

**BIBLIOGRAPHIC DATA SHEET**

1. CONTROL NUMBER

PN-AAK-828

2. SUBJECT CLASSIFICATION (695)

ND00-0000-0000

## 3. TITLE AND SUBTITLE (240)

AID experience in the development and evaluation of integrated health delivery systems

## 4. PERSONAL AUTHORS (100)

Shutt, Dr. Merrill M.

## 5. CORPORATE AUTHORS (101)

World Health Organization

## 6. DOCUMENT DATE (110)

1977

## 7. NUMBER OF PAGES (120)

17p.

## 8. ARC NUMBER (170)

## 9. REFERENCE ORGANIZATION (130)

WHO

## 10. SUPPLEMENTARY NOTES (500)

(In WHO/UNICEF Inter-Agency Consultation on Primary Health Care)

## 11. ABSTRACT (950)

## 12. DESCRIPTORS (920)

health  
 health delivery  
 health education  
 health servs.  
 health training  
 integrated development

maternal/child health  
 paraprofessionals  
 preventive medicine  
 primary health care  
 public health  
 rural health  
 family planning  
 nutrition

## 13. PROJECT NUMBER (150)

~~Unknown~~

## 14. CONTRACT NO.(140)

Unknown

## 15. CONTRACT TYPE (140)

## 16. TYPE OF DOCUMENT (160)

## INSTRUCTIONS

1. **Control Number** - Each document shall carry a unique alphanumeric identification number. Use uppercase letters, Arabic numerals, and hyphens **only**, as in the following example: PN-AAA-123.
2. **Subject Classification** - Each document shall carry a valid subject classification code used to classify the research/technical document under a general primary subject, secondary subject, and/or geographic index code. Use uppercase letters, Arabic numerals, and hyphens **only**, as in the following example: AA23-0000-G518.
3. **Title and Subtitle** - The title should indicate the main title of the document and subordinate subtitle (if any).
4. **Personal Authors** - Enter the author's name(s) in the following sequence, **last name, first name (or initial), middle initial**.
5. **Corporate Authors** - Enter the corporate author(s) name.
6. **Document Date** - Enter the document publication year(s) as follows: **1979** or **1978 - 1979**.
7. **Number of Pages** - Enter the total number of pages followed by 'p' for pages and a period, i.e. **123p**.
8. **ARC Number** - Enter the AID Reference Center catalog number.
9. **Reference Organization** - The reference organization must be a valid reference organization. Enter the name, acronym, or abbreviation.
10. **Supplementary Notes** - Enter any useful information about the document that is not included elsewhere. Each note should be enclosed in parentheses.
11. **Abstract** - Include a factual summary of the most significant information contained in the document.
12. **Descriptors** - Select the proper authorized terms that identify the major concept of the research/technical document and are sufficiently specific to be used as index entries for cataloging.
13. **Project Number** - This is a unique number(s) composed of the AID project number followed by a sub-project suffix.
14. **Contract Number** - Enter the AID contract number under which the document was produced.
15. **Contract Type** - Enter the type of AID contract which funded the research/technical activity responsible for producing the document.
16. **Type of Document** - Enter a valid code representing the document type.

**WORLD HEALTH  
ORGANIZATION**



PN-AAK-828  
**ORGANISATION MONDIALE  
DE LA SANTÉ**

**Regional Office  
for the Eastern Mediterranean**

**Bureau régional  
pour la Méditerranée orientale**

**WHO/UNICEF INTER-AGENCY CONSULTATION  
ON PRIMARY HEALTH CARE**

**Alexandria, 26 to 28 October 1977**

**EM/WHO-UNICEF/IA.CONS.PHC/10**

**AID EXPERIENCE IN THE DEVELOPMENT AND EVALUATION  
OF INTEGRATED HEALTH DELIVERY SYSTEMS**

**by**

**Dr. Merrill M. Shutt  
Health and Population Officer  
United States Agency for International  
Development (US AID), Cairo**

---

**\*Originally presented at the 104th Annual Meeting of the  
American Public Health Association.**

The process of development requires a multi-sectoral approach to achieve economic and social equity, and to come to terms with man's physical environment. Solutions to the health problems of developing nations are part of the development process. The role of health in United States foreign assistance has varied in terms of emphasis and direction, but has been an integral part of our foreign assistance program since its inception.

