

AGENCY FOR INTERNATIONAL DEVELOPMENT WASHINGTON, D. C. 20523 <b>BIBLIOGRAPHIC INPUT SHEET</b>		FOR AID USE ONLY ARDA <i>Batch 84</i>
1. SUBJECT CLASSIFICATION A. PRIMARY <b>Health</b> B. SECONDARY <b>General--Latin America</b>	NA00-0000-G302	
2. TITLE AND SUBTITLE <b>Health sector assessments; comparative summary report: Bolivia, Dominican Republic, Nicaragua</b>		
3. AUTHOR(S) <b>(101) Westinghouse Health Systems, Columbia, Md.</b>		
4. DOCUMENT DATE <b>1978</b>	5. NUMBER OF PAGES <b>153p. / 189p.</b>	6. ARC NUMBER ARC
7. REFERENCE ORGANIZATION NAME AND ADDRESS  <b>Westinghouse</b>		
8. SUPPLEMENTARY NOTES ( <i>Sponsoring Organization, Publishers, Availability</i> )		
9. ABSTRACT <p>Summarizes on-site evaluations of the Health Sector Assessment (HSA) process in Bolivia, Dominican Republic and Nicaragua. The HSA process was first used in Colombia in 1972 and then in Bolivia and the Dominican Republic in 1973-74. The basic objectives of this program were: to provide A.I.D. and other donors with a program planning document to guide grants and loans in the health sector; to improve the quality of health planning in the host country; to produce a document to be used as the basis for a comprehensive national health plan and strategy by the host country; to stimulate and institutionalize changes in the health care system sector-wide; to upgrade the skills of planners and administrators in the health sector; and to stimulate and improve coordination within the health sector generally and among A.I.D., host country governments, other donors, and private sectors in the host country. While the HSA process has been fundamentally productive, it has inherent limitations because of conflicting multiple-objectives, priorities and mandates. Existing HSAs may be usefully adapted to take greater cognizance of host country differences. Four models are presented, drawn from a spectrum of program planning possibilities. It is recommended that more attention be devoted to planning the choice of model or the model variant before starting the HSA. In addition to the comparative summary report, which contains the recommendations, a descriptive report has been prepared for each country visited.</p>		
10. CONTROL NUMBER <b>PN-AAF-579</b>		11. PRICE OF DOCUMENT
12. DESCRIPTORS <b>Bolivia</b> <b>AID</b> <b>Dominican Rep.</b> <b>Evaluation</b> <b>Health services</b>		13. PROJECT NUMBER
<b>National planning</b> <b>Nicaragua</b> <b>Project planning</b> <b>Sector analysis</b>		14. CONTRACT NUMBER <b>AID/afrc-C-1145 GTS</b>
		15. TYPE OF DOCUMENT

30 June 1978

Contract No. AID/AFR-C-1145 *GTS*  
Work Order No. 8

Submitted to:

Office of Health  
Technical Assistance Bureau  
Agency for International Development  
Washington, D.C. 20523

Submitted by:

Westinghouse Electric Corporation  
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REPORTS  
FOR THE  
EVALUATION OF  
HEALTH SECTOR ASSESSMENTS  
Comparative Summary Report  
Country Reports  
Bolivia  
Dominican Republic  
Nicaragua

TABLE OF CONTENTS

	PAGE
ACKNOWLEDGEMENTS	iv
LIST OF TABLES	v
ABSTRACT	vi
I. INTRODUCTION AND SUMMARY	1
Purpose of this Evaluation	2
Summary of this Evaluation	3
Issues	3
Background Factors	5
HSA Objectives	5
Recommendations	6
Spectrum of Program Planning Models	7
Process Variables	8
Methodology	11
Composite Summary and Analysis	12
Background Factors	12
Planning/Organization	14
Staffing	14
Implementation	15
Achievement of Objectives	16
II. FRAMEWORK FOR PROGRAM PLANNING PROCESSES	19
Issues	19
A. Conflicting Interpretations of the HSA	19
B. Conflicting HSA Objectives	21
C. Conflicting AID and Host Country Objectives	22
D. Host Country Commitment to the HSA	23
E. Approach to Data	24
Background Factors	25
Objectives	28
III. RECOMMENDATIONS	37
Alternative HSA Models	38
Process Variables	40
A. Scope of Work	41
B. Planning and Organization	42
C. Implementation	46
D. Follow-Up	50
E. Guidelines for HSAs	53
Study Follow-Up	54

TABLE OF CONTENTS (continued)

	<u>PAGE</u>
IV. COMPOSITE SUMMARY AND ANALYSIS	55
Background Factors	55
General Ambient Variables	55
Health Sector Plans and Priorities	56
USAID-Host Country Relationships	57
Staffing	58
Planning/Implementation	59
Host Country Participation	61
Logistics	64
Follow-Up	64
Budget	65
Achievement of Objectives	66
Unanticipated Outcomes	80
AID/Washington Program Priorities/Emphases	81
V. COUNTRY REPORT: BOLIVIA	85
Background Factors	85
HSA Process	87
Scope of Work	88
Start-Up	88
Implementation	89
Participant Evaluation of Outcomes	94
Participant Conclusions	97
Participant Recommendations	100
Evaluation Team Summary	101
VI. COUNTRY REPORT: DOMINICAN REPUBLIC	105
Background Factors	105
HSA Process	107
Scope of Work	107
Start-Up	108
Implementation	111
Participant Evaluation of Outcomes	117
Participant Conclusions	120
Participant Recommendations	126
Evaluation Team Summary	127

TABLE OF CONTENTS (continued)

	<u>PAGE</u>
VII. COUNTRY REPORT: NICARAGUA	131
Background Factors	131
HSA Process	132
Scope of Work	133
Start-Up	135
Implementation	138
Participant Evaluation of Outcomes	143
Participant Conclusions	148
Participant Recommendations	153
Evaluation Team Summary	153
VIII. APPENDICES	157
A. Methodology	158
B. Questionnaire	167
C. List of Interviewees	177
D. Financial Analysis	179

## ACKNOWLEDGEMENTS

The Westinghouse Health Systems team wishes to thank all of the respondents (in Bolivia, Dominican Republic, Nicaragua; at AID/Washington and the Office of International Health (OIH); and those contacted by telephone) for giving generously of their valuable time and thoughtfully answering our numerous questions. A special thanks to the Government Officials in the three countries who not only participated in the interviews, but assisted us in arranging other interviews with their compatriots.

Also a special thanks to the Public Health Officers in each of the three USAID Missions who provided us with many hours of their time answering questions, often beyond those of the interview and arranging for USAID staff assistance in scheduling interviews.

Finally, special appreciation goes to Dr. Ken Farr and Ms. Karen Lashman of OIH/DHEW for their technical guidance and assistance during the planning and execution of this study.

## LIST OF TABLES

<u>TABLE</u>	<u>PAGE</u>
4-1 HSA Objectives Identified by AID and Host Countries	67
4-2 Accomplishment of Objectives	78
4-3 Unanticipated Outcomes	80
4-4 AID/Washington Priorities and Emphasis	83
<u>BOLIVA</u>	
5-1 Respondents Views of the Objectives of the HSA	90
5-2 Positive Outcomes Identified by Respondents	95
5-3 Negative Outcomes Identified by Respondents	96
5-4 Factors Essential to Positive Outcomes	98
<u>DOMINICAN REPUBLIC</u>	
6-1 Positive Outcomes Identified by Respondents	117
6-2 Negative Outcomes Identified by Respondents	119
6-3 Respondent Opinions of HSA Findings and Recommendations	120
6-4 Factors Essential to Positive Outcomes	122
<u>NICARAGUA</u>	
7-1 Respondents Views of the Objectives of the HSA	134
7-2 Positive Outcomes Identified by Respondents	144
7-3 Negative Outcomes Identified by Respondents	147
7-4 Factors Essential to Positive Outcomes	150

## ABSTRACT

A Westinghouse Health Systems team of health planners has recently evaluated the Health Sector Assessment (HSA) process through field interviews of participants in three Latin American countries (Bolivia, Dominican Republic, and Nicaragua) where the Agency for International Development (AID) has conducted HSAs. It is concluded that the HSA process has been fundamentally productive. However, respondents in each country identified additional accomplishments which the process could have achieved. It was generally observed that the HSA process has inherent limitations because of conflicting multiple-objectives, priorities, and mandates. Respondents further observed that the existing HSA process may be usefully adapted to take greater cognizance of host country differences. Therefore it is recommended in this report that the HSA process be expanded to include four models drawn from a spectrum of program planning possibilities. Concurrently it is recommended that more attention be devoted to planning the choice of model or the model variant before starting the Health Sector Assessment. Also included in this report are detailed recommendations concerning the process variables generic to all HSAs and commentaries on the fundamental issues affecting HSA implementation.

In addition to the comparative summary report, which contains the recommendations, a descriptive report has been prepared for each country visited.

## I. INTRODUCTION AND SUMMARY

The Health Sector Assessment (HSA) process was first used in Colombia in 1972 and then in Bolivia and the Dominican Republic in 1973-1974. As described in the original guidelines issued by the Technical Assistance Bureau/Health of the Agency for International Development (AID), the objectives were:

- To provide AID and other donors with a program planning document to guide grants and loans in the health sector,
- To improve the quality of health planning in the host country,
- To produce a document which could be used as the basis for a comprehensive national health plan and strategy by the host country,
- To stimulate and institutionalize changes in the health care system sector-wide,
- To upgrade the skills of those responsible for planning and administration in the health sector, and
- To stimulate and improve coordination within the health sector generally and among AID, the host country government, other donors, and the host country private sector specifically.

The initiative for HSAs came originally from the Latin American Bureau of AID. The need derived from three principal factors:

- A general Congressional mandate for AID involvement in health programming,
- AID's limited experience in the health sector in Latin America, and
- A general lack of the information required for health program planning in countries where AID was operating.

AID envisioned the HSA as a major research, analysis, and planning effort to be conducted principally by the host country, with AID/Mission (USAID) technical assistance\* and financial support as required. The end

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\*Much of USAID's technical assistance was provided by staff of the Office of International Health (OIH) of the Department of Health, Education and Welfare, under an inter-agency agreement, as well as by AID/Washington staff, and consultants.

product of the HSA process was to be a program planning document containing a comprehensive assessment of the existing health situation in the host country (including health conditions; physical, financial, and human resources; and contributing socioeconomic, cultural, environmental, and institutional factors) and a strategy for AID/Mission interventions. The HSA was to serve as a mechanism through which host country needs and AID's mandate could be reconciled. Most importantly the HSA would help to identify and establish host country priorities for the health sector. The document and the process itself were to serve as vehicles or starting points for institutionalizing and improving health planning in the host country. The HSA was to be a long-range, on-going process and not a one-time, action-output effort.

This was a new program planning process for AID, and the first few HSAs, while designed to meet stated objectives, were also pilot efforts through which AID sought to develop a workable structure and procedures. It is the contractor's understanding that variations on the original HSA models have been applied more recently in five other Latin American countries, Jordan, and the Caricom countries, and that these efforts incorporate some of the changes recommended in subsequent sections of this study.

#### PURPOSE OF THIS EVALUATION

AID is now considering requiring some type of program planning process in all countries where health programs are to be started, re-directed or expanded. It is therefore looking at the HSA as one possible process to meet the requirement and is interested in determining how this process can be improved.

In October 1977, Westinghouse Health Systems was awarded Work Order #8, under the Indefinite Quantity Contract, by USAID to conduct a project designed to: "Improve Agency Efforts in Health Sector Assessment (HSA) by Evaluation of Previous Assessments."

The scope of work called for the Westinghouse evaluation team to review appropriate HSA documentation, conduct site visits in three countries to interview participants in past HSAs, analyze the effectiveness of the HSAs implemented, and to develop recommendations for improving the HSA process. The three countries chosen by USAID for on-site evaluations were Bolivia, Dominican Republic, and Nicaragua.

The purpose of this evaluation was to look at the processes through which the HSAs were executed and to propose ways of improving them. As such, the evaluation was to involve a detailed examination of objectives, planning approaches, methodologies, and constraints encountered in implementing the three HSAs. Achievement of objectives and outcomes were looked at to provide indications of the effectiveness of the process and method of implementation. Similarly, participants work was examined only to ascertain strengths or weaknesses of the process. No effort was made to verify actual outcomes or to evaluate the performance of any participant.

The designated project deliverables were to be a report containing descriptions of the HSAs in each country, a composite summary and analysis of the three HSAs, and conclusions and recommendations concerning the future implementation of the HSA process. All of these items are contained in this document.

#### SUMMARY OF THIS EVALUATION

##### Issues

The evaluation of the three HSAs revealed a number of issues involving AID's policy for Health Sector Assessments. These policy issues which need to be addressed by AID, will directly affect future HSA processes and outcomes.

- A. Conflicting interpretations of the HSA -- AID staff in Washington and the Mission differed in their views as to what the HSA was or should be. A fundamental lack of definition at the start of each HSA as to the nature of the HSA has permitted these differing interpretations. This affected the degree of commitment brought to the process, the scope of the effort, and the pursuit of the various objectives.

- B. Conflicting HSA objectives -- The HSA was designed to accomplish multiple objectives, from producing a USAID program planning document (the bottom line objective) to developing a comprehensive national health plan. Pursuit of the other objectives conflicted with the timely and efficient completion of the USAID document. On the other hand, that objective, which was tied to the AID funding cycle, imposed a severe time constraint which hindered the accomplishment of the longer-range objectives, such as institutional change. To attempt to accomplish all objectives required spreading resources so thin that no objective could be adequately addressed.
- C. Conflicting AID and host country objectives -- The objective of producing an USAID program planning document limits the HSA to AID's narrower interest. This, in turn, conflicts with the host country's broader concerns, for example of preparing a comprehensive national health strategy and plan. Similarly, tying the process to AID's funding cycle conflicts with the intent of creating changes that must occur within the host country funding cycles. Other conflicts are discussed in detail in Section II of this report.

A related issue is the choice of criteria for evaluating various aspects of the HSA. USAID and host country judgements of such elements as the adequacy of existing data or adequacy of existing national health plans were often opposed. Whose criteria or what criteria to use needs to be carefully negotiated to avoid unnecessary tension. The extent to which the standards of developed countries are applicable in countries doing HSAs is a fundamental question.

Finally, there is the issue of whether it is appropriate to ask a developing country to commit scarce resources to a planning process in the absence of such things as any guaranteed return for their investment, assurance of participation in the entire process, or the assurance of a project large enough to have impact on the host country health sector.

- D. Host country commitment to the HSA -- The principal issue here concerns the extent to which USAID should become involved in a broad HSA without some guaranteed commitment from the host country. The commitment would cover the timely provision of adequate resources and assurance of the institutionalization of a program planning process.

Of special concern have been the assignment of participants to positions outside the health sector, after the HSA, the failure to push the involvement of significant health institutions and appropriate government staff in the HSA, and the failure to implement the recommendations of the HSA.

- E. Approach to Data -- Data collection appears to have been a difficulty in all three HSAs. The reason seems to have been insufficient planning as to real data needs and feasibility of obtaining data. There is no evidence to suggest that the new data improved the outcome of the HSA to the extent that the effort of obtaining it was justified. Nor is it clear that the HSAs could not have been completed using existing data subject to improved analysis.

### Background Factors

The evaluation revealed certain background factors that existed in the three countries that could, at a general level, be used to determine the feasibility of conducting some type of program planning process, including an HSA. Some are given characteristics of the country which cannot be changed; others are situations or attitudes that are not constants. A model process should be selected based on analysis of those factors.

Those which emerged as most important to the HSA were political climate, resources - principally human and logistical/support services, institutional characteristics of health sector, and host country commitment to the HSA - in terms of level of government support, leadership, and staffing. Although this list is narrow, it reveals the essential issue to be resolved before starting an HSA. No doubt, evaluations of other HSAs, especially in regions other than Latin America, will reveal other background factors of major importance in starting HSAs.

### HSA Objectives

As noted, the HSA is a multi-objective process. The evaluation indicated that certain preconditions are necessary for the achievement of the objectives. For example, institution building requires a long-range effort and commitment of the host country to support the

new institutions. Improving the country's health planning capability requires government recognition of the need to conduct health planning. Coordination appears to be impossible without firm support from all participating institutions.

Many of the objectives require substantial resources if they are to be met. Clearly the HSA does not provide sufficient funding to address all objectives. An early analysis of host country capability to provide resources should be part of the model selection. Those objectives which appear most feasible and desirable from both USAID's and the host country's points of view should become targets for resources. Quantifiable outcomes should be spelled out for the objective. Some other objectives would be addressed, but not formally and with fewer resources.

#### Recommendations

Despite the problems encountered with the HSAs and the feeling that accomplishments could have been greater, the evaluation team concluded that the HSA is, with certain modifications, a viable and useful program planning process. The team was well aware that at the time the three HSAs evaluated were implemented, the process was new and mistakes were inevitable. (It is also understood that subsequent HSAs have already been modified, incorporating some of the changes discussed later; Guatemala is the most recent example.) Nevertheless, the current HSA model is clearly not suitable for all program planning needs and should be considered only as one model in a spectrum of alternatives. AID has already applied a number of other assessment models and this approach is appropriate.

As a backdrop to the specific recommendations, the contractor has outlined a spectrum of possible program planning processes. Some could be implemented under existing AID legislation and policy, others would require changes. An HSA could be structured as a variant of any of these.

## Spectrum of Program Planning Models

### Alternative I: Preparation of the USAID Program Plan Only.

This is the most limited model. It could be conducted as quickly and cheaply as possible, consistent with the quality of the end product and sufficient consultation with host country officials. It would be conducted by USAID, either in-house or through consultants, and it would be tied to the AID funding cycle.

### Alternative II: Preparation of an USAID Program Plan, with Selected Additional Objectives or Tasks

This model is likewise quite limited in scope, differing from the first only in the addition of one or more clearly defined objectives or tasks of special interest to USAID or host country. Examples of additional objectives would be formal training, or a limited household survey on nutrition. The work would be principally conducted by USAID, but would involve ongoing negotiations with the host country beginning with the added objectives. This model would be tied to the AID funding cycle.

### Alternative III: Preparation of an USAID Program Plan, with a Parallel Multi-Objective Health Planning Effort

This model, which would require AID policy and possibly legislative changes, addresses USAID's requirements for a program plan and the host country's and/or USAID's interest in using the process to achieve broader objectives. Involvement by the host country would be much greater, presumably with some sort of negotiated commitment. The USAID plan preparation would probably be a more extended effort, geared to the achievement of the long-term objectives. However, the program plan would still correspond to the funding cycle and would be primarily a USAID responsibility. The long-term objective activity would begin with the program plan activity but would not fall within the funding cycle. This would entail some funding commitment from AID

before a total program plan was submitted. Such funding would be focused and probably based on an early "windshield survey". Third country or U.S.A. training is a good example of an activity in this category.

Alternative IV: Preparation of a National Health Plan, with other HSA Objectives Followed by Preparation of an USAID Program Plan

This model would be similar to the current HSA with two major exceptions -- the bottomline objective is a comprehensive national health plan, from which the AID program plan would derive, and it would be carried out independently of the AID funding cycle. Quite obviously this alternative requires the greatest investment of resources and the most intensive involvement by the host country government, including involvement in the development of the USAID program plan.

A more detailed explanation of these models is given in Section III.

Process Variables

Process variables refer to the elements that make up a program planning effort. The manner in which they are addressed has a strong influence on the nature and scope of accomplishments and the effectiveness of the process. The variables are organized according to the principle stages of the HSA -- scope of work, planning and organization, implementation and follow-up. Recommendations address those variables which emerged as problems in the views of the respondents.

- A. Scope of Work -- The principal requirements in this stage are an assessment of the political climate and of likely host country commitment to any HSA process, selection of a suitable process, general definition of its content, preliminary scheduling and budgeting, identification of resource and data needs and availability, and negotiation of host country involvement.

Key recommendations are:

- Negotiate host country guarantee prior to undertaking the process;
  - Account for cultural and academic differences that can affect schedule, budget, and task completion;
  - Assess actual data needs and determine a viable approach to data collection and analysis.
- B. Planning and Organization: The evaluation team felt that this stage was, and is, the key to successful implementation of any program planning process. Adequate time should be allotted to planning and establishing methodologies. Those tasks should be completed before the work plan is begun. Key steps are definition of objectives and tasks (with quantifiable outcomes), development of a work plan, design of methodologies, laying the political groundwork within and without the health sector, staffing, team organization, management and administration, scheduling, and planning of training.

Key recommendations are:

- Lay adequate groundwork to ensure host country and multi-institutional support;
- Identify and recruit staff -- host country and consultants -- on the basis of formal criteria, not availability alone. Plan for longer consultant visits, necessitating few consultants with broad expertise in several health areas;
- Schedule start-up according to readiness not outside time constraints;
- Arrange a suitable location for HSA team and develop a structure which emphasizes subgroup coordination;
- Develop strong management procedures, especially with respect to supervision of task completion;
- Plan details of local and foreign training, as required;
- Develop methodologies with host country participants and jointly examining their applications and limitations;
- Provide adequate orientation, with clear documentation in both English and the host country language where possible;
- Provide AID/Missions with the technical assistance of an HSA expert throughout this period.

- C. Implementation -- This stage involves carrying out and completing the work plan, especially the data collection and analysis tasks, report preparation, translation, and distribution.

Key recommendations:

- Ensure availability of logistical support on time;
- Monitor data collection efforts closely;
- Provide adequate supervision;
- Involve host country participants throughout, especially in the analytic, strategy, and recommendation formulation steps;
- Prepare USAID report;
- Ensure host country completion of its report;
- Translate the USAID into host country language;
- Focus on the educational aspects of the process.

- D. Follow-Up -- The primary requirement is to sustain the momentum and continuity of the process, so that it does not become a one-time, immediate output effort. Activities fall into the categories of dissemination of findings and recommendations, implementation of recommendations, continuation and updating of planning activities, and evaluations.

Key recommendations:

- Publicize the HSA and its outcomes, consistent with political acceptability;
- Evaluate process and outcomes with involvement of participants;
- Provide follow-on educational activities for participants;
- Encourage implementation of recommendations;
- Provide follow-on loan;
- Support continuation and updating of plan and data;

- E. Guidelines -- Of particular interest is the matter of guidelines: What sort should be provided, whether they can be "cookbooked?" Guidelines need to be flexible so they can be adapted to country-specific conditions. This would seem to suggest that cookbooking is not suitable. However, there are many steps in a program planning process for which a general framework and approach can be developed, leaving the details to be worked out in-country.

Key Recommendations:

- Definition of objectives;
- Identify host country characteristics to be assessed for design of process model procedures;
- Develop checklist of content;
- Identify solutions to common problems and potential pitfalls;
- Identify steps in a plan development and alternative methodologies (including cost-benefit analysis).

Methodology for Evaluation of HSAs

After an initial review of selected documents in order to establish a background and framework for the HSA, the evaluation team prepared two questionnaires for use in the interviews. One version was designed for USAID participants, the other for the host country. The questionnaires contained open-ended questions organized around background variables, HSA processes by stage, participant evaluation of the HSA outcomes, participant evaluation of the HSA process, and their recommendations on ways to improve the HSA process.

The 66 interviewees included participants from AID/Washington, AID/Missions and each host country, as well as consultants, representatives of the Pan American Health Organization (PAHO) and OIH.

The data gathered through the interviews was tabulated and analyzed by country, then it was compared across the three countries. The intent was to describe, by country, the process used, identify the outcomes, identify factors influencing the process and the outcomes, and draw conclusions concerning the effectiveness of the process, the causes for what happened, and the possible ways the process could have been improved.

The analyses by country was then aggregated. The purpose was to see how the three HSAs were similar and different, the causes of the differences, whether any one was more successful than another, what were the common strengths and weaknesses, and what general lessons should be learned from them, (i.e., where an HSA is appropriate, what are feasible objectives).

The next step was development of the recommendations. While the evaluation dealt solely with the HSA, it was clear that no single process could be appropriate everywhere. Therefore, in developing recommendations, the contractor expanded on the scope of work to include: a spectrum of program planning models within which an HSA could be one alternative, discussion of certain policy issues and background factors that emerged during the evaluation and which are pertinent to the selection of an HSA model; and a discussion of the feasibility of current HSA objectives in terms of the conditions necessary for their accomplishment and their appropriateness to different models.

#### Composite Summary and Analysis

Following the analysis of data for each country, the evaluation team prepared a composite summary of the three HSAs, noting similarities and dissimilarities in outcomes and trying to relate those to like similarities and dissimilarities in the background factors and the process variables. The purpose, as stated earlier, was to draw conclusions from which recommendations could be developed. This analysis aided in identification of the HSA issues, discussed earlier in this Section and in Section II.

The analysis focused quite heavily on the problems of the HSAs, since the purpose of the evaluation was to identify how the process could be improved. The three HSAs evaluated were among the first such efforts, and therefore more difficulties were encountered than might normally occur. The team felt that the HSA is inherently a viable program planning process which, with modifications, would be appropriate to both USAID and host country health sector planning.

Following are highlights of the composite summary and analysis.

#### Background Factors

Background factors did not seem to have had any substantial effect on the process in terms of immediate outcomes, but do appear to have either encouraged or hindered changes over the long run.

Among the more important factors are political factors, existing health planning activities, and USAID - host country relations.

Where there was broad based political support for the HSA, the chances of sustaining the momentum of the HSA and of implementing recommendations was enhanced. Where support came principally from a single, politically strong and highly placed official, the HSA was certainly benefitted but only for as long as the official occupied a position of authority. The potential long-range impact of the HSA was jeopardized by reliance on one individual as the source of government commitment and support.

For the most part, existing health activities were a neutral factor. However, in one country the government had already prepared a national health plan and felt also that it had an adequate health planning capability. Its interest in the HSA was therefore tied primarily to the prospect of a loan. Because of its disinterest in the process itself and the absence of a follow-on loan, the long-range impact of the HSA was slight.

On the other hand, one other country was in the process of initiating some new programs at the time of the HSA, and it appeared that more importance was being attached to health. In this instance, the HSA was actively supported, and the long-range impact in terms of programming has been substantial. Of course, a follow-on loan was important in promoting those advances, and fortunately the HSA corroborated the directions in which the government was already moving.

In one country, long-standing anti-Americanism had a negative impact on the smooth implementation of the HSA. However, final outcomes do not appear to have been affected.

### Planning/Organization

A number of difficulties were cited. Start-up was slow and disorganized in the three HSAs. Many participants felt that planning of the process had been inadequate and that objectives and tasks were not well explained. Methodologies were developed ad hoc with numerous changes.

### Staffing

Human resources were a factor in principally two ways. First, was the unavailability of certain skills or areas of expertise. This contributed to gaps in the study and often to the failure of the host country team to produce a final document. Areas in which host country skills typically were noted as lacking were health planning, data analysis, strategy development, health economics, and sociology. Likewise because the HSAs were tied to AID funding cycles and hence had to meet a set deadline, USAID staff and consultant support often had to be selected on the basis of availability, and not necessarily expertise.

Second, was work norms in host countries. The implementation of the HSA was hindered by traditional work patterns such as a short work day (8am to 2 pm), a large number of holidays, and the holding of two or more jobs.

These factors probably did reduce both the effectiveness of the process and the achievement of certain objectives.

For the most part consultants were considered to have been assets to the HSA process, although some consistent concerns were voiced across the three countries. Some did not or were not able to collaborate adequately with their host country counterparts. Others were said to be unfamiliar with the country or the language. Their potential effectiveness was sometimes diminished by the short duration and, on occasion, poor timing of their visits. Disorganization within the teams and team politics also made working difficult for short-term consultants.

In no HSA can it be said that institutional representation on the team was as complete as desired, despite efforts to include all major groups in the health sector. For the most part the non-participating institutions did not express interest in the HSA. It is also true that the host country teams, two of which were set up as independent units, the kind of which was under the health ministry, did not pay adequate attention to their relationships with other government and non-government groups.

#### Implementation

Data collection and analysis posed difficulties. Often mentioned was the unavailability of some data, delays in obtaining data, and unreliability and incomplete analysis of data. While logistics did not surface as a major problem, team operations generally suffered from inadequate management and supervision. As a result of these kinds of problems, deadlines were rarely met.

Perhaps the major issue in implementation was the exclusion of host country participants from the analytic and strategy formulation phases of the HSA. Generally this occurred because the host country team did not complete the integrated, analytic reports USAID needed in order to prepare its program plan. As its submission deadline neared, USAID had to assemble their own team to get the report completed on time. The USAID team did use whatever host country documentation was available, and it did consult with host country officials. However, the analytic and strategy processes were isolated from direct host country participation because of the deadline pressure.

