient resources, but the inappropriate allocation and organization of resources.

"Generally, the health services which should be improving the health status of people are not doing so to the degree desired. Large segments of the world's population have limited or no access to the health services. In other areas these services have often operated in an isolated manner, neglecting other aspects contributing to human well-being such as education, communications, agriculture, social organization, community motivation and involvement. One of the reasons for this is that the approach adopted has been largely promotive of highly sophisticated and centrally located medical care and, even when not so, has frequently been unrelated to local realities. Available financial and human resources, including training programmes, facility designs, and equipment purchased for use, have been mainly used to provide this kind of medical care in urban areas to selected parts of the population."<sup>2</sup>

The new strategy, labelled the primary care approach, "consists of simple and effective measures, in terms of cost, technique and organization, which are easily accessible to the people requiring relief from

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<sup>1</sup> Promotion of National Health Services Relating to Primary Health Care, Annex 15 of Official Records of the World Health Organization, Twenty-Eighth World Health Assembly, Geneva, 13-30 May 1975, pp. 112-119.

Health Sector Policy Paper, World Bank, March 1975, 83 pp.

<sup>2</sup> Ibid., Promotion of National Health Services, p. 113.

pain and suffering and which improve the living conditions of individuals, families and communities."<sup>3</sup> The approach implies, or calls for, new perspectives and techniques of design and management capacities.

David Korten has recognized this need in examining population programs.

"...managing population programs of the next decade will present many difficult challenges. The requirements will be far more varied and complex than those of managing the small clinic-based, single-service contraceptive delivery program of earlier days. Programs will be larger, more diverse, more closely interrelated with other development activities and organizations, and more oriented to relatively less accessible rural populations. They will be less medically oriented, will rely on less educated personnel, and, while they will include a major service delivery component, will give relatively greater attention to the motivational correlates of limiting family size than in the past. As a result, they will require more sophisticated organizational forms, greater managerial expertise, and greater use of social science research."<sup>4</sup>

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<sup>3</sup> op.cit. Promotion of National Health Services, p. 114-115.

<sup>4</sup> "Population Programs 1985: A Growing Management Challenge," Studies in Family Planning, David C. Korten, July 1975, p. 181.

Some of these problems of design and implementation fit our\* mandate to apply organizational knowledge and skills to the improvement of technical assistance.

Since 1973 we have worked with Dr. Ned Wallace, Director of the MUCIA Center for International Health, and with other MUCIA international health faculty, exploring the "state of the art" of health project design. In addition, we have identified more than three dozen other relevant faculty persons--medical and nutritional anthropologists, sociologists and geographers, health management specialists, health economists, health evaluation specialists, nutritionalists, and systems engineers experienced in health system analysis. There is a rich array of potential resources within MUCIA for addressing health delivery problems and opportunities.

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\* The Program of Advanced Studies in Institution Building and Technical Assistance Methodology is an element of the Midwest Universities Consortium for International Activities comprising Illinois, Minnesota, Wisconsin, Indiana, Michigan State, Ohio State and Purdue Universities. It acts as a catalyst within these seven universities identifying, applying, and thus strengthening faculty and institutional resources which can provide appropriate assistance to practitioners designing, implementing, and evaluating development programs and projects. It provides training and information services, and produces publications resulting from activities it supports or coordinates. Panels of experts drawn from MUCIA universities provide advice, review products, and help identify and evaluate consultative resources in PASITAM-focused work on rural development, evaluation, project analysis and management techniques as well as health service systems.

These and other international health assistance professionals are aware of the need for new methods and patterns of project development. There is relative consensus on the importance of going beyond health projects: 1) centered in hospitals or clinics; 2) dominated by doctors; 3) emphasizing curative care; 4) using the most modern technology; and 5) providing minimum outreach to rural populations.

The new ideal stresses community-centered programs: 1) minimizing capital costs in hospital and clinic construction; 2) involving a variety of health technologies (nutrition, preventive, family planning); 3) maximizing the use of paraprofessionals; 4) emphasizing preventive measures; 5) using "appropriate" technology; and 6) with maximum community presence in the form of primary health care auxiliaries and health promoters drawn from the community.

Implementing this ideal requires integration:

1) more effective health assistance interventions will attempt to integrate curative care, nutrition and sanitation measures, mother-child care, and family planning;

2) in rural areas, such program or projects must increasingly be integrated with more comprehensive development efforts;

3) institutionalizing health service at the community level requires maximum use of local resources, and projects must elicit and maintain community participation.

There are yet no standard patterns for implementing this ideal and no sufficient supply of site-specific solutions to the problems confronted by health project designers and implementors.