Until the 1970's the health delivery activities of the Agency for International Development (AID) and its predecessor agencies were largely supportive of assisted-country efforts to improve health status by establishing health delivery systems patterned on the western model. This model relied heavily upon highly trained professionals and curative services delivered through urban-based clinics. These programs were augmented by vertical campaigns directed against specific disease and health related problems, and by the provision of sources of potable water.

While centers of medical excellence were created in developing countries, and advances made against some specific problems such as trachoma, smallpox and malaria, the grafting and expansion of this western model in the developing world resulted in the support of health delivery systems which reached only the few, the urban and the relatively affluent.

Beginning in 1971 with a single project designed to provide majority coverage, the Agency has moved its support towards development of integrated health delivery systems capable of delivering minimal maternal

and child health, family planning and nutrition services to majorities of populations, in locales in which they live, at costs which the developing country can afford without prolonged external assistance. Integration implies that the population served will have access to available health, family planning and nutrition services at the primary entry point in the health system. Administrative integration at all levels is not a prerequisite for developing such a system. AID does not reject the concept of vertical or "free standing" delivery of specific services as a temporary measure in order to move ahead more rapidly on problems of critical and immediate concern, but strongly encourages careful planning of such systems to avoid squandering resources, and supports incorporation of these services into the general health delivery system as soon as practical.

AID's efforts in integrated low-cost health delivery systems focus on women of childbearing age and preschool children. Supported projects depend heavily upon paraprofessionals, auxiliaries and volunteers, build upon existing traditional and formal delivery systems, and seek affordable alternatives which emphasize prevention, easy access to services, and appropriate referral channels. The AID strategy is to help each country develop a system which can consistently reach the majority of the targeted populations with simple, low unit cost services. Once established, the system can be progressively augmented qualitatively and quantitatively to respond to social and political factors inherent

in each country, and in keeping with the ability to add services in an economically self-reliant manner.

For most countries, providing acceptable and accessible health, family planning and nutrition services to the majority will require an assessment by the host country of needs and resources available, a ranking of priorities, extensive planning and reallocating of resources, orientation of the providers and of the community, the training of existing personnel, and training of new categories of personnel. Ideally, comprehensive health sector analysis, country health programming or similar analysis precedes the development of a comprehensive delivery system to provide expanded coverage. AID is willing to assist such analyses.

AID has no preconceived or set model for health delivery systems.

A system developed for one portion of a country may need extensive modification to reach majorities in other parts of the same country. Systems which might work well for one country may be completely inappropriate in another country for economic, cultural, political or other reasons. The system designed will inevitably undergo change as it is implemented, as each country finds what will work best for it. For these reasons AID encourages requesting countries to establish demonstrations to develop country-specific approaches to health delivery prior to radical modification of the national system. Continuous testing and evaluation in a defined study area of sufficient population (usually 100,000 or more) is encouraged to serve as a guidance

and feedback system for national planning of cost-effective delivery systems.

The planning of the system is done largely by the host country. AID can provide support during the planning stage by funding technical expertise to assist the requesting host-country to determine feasibility of alternative systems and in program design. Once a project is designed and acceptable to both the country and to AID, AID assistance usually takes the form of offsetting start-up costs, supporting training and retraining efforts, and assisting with system evaluation. These costs largely represent risk capital which is severely limited in many developing countries. AID may also provide limited commodity assistance. Basic local operational costs are generally borne by the participating country.

The intent behind this program approach is that refinements of those elements tested and found effective in the demonstration area can be carried forward and replicated on a national scale within resources available to the country and without prolonged external assistance.