Two very common criticisms of the HSAs were USAID's choice not to translate its report into Spanish and the very limited distribution of the document among USAID and host country personnel. Aside from causing frustration to team members who never saw what had happened to their work, the impact of the HSA was considerably reduced because few people knew of the conclusions and recommendations nor were the data developed in the study available to them. Subsequent health activities could not

be related back to the HSA. (In one country there did seem to be a fairly high level of awareness of the relation between the HSA and the AID health loan).

Many participants expressed dissatisfaction over the absence of any follow-up to the HSA. They felt it should be an ongoing process, not a one-time effort. However, no one really was able to define follow-up nor to assign responsibility for it, except in terms of a loan. While the AID Missions said that they had never indicated loans would necessarily result, most participants believed they would. The one instance of follow-up involved a conference held for the purpose of disseminating information on the report to officials of ministries, other donors, and interested parties.

#### Achievement of Objectives

The HSA was intended to achieve multiple objectives, as summarized below:

- Preparation of an AID and donor program plan,
- Improved host country health planning capability,
- Institution building/improvement,
- Improved coordination (by AID and/or the host country with one another, other donors, other sectors, private voluntary organizations and the private medical sector),
- Attitudinal changes,
- Education (skills upgrading),
- In-depth knowledge of the health sector,
- Development of a comprehensive national health plan strategy.

Overall, it can be said that the HSA was able to attain results under all objectives except that of coordination. However, the general consensus is that substantially more could have been accomplished. It is only fair to note, however, that many of the objectives are long-range and slow in evolving, and final judgments as to success or failure would be premature.

In all cases the HSAs resulted in an AID program planning document, although in no case was it based on a final report produced by the host country, as was intended. Only one country produced such a report, and then six months late.

In two countries the AID/Mission reports were accepted by both AID/Washington and the host country, while in the third it was only partially accepted. It is worth noting that several participants indicated that the HSA, while intended to develop a program plan, in fact was used to justify already proposed projects.

Implementation of recommendations has been spotty; where AID has made follow-on loans some activity has been generated. To what extent the HSA was the catalyst of new activities, or simply reinforced existing trends was unclear.

Health Planning skills were increased by the HSA though the improvement seems to have been more personal than institutional. The degree to which health planning capabilities were improved by the HSA appears to be limited. As mentioned earlier, neither a national health plan nor a strategy were outcomes.

A number of new institutions were established or existing ones expanded as a result of the HSA or follow-on loans. In some cases they are functioning well and have achieved considerable authority. In others, they are really paper organizations.

Attitudinal changes were the achievement most frequently noted. The types of changes were greater awareness of health problems, a broader acceptance of new programs or approaches to programming, and greater interest in health issues. The question must be raised, however, as to the extent to which these changes have been institutionalized or are personal.

As indicated above, participants did feel they had gained a better understanding of the health sector. Many noted that the HSA has provided an opportunity for pulling together in one place for the first time the scattered information available on the health sector. At the same time, most indicated that there were still substantial gaps in the data base.

During and subsequent to the HSA, new programs and projects were initiated in all three countries, most with a rural orientation and directed toward the lower income groups. While it cannot be said with assurance that the HSA generated these developments, clearly it reinforced them. It could also be said to have furthered them indirectly, where the projects were supported by loans which were planned through the HSA.

## II. FRAMEWORK FOR PROGRAM PLANNING PROCESSES

### ISSUES

Certain issues emerged in the course of evaluating the HSAs conducted in the three Latin American countries. For the most part they concern program planning policy matters which need to be addressed prior to selecting, designing or implementing any program planning model. Some involve general policy, others relate to the selection and design of a specific model, given the conditions which prevail in a particular country. While these issues were derived from the HSA model, the evaluation team feels they pertain to all models.

#### A. Conflicting Interpretations of the HSA

Within AID--both Washington and the Mission--there were conflicting interpretations of what the HSA was or ought to be, its value, and its appropriateness to a particular country. As such, there were varying degrees of commitment to the HSA itself and its various objectives (see Table 4-1). The newness of the process and the multiplicity and scope of the objectives were confusing, and the purpose of undertaking such a large scale effort did not always seem clear. Participants saw the HSA as a legislative or bureaucratic requirement, and educational tool, an unnecessarily complicated effort to justify proposed projects, and/or a legitimate planning effort.

While this problem relates directly to the fact that these HSAs were the first implemented, it is also true that their purpose and methodology had not been clearly defined in advance by AID. There needs to be a broader understanding and agreement as to the purpose and nature of any program planning process prior to its implementation.

Related Subissues are:

• Planning vs. Justification

The stated purpose of the HSA is to produce a program planning document which gives recognition to host country desires and objectives. However, in the three HSAs evaluated, the HSA served to justify program already proposed. If the HSA has become or is likely to be used as a process to justify proposed projects or loans, then AID will need to develop some mechanism for ensuring that those independently proposed projects account for host country interests and are acceptable to it. More important, should scarce resources be devoted to implementing a major planning process that is not really "planning" anything? If it is a justification process, then it would seem more appropriate to narrow the focus of the HSA to that of developing a detailed plan for the proposed projects.

• Conflicting Evaluation Criteria

In some instances it seemed that AID respondents were more negative in their evaluation of the HSA process than were host country respondents, and that the two had substantially different perceptions of what were positive outcomes and what were not. To an extent the conflict results from AID's needing quantifiable results in order to justify its programs before Congress. Achievements which a host country recognizes as important often cannot be quantified, (such as attitudinal changes), or may not seem significant to outsiders, (such as verification of a health problem.)

In general, results in the area of health planning are hard to quantify, particularly over the short run. AID should be permitted to have and should apply certain flexibility with respect to this matter. Otherwise, it should probably not become involved with activities or objectives that cannot be quantified.

Related is the question of whose criteria should be used in evaluating such things as outcomes, capability of professionals, or adequacy of an existing health plan. In one country host country participants rejected what they felt to be disregard for their country's health plan, which to them implied that AID had found the plan inadequate and their capabilities weak. AID had not ignored the plan; staff had assessed it as inadequate for their needs. What criteria did AID use and how were they developed? Were they applicable to that country's situation, or was the plan in fact inadequate? How does the political cost of offending the host country or of losing its commitment measure against the benefits of AID's producing its own planning document?

#### • Compatibility of AID and Other Donor Objectives

Among the HSA objectives is improved coordination with donors. Again, achievement of this objective would need to be based on a correspondence of interest. Is AID willing to adapt its process so as to be useful to other donors and gain their interest?

#### B. Conflicting HSA Objectives

Table 4-1 lists the objectives of the HSA as currently stated. Based on the evaluation of three HSAs, there seems to have been conflicts among the objectives which adversely affected outcomes.

The bottom line is that the HSAs were efforts to produce AID program plans. At the same time, they were supposed to serve as major educational tools and as catalysts for change and development in the health sector, much of this to be achieved by having the host countries participate in the process.

If the principal purpose of an HSA was to produce a program planning document, efficient achievement of that objective probably was reduced by the efforts to implement other objectives. A planning document could have been produced in less time and at less cost, while still involving the host country adequately though in a different manner (It is also worth investigating whether the best possible program plans were produced, given the intense pressures and short time-frame in which they ultimately had to be prepared. The evaluation team did not try to make this determination).

On the other side, if the HSAs were truly meant to achieve other objectives such as training, coordination and institution-building, then those objectives were adversely affected by the need to prepare a planning document. That objective bound the HSAs to the AID funding cycle, which imposed time limitations inappropriate to the achievement of other objectives. The time constraint caused several other problems that no doubt adversely influenced achievement of objectives: staff sometimes had to be chosen on the basis of availability and not experience; flexibility to adjust to or take advantage of changing conditions was limited; adequate time to plan the effort was not available; time to accomplish long-range objectives such as institution-building or coordination was not available; and start-up occurred before the teams were ready.

The funding cycle constraint also tended to make the HSA a one-shot effort as opposed to the ongoing planning process. According to the guidelines, an HSA was to be the first step leading to institutionalized health planning.

Another conflict pertains to resources. The HSA is highly resource intensive, as currently structured. Each objective is major and could absorb all the resources of an HSA. Most are long-term in nature and optimally require sustained support. Dividing resources among all the objectives may lessen the possibility of successfully accomplishing some. Further, even while its objectives are worthwhile and may be accepted by all parties, the strain imposed by the HSA on both the Missions and host country governments may of necessity limit commitment and interest.

### C. Conflicting AID and Host Country Objectives

While at a general level AID and host country objectives appear to be consistent, level of interest, priorities and sub-objectives may differ. For example, a host country may be less concerned with the AID planning document and more interested in training opportunities less interested in coordination or institution-building and more interested in expanding its knowledge of the health sector. A country may wish to carry out a comprehensive HSA, rather than having it delineated by AID

This issue relates back to the earlier ones of AID flexibility and host country commitment. Is AID able to be flexible in order to accommodate host country objectives so that maximum commitment can be obtained, and is the host country willing to guarantee its participation?

A related subissue is:

• Future Benefits from the HSA

The HSA requires the host country to commit scarce resources in the hopes of a future loan which may or may not be forthcoming and may or may not constitute a significant percentage of its overall health budget. For example, AID may be asking a host country to commit several hundred thousand dollars on the possibility of a \$6 to \$10 million loan, a fraction of its overall health budget. Another donor may be offering \$40 million with no demands on resources.

Because of the requirement to get an AID programming document out, AID has often been forced to cut host country personnel out at the very stage during which they can learn the most - the analysis and document preparation stage. Thus even the educational benefit is lost.

The issue of future benefits raises difficult questions. Should AID be asking a host country to provide scarce resources without assurance of some substantive return i.e., a loan or at least the maximum possible education from participation? What are the political costs of not providing a loan? While legally AID cannot guarantee a loan, could it at least offer a grant? In general, to what extent is AID willing to be flexible in order to provide for host country benefits? If flexibility is not possible, perhaps AID should not initiate a full-scale HSA but should focus only on a planning document.

D. Host Country Commitment to the HSA

On the other side, in some cases results of an HSA may have been less than desired due to a lack of host country commitment and its failure to provide the resources agreed to. For example, in the three HSAs examined impact of the HSA was lessened because the final

reports were not disseminated by the host country. Time-consuming and costly delays were the result of host country governments failing to provide promised non-financial resources such as office space and vehicles. In all three, several participants were transferred to positions outside the health sector.

AID might consider examining to what extent it can or is willing to dictate terms or require host country guarantees for carrying out the HSA (or another program planning process). Should AID be investing health funds that may improve the human resource base of a country as a whole, but not specifically that of the health sector? Should there be some assurance that, at least for a time, participants continue working in the health sector?

While establishing conditions for the conduct of an HSA may seem politically unacceptable, it should be remembered that AID loans contain requirements, consistent with host country interests, and that procedures seem to be acceptable. This approach should be extended to the HSA process from which the loan would flow. Several respondents in fact noted with approval that AID can act as an agent of change primarily because it can specify preconditions.

#### E. Approach to Data

Although data collection is not strictly an issue in terms of AID policy, the difficulties with it were significant enough to justify recommending that AID specifically investigate how data collection should be handled. The assumption seems to have been that implementation of an HSA required collection of data, often a significant amount. In the Dominican Republic another situation prevailed. At the request of the Dominican government, AID funded a separate national survey. While much of the data was not needed for the HSA, the two somehow became closely linked, which caused considerable delays to the HSA. Once the HSA was over, support for completing the analysis of the survey data diminished and much of the data was never analyzed.

Several questions need to be explored. Is new data so much better that the time, resources and delays required to obtain it were justified? Did it result in different conclusions or recommendations or substantially increase understanding or knowledge of a country's health situation?

If the program planning process were continuous, major efforts at data collection might be justifiable. If it is to be one-time or of a short duration, then another approach should probably be contemplated. For example, instead of collecting new data, existing data should be gathered and carefully analyzed, which quite often has not been done. Deficiencies and gaps should be noted, and perhaps a collection effort funded as a separate future project. If new data has to be collected for the HSA, what is needed should be carefully identified and the effort kept as small as possible and scaled to be achievable in the time available.

Where there are serious problems with the information available in the country, then perhaps a major data collection effort should be undertaken prior to the analytical HSA.

#### BACKGROUND FACTORS

This section addresses certain factors existent in a country which will act as parameters within which a program planning process must be selected and then specifically designed and implemented. However, they will have to be assessed specifically for each country. Here they are treated generally:

##### A. Political Climate

Adequate attention must be paid to the political climate of a country as a whole, and within the health sector in particular, in advance of deciding what sort of process to implement, if any at all. For example, in the case of the Dominican Republic, where there was already heightened interest in developing the health sector and where the Secretary of the Health Ministry was favorably disposed toward an HSA, it was feasible to carry out an extensive planning process. On the other hand, it may

not have been feasible, as part of that HSA, to carry out the detailed analysis of the Dominican governmental structure and its impact on the health sector. Although the study produced interesting information and detailed accurately certain institutional problems, it was too sensitive for Dominican officials to release. Thus the value of the study was lost. That difficulty could have been identified in advance and the resources invested otherwise.

In one country, where the government's interest in the HSA was generated solely by the prospect of a loan (the anticipated size of which was considered insignificant), and where there was an existing plan felt to be adequate, political support was likely to be minimal. In such a case, the full-scale HSA may not have been appropriate.

Other kinds of political factors are: host country policy opposed to AID's program interest (Bolivia's opposition to family planning); personal interests or biases of people in positions of authority; absence of political support beyond that of a single high level official subject to transfer or fall from power; and the level of priority given to health or health planning.

#### B. Human Resources

It is important to assess realistically the level of human resources that can be and will be committed to the HSA. In a country where there is a scarcity of these resources and where the functions of government are extremely dependent on those few available, USAID should probably not propose a process which will remove those people from their jobs for long periods of time. That factor may mitigate against a full-scale HSA or may alter expectations with regard to host country participation. On the other hand, if there is interest in health planning, USAID may choose to conduct an extensive training program prior to an HSA and to use the HSA to build a new planning capability.

#### C. Financial Resources

For the most part, financial resources were not a major issue. The support provided by the host country most frequently was in the form of salaries and back-up services. Given the level of fiscal resources in most developing countries, AID should not count on much in the way of financial contributions. Despite that caveat, the experience in Nicaragua, where substantial host country funding was provided, suggests that a financial investment by a country can generate some long-range support for the HSA. AID might want to explore a means of getting more such funding where a country can provide it.

#### D. Logistical Support

Other resources include infrastructure, support services, housing, office space and other items that ensure smooth operations. In most HSAs host country government volunteered these kinds of non-financial resources. Too frequently they were neither forthcoming on time nor adequate, and AID Missions found themselves backstopping a lot. Quite often delays resulted which not only extended the process but frustrated participants. The potential availability of these resources and the probability of their being made available should be carefully estimated.

#### E. Institutional Characteristics

This refers in particular to the nature and organization of institutions within the health sector, as well as to the structure of the government as a whole. In the case of the Dominican Republic, it was unrealistic to hope to achieve much in the way of reorganization of the health sector, or even reorganization of the health ministry, beyond the regionalization plan proposed by PAHO and already being implemented. The government as a whole was highly centralized around the President and the Treasury Ministry, and no change in the ministry of health could be effective unless that structure was altered.

In Nicaragua, the changes of AID's achieving long-term changes were lessened by the fact that the Ministry of Health controlled only 10% of the health budget, whereas the Institute of Social Security controlled 80%. It is the Ministry of Health which deals with rural areas and public health and most of what AID wants implemented will have to go it. Unfortunately, it has the least resources.

#### F. Host Country Commitment

Host country commitment is a somewhat malleable factor, in that its level can be influenced by the prospect of a loan. Perhaps the important thing is to distinguish "real" from "practical" commitment. Given an HSA of a year's duration, with objectives that will take longer to achieve and require host country support, genuine commitment will be critical to sustain momentum. In Nicaragua, when the HSA process was completed in December before the Nicaraguans were finished, they were able to continue the process themselves because the government had funded the team. AID might want to explore possibilities of negotiating some kind of guaranteed commitment from a government where long-range objectives are involved.

The HSAs were affected by the existence of a highly placed host country official supporting them. In both Nicaragua and the Dominican Republic, Cabinet-level officials provided a strong impetus to implementation. However, when that official in Nicaragua left office, support for the HSA and implementation of its recommendations, was greatly diminished. In Bolivia, the official in charge had once been cabinet-level but was not so at that time, and he did not appear able to generate the desired interest and cooperation.

It seems, then, that involvement by a high ranking official is important. However, for more important is a broader or more institutionalized base of support, because of the likelihood of turnover in the upper levels of government.

#### G. Time

One aspect of this factor - the AID funding cycle - was discussed earlier in the Issues section. It can impose quite severe limitations. Host country governments may also have relevant time cycles, such as Five Year Plans. The flexibility or inflexibility of these factors can be a determinant in the selection of the type of HSA to implement and the objectives to pursue, since some may not be achievable within the allotted time. Time in other aspects can be manipulated somewhat. For example, the way in which manpower is scheduled can affect time factors, as can planning and organization. The time available and required for a task must be realistically assessed and adjusted until the two correspond.

#### H. Health Sector Attitudes, Structure and Activities

For the most part, this factor was neutral. However, it can become a negative factor or a missed opportunity, if it is not addressed realistically. In Bolivia, the failure to deal satisfactorily with the existing health plan was a negative, while in the Dominican Republic, AID was able to capitalize on an active health ministry. In Nicaragua, the failure to deal more directly with the institute with the largest budget -- the Social Security Agency -- was probably a missed opportunity.

### OBJECTIVES

In general it can be said that there were positive outcomes with respect to most objectives of the HSA, but that accomplishments were neither as many nor as in-depth as was expected or desired. The evaluation

team agreed with participants that more could have been achieved in terms of some objectives, but found that others did not seem to be feasibly as primary points of focus. Nonetheless, all objectives are worthwhile and should be part of the program planning process, even if not individually singled out.

This section contains the contractor's evaluation of the feasibility of each of the different objectives (listed in Table 4-1) and the pre-conditions that should be present if they are to be pursued.

As a general principle, more clearly defined, quantifiable outcomes should be set for each objective.

#### Objective A. AID Program Planning Document

With respect to AID's objective of producing a program planning document, it seems clear that the HSA is a reasonable tool. It is also likely that with proper planning and implementation (see Process Variables), the host country team would produce, within the time limits imposed by the AID funding cycle, a analytic document which could serve as a basis for the USAID document, as the HSA guidelines call for. If the host country is to be involved in the planning process, then it should be so in all stages, especially those involving analysis and formulation of recommendations. To ensure that type of participation may require more formal training of host country participants and more time. Unless AID is prepared to make that investment, and to commit itself to full host country participation, it would probably be better to prepare the plan in-house, in consultation with host country officials.

#### Objective B. Improved Host Country Health Planning Capability

With respect to improving health planning capabilities, while the results were not particularly positive, the evaluation team felt that the objective is appropriate, with certain changes in procedure.

Host country team members need to be involved not only in the research and data collection stages of the HSA, but also in the analytic and strategy planning stages where their greatest skill needs are. Further, members should represent the institutions which are (or would be) involved with health planning so that improvements of their skills will also mean institutional improvement. Formal training programs should probably be set up, and team members selected in part on the basis of the skill needs of health institutions, which training would address. Finally, the host country must be allowed and supported in its efforts to continue the HSA process through to the end.

While initial positive steps can be taken within the time frame of a year that seems to have evolved as the average for an HSA, this objective can be most effectively pursued through an ongoing process. Attention should be paid, perhaps through the loan, to sustaining the momentum initiated under the HSA.

#### Objective C. Institutional Changes and Reform

The HSA did result in the creation of a number of new, or the expansion of some existing, institutions, one subobjective under institutional change. For example, two health planning units and a nutrition coordination unit were set up. However, it appears that these units were often the result of a subsequent AID loan requirement. The HSA itself may not be able to induce the level of government commitment necessary to sustain their continued operations. Nevertheless, most participants seemed to feel that the creation of institutions during an HSA is an important first step and should not be downplayed.

Perhaps where this subobjective is contemplated as part of the HSA process, it should be linked to the leverage of a future loan. In addition, to host country government might be encouraged to make a commitment that team members be assigned a health institution after the HSA. Finally it seems essential that this objective be pursued only where the government is truly willing to support the institution and to give it some authority.

Very little was accomplished in the area of reorganization of the health sector or of health institutions, other subobjectives. They may be impractical, since generally organizational deficiencies are systemic to all of government and cannot be addressed by reform of just one institution or any part of it. Further, the principal problem is often political, something a U.S. agency would be hard pressed to deal with under any circumstances. Finally, organizational changes require time, not always available with the HSA. Even if the HSA were ongoing, this still might be an impractical subobjective for the other reasons mentioned.

It is suggested that unless there is a strong indication from the highest levels of government that it is interested in reorganization, and the prospect for change seems realistic, this subobjective should be assigned a low priority.

#### Objective D. Improved Coordination

While this objective is clearly desirable, it may be unrealistic to hope that the HSA can improve coordination among certain segments of the health sector. For example, in trying to improve coordination between the private sector and the host country government, the HSA is bucking a tradition of independence between the public and private health sectors and trying to overcome longstanding animosity and distrust.

To achieve multi-sectoral coordination is also extremely complicated, again because of the structure of host country governments and the major organizational changes that multi-sectoral coordination implies. Even coordination within the governmental health sector, where the HSA can act as an initial impetus, may not be worth formally pursuing without some strong indication of governmental commitment. Too often the coordinating units set up under HSA were regarded as temporary and prefatory units.

Nevertheless, some procedural changes could be instituted that would lessen the possibility of the HSA acting as a divisive force. Where a team consists of numerous study groups, these must be well-coordinated, with frequent interaction and collaboration and sharing of information

and reports. Greater representation from the various health institutions and other agencies which deal with health matters should be pushed. (This was attempted, but proved unsuccessful in Bolivia). Achieving that representation may require more initial groundwork selling the HSA process and more support from the highest levels of government.

With respect to improving coordination with donors it is probably difficult for an outside third party like AID to promote better cooperation between other third parties and the host country. That coordination probably has to be generated from within the host country government. Some respondents did, however propose that a suitable objective for AID in the HSA is to help the host country develop a methodology for coordinating and directing the aid of donors. Perhaps that is the proper objective to pursue in terms of host country and donor coordination, and it fits neatly with the objective of improving planning capabilities.

The document produced by AID could serve as a means of coordination donor activities if it were expanded to include donor interests and priorities such as urban services or infrastructure. Currently, these are excluded from the HSA since they are not primary interests of AID. AID should investigate ways of expanding its efforts through collaboration with or participation by other donors so that a timely, comprehensive plan can be developed. Such a plan would have the added advantage of providing the host country government with a vehicle for coordinating donor aid.

Finally, briefings or news releases could be instituted as a way of sharing and disseminating information to donors.

The objective of coordination also applies to AID itself, with respect to its dealings with other donors, with private voluntary organizations, and with other sectors within AID. Here, too, there was little success.

#### Objective E. Attitudinal Changes

Achieving attitudinal changes within the health sector appears to be a very appropriate objective. Almost every participant indicated increased awareness of various health issues and program needs, of new

concepts such as the multi-sectoral approach, and of the nature of his country's health problems. However, most changes in attitude appear to have been personal as opposed to institutional. Further, unless a participant achieves or is already in a high-level position, his changes in attitude may not result in program or policy changes.

Institutionalization of attitudinal changes may best be accomplished by greater involvement of officials in policy-making positions and of technical staff in health agencies. Certainly the follow-on loan or grant is important, since it enables a person to put recommended changes into practice.

#### Objective F. Education

Education is the objective with which most participants concurred and where interest was greatest, but where the greatest disappointment was felt. Most participants spoke of education in terms of skills training or upgrading and learning how to carry out new tasks. Again, achievement seems to have been personal rather than institutional.

The HSA should be a very effective tool in upgrading skills that will improve institutional capabilities within a short period. First, however, this objective must receive more formal attention. Skill needs must be carefully assessed so that relevant training programs can be set up. Goals need to be clearly established. Consultants should also focus more specifically on training, in addition to accomplishment of tasks. All steps of the process should be reviewed and explained, i.e., how a methodology for a task is developed. Activities and reports should be reviewed and critiqued with participants, in process and after completion. Education must be viewed as a continuing process, which will mean adequate follow-up, e.g., refresher courses. Where possible, it would be interesting to review with participants the longer-range outcomes of the HSA activities and the reasons for them.

One educational subobjective was to promote changes at universities, for example, new public health courses. Universities in all three HSAs were only marginally involved because of the traditional separation of universities and host country governments, as well as the general anti-Americanism found on campuses. Fostering curricula changes may be difficult under these circumstances. However, because of the capabilities found at universities and their role in training future professionals, AID should explore new approaches to including them.

#### Objective G. Develop In-depth Knowledge of Health Sector

Most participants expressed a strong interest in the objective of developing an in-depth knowledge of the host country health sector, particularly in countries where a good data base did not exist. Many were partially dissatisfied with the results achieved, principally because they felt the data were not of good quality, because there was still significant gaps, or because not all the data were analyzed. There was also a feeling that not much new information had emerged (with some notable exceptions). However, participants saw a major accomplishment that for the first time the many pieces of scattered information were pulled together in one document and often reanalyzed so that they were usable.

With a more systematic approach to data collection, analysis and dissemination, better results can be obtained (specific recommendations are contained in the Process Variables section). It seems inappropriate, however, to undertake any major data collection efforts, unless a broad HSA is contemplated which would afford adequate time and resources to achieving that goal.

Finally, AID should look carefully at the question of just what categories of data and what level of quality are required for adequate program planning. Several participants felt that more effort was expended than was necessary or justified by the results.

#### Objective H. Develop a National Health Planning Strategy

While the results with respect to this objective were not judged to be satisfactory, it should be an achievable outcome. First, however, AID must be committed to achieve it, then adequate resources and support, principally training, must be provided. This objective seems particularly suitable in light of the related objective of improving health planning capabilities. It also seems clear that an HSA is an effective tool in promoting certain strategies such as preventive health care and facilities or the use of low cost rural health care delivery systems (see below)

One issue that must be dealt with more adequately is that of existing health plans and their relation to an AID program planning process. This is an issue which USAID should investigate, since ignoring an existing plan can generate resentment and reduce host country commitment.

A subobjective of AID/Washington was to have the teams develop strategies based in part on cost-benefit analyses of alternatives. Several participants felt that no methodology was available for doing this in developing countries. At present a capability does not seem to exist, although part of the problem may be a lack of familiarity with the approach. AID should consider developing guidelines on various methodologies and developing an in-house capability to work with Mission staff and consultants on methodologies.

#### Objective I. (Building AID's Image)

This objective is mentioned in parentheses since it was and is not a formal one. However, AID's image certainly was affected by the HSAs. While it is inappropriate to make that an explicit objective, more could be done to enhance AID's image through the HSA. Certainly ensuring that people know of the outcomes is important. Publicity for the HSA could be contemplated (that would have the added advantage of building support for the recommendations). Finally, USAID should make clear its roles and responsibilities in the HSA, as distinct from those of the host country.

### Additional Objectives

The evaluation of outcomes in the three Latin American HSAs revealed few unanticipated results that indicate potential new HSA objectives. However, several new programs were initiated directly or indirectly by the HSA, and it seems that there is some merit to host country adding project development as an objective.

Planning actual projects would be an excellent complement to the national planning effort of the HSA and could generate additional host country commitment. Even better would be to fund a small health planning related project as part of the program planning process. The evaluation team noted that lack of commitment was a major factor limiting the accomplishments of the HSAs and feels that there needs to be some tangible, immediate benefit that derives from the process. This is particularly necessary where a loan may not be forthcoming. AID should explore the possibility of making a small grant in conjunction with the HSA that would allow host country participants to plan and implement a project. It would relate to the health planning efforts -- e.g., development of some aspect of the data collection system, a new data analysis program, development of an in-house training program. While the purpose of the HSA is to plan what projects should be implemented, the evaluation team believes that a small health planning project need could be identified and the benefits that would accrue from funding it could be important to the overall HSA.

### III. RECOMMENDATIONS

The evaluation of the three HSAs indicates that in concept the process can achieve worthwhile results and can address multiple objectives successfully. However, disappointment was expressed by many participants that more was not accomplished, and the contractor concurs in that judgment. Nonetheless, it is recognized that the team looked at three of the earliest HSAs all of which were based on one model - a year long, comprehensive planning effort conducted jointly by the host country and the AID/Mission. Of necessity the processes were formative and exploratory, mistakes inevitable. Many lessons were learned, and the contractor is aware that improvements have already taken place with respect to the HSA model (i.e., Guatemala) and that, in addition, other models have been tried (in Haiti and Jordan, for example).