What appears to be needed to fill the gap between desired goals and effective means are:

1) models drawn from experience, describing alternative strategies and the conditions under which they appear to work;

2) tools tailored to the needs of health project specialists to enhance their capacity to cope with increasingly complex problems of organizing, managing and evaluation;

3) mechanisms for incorporating the knowledge and skills of non-health disciplines to supplement their own capacities.

Second only to the scarcity of appropriate resources for providing health services to unserved or underserved populations is the lack of systematic knowledge of how such resources may be most effectively organized and deployed. But we are learning from experience, and there is a growing consensus among international health experts about both requirements and potentials for improving programs and projects through the application of lessons from this experience.

In these circumstances, what needs might PASITAM best address?

#### Models for Conceptual Clarification in Organizational Analysis and Design.

Clear thinking is the first requirement for dealing with the complexities of health assistance. This begins with conceptual clarification of such elements of current doctrine of international health assistance professionals as these: primary health care, community involvement, integrated services, use of auxiliaries, voluntary action, evaluation, decentralization, impact on higher health resource allocation.

This clarification can be furthered by drawing up models of alternative patterns of project organization. But model building can be academic in the pejorative sense if the models are merely logical constructions. To be useful they must be linked with experience. Empirically based models serve several purposes:

1) They display the components of a system of action that must be dealt with in any particular project.

2) They also help identify the environmental factors which determine or influence the effects of a system of action impact.

3) Thus, they guide thinking toward the critical questions or issues of choice among alternative arrangements; and

4) They help show how such choices are related. Consequences of the choice of a given strategy or arrangement can be traced through other components of the system.

5) Finally, identifying the factors which affect a system of action indicates what needs to be known about the environment, and leads toward knowledge of the conditions under which different models are likely to work.

Modelling should be selective. It is neither practical nor necessary to examine every documented project. It is necessary to represent the major kinds of projects, and cases can be identified by a body of experts.

For example, under a grant from the UNICEF-WHO Joint Committee on Health Policy, WHO's Division of Strengthening of Health Services

identified cases for study on the basis of recommendations from the WHO Expert Advisory Panel, Regional Offices and information from various documents, reports and publications. The purpose was to analyze innovative programs at the national level, more localized projects, and programs with distinctive potential for extending or improving health services coverage. The case data were used to identify problems and alternative solutions as a basis for recommendations.\* Although the cases were not used to extract models, or to identify the factors critical to the success or failure of the projects, they do provide the documentary basis for this next step.

If such models are to be useful to practitioners, they must include information about certain key issues faced in designing, implementing and evaluating projects, including: 1) project-client interface and community involvement in the provision of services, 2) integration of health services and of these with other development efforts, and 3) evaluation of impact to learn what works best under what conditions.

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\* WHO-UNICEF Joint Study on Alternative Approaches to Meeting Basic Health Needs of Populations in Developing Countries. UNICEF-WHO Joint Committee on Health Policy, Twentieth Session, Geneva, 4-6 February 1975, p. 122.

### Client Interface and Community Involvement

Efforts to develop locally sustainable capacities for improving health will require substantial community participation in providing financial and labor resources. Health project interventions must also be integrated into the traditional health system to the greatest possible extent. Thus, information about beliefs, practices, social structure, authority and decision-making is needed for project design and implementation. Models of alternative patterns of community involvement should reveal how incentives can be provided to elicit and maintain voluntary efforts.

This does not mean that every health project designer and manager must be an amateur anthropologist. The use of local health informants has been pioneered by an anthropologist formerly connected with the International Development Research Center at Indiana University. His technique offers some exciting possibilities. There are also well-established theories and techniques of community organization which can be of great value to health project personnel. Finally, there are important lessons to be learned from experience, in the US as well as in LDCs, with community involvement and use of volunteers.

At this point, it seems to us that the appropriate questions for further investigation are:

How can community participation be achieved in the design, implementation and evaluation of community focused projects? What are the

costs and benefits of community participation of various kinds and degrees? What are the requisites for such participation? Are they consistent with other constraints on project process? What do we know of "maximum feasible participation" from the US war on poverty experience and more broadly? What are the techniques for discovering how participation can be achieved in a particular community? What do we know from experience about advantages and disadvantages of the use of volunteers? What kinds of incentive systems maximize volunteer effort? How can volunteer effort be integrated with professional and paraprofessional paid efforts? How can health projects be designed to make maximum use of traditional healers? What roles do and can traditional healers play in community health? How can modern health practitioners interface with traditional healers?

#### Integration of Development Project Efforts

Just as development projects have suffered from lack of community involvement and impact, so too they have often been isolated from one another even in the same target area. Projects have often focused on physical facilities. They have been bounded by the perspectives of the technical specialists designing and implementing them.