AID's efforts in integrated health delivery are responsive to the Foreign Assistance Acts of 1973 and subsequent years, and to Secretary Kissinger's initiatives in the Seventh Special Session of the United Nations General Assembly. Title III, Sec. 304 of the 1975 Foreign Assistance Act states: "...Assistance provided under this section shall be used primarily for extension of low-cost, integrated delivery systems to provide health and family planning services, especially to rural areas and to the poorest economic

sectors, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach; health programs which emphasize disease prevention, environmental sanitation, and health education; and population planning programs which include education in responsible parenthood and motivational programs, as well as delivery of family planning services and which are coordinated with programs aimed at reducing the infant mortality rate, providing better nutrition to pregnant women and infants, and raising the standard of living of the poor."

With reference to easing rapid population growth and disease affecting the poorest countries, the Secretary of State, in an address to the Seventh UNCASS, stated: "One of the most promising approaches to these problems is the integrated delivery of basic health services at the community level, combining medical treatment, family planning, and nutritional information and using lowly trained paramedical personnel. The U.S. will support a major expansion of the efforts already underway, including those in cooperation with the World Health Organization (WHO), to develop and apply these methods. We strongly urge the help of all concerned nations." The UNGA resolution which resulted states: "The WHO and the competent organs of the UN system, in particular UNICEF, should intensify the international effort aimed at improving health conditions in developing countries by giving priority to prevention of disease and malnutrition and by providing primary health services to the communities, including maternal and child health and family welfare."

The Agency is strongly supportive of the resolutions on Primary Health Care passed in the 1975 and 1976 World Health Assemblies and pursuing coordination of AID efforts with those of WHO, UNICEF, other international organizations, and with other donors.

Tables I and II summarize AID assisted health delivery programs for fiscal years 1976 and 1977 (July 1, 1975 to September 30, 1977).

Table I lists AID supported projects which seek to provide as an end of project objective combined health, family planning, and nutrition information or services for the majority in the project area. 25 integrated projects in 23 countries will be planned or under implementation during fiscal year 1977.

Table II lists AID supported projects with partial integration of health, family planning or nutrition which do not have as a direct end of project objective delivery of combined health, family planning and nutrition service for the majority in the project area. There are 37 projects listed in 32 countries, as well as 7 regional or worldwide projects.

Full-scale demonstration efforts are exemplified by the DEIDS program in Thailand, the Danfa and Lofa County projects in Africa, and the Minas Gerais and Pernambuco activities in Brazil.

At times, AID supports only a segment of the host country's overall development of an integrated program; in Tanzania, for example, AID supports incorporation of family planning into its maternal and

child health program, and in Lesotho a manpower development project will train nurse practitioners for use throughout the health system. In Cali, Colombia, AID is assisting a research unit of the University del Valle develop an evaluation of an innovative periurban delivery system.

AID also assists programs to develop regional strengths in order to facilitate expanded coverage. The Strengthening of Health Delivery Systems activity in West Africa typifies this approach.

The AID centrally supported MEDEX and Center for Educational Development in Health projects are developing and implementing innovative educational methodologies for training health paraprofessionals and auxiliaries. Through the American Public Health Association, AID is supporting activities in a demonstration project in Lampang, Thailand, assisting a 20-country project in West Africa, developing health systems information exchange, developing evaluation guidelines for low-cost health delivery systems, conducting a State of the Art survey of health delivery systems, and providing technical expertise in health and family planning.

The final activity for mention is the consultative services made available by AID which can provide to developing countries at no cost professional expertise in nearly any facet of low-cost health delivery, including determining feasibility of alternative delivery systems, or designing integrated systems and in developing evaluation methodologies.