It is the contractor's opinion that AID should retain a formal program planning process. AID should continue its current flexible approach under which the current health sector assessment process is but one possible model in a spectrum of program planning processes. With modifications, the existing HSA process is an alternative that will have validity in certain countries. However, there are clearly situations to which it is not appropriate, and therefore other alternative processes should be available.

This recommendations section consists of two parts. The first outlines four alternative program planning models. As examples from the spectrum of possibilities, the models are presented in general terms; each would have to be adapted to meet the conditions unique to each country in which program planning is contemplated.

Some of the premises on which one or two of the alternatives are based may not be possible given current AID legislation or policy. Despite this, they have been suggested because it is understood that AID is contemplating changes to its program planning process and because, with respect to the HSA model itself, the changes could produce substantial improvements.

The second part deals with "process variables", the steps and elements through which the program planning model is implemented. Although this part relates directly to the HSAs investigated, recommendations have broader application, since some or all of the elements would be part of other models.

One caveat should be noted. The contractor looked at only one type of program planning process -- the HSA -- conducted in three countries within a single region -- Latin America -- which has distinct characteristics. It is likely that AID will be conducting HSAs or other models in regions very different from Latin America. Modifications will no doubt be required to adapt the models and process variables to those other conditions.

#### ALTERNATIVE HSA MODELS

##### Alternative I: Preparation of an USAID Program Plan Only

A USAID program plan would be prepared by USAID staff and/or consultants in collaboration with appropriate host country personnel. The plan would address the the HSA objectives as possible projects rather than as components of the program planning process. This model would be tied to the AID funding cycle, place the minimum burden on the Mission and host country government, and require the least funds, time and other resources. It could be used equally well to provide justification of proposed projects or to design detailed plans.

This model would be suitable in countries where there is minimal interest or commitment by the government to program planning, where resources are especially scarce, where background factors do not favor attempting the more difficult HSA models, where adequate data and health planning exist, or where a country has already been studied adequately.

##### Alternative II: Preparation of an USAID Program Plan with Selected Additional Objectives of Tasks

This model is similar to the first, except that a limited number of additional objectives or tasks would be added. They would be selected on the basis of negotiations with host country officials. The criteria would be the probability of accomplishment, adequacy of resources, and compatibility with the AID funding cycle. The relative involvement of USAID and host country staff would also be negotiated. Program planning work would be principally AID's

responsibility; the host country would participate in add-ons. This model depends heavily upon the negotiation portion of the process. It would work as a prolonged detailed negotiation and discussion process between key USAID representatives and key host government representatives.

This model would be applicable in countries where there is a strong directional preference, but still limited interest in health planning. It is also probable that such a country would have limited resources which did not match its interest or directional preferences. A capability in health planning is not required since the output will be largely by USAID and training of host country nationals could be an initial negotiation item. The HSA as it was conducted in Haiti is close to an example of this model.

#### Alternative III: Preparation of a USAID Program Plan, with a Parallel Multi-Objective Health Planning Effort

This model is designed to reconcile the need for a program planning document tied to the AID funding cycle and the desire to use the process to achieve the various HSA objectives which should not be constrained by a time factor. USAID plan preparation would take place over a longer period time, but within the funding cycle, in order that it can support the pursuit of other objectives. The plan would be primarily USAID's responsibility. The parallel activities would be independent of the funding cycle, and could involve anything from the development of a health planning capability to selected longer-range objectives such as extended training or institution-building. They would be negotiated with the host country. The purpose of tying the accomplishment of other objectives to the program planning document would be to capitalize on the staff and consultants involved in that process, to get host country input into that process, to meet host country interests in other objectives, and to provide host country participants with real-life project -- involvement in an actual program planning process. Both AID and the host country would commit resources, AID perhaps funding the parallel effort through a grant.

This model might be appropriate where AID has to produce a program planning document, and a host country is interested in longer-range objectives and willing to commit substantial resources. It would also be appropriate where there is some health planning capability and a strong interest to expand it.

#### Alternative IV: Preparation of a National Health Plan, with Other HSA Objectives, Followed by Preparation of a USAID Program Plan

Comparable in scope to the current HSA, this model has as the bottom-line objective the preparation of a comprehensive national health plan and strategy. To this task can be added any other objectives. The

plan would be developed outside the AID funding cycle, though with its own deadline, probably dictated by the host country. The USAID program plan would follow from the host country plan. The model would require greater attention to coordination with other sectors and donors, than the other 3 models.

This model would require the largest investment in resources. Because of the expanded time frame, and cost, it would also require a more definite commitment from the host country. It would be most appropriate in a country in which is interested in developing a health planning capability or a health plan and which has adequate resources for such a large scale effort. It would also be suitable in an area where politically the U.S. must work very closely with the host country and not appear to be dictating anything to it. A review of host country conditions and of AID policy, general and country-specific, would determine which, if any model, is most appropriate. It would also indicate which among the overall objectives might best be pursued. However, no matter which objectives become the specific focal points of the planning effort, all should be addressed to the extent possible.

#### PROCESS VARIABLES

This section deals with process variables, those elements of the health sector assessment process whose treatment will determine in large part the outcomes of the process. The variables are grouped according to the major stages of the HSA: scope of work, planning and organization, implementation, and follow-up. A separate section on guidelines is included at the end, since those were of special concern to AID. The various elements encompassed by each stage are listed below it. Recommendations address those elements which emerged as problems in the HSA evaluation.

Regardless of the model selected, three principles should always be applied. First, to the extent that it has been agreed to, host country participants should be involved throughout. If USAID must meet a deadline and has to complete a task internally, it should still support the host country team in completing that task, even though it may duplicate USAID's independent effort.

Second, institutionalization should be a theme that underlies all activities. Each time a task is planned, consideration should be given to designing it to maximize the potential for long-term changes or improvements.

Third, because health is affected by a wide range of factors, from diet to housing to cultural norms, health programming should be multi-sectoral. Therefore, program planning processes need to be multi-sectoral, and that approach should be encouraged as much as possible.

#### A. Scope of Work

The stage in which and AID/Washington and Mission team determines what type of program planning model is most appropriate, based on background factors, resources and host country interests; selects a model, generally defines the content of the study; identifies resource needs and availability; estimates preliminary budget; prepare a preliminary schedule, and negotiates host country involvement.

##### Elements

- Selection of participants, host country and AID, for preparing the scope of work
- Assessment of the degree and nature of host country interest/commitment
- Negotiation of host country participation
- Identification of content of study
- Identification of information and resource needs and availability
- Preliminary scheduling and budgeting

An essential part of this stage will be negotiations with the host country concerning the nature of its commitment and involvement, and the resources it will provide. AID should explore means of obtaining a guarantee for the timely delivery of those resources. AID will need to conduct a careful and sensitive assessment of both the country's political climate and of the feasibility of its commitment. It is recommended that the host country be extensively involved in the scope of work.

The duration of the scope of work should be long enough to allow time to conduct all tasks thoroughly. In particular, since data was an issue in each HSA, the scope of work should focus on:

- assessing exactly what data is needed to conduct an HSA
- determining the availability or usefulness of existing data
- determining the difficulties of obtaining new data
- determining whether substantial improvement in information will result from new data and is worth the investment

Resources likewise need to be carefully assessed: what can and will the host country bring to the HSA process?

Scheduling will need to account for different cultural and academic backgrounds which will affect attitudes toward meeting deadlines and implementation of tasks and for the kinds of problems likely to arise in developing countries. In general, a year should be sufficient for a broad HSA; other models may require less time. In the event that a major health survey such as that conducted in the Dominican Republic is contemplated, more time may have to be added. In a country such as Bolivia, where a lesser amount of data collection was contemplated, the HSA time could be reduced. In general, the optimal time required to complete a task should be assessed, and if sufficient time cannot be made available, the task should be redefined accordingly. Relating tasks and time requirements realistically will be a key job in the early stages of the HSA.

#### B. Planning and Organization

As evidenced by the problems encountered in implementing the three HSAs studied, this stage is perhaps the most critical to the successful and efficient conduct of any program planning model. If adequate time is taken to plan and organize the process in detail and to ready the team for the work, then the tasks should proceed smoothly and on schedule.

## Elements

- Planning
  - Definition of objectives and final inputs, with quantified outcomes
  - Definition of tasks and methodologies
  - Development of a resource utilization plan
  - Development of a plan to assess and to build political constituencies
  - Development of evaluation plan for process and outcomes
  - Final schedule and budget
  
- Staffing
  - Development of selection criteria and procedures
  - Identification of needs and resources
  - Institutional representation
  - Team leaders (management credibility and capability)
  - Consultants (development of selection criteria such as knowledge of the host country, experience in human relations, group dynamics teaching experience and language capability)
  - Selection procedures
  - Duration of positions (part time versus full-time, short-term versus long-term)
  - Job descriptions
  - Timing of availability
  
- Team Organization
  - Team location in the government
  - Relations with team, the host country, and AID
  - Team management/supervision
  
- Start-Up
  - Background orientation
  - Training of participants (timing, nature, location and duration)
  - Logistics (office space; office equipment, support staff, transportation, administration)

- Host country participation definition -- scope, extent, content areas, and involvement of high level officials
- Data assessment -- health sector needs, availability, scheduling and coordination with other groups
- Outline of documents -- bibliography compilation and review

A key job in the planning and organization phase will be laying the groundwork for the Health Sector Assessment. A major thrust should be to build ties with and among participating organizations and individuals and to obtain their support and cooperation, especially with respect to data and implementation of recommendations. The tasks and roles of all institutions and individuals should be clearly identified.

Staffing should be based on formal selection criteria. While skills and experience are desirable, their lack may be handled through training. Perhaps more important, especially in terms of institutionalization of improvements, is institutional representation. As many sectors as possible should be included, with extensive involvement by members of health agencies. The extent to which team members are representatives of their institution must be clarified to avoid conflict of interest.

To maximize benefits to the health sector, the team should involve staff from health institutions as much as possible. Optimally these should be technical level staff, since they are more likely to remain within their field than higher level political appointees.

In selection of technical coordinators for the teams, particular attention should be paid to their management capabilities. Supervisory tasks should be made clear. Team leaders should be full-time. To the extent possible, all participants should be full-time, rather than part-time and should not work at other jobs while involved in the HSA.

Consultants should be fluent in the language of the country in which they are to work, have substantial knowledge and sensitivity to that country, be sensitive to local conditions, have expertise in human relations, possess

teaching experience, and have knowledge of group dynamics and human relations. It is desirable that they serve for periods longer than one or two weeks. Since it is costly to field a large team of consultants for longer terms, it may be necessary to find individuals with breadth of experience who can cover more than one area of expertise. Relationships of consultants with AID and with host country should be carefully defined and negotiated with the various HSA participants.

In a country where the human resource base is quite weak and AID desires to undertake a full-scale HSA, extensive training of participants prior to the HSA may be required. This should be done at the beginning of the process, with follow-up as necessary throughout.

Location, organization, structure and management of the team are all key ingredients in an HSA. The team should probably be located outside of any particular institution, especially when the health sector is multi-institutional. However, it is essential that it maintain close relations with all the relevant institutions within the health and other sectors, since an overly independent team can cause further fragmentation and reduce support for future changes.

While structuring a team into a series of study groups is a logical approach, it is vital that thorough and formalized coordination be maintained and that each group be aware of what the other is doing.

Orientation should cover overall objectives of the HSA; clearly define the expected outputs and the relation of the HSA to development of the country as a whole; define the roles of the various participants; and provide a clear explanation of the methodologies to be followed and of the schedule and deadlines.

Another step in this stage is to outline the final document so that it will be available for guidance to team members from the beginning of the process. However, AID should be cautious to use it only for guidance and not as an absolute.

One of the most important tasks in this stage of the HSA is the development of methodologies for the actual work. A major cause of delay has been the absence of methodologies or of individuals who could direct team members in developing them. To enhance the educational aspects of the HSA it would be advisable to include team leaders and participants in their preparation. Particular attention should be paid to methodologies for analyzing and comparing alternatives.

The general HSA guidelines will need to be modified so that they are country-specific. All documentation should be available in English and the language of the host country.

In the HSAs evaluated a number of major problems consistently appeared in the early stages:

- Start-Up Problems
  - Difficulty identifying objectives
  - Difficulty identifying resources
  - Conducting negotiations with the host country
- Absence of guidelines for HSA
- Difficulty in obtaining a technical coordinator or health planner
- Lack of HSA experience in the Mission

Possible options are to:

- Develop a permanent, core expert HSA staff in the government (e.g., OIH), capable of continuing long-term participation in any country during the HSA start-up period;
- Develop a contractor resource to provide long-term temporary technical assistance to OIH and AID during HSA start-up periods;
- Develop and maintain a special consultant pool (by region) of persons specifically knowledgeable and experienced with HSAs; contracting on an as needed basis;
- Bring the USAID/Mission public health officers (by region) back to Washington for an intensive course in implementation of the HSA process, to be conducted by OIH.

### C. Implementation

The broad categories which fall under this stage include task completion; research; data collection, tabulation and analysis; and report preparation, translation, and distribution.

## Elements

- Team Functioning
  - Team management and supervision
  - Coordination
- Administration
  - AID/Mission and AID/Washington support
  - Logistics
  - Host country support
- Host Country participation
  - Publicity
- Data
  - Collection
  - Tabulation
  - Analysis
- Report Preparation
  - Integration of information
  - Develop national perspective
  - Formulation of conclusions
  - Formulation of recommendations
  - Formulation of strategy
  - Formulation of priorities

For the most part no administrative problems were indicated, other than pay policies, red tape and some logistical problems. One pay issue which needs to be resolved concerns salaries of host country participants. In the Dominican Republic, participants received a salary from the institution in which they had been working and in addition a salary from AID. While this motivated participants, it also generated jealousy and antagonism on the part of those people not receiving the extra salary. It also caused a conflict of interest for the participant who felt a need to still be a representative of the former employing organization. From the three HSAs evaluated it is unclear what the best policy is, and this should be looked into.

Logistics were usually handled smoothly, and no major (work stopping) problems arose. Those which did arise usually involved the failure of the host country to provide support as promised. The recurring logistical problem involved office space. Particular attention should be paid to assuring the adequacy of office space. A Mission should probably build into its schedule and resources a certain flexibility to backstop when the host country fails to provide support on time. AID can use its experience in logistics support to teach host country participants these skills.

Supervision and management proved to be somewhat troublesome in all three HSAs. Team coordination and leaders should be full-time, selected not just on the basis of technical skills, but also for their management and supervisory experience. Particularly important is an ability to develop work plans and methodologies for the HSA tasks and to train participants in those processes. In general the leadership must emphasize education of team members. Among the other tasks to which they should pay special attention are coordination -- with subgroups and other institutions, workload distribution, team cohesiveness, sharing of information developed by subgroups, monitoring of deadlines, and facilitation of interaction between consultants and team members.

As indicated earlier, the issues of data and information collection and analysis are of major import to the HSA. If a large amount of data is to be collected (as with the national health survey in the Dominican Republic), perhaps a staging system could be developed, e.g., all the data could be collected at the same time, but analyzed according to needs. Data collection itself could also be staged. This will ensure that data needed for the HSA will be available on time.

The key elements account for when planning the data analysis are availability of human resources and computer facilities; an adequate budget; host country participation; and assistance in integrating the data analyzed. Training may also be necessary. Careful attention should be

paid to insure that data collection and analysis correspond to the existing host country information systems and are linked closely with appropriate institutions. Planning should cover future dissemination of the data and include the preparation of formal system for doing so.

Adequate time should be allotted in this stage for the host country to complete its report and USAID to develop its from their document. More than likely USAID staff will work closely with the country team on the report preparation. Close collaboration must take place between USAID and the host country government in the formulation of USAID strategy and recommendations. The USAID document should be translated and distributed as soon as possible, preferably by USAID.

Because of the problems in past HSAs with this stage, special procedures and techniques may have to be worked out to ensure timely host country completion of the desired report. It should be made clear from the beginning exactly what is expected of team members and when it is due. If there is no tradition for preparing analytic reports, technical assistance will have to be available. Adequate coordination and dialogue must be maintained with those institutions and groups which will be affected by the recommendations. This will help ensure realistic recommendations and build a base of support. Close monitoring of work to ensure meeting deadlines will be necessary, particularly with team members holding outside jobs.

Particular attention should be paid to the educational aspects of this phase. Possibly more time should be allowed in this period than would normally be required in order to enhance the educational objective. In particular, there should be a focus on formulation and analysis of alternatives and development of priorities, two areas of weakness in past HSAs.

Preparation of the USAID document will ideally follow only after the host country document is finished. As to the USAID document, it is advisable to open up that process as much as possible to representatives of the host country government. This increased visibility can enhance the creditability and acceptability of USAID recommendations.

Translation of the USAID document is absolutely essential, and it should be disseminated to participants and other members of the host country government who can use it. It would be useful to translate any backup reports (especially the analytical portions) that are considered particularly good. A plan for report distribution must be worked out and agreed to in advance with the host country government. The past procedure of sending it to high ranking officials in the host government and having them distribute it has not worked. USAID should therefore be responsible for report translation and an item ought to be included in the budget for this task. The host country should be encouraged to distribute the report broadly in the health sector.

Where possible, it would be beneficial to publicize the HSA process and in particular the recommendations. However, this should be negotiated with the host country government, since the results may be politically sensitive.

#### D. Follow-Up

Past HSAs have tended to be one-time efforts, a deficiency noted by many participants. Follow-up involves four aspects: dissemination of the results of the study to various groups; continuity of the planning process; evaluations; and implementation of recommendations.

#### Elements

- Debriefings for participants and other interested parties
- Outcomes
- Process
- Publicity

- Continuity of Process
  - Update data
  - Update analysis
  - Update conclusions
  - Institutional responsibility
  - Conferences
  - New studies
  - Update plan
  - Applicability for other tasks
- Training
  - Evaluation
  - Outcomes
  - Process
- Loans
  - Briefing
  - Timing

Several participants felt that it would be extremely useful and educational to have a debriefing at the end of the HSA to review the work and comment on its effectiveness. Some went beyond this and also said there should be periodic conferences for participants to go over their present work and to provide refresher courses or new skills as necessary. These could be linked to periodic evaluations, as discussed below.

Debriefings might also be held for government officials in various agencies involved with health matters, for Private Voluntary Organizations (PVOs) or other donors, and other interested parties. Presumably these groups will have been involved all along, and they should be informed of the completion of the project and its content. The debriefings are yet another way to encourage implementation of the findings. Debriefings could be combined with publicity as discussed earlier.

Continuity of the HSA process was important to many participants, who felt the HSA should be part of normal operations and not one-time. Certainly in terms of achieving objectives other than the planning document, much more probably could be accomplished if the HSA were ongoing. However,

a long-term HSA raises difficult questions for AID. Would AID want to be able to commit resources to an HSA over a long period of time? How often should it be updated? What should be the host country's responsibility for updating or maintaining the process? What is AID's?

It seems realistic to assume that the host country is not going to undertake responsibility for comprehensive updating. If USAID is interested in updating, it should expect to provide some resources, both human and financial. If in fact the HSA has served as a useful planning process and the country does not have the resources to continue updating the plan, they it would seem a waste of AID's money not to support process continuity.

One aspect that the host country probably should be responsible for is updating data. One advantage to planning and conducting the data collection and analysis with host country statistical institutions is that there is much more of a chance of institutionalizing the data effort and of its being updated.

Continuity can also be fostered by a loan. Many of the outcomes cited in past HSAs related to the subsequent loan, which reinforced the recommendations by either funding projects or making certain requirements for change a precondition for the loan itself. In Bolivia, the negative response toward the HSA can be attributed in large measure to the failure to provide a loan.

Evaluations while an important step in their own right, will also contribute to continuity and additional education. Evaluations would look at outcomes and at the process -- what troublespots occurred, whether they could have been avoided, how they could have been avoided, and so forth. Not only would the information be of use in future evaluations, but if host country participants take part, it should serve as a valuable learning experience.

The evaluations should look at what has happened to the document: have host country participants been able to use it? The evaluation team was unable to evaluate whether or not host country participants would have used the document had it been translated and made available. Evaluations should be institutionalized in the HSA process from the beginning.

## E. Guidelines for HSAs

The early HSAs were done without written guidelines. The early guidelines were developed from the experiences on those HSAs. Since the first guidelines, in 1974, there have been several revisions, some of which have been done by different units in AID than the originating office. The guidelines have not been widely used in any of the past HSAs.

### Elements

- Objectives of AID
- Procedures
- Content
- Production
- Output

Guidelines should focus on procedures rather than content. Essentially, they should provide a framework around which individual program planning processes can be designed, applicable to a particular country. Thus general checklists would be appropriate, for example, of possible areas of expertise, of planning or management tasks, or of follow-up techniques. Content could be addressed in this way as well. Also useful would be general flow-charts covering the various steps in a process and their relationship to one another. For some aspects of the process models might be helpful as guides, for example, possible ways of organizing the team, different outlines for the reports or formats for data analysis.

Because of the problems which the design of methodologies, data analysis and report preparation caused guidelines might be prepared to cover these tasks. Again the focus would be on procedures.

A number of sets of HSA guidelines were issued in the past, not always in accord with one another. It would be advisable for AID to develop one set of guidelines which would govern all HSAs.

Finally, since one specific objective of the HSA -- and presumably a tacit objective of other processes -- is coordination with other donors it would be worthwhile developing guidelines with them.

## STUDY FOLLOW-UP

As with any evaluation of a process which occurred several years earlier, there will be a number of gaps in the information which call for additional work. This section lists briefly the areas which the evaluation team felt needed further investigation. In addition, it lists certain steps which AID could take to improve the HSA or other program planning processes.

### Additional Studies

- Coordination. Responses to queries concerning the causes of the failure to improve coordination in the health sector yielded little useful information. A compilation and analysis of successful coordination approaches used elsewhere could become a useful guide to AID in the pursuit of this objective.
- Develop and analyze techniques for negotiating host country guarantees of support for a program planning process. Such a study might result in certain guidelines or a training course for USAID-PHOs.
- Compile a reference source of alternative means of improving or promoting institutionalization of activities and changes in the health sector, for use in program planning.
- Identify, on a regional basis, the country-specific factors likely to affect future HSAs.

### Additional Tasks

- Develop guidelines for program planning model selection and for choosing variant HSA processes.
- Train expert core group in program planning either AID staff, OIH staff, or through a contract with outside resources.
- Evaluate Guatemalan HSA to determine effectiveness of HSA process changes implemented there and to determine if there are different response patterns when assessing an HSA recently completed.

#### IV. COMPOSITE SUMMARY AND ANALYSIS

This section summarizes the significant aspects of the three health sector assessments, noting both similarities and differences in processes and outcomes. HSA objectives (see Table 4-1) have been used as the framework for examining both planned and unanticipated outcomes.

By nature an evaluation such as this tends to focus more on the negative than on the positive aspects of the subject being studied, since the intent is to identify problems and recommend solutions. In general, however, the three HSAs studied were considered to be successful efforts, despite somewhat more limited results than were desired and a number of problems. Problems were to be expected since the three HSAs were among the first in an evolving process. They were, in a sense, pilot efforts which by definition will provide a number of number valuable lessons from their weaknesses

##### BACKGROUND FACTORS

A number of background factors were examined with respect to their effect on the HSA. These included general ambient variables (such as political, social economic, and cultural factors and personal interests), the existing state of the health sector (health activities, health planning and the political priority accorded health) and USAID-host country relationships.

##### General Ambient Variables

Political factors were an important consideration in all three countries. In Bolivia, where large regions of the country were underpopulated, there was strong opposition to family planning, and USAID's interest in including family planning in its project document was strongly opposed. In the Dominican Republic, health was receiving increasing attention from the government. The HSA itself was favored by a high ranking

official close to the President. Likewise, in Nicaragua the HSA was supported enthusiastically by a high ranking official close to the President. While initially the HSAs benefitted from these ties, over the long run in one country, the team's reliance on one person weakened the effort. When he left office, there was really no other source of political support. In the second country the same situation occurred, but support had been broader initially, and so the official's departure was less significant. Based on these experiences, it would appear that over the long run too close a tie to one key individual can prove to be a weakness, especially in light of the frequent turnover among officials.

A second political/cultural factor in Nicaragua also has a partially negative influence. Existing anti-Americanism led to distrust of the USAID/HSA team and at times resulted in less cooperation from the Nicaraguan team than would have been desirable. It should be noted, however, that officially the government was in favor of the HSA.

Personal interests both helped and hindered the HSAs. Important impetus was given to the processes by highly placed individuals, without whose backing the HSAs might have proceeded more slowly, as mentioned above. However, as noted above, too much dependence on a single person can be a weakness. Similarly, as happened in one HSA, opposition from or strong opinions or biases by a highly placed individual can subject the HSA to undue pressures.

#### Health Sector Plans and Priorities

Existing host country health planning activities can be both a plus and a minus. While for the most part they are positive or neutral, in the case of Bolivia they resulted in a touchy situation in one respect. Bolivia had recently produced a national health plan which officials there believed to be good. They also felt that the country had an adequate health planning capability. To an extent they saw the HSA as a duplication of their own planning process and were therefore less enthusiastic about and committed to the HSA than might have been the case in a country with no plan or planning capability. The situation was further complicated by USAID's feeling that the plan was not useful for the purposes of the HSA as it lacked a detailed strategy and analysis.

Perceptions are bound to vary because of different planning methodologies, practices and objectives. Situations such as this will require an early effort of finding means of linking existing activities to new needs to the benefit of both. It is important that future AID efforts fit into the existing health sector framework, at the same time that framework should be flexible enough to respond to new and positive activities.

#### USAID-Host Country Relationships

USAID and host country relations affected HSAs in two countries. In one, particularly close relations existed between Mission staff and host country officials, and this rebounded to the benefit of the HSA. In another existing relations were not as good and affected cooperation between the team and the Mission. However, that situation probably did not affect the final outcome of the HSA so much as the smoothness of operations.

#### Staffing

Although there were general criteria for staff selection in all three HSAs, time factors tended to mitigate against their application. The intent was to choose host country team members who had skills needed for the areas to be studied in the HSA and who could represent certain key institutions in the health sector. Those selecting the staff also tried to identify people of whom they had personal knowledge. While many AID/Mission and host country respondents felt that host country participants lacked sufficient experience or pertinent backgrounds for the HSA, at the same time they recognized the participants as the best available. Major weaknesses related to analytic skills and experience in preparing an integrated and analytic report. Consultants, because they were to work with the teams, were to match the same skill areas or to fill in any gaps. Additionally, they were to be fluent in Spanish and knowledgeable about the specific countries or Latin America. Frequently, however, availability became the dominant criterion for the selection of any participant.

Finally most teams had difficulty finding people in certain disciplines -- health economics, sociology, anthropology, health planning, biostatistics, and health management.

With respect to institutional representation, in one country members came primarily from universities. The Secretary of Health did not want health ministry staff participating for several reasons: staff would be evaluating their own work; a fresh view of Ministry operations would be helpful; and the requisite skills were not always available. However, the Ministry was to cooperate closely with the study, and was also represented to an extent through the team leader, a former Secretary of Health.

In a second country, members primarily came from the different health organizations. In neither country were there representatives from other sectors, although they were invited. (It was unclear how actively broad representation was pursued.) In the third country most public health institutions were represented, as were representatives of all major health-related sectors; for example, finance, housing, and the national planning office. This multi-institutional approach proved impossible to sustain consistently and involvement by these other groups proved difficult to maintain.

In two countries no donors were directly involved, although efforts were made to include them. In one there was continuous participation by PAHO in one portion of the HSA.

It is possible that more institutional representation might have led to greater collaboration and more support for the recommendations and their implementation. However, this does not seem to have been a primary factor. Because most teams operated independently, members did not truly represent their institutions. The real problem was inadequate attention to consult with, notify, and otherwise involve institutions and win their support. In each country a decision was made to set up a largely independent team, not allied with any institution (other than for administrative purposes). The intent was to avoid having the teams co-opted by any institution and thereby forced to make certain conclusions or recommendations.

This approach has merit. However, without institutional attachments the teams worked in isolation and were unable to generate the institutional support necessary to achieve and sustain changes.

Some respondents were critical of consultants. Some comments were that they did not contribute technically to the process, did not speak fluent Spanish, were not familiar with the countries, and did not collaborate adequately with host country participants. Based on these comments, adequate knowledge of the host country and of its language and good human relations are important criteria for consultants.