Each group of technical specialists--educationists, health professionals, agronomists, engineers, housing specialists--has tended to design and implement independent programs and projects, within the constraints provided by national planners, chiefly economists, bureaucrats

and politicians. This is understandable. Their own training is highly specialized. They can exercise relatively more effective control of projects tailored to their own expertise; collaboration across specialties complicates the project process considerably. And specialized projects maintain the identity of the sponsoring organization or division before its constituencies.

The chief problem with conventional patterns of specialization is that neither the development process nor the structures and needs of most communities neatly fit specialist perspectives or lend themselves to piecemeal manipulation. A community, if viable, is likely to respond to and benefit from more wholistic interventions.

If our impressions of the thinking of the international health establishment is correct, the trend is toward a "systems approach" to development design. The aim is to place such special concerns as health in a broader context. If the current exhortation to build in more community participation is heeded, the specialist approach to development faces even greater difficulties.

In the field of health delivery, two types of integrative needs pose formidable challenges to the health project developer.

First, there is the need to integrate the various types of health services themselves: curative, preventive (nutrition, sanitation), mother-child, family planning, and rehabilitative services. What is the technically most effective mix of services? What are the qualities of health

goods and their appropriate delivery structures, and how can these be most effectively related? What are the obstacles or constraints upon achieving a predetermined mix or pattern of services? Should the integration of services be vertical or horizontal or both? Should integration begin at the national level or take place chiefly at the community level? What are the requisites, costs and benefits of different modes of integration? What does experience suggest about the chances of this sort of integration--about its sheer feasibility?

In this area of integration, there is the related matter of integrating health projects with ongoing health-related activities in the local area--the private practitioners, industrial health services, traditional healers, etc.

Second, health projects are not functionally unrelated to other development efforts affecting the same area or populations. Benefits can be derived through coordination, if not integration, not only from economies in the use of resources, but from complementarities inherent in sector-specific development efforts. For example, agriculture productivity and marketing and nutrition specialists can benefit from each other's knowledge and efforts. If health concerns are to receive more attention and resources at the national or regional level, it is essential that they be part of the thinking of planners and decision-makers beyond the health bureaucracy.

These problems of integration and coordination surpass the capacities of most organizations now initiating and implementing health projects. What will be useful to such organizations are tools for improving inter-organizational cooperation, particularly at the local level, and information facilitating their cooperation with other technical specialists. What does experience indicate in the way of models and lessons?

### Evaluation

Perhaps the most pervasive single concern among many private and governmental health organizations is "evaluation." In this age of accountability, everyone seems to desire to link action and impact, input and output, in some convincing manner, whether to garner a continued flow of resources or to gain knowledge permitting a better choice among alternative means of achieving goals.

Just as pervasive as the topic is the misunderstanding and miscommunication about it. There is a great need for better thinking about evaluation of development projects.

What should be evaluated in health projects? Why? How? At what cost? What are the different purposes of and approaches to evaluation? What organizational capacities are required for a particular evaluation effort and what are the consequences for other organizational activities? To what extent are evaluation tools such as the "logical framework" used

by AID adaptable by private organizations? How can evaluation of health projects qua projects be related to standard techniques of treatment evaluation which are highly developed within the field of health technology?

These questions do not exhaust the concerns which health specialists face in designing and implementing programs and projects. They are the issues which transcend the particular technologies employed in health improvement activities, but treating them requires knowledge and skills beyond the competence and experience of most technical specialists.

Yet our sense of the issues must be validated as relevant and meaningful to experienced health professionals. This is one of the tasks we would like to put before a MUCIA panel.

Should the above agenda or some elements of it be judged by experts as likely to produce useful results the next step is not the laying out of an agenda of original research, but the selective identification, analysis and synthesis of experience as a basis for better guidance toward improved action.

#### Potential Clientele for PASITAM and MUCIA Services

Assuming a sound knowledge-development strategy, whom might it serve?

First, there are those within MUCIA who, on a contract basis, undertake overseas health projects and associated activities. The mechanism for linking together appropriate resources for improving design and

implementation of MUCIA health projects exists now in the MUCIA Center for International Health. In collaborative efforts with this center, PASITAM can complement its health professional expertise by identifying and delivering needed disciplinary expertise. One need is simply a rack up of MUCIA health development experience.

Second, major donor organizations such as USAID, World Bank, and even WHO may benefit from MUCIA products and talents building upon work already begun in the specialized divisions of these agencies dealing with the organization of health service systems and technical assistance interventions to strengthen them.

Third, numerous private voluntary organizations play important roles in health development, some with AID support. Such organizations have fewer resources for design and evaluation, but also fewer constraints than major donor agencies. Some 25 such organizations, many working in health, have received development program grants (DPGs) from AID, to enable them to strengthen their design and evaluation resources. PASITAM ought to be able to assist such organizations in a manner different from conventional consulting organizations. Such collaboration or "thinking together" will in turn provide a significant learning experience for PASITAM as well. Bringing appropriate resources from MUCIA universities to serve these organizations should strengthen the capacities of both to assist in improving health projects.