AID draws from a variety of resources to design, implement, and evaluate its health delivery system activities. From its own ranks, AID can muster limited numbers of public health, family planning and nutrition professionals and generalists, social scientists, design and loan officers, educators, and others. AID augments its own manpower resources through a variety of mechanisms. It has access through inter-agency agreements to manpower resources of the Department of Health, Education and Welfare and other U.S. agencies. Through contracts, subcontracts, and other arrangements, it can draw from professional organizations, private and voluntary agencies, schools of public health, universities, and private individuals. Increasingly, AID looks to a growing body of expertise in the developing world to serve as resources to other countries.

Based on AID's experience, some observations are possible:

- 1) AID's emphasis on integrated health delivery systems is relatively recent. Barely five years ago the Agency decided to attempt to find if it were possible to design health delivery systems capable of reaching majority populations with any kind of integrated maternal-child health, family planning and nutrition services. Developing nations increasingly believe that not only it is possible, but essential to find alternative methods for reaching their majorities. While there is tremendous interest on the part of developing countries in these concepts, the interested countries identify an immediate and critical need to share worldwide experiences and exchange information. AID is

actively supporting development of information exchange and management systems, conferences and workshops to help answer this demand.

2) While alternative delivery mechanisms are sought, radical departure from existing, conventional patterns of health delivery are viewed by policy makers in free societies as political and budgetary risks. AID assistance frequently offsets or minimizes these risks by sharing the planning, training and evaluation costs of demonstrations until countries have some assurance of the effectiveness of the new patterns of health delivery and are willing to provide increasing amounts of their own limited resources to replicate patterns established during the demonstrations.

3) In most developing countries the health delivery system will be successful in achieving majority coverage only if local communities can be stimulated to share major responsibility for provision of their own health care. Existing informal and traditional systems supported by the community can be synergistic to the formal system if pathways can be developed which allow each system to draw upon the strengths of the other.

4) While an increasing number of professional policy makers are advocating alternative delivery systems, organized professional groups, including medical and nursing schools and associations, and schools of public health must be involved and fully participate in the new systems. Intensive efforts are required to assure that professionals understand their partnership role and the roles of all others in the system. Training

volunteers, auxiliaries and paraprofessionals will be wasteful if their contributions are ignored, underutilized or misdirected by ill-advised or uninformed supervisory and professional personnel.

5) A significant cost element of new systems is attributable to training. Even the most remote volunteers must receive some simple guidance in the rudiments of "modern" maternal and child care, family planning and nutrition if he is to best serve his community. In addition to the requirement for rapidly retraining large numbers of existing personnel to perform different roles, new ways to train additional categories of health workers must be developed (and paid for). Trainers must be trained. More effective training methods, borrowing heavily from latest educational technologies, will be required if majority coverage is to be achieved within the financial capabilities of developing countries.

6) Health is influenced more by changes in attitudes and behavioral practices than by specific services delivered. Health education is a vital component in any health system, yet conventional health education techniques appear to fall short in motivating requisite change in attitudes and behavior. AID and other donors should more actively solicit the assistance of behavioral scientists and should support experimentation with innovative ways to promote changes in attitude and behavior beneficial to health status.

7) While it is generally agreed that the major objective of health delivery systems is to improve the health status of the population,

there is no general agreement on the measures of system effectiveness which should be employed. A spectrum of possibilities exists which ranges from simple assessment of the proportion of target population reached by the system to more complex establishment and analysis of indicators of assessing attitudinal and behavioral changes associated with system changes or modifications. A correspondingly wide range of evaluation costs are associated with the complexity of the indicators and measures utilized.

There are a few who argue that no evaluation is necessary. On the other extreme are those who tend to lose sight of the original intent of improving delivery systems and make evaluation the objective rather than an outcome measurement of effectiveness of health service delivery. With a few exceptions policy makers desire evaluation methodologies which will provide answers upon which to base rational changes in any delivery system. AID is prepared to assist in the development of useful evaluation methodologies and guidelines which vary in complexity and cost, but which are practical in the context of a variety of developing world situations.