On the other hand, a number of consultant respondents noted factors that they felt detracted from their ability to perform adequately. Foremost was that most assignments were short-term. Second was the timing of their availability, which did not always coincide with team needs. Third, their tasks were not always well-defined. Fourth, occasionally consultants had difficulty fitting into teams that had been working together for some time in which roles and methodologies were well-established. Fifth, in one instance, team politics and the general political climate led to considerable friction between consultants and host country team members. Finally, some team disorganization and lack of coordination, especially during the early stages, did not permit team members always to take full advantage of consultants.

#### PLANNING/IMPLEMENTATION

In all three HSAs start-up proceeded slowly and seemed somewhat disorganized. The primary problem seems to have been that planning of a number of aspects of the HSA, management, scheduling and data collection and analysis, and logistics, among others, was not sufficiently effective. Many host country participants cited an apparent lack of clearly defined work plans or methodologies and inadequate direction or guidance. It proved impossible to resolve this contradiction, but the extremely lengthy start-up times (often four months or more) and number of negative comments about start-up indicated some problems with respect to direction,

guidelines, and methodologies. To questions on orientation and briefings, many respondents said there had been none or that the tasks, desired outputs, and plans had not been adequately defined.

A number of problems were noted with respect to the implementation of the work scope. Most respondents said there were major difficulties with data collection and analysis. This was one of the weakest areas of the HSA process. The primary reasons given were: an unrealistic assessment of what was actually needed and what could be obtained within available time and resources; insufficient people and skills to do the work; and low ability to do data analysis, from tabulation through interpretation.

In one case, analytic difficulties were compounded by a lack of the computer facilities necessary for analyzing the tremendous volume of data generated by a national health survey. The survey had been added to the HSA at the request of the government. While funds came from another source, the survey became linked with the HSA, even though much of the data was not relevant. Unfortunately the time and resources needed to complete the survey were underestimated. It was an addition beset by a wide array of complications: a national election mid-way through data collection, computers that were not available, an attempt to hand-tabulate the considerable amount of data needed for the HSA in a very short time, inadequate funds, etc. (It was not until this winter, some three years later that the data were finally tabulated, by the U.S. Bureau of Census in Washington, D.C.).

A number of problems affected team operations throughout the implementation period. First among these was weak coordination among subgroups. In all three HSAs the subgroups were described by respondents as operating independently of one another. Secondly, team leadership and supervision were not always strong enough, allowing personal friction to get out of hand, schedules to slip, and the organization to break down. Methodologies were said to have developed on an ad hoc basis, and were subject to frequent changes which delayed the entire process. A need for technical assistance with methodologies development was frequently noted.

One factor which affected the functioning of the teams was the part-time involvement of some members. In Latin America, it is common for professionals to hold more than one job. Therefore many participants were unable to work full-time on the HSA. It appears that the bulk of the work often fell on a few willing team members.

#### Host Country Participation

In general, host country participation in all three countries came to a fairly abrupt end as USAID's deadline neared and it became imperative that the Missions start writing their HSA document. Though these were to be based on host country reports, in none of the three countries did the host country teams finish their reports in time. While subgroup reports were available they had not been integrated into one comprehensive analytic report. The host countries recommendations and priorities were usually missing from the process at that point.

The team in one country produced a descriptive summary, but the Mission could not use it as a basis for its planning document. The pattern was for the Missions to assemble their own writing teams to produce the final reports. Using the data and reports from the host country subgroups and their own consultant reports, and collecting information as necessary, they sequestered themselves in USAID quarters for periods of about a month to prepare the final document.

The final Mission HSA report contained descriptions of the findings of the various subgroups, an integration and analysis of information, development of a strategy, and recommendations for loan projects as well as host country programs. To the extent that the document was based on various subgroup reports, it could be said that the host country provided input, though they did not participate directly in the formulation of AID strategy and recommendations. In addition, in one country there was frequent consultation with USAID team members with regard to the recommendations and findings. The team leader communicated the various alternatives to the health ministry, and in fact, is said to have "sold" the secretary on the idea of low-cost rural delivery systems. In the others the mission-writing teams seem to have written their final report with relatively little contact with host country officials at that time.

Host country participants almost unanimously claimed that they had not been involved in the analysis and the final report preparation. They felt host country points of view were not adequately represented or in one case, misrepresented. Many felt that they had been deprived of an educational opportunity.

Once prepared, the final report was submitted to Washington for review. Generally only the mission public health officer and one or two other Mission staff members were involved. For the most part, AID/Mission personnel did not find the reviews as useful as they would have liked. Once approved, the document was transmitted back to the AID/Mission, usually with requests for changes. Once those changes were made, the report was ready for printing and dissemination.

It is with respect to translation and dissemination of the report that the most frequent criticism were heard from host country participants. In no case was the final USAID document translated into Spanish. In one country the USAID strategy chapter was translated, but most host country participants did not find it useful without the supporting chapters. In addition, it was not entirely consistent with their government's priorities which made the supporting chapters even more desirable for understanding.

In another country there was apparently a misunderstanding as to who was to translate the document. Since most host country participants did not read English, USAID's report, even when available, was not useful. In any event, very few host country participants remember receiving copies, though the Missions say many were sent out.

Respondents were asked whether they would have used the report had it been translated and distributed, many indicated that they would. Even now, many respondents said it was the most comprehensive document available to them as a reference source on the health sector. The Bolivian HSA is now being translated.

It is not entirely clear why the report distribution was so limited. It appears that most copies went to the Secretaries of the Health Ministries who held them because of allegedly sensitive and critical material. However, many participants questioned the actual sensitivity of the reports. They felt all the information was already available somewhere. The HSA reports simply pulled it all together in one place.

One result of the failure to disseminate the report is that many respondents say no relationship between the HSA process and health activities generated by USAID after the HSA. They felt the HSAs had little impact in their countries. A case in point is the Montero project in Bolivia. While the basic project was proposed prior to the HSA, to a certain extent the specific project was an outgrowth of the HSA in that the site was selected and some planning carried out during the HSA. Nevertheless, only two host country respondents linked the Montero project to the HSA.

Although improved coordination within the government health sector, as well as with the private medical sector, donors and private voluntary organizations, was an HSA objective, the process was unable to significantly further this goal in any country. The isolation of the teams was noted previously. In two countries the health institutions, public and private, were not really consulted about their priorities, interests and constraints. It is also true that when attempts were made to involve these groups they often chose not to participate. However, in one case a number of institutions had requested a meeting with the team in order to learn what was happening with the HSA. While that request was honored the team subsequently did not follow up on that expression of interest.

Whatever the situation, active support for the HSA and its recommendations was not much in evidence in two countries. In the third, the recommendations coincided with emerging government activities, so they were backed. In addition, the follow-on USAID loan provided a certain impetus and continuity.

## Logistics

Logistics, often are problem in comprehensive studies of this type, were generally handled smoothly. The most common problem was office space -- usually the responsibility of the host country government. Either there was a delay in obtaining the space, or the space was inadequate.

In one country two additional logistical problems were noted: a delay in providing the transportation for survey interviewers resulted in a lengthy delay in the survey; and delays in paying team members which caused temporary unrest. In another country, field visits by team members had to be limited due to very limited government funds.

One reason logistics went smoothly is that all three Missions backstopped when problems occurred. In fact, very few criticisms were heard with respect to AID/Mission support.

## Follow-Up

There was little follow-up in any country after completion and distribution of the host country government of the report. One interesting instance of follow-up did occur in Nicaragua. The AID/Mission and the head of the Nicaraguan team jointly planned and held a conference in Chinandega, a rural city. The purpose was to gather representatives of all the major health care institutions and present them with the document to alert them to its contents. The conference was seen as a way to gain support for implementation of the proposed USAID loan. Unfortunately the type of support USAID was looking for could not be generated through one conference and while everyone thought the conference good, its impact was minimal.

In a sense a loan itself can be considered as follow-up. It is important to note that in Bolivia and Nicaragua, the loan or grant activities in the health sector which occurred after the HSA were rarely linked to the HSA by host country respondents. In Bolivia participants felt very disappointed that a loan did not emerge immediately after the HSA, since they clearly believed this would be the case.

## Budget

One aspect over which there was a divergence of respondent opinion between host country and USAID officials concerned the budget. For the most part, USAID participants felt that the budget was adequate, some even saying it could be reduced. The one exception was in the Dominican Republic, where the national survey had been conducted. Clearly there was not enough money to carry it out.

Most host country participants, on the other hand, felt that the budgets were not adequate and that had more funds been available, more could have been accomplished.

In general, the budgets seemed adequate, but poor planning and organization and inefficient implementation resulted in waste. For example, the evaluation team felt that host country staff were often hired well before they could be sufficiently used.

It was impossible to obtain an accurate financial picture of each HSA, particularly because of indirect costs such as the salaries of OIH and AID/Washington staff, as well as their travel expenses which are drawn from AID/Washington budgets and do not show in Mission records. Nevertheless, some interesting information did emerge concerning the manner in which funds were handled in each country. The three systems are summarized below. Additional details may be found in Appendix D: Financial Analysis.

- In the Dominican Republic USAID covered the cost of all its operations and logistical support and provided salaries for non-government Dominican participants. Salary supplements were available for government and other employees working on the HSA. The Government of the Dominican Republic continued to pay the salaries of government employees and agreed to provide logistical support, principally office space, vehicles and clerical staff. Because the HSA was to be a Dominican effort, AID funds were transferred to the government and administered by a Dominican administrative coordinator.
- In Nicaragua, AID paid for much of the logistical support for the Nicaraguan team as well as for a major portion of the technical assistance. It also funded, under a separate contract, a nutrition study done by a third agency INCAP (Instituto Nutricional de Centro America y Panama). Salaries of the Nicaraguan team members were paid by the government, which also provided logistical support.

- In Bolivia, USAID did not have to provide as much logistical support since the Bolivian team members used their own offices. Because the Government of Bolivia considered their work on the project to be part of normal operations, they did not receive funds beyond. USAID also provided funds for participant travel to the interior of the country, as well as for U.S. consultants.

#### ACHIEVEMENT OF OBJECTIVES

HSA objectives are presented in Table 4-1; they were compiled from the guidelines, AID policy statements, and conversations with AID officials involved in planning the HSA. The bullets indicate which objectives were held by the various parties - AID/Washington, AID/Missions and the three host countries (the coordination objective is subdivided by Mission and host country, since each had its own linkages with the various segments of the health sector). The information was derived from participant responses to a question concerning their understanding of what the HSA objectives were. Host country objectives were identified by host country participants, USAID's objectives by USAID participants. The information in the table reflects the opinions of respondents and does not necessarily reflect official government attitudes.

TABLE 4-1  
ACCEPTANCE/NON-ACCEPTANCE OF HSA OBJECTIVES

OBJECTIVE	Com mon to All	AID/W	AID/M	Bolivia	Dominican Republic	Nicaragua
A. AID Program Planning document as requirement for loan	•					
B. Improved Host Country Health Planning capability		•	•		•	•
C. Institution-Building/Improvement		•	•			
D. Improved Coordination:						
(1) AID and Host Country		•	•			
(2) Private sector and AID M and HC		•	•	N/A	N/A	N/A
(3) Host country government health sector		•	•			
(4) Other sectors and Mission		•	•	N/A	N/A	N/A
Other sectors and HC		•	•			
(5) Donors and Mission		•	•	•		•
Donors and HC		•	•			
(6) PVOs and Mission		•	•	N/A	N/A	N/A
PVOs and HC		•	•			
E. Attitudinal changes in host country	•					
F. Education (skills upgrading)	•					
G. In-depth knowledge of health sector		•	•		•	•
H. Development of national health planning strategy including host country document from HSA		•	•		•	•
I. Justification of investment health sector		•				
J. Cost benefit analysis		•		N/A	N/A	N/A

Before discussing achievements, it is worth noting a methodological problem in this part of the evaluation. First there is no standard against which to measure accomplishments. In particular, host country and AID criteria, as discussed in the issues section, are very different. Second, it was impossible to verify exactly what had and had not been achieved. Third, it is perhaps unfair even to look at achievements, given how new the HSA process was, and since many accomplishments will take years to realize.

Nevertheless, the evaluation team felt that it had to address accomplishments as one indicator of the effectiveness of the process. As a general observation, the team agrees with the overall assessment that there were some achievements under most objectives, and with the general sense that there could have been many more.

Given the difficulties outlined above, the contractor's purpose in reviewing accomplishments was to identify the areas in which more could have been achieved and why more was not, without getting into what specifically could or should result. The recommendations address the procedural weaknesses that contributed to limited accomplishments. It is left to the planners of each HSA to define specific goals.

#### Objective A: USAID Program Planning Document

In each case, the HSA resulted in an USAID program planning document, but these were not based on an analytic host country report containing strategy and priorities as called for in the HSA guidelines. Nevertheless, they were based in part on host country subgroup reports, and host country officials were consulted. While host country recommendations were included in many subgroup reports, no priorities were set and the recommendations were not usable.

Except in Bolivia, where the family planning section of the report was opposed by the government, the government and most participants seem to have accepted the content of the AID documents, including the recommendations.

Two criticisms of the AID documents were voiced with some frequency. The first is that the document really not a program plan so much as a justification of proposed projects. The second that the plans were not based on an analysis of alternatives.

#### Objective B: Improved Planning Capability

Under this objective are several subobjectives. The first is "improved skills," defined as institutionalized skills improvements within the health sector. In the opinion of the evaluation team, this was not achieved in the Dominican Republic, primarily because the health ministry, including the planning unit, was not directly involved in the health sector assessment. While there was some improvement in the health planning skills of participants associated with the assessment simply because they were not involved through the process, many were not then and are not now involved in health planning.

In Nicaragua, team members were drawn from a number of health agencies. Since most had little health planning background, their planning skills were upgraded. However, many currently are not working in that field, thus lessening the impact of their training.

In Bolivia, team members also came from health organizations and are currently working there. However, many participants said they learned little, especially since they were involved only in the data collection and research stages, the areas in which they already had substantial experience. Nor did they feel they had benefitted from their involvement with consultants, who were in and out too fast. The consultants' short-term contracts clearly did not allow them both to complete their tasks and to interact adequately with host country counterparts.

The second subobjective was to "develop/improve planning methodologies." While respondents in two countries indicated that this outcome had been achieved, their opinion is hard to justify. In neither case was the kind of report that indicates the existence of sound planning methodology'

produced, nor did they participate in the key analytic and strategy formulation. While the team members said they had to develop their own methodologies, that process does not seem to have been systematized and hence repeatable. Nor was there any formal review of their work through which they could learn or evaluate the strengths or weaknesses of the procedures they followed.

Another subobjective was the "preparation of a national planning document." In no country did the document prepared by host country team members constitute a comprehensive, strategic plan nor did the HSA develop the information necessary to prepare one. The Dominican documents were described as primarily descriptive; they never were integrated and contained little analysis. The Bolivia health sector assessment team had little interest in producing an analytic document, since Bolivia had already a national health plan. To an extent, the team viewed the assessment as a duplication of its planning effort. While the Bolivians produced a list of 161 recommendations, these were not prioritized and could not be considered a plan. While many of the Nicaraguans were satisfied with the document they produced, some judged it was weak analytically. However, the Nicaraguans did produce a comprehensive 5 volume HSA document with prioritized recommendations although it was done 6 months after USAID's HSA. The USAID documents was never really intended to serve as a national plan, since USAID's interests are much narrower.

It does not seem that the subobjective, "improve/create institutional planning capability" was well achieved. The evaluation team felt, aside from the problems discussed in the previous sections, there is an additional one not raised by participants. Because the ultimate purpose was a USAID program planning document, the scope for the HSA was never designed in such a way as to produce a national plan. At best, it could result in a national plan for certain aspects of the health sector. Here is a good example of conflicting objectives and the need to define more clearly what an HSA (or any program planning process) is to be.

### Objective C: Institutional Changes

In spite of the creation of new institutions and the expansion of existing institutions in all three countries, a number of participants felt the results were too limited, and/or that changes could not be definitively attributed to the HSAs. In Nicaragua, the health planning unit that evolved out of the HSA team existed only on paper. It was not established as a legal unit (though legislation has now been proposed), and operated primarily by agreement of the four primary health sector institutions. Thus, its role was limited, and it was effective only to the extent that the institutions represented were willing to cooperate. This in turn depended on the people in charge of them. At present, there is substantial cooperation, and in fact, just before the contractor's team left Nicaragua, a major initiative in coordination of the health sector was proposed.

In Bolivia, Mission participants noted that the health ministry planning office had been expanded from two to approximately 10 persons. However, they did not see a corresponding increase in activity or attention to the need for planning. Nevertheless, this too may be seen as a vital step in a change that is always slow.

As can be seen in Table 4-2, all three countries claimed to have initiated action in the area of reorganization of the health sector and health institutions. This indicates that the countries are aware of the need for this kind of activity and attitudinal change. However, most observers felt actual achievements are still unnoticeable. Again, this type of change tends to proceed slowly.

### Objective D: Coordination

Coordination is the objective where the HSA was perhaps able to achieve the least. USAID's assumption had been that by having representatives of various organizations work together on a team, coordination

could be promoted throughout the health sector. Unfortunately it proved to be almost impossible to get representatives of the different segments of the health sector to join the team; when they agreed to participate, it proved impossible to get them to do so consistently over the whole process.

Efforts to improve coordination with the private sector were particularly unsatisfactory. Mutual distrust and the long-standing independence of the private sector are unlikely to be affected by an HSA. In the Dominican Republic, some linkage was obtained because the technical coordinator had in the past been head of the medical association. That link may have prevented the anticipated controversy with the private sector over some of the paramedical and rural programs proposed under the health sector assessment, but it was not strong enough to improve overall collaboration.

With respect to other donors, the AID/Mission in Bolivia made a major effort to coordinate them. It was not successful apparently due to a lack of interest on the part of the donors. In the Dominican Republic, USAID, the Dominicans and the Inter-American Development Bank (IDB) did cooperate near the end of the health sector assessment when it was learned that the Bank had been asked to fund the same kind of programs as USAID. However, even then, coordination was only at the project level and was in response to a specific issue. Interestingly, several Nicaraguans indicated that a major loan by the Inter-American Bank to the government of Nicaragua for a health facilities program was based on information and strategy developed in the HSA.

Attempts to coordinate with private voluntary organizations were not really a feature in any HSA.

Improved coordination within the governmental health sector was not really achieved in any country. Bolivia has a highly fragmented health sector involving other ministries and the assessment was able to do little to improve the situation. However, there are indications that the government may now want to tackle this problem.

As stated earlier the Nicaraguan coordinating unit was established as an informal agency with no legal authority. Nevertheless, recent initiatives have been undertaken to improve coordination through that agency.

Because the health ministry in the Dominican Republic is highly centralized and quite strong, coordination with the government was not a major issue; rather the need is for administrative reorganization.

Multisectoral coordination -- both within AID/Mission planning and programming processes and within the host country -- was a specific interest of AID/Washington. Aside from the inherent difficulty of overcoming a history of fragmentation, aspects of the regionalization policy at AID made it difficult to begin to tackle this objective.

Despite this somewhat negative review of what happened with respect to coordination, the recent initiatives in Nicaragua and Bolivia are favorable signs of HSA impact. Again, because of political factors, changes in this area would be virtually impossible to achieve in one year. It is perhaps more realistic to see the HSA as a means of sowing the seeds for future change.

#### Objective E: Attitudinal Changes

In contrast to coordination, a great deal seems to have been in terms of attitudinal change. Participants' awareness of a range of health issues for a multi-sectoral approach to health programming, was expanded, according to most participants. Greater understanding of the problems involved in health programming was also attained. Acceptance of new service delivery approaches, such as low cost rural systems, was generated or reinforced. While the level of priority assigned to the health sector does not appear to have been affected by the HSA, this type of change would have a long lag time.

In one important respect, it is possible that more should have been achieved -- the institutionalization of attitudinal changes in the health sector. The degree to which the changes are institutional or just personal was something the evaluation team could not determine. Where participants are no longer in the health sector, the impact of attitudinal changes will obviously be lessened. The level at which the participant now works in the health sector is also important to the degree of impact. Policy changes will initiate from high-level officials; most of those involved in the HSA; already had fairly broad perspectives on health programming. Actual policy changes in the three countries visited will derived from the chief of state, and the extent of their interest in the HSA is undertermined. It is perhaps the attitudes of technical staff where the most change was seen. The impact there will be delayed and depend on their rising to high level positions.

The evaluation team felt that this objective did not receive the formal attention that it needed in order to maximize accomplishments. The approach seems to have been to assure that by becoming involved in an effort which encompassed studies of new ideas, etc., participants' attitudes would automatically be changed and broadened. This in fact is happening.

#### Objective F: Education

Education was never clearly defined by USAID, but seemed to refer principally to skills upgrading specifically in terms of health planning. This objective was a priority with the host country. In general there were positive accomplishments, but whether these were institutionalized or just personal is not clear. It is likely more could have been achieved. This is also interesting that participants who cited educational benefits never seemed to specify what were those benefits.

For this reason, and because many participants are not working in the health sector, the evaluation team felt that educational accomplishments were primarily personal and were somewhat more limited than is indicated by the favorable interviewee responses.

Again, this objective was informally pursued -- education was seen as an inevitable spinoff from participation in the process. No attempts were made to establish formal training programs or training goals. Further, host country participants were never part of the stage in the HSA from which they could have derived the most benefit -- that of the analysis and strategy development.

Another aspect of the education objective is academic programming. Academic educational improvements such as changes in health curricula are achieved in both Bolivia and the Dominican Republic. In Nicaragua, where there has been considerable animosity between the universities and the national government there was no formal university representation to the team.

In the Dominican Republic, many key participants were from universities and planned to return there after the HSA. Although there were no direct ties to the institutions themselves, the fact that the participants were planning to return to the university (and in some cases were still working with the university while involved in the HSA.) enhanced the possibility of achieving program changes there. There has been an indication that entire new university programs in health are in fact being developed in the Dominican Republic.

#### Objective G: In-Depth Knowledge of Health Sector

There were some accomplishments for all three subobjectives with the exception of improvements to the information system in Nicaragua. It is likely that this had to do with the disappearance, at the end of the HSA, of the sector assessment unit as an operating unit, without ever having transferred to any agency the information it had compiled. It is also true that not as much data collection and analysis were done in Nicaragua as in the other countries.

Despite their response citing accomplishments under this objective, host country participants indicated dissatisfaction with the degree of achievements. While new data had been obtained there were still substantial gaps, and institutional improvements to information systems were few. New data were not being routinely updated, and some was still not analyzed.

It is worth noting one achievement cited by many host country participants to which they attached much importance. The HSA resulted in a document that pulled together for the first time in one place the numerous pieces of information and data on the status of health and the health sector that had been accumulating over the years. It was also the first time that much of that data had been adequately and systematically analyzed. However, the scope of this achievement was reduced as a result of USAID's failure to translate the documents, combined with a very limited distribution in all three countries.

In terms of the subobjectives of conducting cost-benefit analyses and development of funding plan, two important components of a national health planning strategy, none of the three countries were able to complete either of these tasks. In Nicaragua and the Dominican Republic, they were never even considered as objectives by either the Mission or the government. In Bolivia, a cost-benefit analysis was an objective of the AID/Mission alone and then only because the Ambassador wanted it done.

USAID had also hoped to use the HSA as a means of promoting low-cost rural health care and preventive health care delivery systems as specific components of a comprehensive national health planning strategy. Thus, it has been included as a subobjective. USAID has provided loans for related projects in all three countries. It is unclear if the HSA generated these new activities, or reinforced directions in which the governments or AID/Missions were already moving. It appears that in the Dominican Republic at least, the health ministry had already adopted these new approaches to health care.

As discussed earlier under Objective E: Attitudinal Changes, the HSA did not seem to be suitable tool for affecting priorities. The subobjective of developing a methodology for their determination was not achieved. Had the last stages of the HSA been structured to focus on strategy formulation, perhaps this subobjective could have been achieved. However, because the HSAs were directed toward USAID's interest, it is unlikely a comprehensive national survey would have resulted.

Table 4-2 is a composite of the respondents views of achievement of specific objectives by country.

TABLE 4-2. ACCOMPLISHMENT OF OBJECTIVES

	Bolivia	Dominican Republic	Nicaragua
A. Aid program planning document	1	1	1
B. Improved health planning capability in Host Country			
- Improve skills	1	2	3
- Develop/improve planning methodology	1	1	3
- Development by host country of a major planning document	3	2	3
- Improve/create institutional planning capability	1	1	1
C. Institutional changes and reform			
- Create new institutions (Health/Nutrition/Population)	1	2	2
- Reorganization of health sector	1	1	1
- Reorganization of health institutions (MOH, etc.)	1	1	1
D. Improve coordination with:			
- Private sector of host country	3	3	3
- AID	1	1	3
- Donors	3	3	1
- NGOs	3	3	3
- Other host country sectors	3	3	3
- (Within) host country government health sector	1	3	2
E. Attitudinal change concerning health sector			
- Raise priority of health sector	1	3	3
- Raise multi-sectoral awareness	1	1	1
- Raise awareness of host country issues/program needs	1	1	1
F. Education			
- Develop/improve health curriculum	1	1	1
- Up-grade skills	2	2	1

TABLE 4-2. ACCOMPLISHMENT OF OBJECTIVES  
(continued)

	Bolivia	Dominican Republic	Nicaragua
G. Develop an in-depth knowledge of host country health sector			
- Improved data base	2	1	2
- Improved information system	1	1	3
- Increased knowledge about health sector	1	1	1
H. Develop national health planning strategy			
- Establish priorities for health sector	1	3	1
- Use cost-benefit analysis	3	3	3
- Low-cost rural health care delivery systems	1	1	1
- Preventive health care emphasis	3	1	1

CODE: 1 - Achieved  
2 - Mixed  
3 - Not Achieved

## UNANTICIPATED OUTCOMES

Beyond the achievements relating to the stated objectives, there were a few "unanticipated" outcomes noted by participants. By this is meant that they were not specifically stated objectives. They are summarized in Table 4-3.

In all three countries, new health programs were undertaken after the health sector assessments. It is not entirely certain whether interest in these program preceded the HSA or resulted from it, and whether it was the HSA or subsequent loan which had the most affect. Some participants in both Nicaragua and Bolivia indicated that the decision to undertake rural health projects was solely because of the possibility of AID funds, an indication that the projects resulted from the health sector assessment. However, Bolivian participants did not seem to link the Montero project to the HSA.

In the case of the Dominican Republic the basic health service program which involved the training of village health workers and community health services had already been suggested by the government.

TABLE 4-3  
UNANTICIPATED OUTCOMES

	BOLIVIA	DOMINICAN REPUBLIC	NICARAGUA
Impact on other sectors	3	1	3
Benefit USAID (image, programs, etc.)	1	1	1
New programs	1	1	1

CODE: 1 - Achieved  
2 - Mixed  
3 - Not Achieved

One area which is often included in health programming but is not strictly part of the health sector is nutrition. Here the HSA did serve to increase interest in nutrition and provided a better understanding of nutrition and nutrition problems.

Whether or not the HSA was a casual agent in changes, it no doubt reinforced them, an important achievement in itself.

In the Dominican Republic, one respondent noted a spillover effect from the health sector assessment into the education sector, where a similar effort is now being contemplated. In neither Bolivia or Nicaragua was there any impact outside the health sector.

While USAID, of course, hopes to benefit from the HSA, that has not been an explicit objective. It appears, however, that the health sector assessments did benefit the AID/Missions in terms of their image in all three countries. One respondent indicated that the HSA showed that USAID really was interested in the health sector. Another said that had a health loan emerged for Bolivia, the HSA would have greatly increased its chances of acceptance by the government because it "proved" the strategy USAID was proposing.

Nevertheless, there were also people in each country who indicated negative feelings toward USAID as a result of the HSAs. In Bolivia, for example, many persons were very disappointed because no loan or project was forthcoming after the assessment. They felt cheated, after all the effort and energy they and the government put into the project.

#### AID/WASHINGTON PROGRAM PRIORITIES/EMPHASES

Table 4-4 presents a number of AID/Washington program priorities or emphases that formed the parameters for the HSA and subsequent loans. They are currently factors with which a host country will have to deal, if it

agrees to participate in an HSA or to accept a loan. A dot indicates that a particular priority was actively supported, an asterisk that it was actively opposed, a blank that there was no real action. The purpose of the table is to provide an indication as to the acceptability of AID's program interests.

Based on respondents' comment about AID program interests, these did not seem to have had much impact on the HSA, except in Bolivia which opposed family planning. However, as mentioned earlier, a focus on these areas may have conflicted with a host country's interest in taking a broad look at the health sector, and with the objective of developing a national health plan.