Our contacts with private voluntary or humanitarian service organizations lead us to conclude that:

1) a number seek to expand the scope of their activities, moving from emphasis on materials delivery and relief services to developmental projects;

2) the experience and expertise of such organizations offers services to make projects more effective at the community level;

3) these organizations may in some ways benefit from systems or tools used in donor organizations such as AID, but cannot sacrifice their autonomy as the price;

4) there is a need for operational cooperation and sharing of knowledge among those carrying out community-focused health project assistance;

5) there may be significant opportunities for private organizations working overseas to engage in projects which will aim chiefly at building indigenously sustainable service capacity. This raises questions about needs of these private voluntary organizations for redesigning their strategies.

When a project goal is a developmental impact, how can health project interventions be designed and implemented to maximize capacity transfer?

#### Responses to the Needs of Potential Clientele

PASITAM's interests and concerns are predicated upon certain assumptions: 1) that many important health development issues and needs center upon problems of better design and implementation of efforts; 2) that these problems of design and implementation require multidisciplinary attacks which include knowledge from fields of organization theory,

management, community sociology, anthropology, etc.; 3) that practical incremental contributions can be made through mid-level approaches to knowledge building and analysis; and 4) that PASITAM is a suitable vehicle for getting involved in this business.

Can PASITAM-organized activities contribute to health project development within MUCIA, among donor agencies, and among private humanitarian organizations? Are our assumptions about their needs correct? What are the most appropriate mechanisms by which a contribution can be made most effectively? Can we focus our efforts on particular organizations and specialists within them? Which ones? Is our view of the current needs of international health professionals and their organizations congruent with what is going on or is it more the reflection of the rhetoric of formal policy pronouncements having little impact on program and project activities? We seek expert advice on these questions, believing they are the chief concerns of those who seek to improve international health assistance to unserved populations of LDCs. No organization can deal authoritatively with all of these issues, but many can contribute to something.

PASITAM's mandate is to help improve technical assistance arrangements by building upon the experience of past project efforts and improving the tools available for design, implementation and evaluation of projects. Such efforts must combine the perspectives and skills of relevant behavioral scientists and experienced practitioners. Such collaboration is most effective when focused on concrete design, implementation

and evaluation problems. The knowledge and testing of tools derived from such collaborative efforts can be made useful beyond the site-specific circumstances of its origin, through careful and limited generalization.

#### Modes and Capacity for Response

Models, tools and knowledge can be disseminated through materials, and then training, or consultation, i.e., bringing in the appropriate skills and knowledge to be directly applied during the project process.

The first task is the development of models, tools and knowledge. PASITAM has already done a certain amount of relevant work. We have developed a two week analytical skills training program for AID and host country program and project personnel. Elements of this course are likely to be appropriate to training in the health area, with appropriate adaptation.

One of the continuing activities of PASITAM is the application of evaluation methodology to the assessment of impact of development projects. A panel of MUCIA experts has been studying the evaluation framework and training effort of AID. We are also studying the application of experimental and quasi-experimental methods to project and program evaluation.

The PASITAM-organized panel on rural development will identify MUCIA experts interested in the role of health in rural development, and will generate products of possible use to health professionals concerned with integrating their projects into larger rural development efforts.

The second task is choosing and implementing the mode of delivery of these models, tools and knowledge. PASITAM is producing Design Notes and Design Studies which address the kinds of questions listed above. We are also able to organize workshops and training activities in collaboration with clients. Finally, PASITAM can help identify consultants to serve operational needs.

These activities must fit the needs and response capabilities of health professionals and their organizations if they are to be of value to them. Getting collaboration in the adaptation and application of perspectives, skills, and knowledge is often more problematic than the production of the materials themselves. When knowledge is instrumental, the means of its application are as important as the knowledge itself.

PASITAM, as a catalytic agent within the seven MUCIA universities, has both the mandate and capability of identifying and mobilizing multi-disciplinary resources and linking them with development practitioners. But marshalling resources requires the prior identification of an agenda of action. The key needs at this point are to shape an agenda, to determine the persons and organization for whom it is most meaningful, to get to work on parts of that agenda, and then to link its products with the most likely users.

In this paper we have taken a first cut at stating the agenda, and identifying both the needed means of improved action and the possible user organizations. Our immediate aim is to get the reactions of a few experts within and without MUCIA. Depending upon their response, we expect to refine our own views and assumptions, as the basis for the

next step: knowledge-building activities within a sharpened agenda, and interaction with some potential users. Right now, the most important task is to assess the assumptions laid out in this paper. We invite your response.