TABLE 4-4

## AID/WASHINGTON PRIORITIES/EMPHASES

	COM- MON TO ALL	AID/W	AID/M	BOLIVIA	DOMINICAN REPUBLIC	NICARAGUA
Rural Health Emphasis		•	•	•	•	
Target Populations (poor majority, pregnant, locating women, children, infants)		•	•			
Population/FP Priority		•	•	*		
Nutrition Priority		•	•			•
Low Cost Rural Health Care Delivery Systems		•	•		•	
Socio/Cultural/Economic Analysis		•	•			
Multisectoral Analysis		•				
Cost-Benefit Analysis of Health Investment		•				
Host Country Participation	•					

\* This particular priority was strongly opposed by Bolivia.

## V: COUNTRY REPORT: BOLIVIA

The Westinghouse Health Systems team for the evaluation of Health Sector Assessments conducted a field visit in Bolivia from 4 March through 17 March, 1978. During that time the team interviewed 17 persons associated with the Health Sector Assessment of 1973-1974. One additional interview was held in Washington, D.C. after the team's return. The team also reviewed the documents files relating to the Health Sector Assessment at the USAID Mission in Bolivia and at the Office of International Health (OIH) in Rockville, Maryland.

Of the people interviewed, three are currently with the AID/Mission in Bolivia, one is a consultant to an USAID project in Bolivia, and one is an employee of AID/Washington. Among the Bolivians, one is retired but works as a special consultant to the government, six are employees of the Ministry of Social Welfare and Public Health, one works for the National Council for the Economy and Planning, one works for the National Institute for Social Planning, and two are associated with schools or universities. One interviewee works for the Pan American Health Organization (PAHO) in Bolivia. At the time of the Health Sector Assessment, interviewees associated with USAID served in the following capacities: two were employees of USAID, one was hired as USAID's technical coordinator for the Health Sector Assessment, and one contributed short-term technical assistance to the USAID Mission and the Bolivian team. (The fifth USAID interviewee joined the staff after the assessment and has been involved in implementing the projects that grew out of it). All Bolivian interviewees were participants on the HSA team. One directed the Bolivian effort; the other 10 were either leaders of team subgroups or were subgroup members. The PAHO representative was a member of the Bolivian team. Most participants were involved throughout the assessment.

### BACKGROUND FACTORS

AID/Mission representatives, Bolivian participants, and the documents all indicated that there was little activity by the Mission in the health field prior to the HSA. USAID had attempted to start

a maternal and child health program which included some family planning, but it was opposed by the government. It was involved with PAHO in a malaria eradication program in the lowlands and had cooperated with PAHO and UNICEF to start a rural health program in one region.

The Bolivian government, on the other hand, was quite active in the health sector, although not very extensively. Most programs had an urban orientation or were related to the military, mining and other key industries. The health sector itself was quite fragmented because delivery of services was the responsibility of many different institutions. While the Ministry of Public Health was active in most areas of the public sector, specific sectors were handled by their corresponding ministry-- Defense for the military, agencies of the Bolivian Social Security Institute, and other institutions.

The most notable program gap in public health activities was family planning. Bolivia had a positive population growth policy at the time of the HSA because large segments of the country were underpopulated. This policy became a major issue and stumbling block between Bolivia and USAID because a high Embassy official felt that a population program had to be instituted along with health programs to prevent a rise in the population growth rate, a presumed result of improving health conditions.

Most respondents did not answer questions about the factors which, in 1974, might have been influencing the Mission or Government of Bolivia health sector activities. Due to the time elapsed since the HSA, a large number of respondents have forgotten the details. Of those who did comment, two remembered a low level of coordination among the institutions in the Bolivian health sector and some political instability (the average term of office for a ministry of health was nine months). One respondent also mentioned that the public health was held in low esteem and that salaries within the government were not very high.

On the positive side, Bolivia had been pursuing public health activities for a long period. There was a School of Public Health, as well as various training programs and other health educational institutions. Both AID and Bolivian respondents commented on the extent of planning activity in Bolivia. There was an active planning unit in the Ministry of Health, and representatives from the health sector worked with the Planning Council. While USAID people felt that the planning was not detailed enough and was too narrow in its perspective, one saw the planning unit as a resource. Two indicated that it was inadequate. Of six Bolivian respondents, two indicated it was good and four that it was adequate; none said it was inadequate. PAHO had been working with the unit for a number of years, and it had produced several national health plans, the most recent published the year before the Health Sector Assessment.

While the planning unit, as well as the Ministry of Public Health, are highly centralized, there is a network of public health offices and facilities throughout the country, with major centers in each of the department (state) capitals.

#### HSA PROCESS

The reasons for undertaking a health sector assessment in Bolivia were not entirely clear. It appears that some health staff in the AID/Mission wanted to begin a major health program. However, Embassy policy at that time required that a population program be implemented prior to any health program, for reasons described earlier. The USAID staff saw the HSA as a way, among other things, of demonstrating to the Ambassador that health projects in Bolivia need not create population growth problems. Thus, while the HSA was designed to carry out the objectives stated by AID/Washington at that time, it was also a tool to convince a high Embassy official of the merits of health programs.

### Scope of Work

Because the assessment in Bolivia was one of the first, there were no real guidelines, and the Mission relied heavily on assistance from AID/Washington. Two technical assistance officers from there, with a consultant the Mission public health officer, and other Mission staff, wrote the HSA Scope of Work. There was some Bolivian involvement in the later stages of the effort by high-ranking officials in the ministry of health. According to some respondents, the scope of work was used by the Bolivian team initially.

### Start-Up

The scope of work identified a number of topics to be studied, and eleven subgroups or commissions, were set up to develop information on each. A twelfth was added later.

The commissions were to be headed by people from the health and other ministries where appropriate. Bolivian participants in the work scope process identified people from the Ministry of Health or others who would be available as chairmen. Once selected, they in turn used some of their own staff to carry out the technical work. In some cases persons from outside of the government, such as PAHO or USAID, sat on the commissions. The commissions were quite small, with a number of people simultaneously heading up a commission and participating on others.

As executive committee made up of one member from each of the commissions plus participants from some other ministries or agencies such as the National Planning Council. It was set up to coordinate the team overall. The chairman, a former health minister had overall responsibility for the Bolivian effort. Through him the team was able to call on the resources of the Ministry of Public Health, and he also provided access to high level people in other Ministries and national Councils.

USAID identified the need for a technical coordinator to work with the head of the Bolivian team. A consultant with knowledge of Bolivia joined the HSA in early 1974. USAID also identified a number of short-term consultants to work with the Bolivian team. They provided technical assistance during 1974 as needed. Relations between the two groups were good, in part because relations between the Mission and GOB were good.

One of the interesting aspects of the overall organization of the team was the way the commissions used existing government staff to carry out the assessments. Their ability to do that is demonstrative of the resources available within the government to cope with such a planning effort and of the existing planning capability with the government, including the Ministry of Health. Further, although government activities in the health sector were dispersed among a number of agencies, those responsible for health activities were accustomed to working together in certain ways. This was evident from the cooperation that was obtained from the number of people outside of the public health sector who contributed to and participated on the commissions. They included people from the Bolivian Social Security Institute, the mining ministry, the universities, the School of Public Health and the National Institute for Social Planning.

#### Implementation

As indicated earlier, because this was the first health sector assessment ever undertaken, the material for briefing and guidance was limited. Most host country respondents indicated that they did not receive any sort of guidelines or written guidance, but few did say that they had received some assistance in early health sector assessment planning. Principally these were people who had participated in preparation of the work scope. On the other hand, AID/Mission participants felt that the guidance provided through the workshops and meetings with people from AID/Washington had been excellent.

Many Bolivians indicated that it was left to the commission to plan their work, others that it was done in general by the executive committee and then left to the commissions to define in detail. There appears to have been little coordination among the commissions once the work got started.

When the respondents were asked to describe what they felt were the objectives of the HSA, the following answers were given, based on respondents' remembrance of what was most important.

TABLE 5-1  
RESPONDENTS' VIEWS OF THE OBJECTIVES  
OF THE HEALTH SECTOR ASSESSMENT

	No. of Responses		
	Total Respondents (N-17)	Mission (N-5)	Host Country (N-12)
Compile best information for rational health planning	8	3	5
Provide overall study of health conditions in Bolivia	7	2	5
Develop data base for justifying AID programming	4	2	2
Extend health services to rural areas	3		3
Draw attention to conditions in communicable diseases	1		1
Training in health planning	1	1	
Meet AID Washington requirements	1	1	
Collect data for policy decisions	1	1	
Develop coordination between the Ministry of Health and the Social Security Institute	1	1	

In response to questions concerning data collection and analysis, there was considerable difference of opinion. Of the 12 who answered the question concerning the existence of useful data five Bolivians said there definitely were good data, one USAID person that they were adequate, and four Bolivians and two USAID that that they were not adequate.

No significant quantity of new data was collected during the HSA. However, one consultant and some Bolivian counterparts did conduct limited ad hoc health surveys in few rural regions in order to fill in some gaps and verify existing information. Their data supported existing data.

In terms of data analysis, again opinions were divided as to its effectiveness. USAID people felt the analysis had not been in-depth enough for their needs. On the other hand, the Bolivians felt it was sufficient and at the same level as that in past health planning exercises.

Although there were not many responses to the question concerning use of data after the Health Sector Assessment, the evaluation team got the impression that much of the data had become a part of the larger, ongoing health information system in the Ministry of Health.

One interesting aspect of this data collection stage is worth noting. The Mission arranged trips to the interior of Bolivia for a number of high level Bolivian officials. Many were familiar only with the capital and "altiplano" regions. USAID felt that if it were to sell the government on the need for a rural emphasis to health programming, those in decision making positions needed to be familiar with the other areas. Most officials responded very enthusiastically to the trips.

It was intended that each Bolivian commission would produce a report and that the team as a whole would prepare a final, integrated document to be turned over to USAID as the basis for its report. The Mission hoped to use the Bolivian report almost intact, just adding a section describing USAID's strategy and the project proposed for funding.

However, as work progressed, it became evident that some commissions were not going to meet USAID's deadlines. In addition, the quality of some of the work fell short of USAID's expectations and needs, particularly with respect to analysis. Some commissions did turn in draft reports to the executive committee for its revision, which were in turn transmitted to USAID. In other cases USAID consultants wrote the reports for their commissions. In still others, the commission report submitted to USAID was not useful, and additional USAID effort was required to modify it.

An integrated Bolivian report was never produced in time. The only "summary" received was a list of 161 recommendations, prepared by the commissions. At one executive committee meeting, these were grouped by Bolivian participants into 10 categories; priorities were set by voting on the 10. This information then went to USAID.

In the end the Mission had to put together its own team for the final writing effort. Its Public Health staff, supplemented by USAID Washington advisors and consultants, produced a report using the draft material of the Bolivian team and consultant reports, as well as new material which they gathered. (Ultimately the Bolivian team did produce a largely descriptive summary report containing the 161 recommendations). Their report was submitted to Washington in December 1974.

Two key problems emerged after USAID Washington's review. First was the conflict over the population section. As mentioned earlier, the Bolivian government was strongly opposed to any population program aimed at limiting growth rates. Nevertheless, the Embassy officials demanded the inclusion of a population section. The second problem resulted from the opposition of a high embassy official to a health sector investment. He wanted to see an economic justification and insisted on a cost-benefit analysis to that effect. In his opinion, that section of the report was unsatisfactory and needed to be redone. (The second and third attempts were also unsatisfactory and AID/Washington is still grappling with this problem).

Despite these two problems, the Bolivian Health Sector Assessment was approved pending one chapter. However, that reservation resulted in a delay of the loan, a situation that created ill-will and cynicism on the part of Bolivians toward USAID.

To the question concerning the participation of the Bolivians in the HSA process, USAID people generally answered that their counterparts had little involvement with the final document, although it was reviewed by a few Bolivian officials. However, they felt the document was based on information that the commissions had supplied to USAID and therefore reflected Bolivian interests and priorities.

Chapter 10 of the USAID document, which discussed USAID strategy for pursuing health programming in Bolivia, was translated into Spanish shortly after the assessment was completed and was circulated to a number of participants. However, the entire document was not translated. The evaluation team found that only two of the 12 Bolivians could read English and thus were the only two people who had read it. Thus a good deal of the data and analysis it contained was not available to Bolivians. While several others indicated that they had read the translation of Chapter 10, they found it of little use since it dealt only with USAID strategy. (The Mission is currently updating the data and translating the HSA; it is to be distributed mid-summer 1978).

Information on the cost of the HSA was extremely skimpy. No participant recalled anything concrete about the budget, and documentation was incomplete. The only financial files available for examination were at the USAID/Mission.

Based on the limited information obtained, the budget for fiscal year 1974 appears to have been \$82,000. However, the fiscal year only ran through June, and that figure would therefore not reflect subsequent funding, whereas the assessment continued until December. Nor was there

any indication of whether or not all the money was expended. The \$82,000 figures seems much too low. By looking at the duration of consultant visits and their contracts or PIO/T's, it was possible to come up with a figure of \$130,000 for this item alone, and it, too, may not be complete. Further, a number of people who worked on the assessment were government employees paid through interagency funding agreements; they were also unaccounted for. Finally, there was no indication of resources supplied by the Bolivian government, either funds or in-kind.

It is important to note that relations between USAID and the Bolivian government during the assessment were extremely good. Much of the reason lies with the Mission public health officer, who had been in Bolivia for more than 20 years, and a key AID staff person who was Bolivian. In general, most Bolivian participants spoke highly of USAID participants.

#### PARTICIPANT EVALUATION OF OUTCOMES

The following table identifies the positive outcomes indicated by respondents. Open-ended responses have been categorized and tabulated by frequency of response. These frequencies are further broken down by respondent category (Mission and host country).

The responses to questions on outcomes of the HSA revealed two interesting things. First, with respect to outcomes related to recommendations, six people, all Bolivian, indicated that they either did not know which recommendations had been implemented or what the recommendations were because they had not seen the reports or could not read English. Second, three USAID people and 10 Bolivians failed to mention the rural health delivery pilot project at Montero in connection with the HSA.

TABLE 5-2  
 POSITIVE OUTCOMES IDENTIFIED BY RESPONDENTS

	No. of Responses		
	Total Responding (N=17)	Mission (N=5)	Host Country (N=12)
General educational impact for participants	14	4	10
Specifically mentioned:			
Exposure of Bolivians to their own rural problems;			
Impact of team efforts and team data gathering;			
Excellent training exercises;			
Exposure to global perspective;			
Rural health interest	4	2	2
Specifically mentioned:			
Coordination of rural health activities with IBSS;			
Establishment of a rural demonstration project;			
Integration of the rural health delivery system			
Development of a Department of Human Resources	3	1	2
Data Improvement--National Center for Biostatistics	1		1
Influenced Strategy in the Ecology Division--programs changed	1		1
Changes in the Department of Communicable Diseases	1		1
Reinforced cooperation among health facilities	1		1
Nutrition policy/programs undergoing major changes	1		1

Lack of knowledge of the recommendations may partially explain the failure to relate Montero to the assessment. It is also true that a rural demonstration project had been proposed prior to the HSA, so in a sense it may not have seemed a direct result of the assessment. However, the location of Montero for the project was decided at the executive committee meetings, which a number of respondents had attended, and the assessment did involve considerable planning for the project.

Respondents were also asked to identify outcomes that they felt should have been accomplished, but were not.

TABLE 5-3  
NEGATIVE OUTCOMES IDENTIFIED BY RESPONDENTS

	No. of Responses		
	Total Responding (N-17)	Mission (N-5)	Host Country (N-12)
No major program recommendations implemented	8	3	5
No change in the Office of Planning/MOH	3	1	2
Not educational for participants	3	1	2
Did not contribute to Montero rural project	1	1	
Data not used much for planning	1		1
No impact on Bolivian Social Security Institute system	1		1

The lack of follow-up was a deficiency noted by respondents. They did not, however, indicate what type of follow-up they wanted nor which parties should be responsible. (One Bolivian felt that there was no need for follow-up since Bolivia already had an established health planning process).

All Bolivian respondents said that they believed a loan was to follow the Health Sector Assessment. Negative responses about follow-up might have involved that perception, since a loan was not immediately forthcoming.

No respondent independently observed that the HSA was a duplication of the Bolivian health planning process. However, when the question was raised by the evaluation team, several then said it was duplicative. One explanation may be that the assessment was seen by many as directly related to USAID programming, thus duplication was not a relevant issue.

Since education was a priority for the Bolivians and USAID, it is worth commenting on the responses relating to education.

The positive outcomes table shows a favorable perception of educational benefits in general. To the direct question of whether the HSA was personally educational, four persons from USAID and eight Bolivians responded in the affirmative, two Bolivians in the negative. Most who responded positively believed the process had benefited other participants as well.

Many specifically commented on how they had learned more about their country. Despite this favorable response, the evaluation team repeatedly found that people felt the process had not been as educational as it could have been. The dissatisfaction seems to involve skills upgrading primarily, with most Bolivians feeling that their skills had not been improved.

#### PARTICIPANT CONCLUSIONS

Respondents were asked a number of questions in order to ascertain what they thought of the HSA overall, of certain specific aspects, and of the causes of the subsequent outcomes or process issues.

Unfortunately, because many were unfamiliar with the document, there were very few responses to questions dealing with findings, recommendations and conclusions. Only seven persons chose to comment on the findings. Of those, three from USAID felt they were good, one that they were poor. Three Bolivians felt they were good; none indicated they were poor.

To questions on the impact of the HSA, the majority of interviewees made no comment or indicated that they did not know of any impact. Of the five (four Bolivian and one USAID) who answered the question concerning changes in the health sector attributable to the HSA, all five indicated that they saw no correlation between the assessment and any subsequent changes.

Respondents listed a great many factors which they felt would be essential in order to implement an HSA successfully (implicit in the word "successful" are positive outcomes). The following table lists some of the major ones.

TABLE 5-4  
FACTORS ESSENTIAL TO POSITIVE OUTCOMES

	No. of Responses		
	Total Responding (N-8)	Mission (N-2)	Host Country (N-6)
Capable staff	4		4
Agreement with the HSA objectives	3	1	2
Continuity of the process and broad awareness of the need for coordination	3		3
Acceleration of the HSA process	2	2	
More funds	2		2
Attention to administration and management of the HSA	2	1	1
Improved data for the HSA	1		1
Synthesis of analysis	1	1	
Translation into spanish	1	1	
Information useful to decision-makers	1	1	
Education (training)	1		1
Change in structure of MOH	1		1
Greater interest in public health	1		1
Follow-up loan	1		1

All interviewees responded when asked whether the HSA had generally been "worthwhile." Thirteen felt it was (five from USAID, eight from Bolivia); four had no strong opinion one way or another. Of those persons answering positively, several indicated the process should be ongoing, one saying that it should be repeated every five years, a long enough period for changes to be observed, another every three years, two others at least every two years, and two every year. Yet another said the process should be institutionalized within the Ministry of Health.

Beyond the above items, respondents made other evaluative comments worth repeating. Several expressed a sense of discontinuity since the HSA was not followed immediately by the loan. As indicated earlier, several people mentioned being frustrated at not knowing the outcomes of the process, which in turn related to their not have a Spanish report.

Respondents were asked to assess and comment on the impact on the HSA of certain process-related variables. Following is a summary of these variables and respondent comments:

<u>Variables</u>	<u>Comments</u>
• Funds	Among the USAID people there was a strong feeling that there were enough funds to conduct the HSA. However, among the Bolivians, only one person felt they were adequate; three felt neutrally, and two that they were inadequate.
• Time	Opinions were mixed. Of the 13 persons responding, five (two Mission and three Bolivian) indicated that time was a negative factor, five indicated no problem, and two that it was a positive factor.
• Staffing	Opinions on the adequacy of staffing were divided. Among USAID respondents, slightly more USAID felt they were negative. Additional skills identified as desirable were: anthropology/sociology, economics, and geography. For the most part respondents judged the consultants as adequate



- \*● HSA must be integrated with all sectors. Provide or stimulate coordination with all institutions in the health sector.
- \*● Must provide follow-up. Output must be structured so that follow-up and continuity are automatic.
- \*● Formal presentation of outputs at the end of the HSA, possibly at a conference or meeting.
- \*● Specifically, follow-up in the area of data, in order to test particularly the effectiveness of new strategies and policies.
  - Identification of needs in the Bolivian health sector.
  - Translation of documents into Spanish.
  - Periodic updating of HSA.

#### EVALUATION TEAM SUMMARY

This section summarizes the Contractor's interpretation of the data and information obtained during the evaluation. It is based on an overview of questionnaire responses, the document review, and discussions with people knowledgeable about the current status of the health sector and situation in Bolivia.

In general the HSA was viewed favorably by participants, particularly in terms of personal educational benefits. Many also stated that the HSA provided them with an opportunity to pull information and data together in a way that would not have been otherwise. Even the national health plans did not do this. The presence of an USAID consultants, with analytic capabilities not often necessarily available in Bolivia, was appreciated by several participants.

Nevertheless, the impact on the health sector and health seems slight. Few changes were noted attributable to the HSA. To an extent that result is due to the lack of follow-up after the HSA, most specifically to the failure of AID to provide a loan for health programs. Although Montero eventually was funded, the delay between completion of the HSA and its start-up was long enough that many people did not connect the two. Further, Montero was proposed before the HSA and cannot really be called a direct outcome. The nutrition projects which eventually were funded are apparently different in important ways from those recommended.

It also appears that the HSA created a certain ill-will on the part of Bolivians, though how strong or important their feelings are is difficult to assess. Many Bolivians felt and feel cheated by AID's failure to provide a loan. They suggest that the process may have been a waste of time because of the lack of continuity. When it was called to their attention, many wondered why they had gone through the process when they already had an operational health plan.

USAID's failure to translate the document may have contributed to the negative feelings, as may have their exclusion from the final stage of the HSA. Because most do not read English, they do not even know whether the material they turned in was ever used.

Educational benefits do not seem to have been as great as they might have been, principally because there was no formal or systematized training and because participants were excluded from the analytic phase, from which they could have learned the most.

The Bolivian HSA had certain features that seem to be appropriate lessons for future HSA's. The Bolivian HSA planners made a strong effort to conduct a multi-sectoral HSA, and to an extent were successful. Representatives from many other ministries and institutions and donor agencies were invited to participate, and many accepted and assigned staff. Unfortunately few participated consistently. Perhaps with more support from higher level officials, this effort could have been more successful.

Bolivian comments about consultants were helpful. Participants were extremely appreciative of consultants who spoke Spanish, knew something of Bolivia, and were culturally aware and had strong technical capability. It appears that the consultants were chosen carefully and perhaps were screened with the help of some Bolivians.

Also of note was the success of ad hoc rural health surveys conducted by some of the American consultants with their Bolivian counterparts. The funding of trips to the interior for Bolivian officials was a feature of the HSA praised by many. Finally, the willingness of the government to consider the HSA as a necessary task and to allow the team to use health ministry staff to assist their work was important.

## VI: COUNTRY REPORT: DOMINICAN REPUBLIC

The HSA evaluation team worked in the Dominican Republic (DR) January 15-30, 1978. During that time interviews were conducted with six AID/Mission staff and 12 Dominicans. The former head of the OIH office for Health Sector Analysis, who had been extensively involved, was interviewed in Washington, D.C. Numerous documents were reviewed, including the scope of work, the final HSA document, consultant reports, subgroup reports (principally the work of Dominican team members), and correspondence files. Unfortunately, some months prior to the team's arrival some from AID/Washington had visited the Mission to clear the files of excess paper and had disposed of a great deal of HSA material.

Of the people interviewed, four are currently with the AID/Mission, one is with AID/Washington, four are policy-making level Dominican Officials three are technical staff in different government agencies, and six are in the private sector (primarily doctors and/or university professors). At the time the HSA was conducted, they served in the following capacities - one was a technical advisor and administrator from AID/Washington, five were with the AID/Mission, one was an AID/Mission consultant, two were Dominican policy makers, eight were working at the universities and one was working at the Secretariat of Public Health and Social Assistance (SESPAS) and was consulted by the team. Of the total, five were involved throughout the HSA, 13 at various stages.

### BACKGROUND FACTORS

Both AID/DR and Dominican participants indicated that there was little activity in the health field prior to initiation of the HSA. The Mission's involvement was principally with Public Law 021 construction loans and the P.L. 480 supplemental feeding programs, and was coordinating on some water projects. There was no Public Health Officer, and little formal health planning was taking place. The common opinion was that the Mission was coordinating only with the private voluntary organizations and the Population Council, and with the sponsors of the water projects. A factor that favored the HSA was the considerable interest within the Mission

A factor that favored the HSA was the considerable interest within the Mission for developing some new loans. The 021 loan was almost at an end, an agriculture loan had just been negotiated, and the Mission Director was actively interested in getting other programs started. The Dominican Government (GODR) had turned down an education loan proposal, and the Director saw health as the next area for an AID initiative. This corresponded with the then-recent Congressional mandate for AID involvement in health sector projects that did not involve construction.

In order to make a health loan the Mission had to present AID/Washington with a plan and justification for proposed projects. Whether the Mission would, of its own accord, have undertaken a program planning effort as major as the HSA without that requirement is uncertain.

Respondents were asked to comment on background factors which in 1974 were influencing the Mission's or GODR's health sector activities and which might have an affect on the HSA. With respect to AID, positive factors were AID/Washington's and the Mission Director's strong interest in health and the Mission's good relations with the GODR. Negative factors cited were AID/W administration (red tape and delays), the difficulty of working with Dominicans, AID's strong bias toward family planning, and tension with the universities and private sectors.

With respect to DR, respondents said that the GODR had not shown much interest in the health sector. Existing programs tended to involve construction and curative services and were highly urban-oriented. (However, some indicated that the situation might be changing, as evidenced by a health regionalization plan and some new rural service delivery programs). Many of the then-current activities were supported by donor loans. Half the respondents named the Pan American Health Organization (PAHO) as the principal planner; the other half mentioned the GODR itself. Several plans had been prepared, it was noted, but the consensus was that none had been implemented and that the quality of planning was low. While health was the third largest item in the budget,

that figure apparently meant little since funds could be, and were, frequently transferred to other sectors. Only one respondent rated coordination with other institutions as having been good; another respondent described coordination as poor and non-existent. When specifically asked about GODR interest in developing or improving its planning capability, respondents were evenly divided among high, average, and low interest categories. Three felt that whatever interest was then being shown was probably attributable to interest in an AID loan for which the HSA was a prerequisite.

Positive and negative DR background factors listed were as follows: on the plus side, DR was seen by some as being a state of transition, with an interest in constructive changes; part of that involved an interest in health. On the negative side, several problems were mentioned repeatedly: GODR administrative weaknesses, political instability, excessive centralization, lack of priority for health and an inadequate health budget, a fragmented and weak health sector in general, a lack of analytic and other skills, and the number of jobs held simultaneously by professionals.

#### HSA PROCESS

The impetus for an HSA began when the Mission Director asked two staff members to prepare a Development Assistance Proposal for a health program. After several initiatives AID/Washington requested that the Mission undertake an HSA.

#### Scope of Work

During the early stages of the HSA, a team arrived from AID/Washington, to prepare the scope of work. Some weeks earlier, a member of the Mission's Public Health Office had approached the head of the National Council for Population and Family Planning (CONAPOFA) about the possibility of doing an HSA as a prelude to an USAID health sector

loan. That official referred him to the Secretary of SESPAS, who agreed with the project and expressed the GODR's intention to support it. The USAID team had extensive discussions with the GODR and others to establish the design and content of the HSA. According to several key participants at this stage, the scope of work planning effort was consensual, involving numerous Dominicans, including high ranking officials, and a broad-based USAID group. The team also visited and consulted with a number of key institutions throughout the country. While AID/Washington had defined the parameters of the study (i.e. the overall focus), the Dominican group identified a number of specific issues for study, such as the social factors that effect change. In fact, the GODR, concerned about the availability and quality of its health data, decided to capatilize on the HSA and to conduct a major health survey. AID/Washington approved the project, with funds to come from another source. That the planning process was open and consensual is further indicated by the evolution of the content of the health survey. USAID had intended to focus on population data only, but the Dominicans objected to such a narrow focus. The survey was then expanded to provide more general health data. The scope of work was subsequently approved by AID.

#### Start-Up

During and subsequent to the Scope of Work effort, the key participants began to identify and contract with team members. Neither USAID nor GODR seem to have formulated a detailed criteria beyond noting the skills required by the study areas identified in the scope of work. A principal factor was availability, of particular importance with respect to Dominican team members. Most of the best qualified people there often hold three or four jobs simultaneously and are not free for even part-time assignments. Many people were identified through the personal knowledge of the key team members or through recommendations from others.

The Secretary of the SESPAS, who had assumed overall responsibility for the Dominican effort, had decided that the Dominicans should not come primarily from SESPAS, as this would involve officials in evaluating their programs and work. He also questioned whether SESPAS had the capability to undertake the HSA. He thus decided to look outside SESPAS, principally to the medical profession and the universities. As technical coordinator he selected a former Secretary of Health, who was practicing physician and university professor with considerable prestige and credibility. Although a majority of the team was from outside SESPAS, some were drawn from within the Government, including the administrative coordinator, who was head of CONAPOFA, an autonomous branch of SESPAS.

On USAID's side, it was clear that the Mission would need to be in a Public Health Officer. AID identified a physician with a public health and administrative background. Other Mission Staff were also assigned to the project.

With respect to outside consultants, the scope of work team had agreed that a consultant should be available to each study group. The Dominican technical coordinator requested some additional consultant in areas where he felt Dominican capabilities were weak. Consultants were identified by AID/Washington and through the personal knowledge by team members. All candidates were reviewed with the Dominicans.

USAID also recognized at an early stage it should also have a full-time manager be its liaison and to work with the DR team members. Two U.S. consultants who were then completing a job in the DR were hired.

Ultimately, a team of 45 full-time and part-time members was selected, along with 12 consultants. Other than one or two, none had been involved in a HSA previously, and most had never been involved in such a large research and planning effort. Most Dominican institutions

involved with health were represented, though not necessarily formally or as part of the day-to-day team operations. For example, a number of university professors participated, but the universities as institutions did not. Likewise, SESPAS had close ties through the Secretary, but were not directly involved. Among others donors, only Pan American Health Organization (PAHO) was represented, despite efforts to obtain their assistance. One respondent said that the PHAO had agreed to provide a population expert and then failed to do so, causing some problems with that section of the study. The private voluntary organizations were also not involved. The private sector -- principally the Dominican Medical Association -- had expressed reservations about the venture and did not participate. One reason for the choice of Technical Coordinator was that he had once been president of this Association and still maintained close ties to it.

The team as a whole was divided into eight subgroups, each focusing on a specific study area. Each was headed by a team leader responsible for its work and a consultant counterpart. Both the Dominicans and USAID felt that the HSA should be principally a Dominican effort, with technical assistance from USAID.

In terms of management, the picture is somewhat complicated, and most respondents could not clearly identify how it was organized. Most named the Dominican technical coordinator as having day to day responsibility and stated that they were to report to him. Some recognized the Secretary of Health Ministry as the ultimate authority. However, much of the day-to-day administration was said to have been handled by the USAID manager, who was seen as counterpart to the Dominican Technical Coordinator. One AID/Washington technical assistance officer was regularly in DR and was seen as a technical advisor and head of the U.S. team. The Mission Public Health Officer, perhaps because he was not visibly active until the writing phase, was not usually mentioned by the Dominicans. Some

cited a second mission staff member as head of the U.S. team members or as the USAID contact point. Those familiar with the administrative side of the HSA were aware that both AID and the Dominicans had assigned people specifically as coordinators on that aspect of the HSA. When questioned about such matters as ultimate responsibility, day-to-day reporting, etc., most respondents were vague. Some could not answer any management questions. Very few could explain the rationale for the team's organization.

Administratively, the team was placed under CONAPOFA. Because it was to be a Dominican effort, funds were to be channeled from USAID through a Dominican agency. CONAPOFA was selected because it was autonomous and could disburse the funds with fewer restrictions and less paperwork and because of the authority of its leader.

#### Implementation

The HSA began in February 1974, with the goal of producing a report by September of that year.

Members of the DR team had little remembrance of any briefing/orientation. Some recalled only informal meetings headed by AID/Washington and Mission staff. Similarly, most did not remember any formal guidelines or written documents. Some mentioned the availability of miscellaneous HSA documents such as a draft of the Bolivian HSA, but indicated that they were not important. Most described the development of methodologies as ad hoc, something that each group developed as it went along, and according to one participant, strongly rooted in local experience. One respondent volunteered that initial planning was inadequate and the start-up disorganized and hasty. Another remarked upon the number of times methodologies were changed during the early stages.

When asked to describe the objectives of the HSA, respondents gave the following answers (each objective is followed by the number of respondents who cited it; if it was cited more frequently by one category of respondents, that is also noted):

- AID program planning - (13) - AID and DR
- Analysis of DR health conditions, resources and needs and strategy development - (10) - mainly DR
- Promote improvements in the DR health sector - (6) - AID and DR
- Need for new AID program - (5) - mainly AID
- Improve DR planning capability and promote institutional change - (4) - only AID
- Congressional mandate for AID - (2) - only AID

Several respondents also noted USAID's strong family planning bias, implying it was a motivating factor. A major part of the HSA effort involved the collection and analysis of data. However, most answers to data-related questions were very impressionistic. In general, respondents felt that there was very little useful data on which to build. It was for this reason that the GODR requested a major survey. Some participants did feel that data was available; it simply needed to be located, tabulated and analyzed.

Opinions on the outcome of the data collection effort varied. Many Dominicans felt that useful data was obtained in most areas; Mission personnel were less positive. Areas noted as weak were nutrition; causes of mortality/morbidity; economics; and the private sector (i.e., the pharmaceutical industry or private services).

In reply to queries about data analysis, the collective opinion was that very little of the survey data was analyzed. Some -- that which was needed for immediate use for the HSA report -- was handled manually. According to one participant, much of the analysis by the groups was based on "brainstorming," intuition, historical precedence and educated guesses. Mission participants mentioned on occasion the Dominican analysis had not been adequate, and that the consultants had to redo the work.

The most common reasons given for the difficulty with analytical tasks were: lack of skills, insufficient funds (specifically for the survey), insufficient time, and lack of computer facilities and capability. Also mentioned was poor formatting of data sheets and inadequate interest on the part of either USAID or the Dominican government in the data after the HSA was completed.

With respect to the national survey, it is worth noting some of the specific problems encountered with it. The effort was a household survey, carried out by a trained team of 100 students, supervised by several student coordinators who had experience with previous surveys. The statistician in overall charge of the work experienced frequent frustration to the extent that at one point he threatened to resign. A primary problem was the failure of the GODR to deliver the trucks needed for field work, the survey was also disrupted at the midpoint by the national election, during which time it was difficult to obtain public cooperation. (The GODR suggested as a solution that interviewers have a policeman accompany them). The survey effort was also affected by delays in paying the interviewers and by other administrative problems. Once the data was collected, there were insufficient funds with which to pay for its tabulation. As mentioned, analysis of the information required by the HSA was done by hand. The remainder of the data was ultimately sent to the U.S. Bureau of the Census, which completed the analysis in late 1977. The analysis has yet to be interpreted or incorporated into the health information system.

It was assumed by USAID that each subgroup would prepare a report which the team leaders would integrate into a single report which would constitute a national health plan and strategy, presumably with priorities. The USAID team would use that document as the basis for preparing its HSA report for submission to Washington.

According to interviewee responses, the process seems to have worked as follows (again, recall was weak). Each team did prepare one or more drafts which were reviewed by the Technical Coordinator. Ultimately, in fact, the Dominicans turned in over 1000 pages of material which, for the most part, were late. The reports were never integrated into a single document.

The USAID team found the material to be of varying quality. The Technical Coordinator never accepted the population report and ultimately gave it to the Mission Public Health officer for revision. Many participants (both USAID and DR) felt that the drafts contained too much description and not enough analysis. In several instances, AID consultants were asked to revise the drafts. One report -- considered to be a key one-- was judged by Dominican officials to be too sensitive to release. It was called the Dynamics of Change and dealt with the social, political and institutional factors affecting health activities and the health sector. Its suppression was ironic, for the government had been extremely cooperative on this issue throughout the study.

It became evident to the USAID team managers as the AID deadline approached that the Dominicans were not going to produce an integrated and analytic document in time for Mission use. A decision was made to form a special working team to prepare the USAID document. This team sequestered itself in wing of the Embassy for more than a month and turned out its report, largely based on the subgroup reports (where useable) or on consultant reports. The draft was reviewed and edited by the AID/Washington technical assistance officer and then submitted to the Public Health officer for review and editing. The final draft was turned over to the Mission Director and Assistance Mission Director for review.

It appeared that the Mission Director was dissatisfied with a number of sections of the report and made some substantial revisions, including the addition of a recommendation that USAID fund a project to reorganize both the health sector and SESPAS. Since the submission deadline was immediate, he did release the document to Washington despite some reservations but classified it so that access would be limited. With a request for some minor changes, the document was accepted by the Development Assistance Executive Committee (DAEC) review. The Mission made the changes, and the report was subsequently declassified and released in English.

Perceptions of respondents regarding dissemination of the report were highly divergent. Almost all Dominican participants except those in high level positions stated that they did not receive either a full or partial copy of the HSA document ( a number said they never got copies of their draft reports). Most Mission participants reported that they had received a copy. Of those few Dominicans who did obtain copies, one thought it was only a partial copy, and two respondents obtained theirs through unofficial channels. Most believed that the distribution had been very limited, i.e., several mentioned that only seven copies were made available, and these went to the Secretary at SESPAS. One or two respondents understood that the document was classified.

When AID/DR participants were questioned about dissemination of the report, several recalled that over 100 copies had been sent out, although none could remember a distribution list. (The evaluation team tried to clear up this matter, but it proved impossible).

Two closely related aspects of the document preparation process were of particular interest to the evaluation team; responsibility for final content, and the nature of GODR participation. It appears that each sub-group was free to determine the content of its draft reports, including the recommendations. There was no way to ascertain to what extent content was actually dictated or revised by the high-level Dominican participants. With respect to the content of the AID document, there appear to have been several levels of decision-making, but final authority rested with the Mission Director. While he was open to discussion some points, i.e., the nutrition proposals, his was the last word.

Although USAID set up a special writing team, the Dominicans were not excluded from the USAID decision-making process. A number of participants indicated that Dominican participating had been more than adequate, and only three respondents (one Mission, two Dominicans) felt it had been inadequate (however, a fairly large number expressed ignorance on this issue).

One Dominican policy maker said that he was in continuous contact with the USAID team throughout and that all decisions were consensual. One person mentioned that the Technical Coordinator was responsible for selling some recommendations to SESPAS, principally through discussions with the Secretary. No respondents suggested any substantial differences of opinion between the USAID and Dominican team members, since they had been consultant with one another throughout. A number of respondents said that they believed the USAID document was based to a large extent on the subgroup reports. (While it seems clear that there was participation by Dominican policymakers, it appears that the technical members of the team were excluded from the analysis and formulation and strategy and recommendations).

Information on the HSA budget was extremely scarce. No participant recalled very much about it, and the documentation was not particularly helpful. Based on the limited sources available, the Mission may have spent approximately \$338,000. It is believed however, that this amount does not reflect total expenditures and probably does not include GODR funds. The team had heard that the original budget had to be increased across-the-board, but did not know the causes or size of the increases.

Following are some other questions and responses of individual respondents which are worth noting:

- Were additional items added to the scope of work?  
Only one person answered, in the affirmative
- Were changes made in the team structure?  
One respondent mentioned personnel changes, but nothing significant
- During the HSA, how would you characterize coordination between the team and the Mission, GODR and other donors?  
In general, respondents reported little or no coordination with donors, despite early efforts to work with them. Although relations were good between the team and the health secretary, there was some friction with the ministry. The principal problems seem to have been territoriality -- the team was doing what SESPAS was to do, and jealousy -- the study was viewed as somewhat threatening. The Technical Coordinator was also the principal link to the private sector, which was reasonably cooperative; little of the anticipated opposition arose. Finally, a few people mentioned some friction between the DR team and the Mission. To the extent it existed, it stemmed in part from the administrative problems such as pay delays, and in part because of a specific incident involving AID's desire to add a consultant to a subgroup which was perceived as "interference."

PARTICIPANT EVALUATION OF OUTCOMES

The following table summarizes the positive outcomes identified. Open ended responses have been categorized and tabulated by frequency of response. These frequencies are further broken down by respondent type (Mission or host country).

TABLE 6-1  
POSITIVE OUTCOMES IDENTIFIED BY RESPONDENTS

	No. of Responses		
	Total Responding (N=17)	Mission (N=5)	Host Country (N=12)
<ul style="list-style-type: none"> <li>● Institutional and attitudinal changes</li> </ul> <p>Specifically mentioned: changes in the university medical program; the establishment of a Nutrition Coordination Office in SESPAS and a Planning Office in SESPAS; impetus to organizational reform in SESPAS and the health sector; more awareness of nutrition-related health problems; greater interest in auxiliary health professions; greater awareness of the need for health programming; increased awareness of the need to integrate social medicine, research, etc., with public health; end to the "construction mentality;" new attitudes among the technical staff.</p>	12	4	8
<ul style="list-style-type: none"> <li>● Education</li> </ul> <p>Specifically mentioned: participant skills upgraded; corps of people trained who can be used in the future; process and documents useful for teaching.</p>	10	2	8
<ul style="list-style-type: none"> <li>● Personal benefits</li> </ul>	6	5	1
<ul style="list-style-type: none"> <li>● Program changes</li> </ul> <p>Specifically mentioned: regionalization of health services; more community health services through the basic health services program; upgrading and greater use of local health promoters; rural health care delivery emphasis; increase in preventive health services; increase in mass immunization</p>	8	6	2

	Total	Mission	Host Country
<ul style="list-style-type: none"> <li>Improved planning capability</li> </ul> <p>Specifically mentioned: upgraded planning skills; a document and information to serve as a basis for the formulation of health policy and planning; increased interest in health planning; improved nutrition planning; availability of a more specific detailed plan; development of a methodology applicable to DR</p>	5	1	4
<ul style="list-style-type: none"> <li>Improved information</li> </ul> <p>Specifically mentioned: increased data; greater understanding of the health situation in DR; confirmation of existing information ; greater interest in improved information; people continuing to analyze data</p>	1		1
Other outcomes :			
<ul style="list-style-type: none"> <li>Use of HSA as basis for USAID loan</li> </ul>	4	1	3
<ul style="list-style-type: none"> <li>Mission learned more about health planning</li> </ul>	2	2	
<ul style="list-style-type: none"> <li>Possible impetus to Ministry of Education to do an education survey</li> </ul>	1		1
<ul style="list-style-type: none"> <li>Produced useful document</li> </ul>	1		1
<ul style="list-style-type: none"> <li>Gave credibility to loan</li> </ul>			1
<ul style="list-style-type: none"> <li>Improved image of USAID as positive force</li> </ul>	1		1
<ul style="list-style-type: none"> <li>Greater awareness of the survey work</li> </ul>	1		1
<ul style="list-style-type: none"> <li>Better coordination with DR</li> </ul>	1	1	
<ul style="list-style-type: none"> <li>Mission learned more about DR</li> </ul>	1	1	

On the other side, many respondents listed outcomes that they felt should have been achieved but were not or ones they felt were negatives:

TABLE 6-2  
NEGATIVE OUTCOMES IDENTIFIED BY RESPONDENTS

	No. of Responses		
	Total Respondents (N=15)	Mission (N=5)	Host Country (N=10)
Document not translated	7	1	6
More participation by Dominicans in the analysis and writing of the final document	7	2	5
Incomplete analysis of data, especially causes of mortality/morbidity	7	2	5
Dominicans did not produce a final document; draft reports too descriptive, not analytic enough	6	4	2
Little follow-up on the HSA process	6	3	3
Few positive results	5		5
Inadequate dissemination of the report	5		
Inadequate use of the HSA in preparing loan	3		3
Little in-depth study	3	1	2
Little use made of document	3	1	2
Nutrition study considered one of the weakest parts of the study	3	2	1
No institutional changes	2		2
Little new information obtained	2		2
Few educational benefits	2	1	1
Data collection was inadequate	1	1	
New planning office in SESPAS was accorded little influence	1		1
People in positions of authority were not involved or trained	1		1
No improvements in programming	1		1
Few recommendations in USAID document	1	1	

## PARTICIPANT CONCLUSIONS

Respondents were asked a number of questions in order to ascertain how they rated the HSA overall, and in certain aspects of it, and what they thought to be the causes of the event or outcomes.

When asked what they thought of the findings and recommendations, interviewees responded as follows:

TABLE 6-3  
RESPONDENT OPINIONS OF HSA FINDINGS AND RECOMMENDATIONS

	No. of Responses		
	Total	Mission	Host Country
<b>FINDINGS:</b>			
• Realistic	8	3	5
• Unrealistic	2	1	1
• Did not know	2		2
<b>RECOMMENDATIONS:</b>			
<u>Mentioned as Realistic</u>			
• Recommendations in general	8	2	6
• Basic health service program	2	2	
<u>Mentioned as Unrealistic</u>			
• Administrative reorganization	6	3	3
• Planning reform	1	1	
• Food supplements	1	1	
• Coordination with the private sector	1		1

A second judgement question was the extent to which respondents felt that changes in the health sector and the nature of the subsequent Mission health loan were a result of the HSA. Many respondents found the first difficult to answer since it is hard to attribute change to a single cause; the latter elicited few responses. Many felt that the HSA had definitely been influential, contributing but not causing changes.

Two Mission respondents however, said the HSA was necessary to change; and a third indicated that DR might not have accepted the health loan without the funding of the HSA. One Mission participant stated that the HSA was weak in the area of recommendations and that the loan went well beyond it. Dominican responses ranged from the belief that health planning would have improved anyway to a belief that the HSA was an agent of change.

Respondents listed many factors which they felt were essential in order to implement an HSA successfully (implicit in "successful" is positive outcomes).

TABLE 6-4  
FACTORS ESSENTIAL TO POSITIVE OUTCOMES

	No. of Responses		
	Total Responding (N-18)	Mission (N-6)	Host Country (N-12)
A realistic assessment of the resources and capabilities available for carrying out an HSA	7	1	6
Host country participation, with training if necessary	6	1	5
Consultants fluent in Spanish, good at human relations and knowledgeable about DR	4	1	3
Adequate follow-up, including loan	4	1	3
Capable staff	4		4
Adequate planning in the early stages, especially relating to data and methodologies	3	1	2
Adequate and favorable timing	3	1	2
Full-time team manager/coordinator	3	1	2
Participation by people in positions of influence	3	1	2
Team spirit/motivation	4	2	2
Good team organization	2		2
Adequate salaries	2		2
USAID's leverage as a loan agency	1	1	
Publicity after the process is complete	1	1	
Adequate funding	1	1	
Release of documents	1		1
Multidisciplinary team	1	1	
Smooth contractor processing	1	1	
Interest in conducting HSA (Mission and Host Country)	1	1	

When the interviewees were asked whether the HSA had been generally "worthwhile," 14 responded. Of the Mission respondents, 3 felt it had been "worthwhile," 2 felt it was just "adequate." Among the Dominican respondents, 8 felt it was "worthwhile," only one felt it was just "adequate." Four persons did not respond to this question. No one held a negative opinion of the Dominican HSA.

Apart from the specific reasons mentioned earlier, more general reasons cited for the usefulness of the HSA were that it:

- Allowed the country to identify problems and define rational solutions and plans
- Confirmed or denied commonly held but untested beliefs about health conditions
- Acted as a catalyst to positive change by raising levels of awareness and motivation
- Showed that the U.S. interest in health was sincere.

Respondents made some other comments about the process which are worth recording. Some expressed a sense of feeling cheated when they did not or could not get a copy of the report. A number were bothered by the team's not having produced a final report or not having been more involved in the USAID writing process. One frequent problem with the staffing (discussed below) was that many DR professionals on the team held more than one job. Thus they were unable to devote full attention to the HSA. Some people felt that the Technical Coordinator's role was diminished by this situation. (It was observed by one participant, that it is unrealistic for a doctor to give up his practice for a short-term job and that perhaps people in the medical profession should not be considered for the role of coordinator). Finally, one U.S. respondent expressed strong concern over the methodology used. There was little consideration of alternative solutions; rather, a problem was identified and a single solution identified and proposed.

Interviewees were also asked to assess the impact of a list of variables on the process and to comment as necessary. As will be seen, a number of problems were cited, but interestingly none were felt to have had a negative influence on final outcomes.

Variable

Comment

● Funds

Generally considered adequate by the Mission. DR Participants felt they were inadequate, especially for the survey.

● Time

All respondents cited problems with time. However, many felt that the time should and would have been sufficient if the process had been better planned and implemented. Scheduling was said to have been unrealistic, especially the time required for report preparation, the survey, and bringing people up to speed. There was no flexibility for dealing with problems such as the national election in mid-summer.

● Staffing

Respondents identified a number of problems relating to staffing. The issues of participants holding more than one job was mentioned earlier, as was the difficulty of getting good people to take on short-term assignments. While both groups expressed concern about the lack of experience of many Dominican participants (proportionally more Dominicans held this view), most agreed they were the best available people. One or two respondents in each category also mentioned the general academic backgrounds that the Dominicans brought to this type of study -- their training had stressed descriptive rather than analytic research and did not emphasize the preparation of written documents. It was suggested that the following skill areas should have been represented: administrative management; economics; health planning (at the beginning); surveys/statistics; systems analysis; research methodology, and nutrition planning.

As far as any personnel problems affecting the HSA effort, few were noted. As is true with any group some members did not get along, but this did not have a negative impact overall. While the AID manager apparently had an unduly heavy workload, he did not appear to be a bottleneck. Some Dominicans were bothered by pay problems -- in some cases delays, in other cases the refusal of Dr. Fabra to pay anything in advance of tasks being completed. Again, none of these was considered to be a serious problem.

Variable

Comment

- AID Support  
Dominican respondents were divided as to adequacy of AID support; the Mission felt it was adequate or a positive factor. The Mission did provide or arrange for a great deal of logistical support which was supposed to have come from the GODR - office equipment and space, etc. Nevertheless, AID was said to have been slow sometimes in delivering, leading Dominicans to question AID's sensitivity. One person felt that AID was more concerned with getting its document out than in helping the DR.
- GODR Support  
Most Mission respondents felt that GODR had done as much as it could, given the demands on its limited resources. The main criticism was over the inadequacy of the office space provided and the GODR's failure to deliver transport to the interviewers when promised. A number of interviewees praised SEPAS for its cooperation in the data collection effort; others felt it should have been more involved. Two Dominicans said that AID got far more work from some participants than it paid for. Two others and one Mission participant said that the HSA had really been a DR effort.
- Leadership  
Respondents had mixed feelings. Some considered the lack of coordination between the technical and administrative coordinators to have been a negative aspect and that the initial disorganization indicated structural problems.
- Team Structure/  
Organization  
A number of respondents indicated problems, among them: initial disorganization; no clear lines of responsibility; the tendency of each group to operate in isolation; and the size of the team. Nevertheless, not many people considered this variable as disruptive.
- Orientation/  
Briefing  
A number of respondents viewed this as a weak aspect of the process. Generally, participants (especially Dominicans) felt they had not adequately understood the purpose of the HSA or their tasks and methodology to be followed.
- Disruption of  
normal operations  
The sole respondent said that while the HSA imposed a heavy burden on the Mission, an HSA this should be considered a part of normal operations, since it was required for program planning

<u>Variable</u>	<u>Comment</u>
● Problems in data collection and analysis	Numerous problems were noted in this area, most discussed previously: inadequate skills; lack of computer facilities; lack of funds; insufficient planning; unclear objectives; insufficient methodology; and others. However, in a related question, no one felt the data problems had had any negative impact on the HSA overall.
● Logistical support	As mentioned previously, the primary problems were office space, pay problems, transport for the survey, and scheduling. While these caused delays, no one felt they affected the overall outcome of the HSA.

#### PARTICIPANT RECOMMENDATIONS

The last series of questions dealt with how participants would improve the HSA process. Following is a list of respondent suggestions (\* denotes more than one respondent mentioning it):

- \*● Better planning and handling of the data collection and analysis tasks, including better evaluation of the availability and usefulness of existing data.
- \*● Better planning, orientation, guidelines, methodology and scheduling (with some means of enforcement).
- \*● More full-time supervision and management.
- \*● Greater coordination within the team and between the team and other groups.
- \*● More training of Dominicans and greater attention to the educational aspects of the HSA.
- \*● More follow-up in terms of process and outcome evaluation, data updating, continuous planning, and defining.
- \*● Translation and dissemination of the documents.
- \*● Periodic updating of the HSA.
- \*● More Latin American technical assistance consultants with sensitivity to Latin America with country participating in their selection.
- Closer ties with key institutions and involvement of influential people, including those in the private sector.

- Emphasis on future implementation.
- Use of HSA specialists (individuals with HSA experience)
- Conduct HSA with a broader national perspective that encompasses the various sectors such as agriculture, education and housing.
- More open process with more publicity.
- More attention to institutionalization.
- Better definition of roles.

AID had expressed a special interest in the type of guidelines that might prove useful. Unfortunately, few respondents addressed this question. Those who did emphasized that the guidelines should be loose so that they could be adapted to different countries. In other words, they should be flexible and serve to "guide," not dictate.

#### EVALUATION TEAM SUMMARY

This section summarizes the Contractor's interpretation of data, based on an overview of responses to the questionnaire, a document review, and discussions with people knowledgeable about the current health status in the Dominican Republic.

Overall, it seems clear that the HSA did accomplish a number of things, although not to the extent that was desired, and perhaps at too high a cost. It should be noted, however, that many accomplishments are hard to quantify and that some results will probably take more time to emerge, as change is always slow.

The predominate outcome seems to have been attitudinal changes, an achievement that is difficult to quantify or "cost out." Institutional changes also resulted, but these appear to have been pro forma, i.e., responses to a USAID requirement and thus not fully supported. Educational benefits accrued to participants (interestingly, apparently more to Mission than to DR staff), but were limited. Since they tended to be personal benefits, they were not firmly institutionalized. There were some important advances in low-cost rural service delivery and preventive medicine, and an increased awareness of the importance of allied health

professions, but it is unclear if these can be attributed to the HSA. Rather, the HSA seems to have reinforced existing trends. An opportunity to improve the data base substantially was missed, although it is possible that progress will be made in the future. There are still some serious gaps in data such as accurate mortality or morbidity data.

Respondents also cited a number of outcomes that were anticipated but unfulfilled. Overall, most felt that more could have been achieved. These outcomes include: educational benefits, improved data, and the preparation of a useful planning document. A number of Dominicans expressed frustration over USAID's and the GODR's failure to let them know the results of their work and to provide them with a copy of the report in Spanish. Not having the report, they also could not see the relationship between the USAID loan and the HSA, thus causing them to feel that the HSA had had minimal impact. Participants were also very much bothered by not having been able to take part in the final stages of analysis and report preparation.

With respect to the causes of the impact, of the HSA, a number of areas or variables emerged as critical factors:

- Most country participants had inadequate backgrounds for the type of analytic study contemplated by the HSA. Because many had more than one job, they were unable to devote full attention to the work. Often the best people were unavailable for short-term assignments.
- Inadequate planning (in terms of a realistic assessment of data needs and availability), failure to develop a useful methodology, and unrealistic scheduling caused delays, disorganization and missed deadlines, as well as confusion.
- Orientation did not adequately define the HSA objectives, the expected products or a methodology.
- Despite separate funding, the Health survey was much too ambitious given the available time and resources. Moreover, it was impeded by logistical problems.

- The team structure did not encourage coordination among the subgroups nor linkages with the various elements of the health sector, private and public. Leadership was not as consistent or as strong as was needed to maintain schedules and ensure satisfactory output.
- Consultants, while generally considered to be good, did not spend enough time in-country to be of adequate use to team members.

Some comments on other factors:

- Time, cited by many as a negative factor, should and would have been adequate had there been better initial planning and smoother implementation.
- There seemed to have been a genuine interest by the GODR in the HSA and a willingness to support it to the extent resources permitted. This situation certainly contributed to the accomplishments. Similarly, despite the lack of experience, most participants seemed to want to do a good job and were distressed that more was not achieved. However, the highly centralized nature of the GODR and the low priority assigned the health sector imposed limitations on possible outcomes, such as far-reaching institutional changes. One of the more interesting and novel studies, the "Dynamics of Change," was not released due to political sensitivities.
- AID/Mission support was considered to be quite adequate. A close tie to a high-level Embassy official provided some flexibility to respond to unforeseen problems which Mission resources might not otherwise have been able to handle.

## VIII. COUNTRY REPORT: NICARAGUA

The Westinghouse Health Systems Health Sector Assessment evaluation team was in Nicaragua from 20 February 1978 through 14 March 1978. During that period the team interviewed two USAID/Mission staff, nine Nicaraguans, and one consultant from a third country. All had participated in the HSA. One interview with a Nicaraguan, the former Minister of Health, never took place as he was unavailable. Interviews were also conducted in Bolivia with the former USAID technical coordinator and in the United States with two American consultants who had also participated in the HSA. In addition, the team reviewed documents and reports on the HSA, obtained from the files at the USAID/Mission and the Office of International Health, Washington, D.C.

Of the people interviewed on the USAID side of the HSA, three were USAID staff at the time of the HSA and three were consultants to USAID. Of the Nicaraguans interviewed, seven were participants and two were outside the HSA process, but involved in either health planning or implementation of HSA recommendations. Three Nicaraguans at the decision making level were interviewed; only one is still in the health sector. All other participants are still in the health sector and actively involved in public health.

### BACKGROUND FACTORS

USAID had been involved in the health sector in Nicaragua since the earthquake in 1972. However, until the HSA, activities in this sector were piecemeal and directed at scattered programs, primarily in the area of facilities construction. There were some health activities in other sectors:

Agriculture	-	Nutrition Environmental Sanitation
Reconstruction	-	Water Systems Urban Systems
SNEM	-	Malaria Eradication

Prior to the HSA, USAID had shown very little interest in health and health planning. For a number of years, proposals for major health projects had been tabled. The impact of the earthquake of 1972 and the need to recover from that catastrophe may have been a large factor in postponing major health programs. In addition, agriculture was far more of a priority. In fact, the Mission had conducted an agriculture sector assessment in 1973-74.

During that period prior to the HSA, relations between USAID and the Nicaraguans had been somewhat strained. USAID officials were concerned by Nicaraguan political situations. On the other side, Nicaraguans harbored long-standing anti-American and anti-USAID feelings, and there was general distrust of any activities which involved USAID.

For its part, the Nicaraguan government was quite active in providing services in many areas and in general supported health activities. Most services were, however, curative, and there was not much interest in preventive medicine or health planning. The planning unit in the Ministry of Health was regarded as weak.

The Nicaraguan health sector was and still is divided into five principal segments:

- The private sector
- The Ministry of Public Health (MSP)
- Junta Nacional de Asistencia y Prevision Social (JNAPS)
- Junta Local de Asistencia Social (JLAS)
- Instituto Nacional de Seguridad Social (INSS)

#### HSA PROCESS

The impetus for starting any major program, including health, would normally come from the Mission Director. However, the head of the Nicaraguan HSA team, a highly placed government official close to the President of Nicaragua, claimed that the idea originated with him.

He had been in charge of the agriculture sector assessment and felt the same analysis should be carried out in the health sector. In any event, the HSA did have support at the highest government levels.

#### Scope of Work

Initial discussions concerning the HSA were conducted in the fall of 1974 by the Mission Director and the Secretary to the President, who assumed responsibility for the Nicaraguan effort. In order for the AID/Mission to conduct the assessment, the effort needed the support of such a high official was essential.

This official worked with the Mission Director, an USAID staff member and an AID/Washington consultant from OIH in developing the scope of work for the assessment. At that time, the need for a professional health planner on the USAID side was also identified, and a doctor was subsequently hired as the Mission's Public Health Officer.

In the course of preparing the scope of work, a number of items were negotiated by USAID and the Nicaraguan government. These included the formation of a Nicaraguan team to carry out a large portion of the sector assessment, clarification of USAID's role and relation to the Nicaraguan team, and use of USAID short-term technical assistance consultants to supplement the Nicaraguan team. Also at this time, it was agreed that Nicaragua would pay the salaries and expenses of its team, while USAID would cover the salaries of consultants and provide some logistical support.

In spite of a detailed scope of work and specific agreements between USAID and the Nicaraguan government, there was still a great deal of ambiguity about what was to be done. This lack of clarity pervaded the whole assessment and caused a number of organizational problems and numerous delays.

The identification of objectives for the HSA in Nicaragua occurred over a long period during the strat-up. While an early consensus on objectives was probably achieved between USAID and the Nicaraguan team, they were actually in flux for a long time after work started. Respondents indicated their respective understandings of the objectives grew divergent as the HSA developed. This was true among the Nicaraguans, as well as between their team and USAID. Table 7-1 indicated the overall recollections of respondents about the major objectives of the HSA.

TABLE 7-1  
RESPONDENTS' VIEWS OF THE OBJECTIVES OF  
THE HEALTH SECTOR ASSESSMENT

	No. of Responses		
	Total Respondents (N=8)	Mission (N=2)	Host Country (N=6)
Establish health sector priorities	5	1	4
Develop reliable health sector data	4	2	2
To rationalize USAID programming	4	2	2
An AID/Washington requirement	3	2	1
To build support for health sector programs (policy)	3	1	2
Unify the health sector	3	2	1
Build a health planning capacity	2	2	
To get a USAID loan	2		2
To get an overview of health sector	1		1

## Start-Up

The Nicaraguan team was selected principally by the Secretary to the President, according to most participants. There were no formal criteria; it appears he wanted young, intelligent, apolitical (but politically acceptable) government employees interested in the work. Final selection was based on friendships and people known or recommended to him. There were also, however, some political and personal appointments to the team.

According to the interviewees, the selection process was not clear to the HSA participants themselves. Most were chosen without knowing how or why; they simply received a written notice from a high official; e.g., the Minister of Health, to report a certain place at a certain time on a certain day.

In general, the team did not have a health planning background; some had no prior involvement in the health field at all. There were only two trained health planners in Nicaragua at the time, one of whom was part of the team.

USAID foresaw the need for short-term technical assistance under this project and put together a list of experts in skill areas needed. The Public Health Officer requested the assistance of AID/Washington in locating and contracting with these people. Many proved to be unavailable, and a second list had to be developed with AID/Washington's assistance. It then became the task of AID/Washington, with the support of OJH, to obtain and secure the needed technical assistance.

Early in the project, AID identified the need for a full-time technical coordinator, since the Public Health Officer did not have enough time. However, it took over six months to get a person on board; he finally arrived in June 1975.

The Head of the Nicaraguan Health Sector assessment effort set up an independent, apolitical team in order to avoid the political complications and pressures inherent in Nicaragua's network of highly fragmented and competitive health institutions. His own political power and position were important in terms of securing autonomy for the team. His direction to the team was to produce a technically competent, objective analysis. Although the team's close tie to him later proved a disadvantage, it was considered positive at the time.

Day-to-day responsibility was assigned to a technical coordinator, beneath whom was a loosely structured set of study groups, each with a number of researcher/analysts. The study areas had been determined during the work scope stage and were not altered significantly after that time. In the beginning, some team members continued to be active in their other jobs, but as the work developed all became full-time. Team leaders met regularly with the Secretary to the President according to some almost weekly. He also met regularly with people from USAID, in particular with the USAID technical coordinator.

The team began meeting in December 1974. One of the major problems from the beginning was the technical coordination. There were a total of three technical coordinators over the course of the health sector assessment. The first team leader did not have a health background and evidently was appointed for his administrative capabilities (and possibly other personal reasons). He apparently spent little time with the team, abrogating his leadership responsibilities. Early in the process and under pressure he resigned. Not much significant work had been done to that point.

A second team coordinator was selected by vote in January 1975 from among the team members. He served almost six months, but his term was marked by turmoil and disorder. He tended, according to many, to work in isolation of the team and his overall leader, and apparently

also minimized the interaction between USAID members and consultants and the Nicaraguan team members (a factor in the negative feelings of many participants toward the consultants).

A third and final team coordinator was selected after the second resigned, apparently also under pressure. Just prior to this several AID consultants and the AID technical coordinator had arrived. Following these changes and events, the effort began to move somewhat more smoothly and rapidly. However, as is discussed below, the third Nicaraguan technical coordinator faced a number of difficulties as a result of his having joined the project six months into its operation. Overall, the weakness in leadership and frequent turnovers left the Nicaraguan team without direction and resulted in considerable disorganization, delay and frustration.

There was a general feeling among the Nicaraguan team members, especially those in non-leadership positions, that they had not received adequate guidance or briefings early in the project. They did not recall seeing any guidelines. One premise beyond those mentioned previously, is that the Nicaraguan team leaders filtered much of the USAID information, presumably to make the team seem autonomous of USAID.

As a result of these organization and planning problems, the subgroups spent a large part of the early months of the project developing their own scopes of work and methodologies. This task was difficult since they did not fully understand the objectives, nor did they have the experience required to formulate what was needed. In fact, some participants said they did not know of USAID's role until the last six months. They were not aware of the requirement for a USAID loan planning document to be prepared by December 1975 until the end of the project. When the USAID Coordinator appeared on the scene in June of 1975, many members were completely baffled by his presence.

One of the interesting questions about this early period concerns orientation. The Mission staff stated that they had some workshops and meetings on the health sector assessment and that they also prepared written documents in Spanish. The Nicaraguan team members, particularly the non-leaders, have virtually no recollection of this. Some Nicaraguans participants indicated that they received assistance and guidance from the USAID coordinator in June and July. However, this direction came too late in the process to enable them to meet its deadlines.

Some USAID participants likewise had no recollection of the guidelines. The Public Health Officer relied on notes left by the AID/OIH consultant from the work scope effort and on copies of draft versions of assessments done the year before.

Throughout the HSA, the PHO kept Washington apprised of the progress of the health sector assessment. He also served as liaison with the Nicaragua team leaders about things the USAID staff needed for their documents.

#### Implementation

Data collection began early in 1975 and continued through the summer. The availability of health sector data was, of course, of major importance to the HSA analysis. USAID felt that much of the existing data was weak, but indicated that it would have accepted its use with some selective updating and improved analysis. However, the Nicaraguan team, because of the atmosphere of distrust that prevailed the country at that time, decided it had to collect new data, if for no other reason than to verify existing data. The approach was not to conduct a massive survey, but to do a number of small sample surveys in specific areas.

The early months were according to a number of participants, characterized by much floundering around as the subgroups tried to develop methodologies in the absence of any technical guidance. AID was presumably

reluctant to step in, given the team's desire for independence. Nor did USAID have, at this point, a technical coordinator. The first Nicaraguan team coordinator, as mentioned previously did not provide much technical assistance. One Nicaraguan participant described the first few months as an exercise in futility, with long hours spent talking about how to proceed, without ever proceeding. Because of the delay in identifying and hiring the consultants, they were also unavailable during most of this period. Many respondents concluded that most of the period from January to June was wasted, although eventually the groups did develop what they felt were suitable methodologies.

In June, as mentioned, there were a number of changes. The third technical coordinator took over, and although he did not have a planning background, he apparently was better at human relations, a key need at that point. USAID consultants were also available with increasing frequency. Finally, the USAID technical coordinator arrived.

While operations did improve, there were still old problems that limited what could be done. Much of the prior work was felt to be technically weak. Some members still had only a hazy understanding of the relation of USAID to the HSA, and they resented the arrival of both USAID's coordinator and the consultants. They were seen as outsiders particularly after six months of struggling and finally coming up with what the members felt were workable methodologies, there was little appreciation for consultants coming in and telling them it should be done a different way.

Although Nicaraguan members felt it was never clear, they were supposed to submit a final, integrated, analytic report to AID in early fall in time for the Mission to use it in writing its final report. Realizing that the Nicaraguans were behind schedule, the Mission got an extension to December 1975. Even that deadline could not be met, the Mission realized. Therefore it formed a special writing

team composed of some USAID Mission staff and consultants available at the time. For example, one USAID consultant who was in Nicaragua for another assignment indicated that, because of the workload he was relieved of his original scope of work and asked to help on the final document.

The division between USAID and the Nicaraguan team became evident when USAID asked the Nicaraguan team for its data. The team would not make it available to USAID. One Nicaraguan suggested that it was withheld for security reasons, but most Nicaraguan team members had no knowledge of this. (On the other hand, many did not know that a USAID document was even being prepared). Eventually the Nicaraguan team did make available a draft summary of what was to be its final report. The document arrived too late for USAID's use and was not found to be really useful since it contained only descriptive information, with no indication of priorities or strategies.

Because of the difficulty in obtaining the data, the USAID document was written principally from information available before the assessment. The writing team analyzed it as best they could in order to produce their document. While this approach was not ideal, the general consensus is that it was adequate for the task at hand.

Thus the final USAID document was produced almost completely internally. One respondent speculated that USAID may have benefitted from not being a part of the final Nicaraguan effort. The Nicaraguan document became a total Nicaraguan effort without USAID activity, and the USAID document was done relatively free of Nicaraguan political pressures. On the other hand, one Nicaraguan expressed resentment over not having known about the USAID document, especially at the time it was being produced.

Before the final USAID document was submitted to Washington, it was seen by the Secretary to the President and President Somoza himself. Nobody else in the Nicaraguan health sector apparently saw it.

The Mission completed its document on time and sent it to Washington for the DAEC review.

About a month later the Mission in conjunction with the Secretary conducted an interesting follow-up activity. They held a conference at the rural city of Chinandega. The 22 participants were high-level Nicaraguan officials from all major ministries and institutions, representatives of donor agencies, and AID/Washington and Mission staff. The purpose was to introduce the report, with its proposals for an USAID loan, in order to get feedback and generate support for the recommendations. While every one agreed that it was a good conference, its impact did not seem long-lived.

Between December 1975 and June 1976, the Nicaraguans continued to work on their own report. In June 1976 they finally finished 21 volumes, of which five were a summary. The material included recommendations concerning the health sector and ultimately a list of priorities for intervention. The report was produced by an editorial team of five of the Nicaraguan team members, two team leaders and the Secretary to the President. The actual writing took place in his office, under his close supervision, and he had sole review and approval power. Members of the editorial team who were interviewed unanimously thought they had been selected because of their technical capability and political neutrality. The team used as the basis of its report the draft documents of each of the study groups.

Neither the USAID nor the Nicaraguan document were widely circulated. USAID's was never translated, and apart from the AID Mission, it was sent to only a few high level Nicaraguan government officials, who were to be responsible for distribution. Very few Nicaraguans have seen the American Document (though few could have read it since many do not know English). Despite curiosity as to what the USAID document said, the Mission reports that there have been few requests for copies.

For reasons which also remain unclear, the Nicaraguan document also had very limited distribution, and many participants saw only their own section .

USAID participants made a number of comments on the HSA's implementation. One addressed the difficulty the Nicaraguan team had in conducting its business, which stemmed from distrust and political fear among the Nicaraguan team and the lack of leadership and guidance. In the beginning, the team attempted to do everything together because of the fear that people, if left on their own, would in some way subvert the effort. A story was told of one team member who went to Paris for a week - having locked all the data up before leaving.

Only after a good deal of time was lost attempting to work in this way did the team finally admit that a new approach was needed. At that point, they began to work seriously as subgroups as originally planned. However, adequate coordination among the subgroups never developed. Another interesting problem affecting team operations were the class differences among members.

With respect to the Nicaraguan report itself, USAID and the Nicaraguans had opposing views. Some Nicaraguan team members felt it was a useful document, while USAID on the whole found it to be shallow. Eleven respondents indicated that the data collected was not useful because of its structure, format and gaps. For example, under the disease indicies, the largest single category was "undefined," almost three times the size of the larges diesase category known or labeled. The main weaknesses appear to have been the data on morbidity and mortality, finances, and use of resources. While, all three USAID respondents felt the Nicaraguans had analyzed the data credibly, among Nicaraguans views varied widely. The majority stated that it had not really been analyzed and that the report was only descriptive. One Nicaraguan said that the HSA had still been an important educational process no matter how the final product was judged.

With respect to subsequent use of the newly collected data, five respondents, four of them Nicaraguans, believed that the data have since been used. A couple indicated specific areas, including the rural health program.

#### PARTICIPANT EVALUATION OF OUTCOMES

This section summarizes the outcomes of the 15 respondents identified. Where important, the number of respondents or their institutional attachment (six were AID Mission representatives and nine were affiliated with the Nicaraguan government) is indicated. The number responding to a particular question was generally less than the total interviewed.

All USAID recommendations were included in the loan paper that was funded following the assessment. It was generally agreed by the AID respondents that this was a totally positive outcome. Some shifting of mission health priorities had resulted from the assessment, but nothing of major nature. It had been anticipated this kind of shifting would occur as a consequence of the HSA, since one of the objectives was to produce data enabling better and more detailed planning. The health sector assessment document was essentially the only source of health planning for AID, and particularly the only source of information for a loan at that time.

The following Table (7-2) shows the respondents' identification of positive outcomes of the HSA. It is interesting that two personally oriented outcomes top the list, instead of institutional ones. This is consistent with Table 7-3, which indicates lack of institutionalization of HSA recommendations as a major negative outcome. However, this does not diminish the value of the strength of the personal benefits.

TABLE 7-2  
 POSITIVE OUTCOMES IDENTIFIED BY RESPONDENTS

	No. of Responses		
	Total Respondents (N=14)	Mission (N=5)	Host Country (N=9)
Personally benefited from HSA	10	3	7
Human resources (training)	8	3	5
Developed new data for health sector	8	3	5
Strengthened rural health programs	6	4	2
Improved health planning and programming	4		4
JNAPS reorganization (bid loan)	3		3
New motivation and change in health sector	2		2

USAID participants indicated unanimously that there were no un-anticipated outcomes from the health sector assessment.

On the Nicaraguan side, it was generally noted by respondents that many recommendations were made by the Nicaraguan team, but only a few were implemented. The team produced a very lengthy list of priorities, knowing that only a limited number would probably ever be implemented or achieved. Because of the insufficiency of its resources, the government had to rely on USAID and Inter-American Development Bank (IDB) funding to implement many of the changes it wanted.

The following positive outcomes were noted by Nicaraguan respondents. Those mentioned most frequently are listed first and were generally felt to be a direct result of the assessment.

- Establishment of a human resources institute
- New data
- Nutrition program
- Improved planning and programming for health in Nicaragua
- Junta Nacional de Asistencia Social loan from the Inter-American Development Bank
- Rural health care delivery system
- Improved coordination within the Nicaraguan health sector
- Motivation and changes of attitudes among personnel within the health sector

In addition to these outcomes, a few Nicaraguan participants identified some additional, unanticipated accomplishments. The conference at Chinandega was clearly one, which many Nicaraguans believed that it was a product of the Nicaraguan work.

Although one person indicated that an important unanticipated outcome was the exposure of people throughout the health sector to new data, others indicated that there really had not been very much or very widespread exposure to that data. One respondent noted an increased interest in the Nicaraguan health sector by other donors, but this interest probably was developing independently.

Additional comments were made about recommendations felt to be important and not implemented. The failure to retain the sector assessment team as an autonomous operational planning and evaluation unit was noted by many. Such had been the intent at the start of the HSA. Presumably its ties to the Secretary of the President were a factor in its downgrading; when he left office in 1976, the sector assessment unit was absorbed in the the Ministry of Health.

Also mentioned as a failure was that JNAPS was not reorganized. Because this institution is a major provider of health care in rural areas and is a major source of power in the health sector, its re-organization of this unit was felt to be absolutely necessary for effective implementation of rural health care delivery systems. It should be noted, however, that recently a new initiative has been taken to reorganize the health sector, and there is hope it will be successful. (This recent initiative illustrates the difficulty of evaluating HSA outcomes so soon after their completion, since major changes may take several years to get underway).

A number of respondents commented on factors that affected outcomes. Principal among these was, as mentioned above, the Secretary leaving office somewhere near the end of the assessment. He had been the only individual really committed to the HSA or its results. Much of what he started was more or less forgotten or ignored by his successor and by the Ministry. The HSA did not get very wise exposure, even within the health sector.

Apart from the Nicaraguan participants, very few people knew of the recommendations or of the information contained in the document. Table 7-3 indicates respondents' views of the negative outcomes of the HSA.

On the positive side, an overriding and unanimously held view among the Nicaraguans and USAID personnel was that the people who participated in this project benefitted from it. Among the respondents, 10 indicated that they had personally benefitted; 9 that others had benefitted. However, one respondent stated that the changes resulting from the Nicaraguan assessment were only personal and not institutional.

TABLE 7-3  
NEGATIVE OUTCOMES IDENTIFIED BY RESPONDENTS

	No. of Responses		
	Total Respondents (N=14)	Mission (N=5)	Host Country (N=9)
Low institutionalization of changes	7	2	5
Almost no knowledge of USAID recommendations among Nicaraguans	7		7
Political down-play of HSA outputs	6	3	3
No update of data	4	1	3
No significant negative outcomes	3	3	

Also, on the positive side, it was felt that the USAID document based on the HSA, had created an interest in the initiation of some Nicaraguan projects that might not otherwise have been initiated.

In contrast, in response to the question about whether participants knew of the Nicaraguan document, four answered positively, 11 negatively. Given the same question about the USAID document, 2 answered positively and 12 negatively.

#### PARTICIPANT CONCLUSIONS

A number of the questions in the evaluation sought to obtain information on how participants and people knowledgeable about the process judged it, as a whole and with regard to some specific areas, including the relationship between the process and subsequent outcomes or events.

As indicated earlier, when questions concerning outcome or impact were raised, many Nicaraguans did not have detailed information because they had not received either the USAID or the Nicaraguan document and therefore were not familiar with the recommendations. However, others felt they had a good deal of information as a result of their involvement.

The 10 respondents to a question concerning the overall value of the health sector assessment were unanimously favorable. Despite many problems, the health sector assessment had made people think. However, several people noted that wider distribution of the report and more follow-up would have resulted in an even broader impact. The technical value of the health sector assessment, especially to those who had participated was also widely noted.

From USAID's point of view, the produce of the HSA -- its final document-- was seen as an important summation and synthesis of information on the Nicaraguan health sector. It was a first and major step at getting a comprehensive picture of the health sector that could be used by USAID in its health programming and hopefully by the Nicaraguans as well.

The Nicaraguans, as indicated before, had almost no knowledge of the USAID document, and therefore had no significant opinions as to its conclusions. However, the 22 participants at the Chinandega conference, when they became familiar with the report, shared USAID's opinion as to its usefulness. It was universally felt to be an important first step despite its shortcomings. Further, the process itself was considered to have been very important for the Nicaraguans, perhaps more so than the results.

In response to questions concerning the impact of the HSA on changes in the health sector, while it resulted in only minor changes in planned programs, it was the development of a capability to make those refinements that was one of the express purposes of the assessment.

Four Nicaraguans believed the assessment probably hastened changes for two reasons:

- The impetus provided by the USAID loan that was based on the HSA
- Changed attitudes among health sector personnel.

On the other hand, there was a unanimous feeling among 10 respondents that the HSA did not produce all that it could have. A lot of time had been wasted in the early stages greatly limiting the possibility of reaching potential goals. Areas in which accomplishments were generally felt to have been insufficient were:

- Data information
- Weakness of the planning unit that grew out of the health sector assessment team
- Failure to integrate health services
- Lack of coordination in the health sector

In response to a question concerning factors which are absolutely essential for successful implementation of a health sector assessment, the following were noted:

TABLE 7-4  
FACTORS ESSENTIAL TO POSITIVE OUTCOMES

	No. of Responses		
	Total Respondents (N=13)	Mission (N=4)	Host Country (N=9)
People with health planning knowledge	8	4	4
Adequate planning prior to implementation	5	3	2
Leadership	4	3	1
Institutional support	4	1	3
Commitment of host country government	3	3	
Group/team relations	3	1	2
Budget/financing	3	1	2
Autonomy of team (apolitical organization)	3	1	2
Full-time/full allegiance of staff	2	2	
Long-term USAID coordinator	1	1	
Release of the final report	1		1
Political climate	1	1	
Donor/outside participants	1		1
Conference	1		1
Personal incentives	1		1
Use of existing data surveys	1	1	
More time and recognition of time constraints	1	1	
On-the-job training in health planning	1		1

A number of questions were posed relative to the impact on the HSA of a number of process variables.

Five of nine respondents felt that the assessment had suffered from very severe cost limitations. Another three felt that funding was a neutral factor, while one felt it had been sufficient and was therefore a positive factor. In a similar pattern, six of eight respondents felt time was a negative constraint on the Nicaraguan effort, one felt it was neutral, and one thought that time was sufficient and therefore a positive factor.

Four out of nine respondents felt that the team skills were a positive factor, two that they were neutral, three that they were inadequate. Five respondents indicated that additional skill areas should have been included with two specifically identifying social and cultural expertise.

Reactions to the consultants were mixed: three people felt they were useful, two that they were neutral, and three that they were negative. Some participants noted the general distrust of consultants. In addition, several Nicaraguans felt they know as much as the consultants and hence learned little. Both USAID and Nicaraguans stated that short-term technical assistance is not nearly as useful as longer-term technical assistance.

Three Nicaraguans commented that personal agendas of team members were detrimental to the operations of the Nicaraguan team, although they did not elaborate on that.

A large number of persons (eight) indicated satisfaction with USAID Mission support for the HSA. Two people had no opinion. One indicated that the Mission's role was not clear until the Chinandega conference. Two people indicated a positive view toward AID Washington support, while two indicated a neutral view and one spoke negatively of it. The Public Health Officer in particular noted that Washington had worked closely with him on the health sector assessment, especially in the early period when more guidance was required.

In terms of Nicaraguan support, five people saw it as positive, two as neutral, and two as negative. The decline in support that came with the Secretary of the President's departure at the end of the sector has been noted several times.

In response to the question concerning participation by Nicaraguans, six people (two USAID, four host country) felt it was adequate, three (two USAID, one host country) inadequate. However, the question was meant to probe Host Country participation in the USAID process and for the most part Nicaraguan participants did not know about the USAID process or the document. Therefore their positive responses to participation tells little about Nicaraguan involvement in the USAID process.

On the issue of leadership of the Nicaraguan team, no respondent saw it as having been positive; two felt neutrally; and four saw it as a negative. On the other hand, both Nicaraguans and USAID respondents felt that USAID's leadership was good.

Of the 10 people who responded to questions concerning the effectiveness of the team organization, two felt it was acceptable, two that it was a neutral factor, six that it was inadequate.

Of the 8 who responded to the data questions, in retrospect six felt negatively and two neutrally; no one was positive. A major problem was that data was not shared because of the distrust of Nicaraguan team members for one another. Personnel were also considered to be inadequate for conducting surveys and carrying out the analysis.

Of the 9 people who responded to the question concerning the adequacy of logistical support, none felt it was positive, two felt it was adequate, and seven felt it was negative. The majority recall in particular the early period when there were numerous logistics problems, in particular, difficulties with salaries and office space.

In response to a question about the time constraint placed on the health sector assessment by the AID funding cycle, there were no positive responses, two neutral, and three negative. The three negative responses were from USAID people. (For the most part the Nicaraguans were totally unaware of this constraint since they were unfamiliar with USAID operations).

## PARTICIPANT RECOMMENDATIONS

In response to a question as to how the health sector assessment process could be improved the following were noted(\*denotes that more than two respondents mentioned it):

- \*● More planning of the health sector assessment process
- \*● Longer technical assistance
- \*● Assurance of loan follow-on
- \*● More/closer collaboration between USAID and the host government
- \*● Distribution of the document
- Guidelines for data collection
- Less time to conduct study
- Team leadership
- Personal interest by high government officials
- More inputs about health sector
- Politically neutral location for team
- More planners
- Full-time USAID technical coordinator

Finally, to a question concerning the desirability of repeating the health sector periodically, 12 of 15 respondents said yes. Three indicated they would repeat the assessment every two years, one indicated every five years, and another that it should be continuous. The remaining seven did not specify how frequently.

## EVALUATION TEAM SUMMARY

This section presents observations by the Westinghouse Health Systems evaluation team as to the HSA process, outcomes, and key variables. It summarizes the contractor's interpretation of information derived from interviews and the investigation of the relevant documents.

An ironic aspect of the Nicaraguan HSA concerns the objective of host country participation. Consistent with that objective, the Mission encouraged Nicaraguans in their effort to conduct the HSA on their own.

The only extensive USAID involvement prior to writing the report was in the initial orientation; in meetings with team leaders (where USAID's role was often passive); and through the U.S. consultants who worked for short periods of time with the Nicaraguan team. As a result, most Nicaraguan members at the technical level (and some of the leaders) were unaware of the relation of USAID to their work. They were also unaware that their reports were to form the basis of the USAID report. Many did not understand or appreciate the presence of USAID personnel and consultants and resented USAID's questions and inquiries. Many chose not to share much of their data with USAID. Even today, many participants still do not understand the relationship of their work to the USAID loan which followed.

While the Mission did achieve a high level of Nicaraguan participation, the price was far lower level of accomplishment in terms of other objectives, i.e., transfer of skills and possibly in terms of USAID's image, since it seemed to many to be meddling. Further, the Mission had to prepare its document largely from its own sources because the Nicaraguans did not see working with USAID as an objective.

Clearly, much of the team's autonomy resulted from its being closely linked to the Secretary to the President, who had a great deal of political power at the time. He felt that he could use his position to protect the team from outside pressures so that it could carry out an objective study, and at the same time guarantee implementation of its recommendations. Theoretically, a sound approach that appeared to have a high probability of success, it suffered from a major weakness. If the person loses political power, the effort will suffer concomitantly, as the case in Nicaragua. Thus the advantages of tying the Health Sector Assessment to someone high in the political structure were outweighed by the disadvantages associated with political change.

This weakness was compounded, in the opinion of the contractor, by the team's failure to coordinate with outer units of the health sector. A base of support could probably have been developed without compromising the integrity of the work. In any event, a totally objective, neutral study, may be unrealistic, since it will have to be implemented in a political environment and must account for that.

The contribution of the consultants to the Nicaraguan HSA appear to have been negligible, even when filtering answers for an undercurrent of anti-American feelings. The evaluation team does not feel this was because of the quality of the consultants so much as a combination of several other factors, including team autonomy, distrust of USAID and poor management. Still another factor was the short time that consultants spent in-country -- many Nicaraguans commented that consultants were in and out too fast. Team members said they were often unaware that consultants were arriving, presumably because the team or group leaders failed to pass on that information. Finally, there was a feeling that consultants did not know enough about Nicaragua. Some respondents felt the HSA proved to be a greater learning experience for the consultants than for the team.

The first six months of the health sector assessment process in Nicaragua suffered from a lack of direction and disorganization. The Nicaraguan team apparently had no knowledge of what it was supposed to do or how to do it. It had to struggle with defining goals, objectives, and tasks and developing methodologies. While the Mission said that it spent a good deal of time early in the project on orientation and workshops, few Nicaraguans recall any such meetings, and the evaluation team was unable to resolve this contradictory information. A number of subgroups were set-up which because they centered on specific disciplines, tended to work independently of each other. The group leaders provided little coordination. This fragmentation was reinforced by the absence of a common base of similar objectives or goals and a work plan. Additional time was ultimately needed for completing the work.

Much of the problem could have been avoided had additional time been devoted to initial planning and to a comprehensive orientation. Better supervision and team management would also have prevented the situation from getting so far out of hand. However, much of the problem relates to an apparently, insoluble conflict between having to accept the Nicaraguans desire for autonomy (actually a political necessity) while at the same time providing direction of the HSA in an acceptable manner. Such situations are often no-win. Perhaps the solution is to forego this type of program planning experience where such a situation exists.

Almost all participants indicated the personal educational benefit made the effort worthwhile. Two people said they were continuing to use the skills they developed (although one person is no longer in the health sector). On the other hand, the HSA created very little additional awareness or understanding of health issues on the part of persons who did not participate, nor is it clear that educational benefits were institutional as well.

For the most part, the Nicaraguan participants had inadequate backgrounds for the type of analytical study contemplated by AID, although they were young, well-educated, and certainly willing to work. These qualifications are not necessarily substitutes for specific technical knowledge in the areas of planning or analysis. However, their inexperience could have been countered by focused training or guidance, which was not provided.

The failure to translate and disseminate the USAID-HSA document into Spanish was a major reason for some of the negative attitudes toward the HSA. Very few copies seem to have been distributed (it is unclear why). In any event, since the report was in English, it would not have been very useful to the Nicaraguans even had it been disseminated. As mentioned earlier, because the Nicaraguans were not familiar with the report, they did not see its connection to subsequent funding. Had that relationship been evident, the Nicaraguans might have felt more positively about the HSA.

## APPENDICES

## APPENDIX A METHODOLOGY

The core evaluation team was composed of Dr. Lawrence Smith, Mr. Nicholas Fusco (Westinghouse Health Systems staff) and Ms. Whitney Watriss, consultant to Westinghouse Health Systems. Dr. Gordon Brown and Ms. Monteze Snyder (consultants to Westinghouse Health Systems) participated in the development of the methodology and assisted in analyzing the data and developing the recommendations.

The AID Scope of Work for the evaluation of the HSAs called for a series of tasks, including the following:

- A review of documents relating to each HSA to be evaluated
- Interviews with selected HSA participants and donor agency representatives
- Discussions with AID and Office of International Health (OIH) staff (under an interagency agreement with AID, OIH staff provide technical assistance on AID projects such as the HSA)
- Development of recommendations on ways to improve the HSA process
- Preparation of a report to include: descriptions of the HSA process in each country evaluated, comparison of the HSA and the recommendations

### BACKGROUND RESEARCH

The first step in carrying out the evaluation was to review three successful sets of HSA guidelines to determine objectives and recommend process procedures. (A number of guidelines bearing an HSA have been issued by various agencies, for example Program and Policy Coordination and the regional bureaus). Those reviewed for this study were developed by the Technical Assistance Bureau for Health/USAID. The final HSA reports and selected correspondence and other documents on the three countries to be evaluated were also reviewed in order to gain an understanding of the procedures followed, the content of the assessments, the type of problems or issues which emerged, and the outcomes.

## QUESTIONNAIRE DEVELOPMENT

Using the information obtained from the background review and the questions posed by AID in the contract scope of work, two questionnaires were developed: one for use with AID participants, the other for host country personnel (see Appendix B). The host country version was modified slightly for interviews with donor agency representation.

In developing the questionnaires, considerable effort was spent in determining whether or not to make the questions open-ended since these might cause difficulties later with respect to tabulation and analysis. Ultimately it was decided that open-ended questions were more appropriate since the process had been conducted as much as four years earlier, detailed answers would probably be difficult to obtain. Answers undoubtedly would be somewhat impressionistic. More importantly much of the information to be sought was to be judgemental (e.g., effectiveness of team organization consultants, education value -- personal and institutional, description of the HSA process etc.). To develop precoded answers for this type of information would have been virtually impossible.

Upon their completion the questionnaires were reviewed by AID and OIH staff, who suggested certain modifications. A final draft was then prepared and pre-tested in Washington. To a degree the initial interviews in the Dominican Republic also served as trial runs -- some questions were made more structured for the sake of comparison with the open-ended ones. The results confirmed the original suppositions. Many details were lacking and responses tended to be non-quantifiable. In some cases, respondents were suspicious or reluctant to be critical. They appeared to be more comfortable with open-ended questions and often provided useful information which the team felt would not have been forthcoming with structured questions. The questionnaire was subsequently organized so that broad "opinion" questions were asked first, with specific follow-up questions to be used as required (see Appendix B).

## RESPONDENT SELECTION AND INTERVIEW PROCEDURES

Prior to visiting each country, a list of potential interviewees was developed, derived from the document reviews and recommendations of AID and OIH.

The objective was to speak with a cross-section of participants including all higher-level host country and AID/Mission team members and key consultants, with key officials in the ministries of health, with representatives of donor agencies. Key AID and OIH personnel were also interviewed. In addition to speaking with HSA participants, the contractor spoke with other knowledgeable individuals, including current host country officials, Pan American Health Organization personnel IAD policymakers, and other consultants in the health field. The purpose was twofold: to ascertain the impact of the HSA on government policies, priorities and programs; and to develop a framework of current AID and host country conditions within which to develop the recommendations so as to make them as realistic as possible.

Upon arrival in each country the team reviewed the list with the public health officer in the missions and with other knowledgeable persons such as the individual who had served as host country technical coordinator. A final list was developed and interviews scheduled.

In most cases, two members of the team were present at each interview: one member to ask questions, the second to take notes. On occasion, two interviewees were available at the same time, in which case the team split up. All interviews with host country nationals were conducted in Spanish.

Participants were informed that their responses were confidential and would not be directly attributed to them, but would be aggregated in the individual country reports. When the interviews scheduled for each site were completed, the team reviewed its notes and met again with the public health officer to go over questions and issues which had arisen.

The team was able to speak with about 80 percent of the participants selected (see Appendix C). A good cross-section of participants were reached.

Although the team had been concerned about the length of the interviews (approximately two hours), with very few exceptions, respondents in all countries made themselves available for that period. Generally the questionnaires had to be adjusted to focus on the questions a respondent could answer which sometimes shortened the time needed to administer the questionnaire.

The contractor visited three countries -- Bolivia, Dominican Republic and Nicaragua. A fourth country, El Salvador, had not completed its HSA at the time of the scheduled contractor visit, and the trip was cancelled.

#### DATA TABULATION AND ANALYSIS

Upon completion of the site visits, the data were tabulated and analyzed for each country, and country reports written up. These were then aggregated to provide a summary across countries. Finally the recommendations were developed. Following are descriptions of the procedures used in tabulating and analyzing data for developing the recommendations.

#### HSA Descriptions by Country

Sections V-VII of the report contains descriptions of the HSA process in Bolivia, the Dominican Republic, and Nicaragua respectively. The information in all but the final portion of each section is a summary of the responses of participant interviewees and information obtained from the document reviews. The last portion contains the team's interpretation and conclusions. The information is organized as follows:

- Background Factors -- Existing conditions or activities at the time the HSA was implemented which might have affected the HSA or which served as a base against which to identify change; awareness of HSA objectives.

- HSA Process -- Key steps and elements of the HSA process which would affect outcomes, impact, and efficiency of the process; covers the process from the scope of work through release of the final USAID document
- Participant Evaluation of Outcomes -- Direct and indirect outcomes, achievements and impacts of the HSA, as well as those which were anticipated, but did not occur as identified by participants.
- Participant Conclusions -- Participants' evaluation of the value of the process and its efficiency, as well as observations about those variables which contributed to outcomes.
- Participant Recommendations -- Recommendations made by participants with regard to improving or changing the process.
- Evaluation Team Summary -- Conclusions about the effectiveness of terms of USAID objectives and host country expectations.

The intent was to provide an idea of how the process was conducted in each country and of participant opinions as to the process, more or less in their own words. The evaluation team's summary section addresses some of the contradictions in participant responses and the reasons for some of the procedures and outcomes.

The data was handled as follows. The responses to questions were aggregated to show the range of opinions and according to category of respondent in order to determine whether any patterns of opinions emerged. This would give an indication of any biases or of different perceptions attributable to USAID or host country affiliation. Those responses which appeared with frequency or which indicated patterns were noted and written up.

#### COMPOSITE SUMMARY AND ANALYSIS

The HSA process and outcomes for the three countries were then aggregated. This analysis was designed to look at:

1. The effectiveness of the processes in terms of USAID and host country objectives.
2. Unanticipated outcomes associated with the processes.

3. Similarities and dissimilarities in the process that might have a bearing on effectiveness and achievement of objectives; process strengths and weaknesses.
4. Problems which the recommendations should address.
5. General conclusions which could be drawn on conditions which favor or mitigate against HSAs on the feasibility of objectives, and other broad issues.
6. To place HSA in USAID and host country programming cycle for health.

To do the comparison, the summaries of responses prepared for each country were prepared. Both content in and of itself and in terms of respondent affiliation were examined. Where differences were noted, effort was made to trace its impact or cause.

#### Issues and Background Factors

The composite summary and analysis revealed some issues and background factors which, in the contractor's opinion need to be addressed with respect to AID policy toward program planning in general, and with respect to the selection of a suitable program planning model given certain country conditions. These issues and factors form the backdrop for the recommendations.

#### Recommendations

In developing the recommendations, the contractor found it necessary to go beyond addressing just the HSA. Because of respondent comments, proposed future directions in health sector program planning as indicated by USAID and OIH officials, and tremendous variations among regions and countries within regions; Westinghouse Health Systems felt that one type of program planning process was not realistic. Therefore this section begins with a broad look at a spectrum of program planning alternatives of which the HSA with modifications would be one.

Because of the feasibility of pursuing various objectives will depend in part on the nature of the model selected, these which looks specifically at them.

Next is a section on process variables. Recommendations address those elements in the process which emerged in the composite analysis as problems. Where these would probably be part of other program planning models that is noted.

Finally a number of specific actions are proposed relative to improving the process.

#### DATA LIMITATIONS

As with any evaluation particularly of activity carried out some years ago, problems were encountered in obtaining information. These did not affect conclusions or recommendations included in this report but are worth noting since they may indicate a need for further study before definitive course of action is taken. Further, some of the limitations could have been avoided had the process been designed so as to facilitate evaluation.

One obvious difficulty was the time that had elapsed since the HSAs were undertaken. The team had hoped to also work in more recent HSA countries, such as El Salvador or Guatemala, in order to have a control against which to ascertain the quality of participants' responses. Internal evidence suggest that reactions were tempered by the passage of time -- problems came to be viewed as less severe. Many details had been forgotten; the team was unable to obtain answers to all items in the questionnaire. Further, as mentioned above, evaluation had not been "built into" the process, so that needed information was not readily available.

Another problem was the difference in respondent perceptions about the HSA resulting from their different roles, levels of involvement, expectations, and affiliation (USAID or host country). Those perceptions sometimes led respondents to different conclusions and judgements about the process. When conflicting responses were received, the team rarely was able to verify an answer. However, definitive answers did not seem as important, in many instances, as the perceptions themselves, since these are what USAID must deal with.

One unforeseen problem (not serious but worth considering in future evaluations) was the location of many of the interviews. Since the team preferred not to use USAID offices, the only alternatives were hotel rooms or the interviewees offices. The latter were often used in order to minimize inconvenience to the respondent; however, constant interruptions from telephones, secretaries, and other staff resulted in a loss of time and some what disjointed answers.

The area in which the team had the most difficulty obtaining data was that of the HSA budget. No complete sets of financial information existed for any HSA. While the Missions can account for most of their direct expenditures, the team was unable to trace AID and TDY expenses. OIH estimates that on the average OIH/TDY advisors spent 25 percent of their time on the HSA and made about four to six site visits. Probably about one-quarter of the Public Health Officer's time was also spent on the HSA.

APPENDIX B

AID MISSION

NAME: \_\_\_\_\_

How to contact if we need further information?

Write: Interviewer will describe project, its personnel and state appreciation of interviewer's time.

(Explain we don't expect answers to every question)

1. Who we are
2. Purpose of AID contract
  - . Identify ways to improve HSA process and impact
  - . Develop guidelines
  - . Develop descriptions of process
3. Not a performance evaluation
4. Confidential
5. No need to answer every question
6. Realize hard to remember, since HSA was a while ago, to the best of your ability.

## PREFACE

1. What is your current position and title?
2. What was your position and the nature of your involvement in the HSA?
3. How long were you involved (at what stages)?

## BACKGROUND

4. a. What do you think was the purpose of the HSA? (If no mention is made of other AID/W objectives such as host country education, improved coordination, AID/M education, etc., draw out awareness of these other objectives, stated and unstated)
  - b. Did you think the goals were realistic (in terms of time, money, staff, political factors, other resources)?
- M 5. a. Prior to the HSA, what types of health activities were being carried out at the Mission?
  - M b. What priority was given to health relative to other sectors?
  - M c. Were there health components in projects in other sectors (agriculture, water, sanitation, nutrition, education)?
  - M d. Was any health planning being carried out? (IF NOT, GO TO 5d (3))
    - (1) If so, who was responsible for the planning?
    - (2) How do you feel about the level of competence?
    - (3) If not, had you done a DAP report?
  - M e. Was there any interest in the Mission in developing or improving its health planning capability?
6. What do you think were the main factors at the Mission (i.e. political, social, religious, economic, personal preference or cultural) which influenced the nature of health activities?
- M/HC 7. a. What types of health activities were being carried out in (the host country) prior to the HSA?
  - M/HC b. Was there any health planning going on?
  - M/HC c. If so, who was responsible for the planning?
  - d. How do you feel about the level of competence?
  - M/HC e. As far as you could determine, was there an interest in (the host country) in developing or improving its health planning capability?
- M/HC 8. What do you think were the main factors (in the host country) (i.e. political, social, religious, economic, personal preference or cultural) which influenced the nature of health activities?

- M. 9. a. To your knowledge, were any of the Mission's health activities, including health planning, being coordinated with other donor agencies?
- b. Was this also true for (the host country)?
- 10. How would you characterize relations between (the host country government) and the Mission? (Lead with specifics as necessary.)

SCOPE OF WORK

- 11. a. Were you involved in the preparation of the Scope of Work? (If not, skip to 16.)
- b. How were you involved?
- c. How was the Scope of Work team selected?
- d. Who wrote the workscope for the Scope of Work team?
- e. Who decided what the content and priorities of the Scope of Work for the HSA would be?
- f. Who approved the Scope of Work?
- g. In what way did (the host country) participate in the preparation of the Scope of Work?
- h. In the course of conducting the HSA, were additional items added to the Scope of Work?

PARTICIPANT SELECTION

- M/HC 12. Do you recall how the team members were selected (U.S. and host country)?
- 13. a. In your opinion, did the key participants have appropriate backgrounds for the HSA?
- b. Were there other people or skill areas which should (or could) have been included?
- M. c. Had any member of the team been involved in other sector assessments?
- M/HC 14. a. Which institutions were represented on the team?
- M/HC b. Were there others which should have been included?
- M/MC c. Was there adequate contact with other donor organizations and with the private sector?

TEAM ORGANIZATION AND MANAGEMENT

- 15. a. Could you describe how the HSA team was organized?

Team Organization and Management Cont'd.

- b. Were subgroups set up?
- c. How were they organized (i.e. around disciplines, issues, power groups, etc.)?
- d. Was there any special reason for structuring the team this way?

IMPLEMENTATION

Orientation

- 16. a. With respect to the briefing of the team, how was it carried out?
  - b. Do you think this briefing gave the team (host country and U.S. - an adequate understanding of the purposes of the HSA, of their specific tasks, and of the procedures for carrying out the process?
- 17. a. Were you given any guidelines for conducting the HSA?
  - b. What did you think of them, i.e. did they serve as standards/norms?
- 18. Do you feel there was adequate planning for the HSA process prior to actual implementation?

TEAM MANAGEMENT

- 19. a. Who had overall responsibility for the HSA?
  - b. Who had responsibility for the day to day work?
  - c. To whom did the team as a whole report?
  - d. To whom did the subgroups report?
- 20. Was the team structure effective in terms of efficiency, accomplishment of goals, minimizing conflict, enhancing communications, smooth operations?
- 21. a. Were changes made in the team structure during the course of the HSA?
  - b. Were they effective?

(Host Country) Participation

- M/HC 22. a. Was (host country) participation adequate (in terms of what it agreed to provide, overall support to the process, number of nationals participating, cooperation of the ministry of health or other key institution)?
  - M/MC b. If not, why not?
  - M/HC c. What could have been done to improve it?

Coordination

23. During the HSA, how would you characterize the coordination between the team and the Mission, (the host country) and other donors?

Logistics

24. As you know, from time to time projects such as this are affected by a number of logistical situations and problems. These may involve housing, office space, scheduling (of consultants and other team members), clerical support, copying, translating, editing, transportation (international and local), communications (local and with Washington), and general backstopping and troubleshooting. Were any of these particularly noteworthy in terms of their positive or negative impact on the HSA process?

Data

25. a. Of the data needs identified for the HSA, how much was available prior to the HSA that was reliable and hence useful?

b. In which of the following areas did data need to be collected?

	23b.	23c.	23d.
	Gathered	Not Useful	Updated
1. Health manpower			
2. Facilities Type Utilization			
3. Population Morbidity/Mortality Growth/Fertility			
4. Social/economic status			
5. Nutrition			
6. Legal			
7. Institutional			
8.			

- c. Were you able to collect useful data in all these areas?
- d. Where there were gaps, what was the effect on the HSA?
- 26. a. To your knowledge, were all the data analyzed?
- b. Do you know why they were not?
- c. Who analyzed the data (host country vs. AID)?
- d. Do you have any idea what analytical techniques were employed?
- 27. a. Do you know if the data were ever used?
- b. If so, by whom and for what purposes?
- c. If not, do you know why not?
- d. Have data been updated in any of these areas?
- 28. a. Looking back, were any problems experienced in the data collection and analysis?

Preparation of the final documents

- 29. a. Were you involved in preparing the final documents? (If not, skip to 30)
- b. What documents were prepared?
- c. Who prepared them?
- 30. a. Could you describe the processes used for preparing the final documents?
- b. For example, was a special writing team formed?
- c. Were different people or groups responsible for different sections of the report?
- d. Who decided what would go into the different sections?
- e. Did drafts of the section contain alternatives/choices or recommendations for review?
- f. Who reviewed the various drafts?
- g. How were decisions made as to final content?
- h. Who was responsible for reviewing the entire final report prior to submission to the Mission Director?
- M/HC 30. What was the nature of (host country) participation at the various stages of the drafting process?
- M/HC 31. a. Were the final documents translated?

- M/HC
- b. How were they disseminated and to whom?
  - c. Did you receive the final report? (If not, skip to 34)
- 32.
- a. What did you think of the findings?
  - b. Of the recommendations?
  - c. Have you used the report?
- M.
- 33.
- a. Were you involved in the DAEC review? (If not, skip to 34)
  - b. What did the DAEC issue paper say?
  - c. Why?
  - d. Do you know who contributed to it?

Impact Questions

34. We are interested in identifying what changes occurred as a result of the HSA process and whether those changes are still in effect. To the best of your knowledge:
- a. In general, how would you characterize the impact of the HSA on the status of health in (the host country) and on the delivery of services?
  - b. What has happened with respect to the recommendations contained in the final HSA report (in AID/M, (host country)?
  - c. Are there recommendations which haven't been implemented or addressed?
  - d. Why not?
  - e. Are there plans to do so in the future?
- 35.
- a. Has the status of planning or planning capabilities in the Mission changed?
  - b. Do you feel that health planning is now being conducted more effectively by the AID Mission?
  - c. Has the status of planning or planning capabilities in (the host country) changed?
  - d. Do you feel that health planning is now being conducted more effectively by (the host country)?
- 36.
- a. Do you feel there has been any institutional/attitudinal changes in the Mission?

- b. If so, what has been their effect?
  - c. Do you feel there have been any in (the host country)?
  - d. If so, what has been their effect?
- M/HC 37. Do you feel there is better coordination now between the Mission and (the host country), particularly with health units of the government, and with other donor agencies?
38. Do you feel there is better coordination of health activities within the (host country) government?
39. a. Do you feel the HSA process was an educational one?
- b. Do you feel that you personally benefitted from participating in the HSA?
- M/HC c. Do you know if people who participated in the HSA are now working in positions where they can apply what they learned?
40. a. Are you aware of any spin-off or unanticipated outcomes that occurred as a result of the HSA (i.e. institutional changes in other agencies, training programs established, greater awareness of health problems, etc.)?

Process Questions

- M 41. a. Was the HSA process affected by the AID funding cycle?
- M/MC b. Was it affected by the (host country) funding cycle?
- M c. What was the effect of the HSA process on normal mission operations?
- M/HC d. What was the effect on normal (host country) operations?
42. AID has asked us to look at a number of factors that may have influenced the HSA process. We would like to get your impression of the effect, positive or negative, of the following factors.
- You may feel that a factor had no effect; if so, please note that.

		None	Pos.	Neg.	Comment
M/HC	a.	Cost limitations			
	b.	Time constraints			
M/HC	c.	Time at which team members are available			
	d.	AID/M support			
M	e.	AID/W support			
	f.	Host country support			
M/HC	g.	Convergence of AID and (host country) goals			
	h.	Leadership			
	i.	Workload distribution			
M/HC	j	Use of consultants			

- M 43. a. As far as you know, was the HSA completed within the available budget?
- M b. Were funds added to the budget during the HSA process?
- M c. If so, why?
- M d. Do you feel the cost of the HSA was reasonable given the outcome of the process?

Evaluative Questions

- M 44. Do you think that the AID Mission health project would have been the same had there been no HSA?
45. a. Can you estimate the extent to which the changes mentioned earlier are a result of the HSA?

- b. Do you think the changes which have taken place in (the host country) would have occurred without the HSA?
- c. As soon?
- 46. a. Were there results that you felt could have been achieved but were not?
- b. Specifically, do you feel more could have been done to achieve the other objectives of AID/W (i.e. education, coordination, (host country) planning, etc.)?
- 47. a. What factors do you think are absolutely essential for the successful implementation on an HSA (logistics, political climate, leadership, etc.)?
- b. Are there ways in which you feel that HSA process could be improved?
- M 48. a. Do you think a single set of guidelines can be appropriate for HSA's in different countries or regions?
- b. What sort of guidelines do you think would be most helpful for conducting an HSA?
- M/HC 49. Do you feel that the HSA should be updated periodically?
- 50. All in all, do you think the HSA was worthwhile?
- 51. Do you think an HSA is appropriate for every mission?

CLOSURE:

- . Do you have any additional comments you wish to add about the HSA process?
- . Any comments on our questions (key persons only)?
- . Can we get back to you, if need be?
- . You can reach us at \_\_\_\_\_, should you have some additional comments.
- . Thank you for your time/trouble and cooperation and your useful commentary.

BOLIVIA

AID

Amadee Landry  
Dr. Alberto Gumiel  
Nancy Ruther  
James Becht

GOB

Ing. Luis Araos Quiroga  
Lic. Walter Villanueva  
Dr. Cecilio Abela  
Dr. Antonio Brown  
Dr. Jorge Quinteros  
Dr. Francisco de Urioste  
Dr. Rodolfo Mercado  
Dr. Adolfo Peredo  
Dr. Constantino Cuevas  
Lic. Abelardo Valdez  
Lic. Carlota Ramirez  
Lic. Jose E. Mallea  
Dr. Julia Elena Fortum  
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Lic. Sergio Iriarte\*  
Lic. Eunice Zambrana  
Lic. Ednae Merett de Valdivia

OIH/Consultants

Dr. John Daly, AID/W  
Representatives of PAHO/Bol.

\*Interview not Completed

DOMINICAN REPUBLIC

AID

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Dr. Donald MacCorquodale  
Gladys De Guzman  
Arturo Valdez  
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DR

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Lic. Cesar Garcia  
Dr. Manuel M. Ortega  
Dr. Luis Gonzales Fabra  
Lic. Mejico Angeles Suarez  
Dr. Inocencio Diaz Pinero  
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Dr. Orantes Aviles  
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PAHO

Dr. Juan Jose Barrenechea

APHA

Patrick Mamane

## APPENDIX D

### FINANCIAL ANALYSIS

One of the contractor's tasks was to investigate and analyze the funding of each Health Sector Assessment. This proved to be extremely difficult. The financial records were usually located in the Mission Controller's offices, but in each case, the files had been cleaned for storage and were incomplete in detail. Most of the records had been moved to the dead file areas, and only the summary documents were available for review. These files were relatively unattended and probably had not been used since the conclusion of the Health Sector Assessments. An attempt to locate the appropriate PIO/Ts was not successful, although these would not have provided all the necessary financial information since a good deal of money was spent under the HSAs from sources other than direct Mission funds. One example of this was the salaries paid to other U.S. government employees who worked on TDY in the Mission on the HSAs under a PSEA or similar type of inter-agency agreement. The Mission paid only their travel and per diem and no records were kept of the time that these persons spent working. It is thus impossible to determine the actual labor value of these individuals. The Mission, moreover, was involved in supplying a goodly amount of in-kind support in the form of logistics, space and equipment. While some efforts were made to track this support during the HSA, the mechanisms fell apart during the final report writing "crunch" when logistical support and expenditures may have multiplied several times over.

#### Bolivia

In Bolivia financial records were virtually non-existent. The files only contained information concerning the contracts of personnel who came to Bolivia on short-term assignments to work on the Health Sector Assessment. There is no indication of any logistical support or other costs beyond that spent on these personnel. The only indication of the total fiscal picture of the Bolivian Health Sector Assessment is

a budget projection for early 1974 which sets the project at approximately \$82,000. However, this is a fiscal year budget and the records kept are for an annual year. All of the contractor and short-term technical assistance funding totals somewhere in the neighborhood of \$130,000. This is the only figure available for the Bolivian sector assessment.

#### Dominican Republic

In the Dominican Republic where summary records concerning the PIO/Ts and project agreements were available, the documents indicated that USAID expenditures were approximately \$338,000 during the period in which the sector assessment was conducted. However, this amount does not include a large portion of OIIL personnel time. It is also unclear how much of this money (if any) was counterpart funds. While counterpart funds are indicated in the program documents there is no record of how or when they were spent. There is some correspondence which indicates that the Dominicans may have spent as much as \$269,000 of their own funds in addition to the USAID money. This is understandable in view of the large household survey. However, the condition of the files and the number of conflicting pieces of information led to the suspicion that the total amounts of money spent, as indicated in correspondence, by the Dominican government or the USAID are, in fact, inaccurate due to overlapped figures.

#### Nicaragua

In Nicaragua, which had the most complete information on project expenditure, the accumulated PIO/Ts and similar documents indicate that USAID spent a little over \$152,000 of Mission funds. In a separate letter from the Mission Director to the head of the Nicaraguan team, dated January 1976, there is an indication that USAID and the Nicaraguan government had together spent approximately \$288,000 on the Health Sector Assessment for the period April through December 1975. However, expenditures were made both before and after this period. Thus this figure is probably incomplete as a total cost. No other information was available which could serve to clarify or qualify this sum of money.