8) There are those who would argue a "medical threshold syndrome"; they would suggest that until countries are able to develop their conventional health systems to some arbitrary level (frequently measured in physician-population ratio, hospital bed availability, per capita health expenditures, etc.), that there is little cause to explore new ways of health care delivery. We hold that it is these very

countries with the fewest resources that most require innovative approaches to provide social equity. The challenge is clear.

Summary:

AID is increasing emphasis on the development and evaluation of integrated health delivery systems for maternal and child health, family planning and nutrition. AID provides assistance to developing countries wishing to develop such systems capable of reaching the majority of their populations with basic services at costs the country can afford. By 1977, AID will be assisting in the design, implementation or evaluation of 25 systems in 23 countries.

Based on AID's experience, there is increasing demand for such assistance. Interested countries identify the need to exchange information and to share worldwide experience. Development of radical new systems involves political and financial risk which can be minimized by temporary external assistance. Success in developing alternative delivery systems will be related to developing community awareness and responsibility, actively involving professional leadership, developing new training methodologies, developing indicators of effectiveness of the systems, and finding innovative techniques to alter health attitudes and behavior.

**TABLE I\* - AID PROJECTS WHICH SEEK TO PROVIDE AS AN END OF PROJECT OBJECTIVE COMBINED HEALTH, FAMILY PLANNING, AND NUTRITION INFORMATION OR SERVICES FOR THE MAJORITY IN THE PROJECT AREA**

**AFRICA:**

Central African Republic	Ouham Province Rural Health
Ghana	Danfa Rural Health
Liberia	Lofa County Outreach
Mali	Rural Health Services
Senegal	Rural Health Development
Zaire	Basic Health Services

**ASIA:**

Korea	Health Loan
Philippines	Bicol Integrated Development Loan .
Nepal	Integration of Health Services
Pakistan	Basic Health Services Loan
Thailand	Lampang Project (DEIDS)

**NEAR EAST:**

Afghanistan	Basic Health Services
Egypt	Improvement of Rural Health Services

TABLE I (Continued):

LATIN AMERICA:

Bolivia	Health Delivery Sector Loan (plus technical assistance component)
Brazil	Integrated Health Delivery (two project areas)
Colombia	Health Sector Loan Tulane - PRIMOPS
Costa Rica	Nutrition Loan Family Planning Services
Dominican Republic	Health Delivery System Loan (plus technical assistance component)
Guatemala	Rural Health Services and Facilities (plus evaluation of services)
Honduras	Integrated Rural Health/FP
Jamaica	Primary Health Care - Cornwall Co.
Nicaragua	Rural Health Development Loan (plus technical assistance component)
Panama	Health Delivery Systems

\*These listings for 1977 programs are estimates made in August, 1976.  
Joint AID and host country decisions may alter the listings.

**TABLE II\* - AID SUPPORTED PROJECTS WITH PARTIAL INTEGRATION OF HEALTH FAMILY PLANNING OR NUTRITION WHICH DO NOT HAVE AS A DIRECT END OF PROJECT OBJECTIVE DELIVERY OF COMBINED HEALTH, FAMILY PLANNING AND NUTRITION SERVICE FOR THE MAJORITY IN THE PROJECT AREA**

WORLDWIDE:

MEDEX  
Center for Educational Development in Health

AFRICA:

Regional	MCH Extension
	FP Training in Health Training Institutions
	MCH & FP Training and Research Development
	MCH & FP Nutrition Training & Development
Botswana	MCH/FP
Cameroon	Practical Training for Health Educators
Central West Africa Regional	Strengthening Health Delivery Systems
Chad	Rural Health Policy Planning & Management
Kenya	Family Planning
Lesotho	Training Program, Manpower
Liberia	Rural Health Delivery Training
Senegal	Family Planning
Swaziland	Health Manpower Training
Tanzania	Manpower Training - MCH
Togo	Family Health Training
Zaire	Health Systems Development
	Health Development Zones
	Maternal Child Health/FP
	Nutrition Planning

TABLE II (Continued):

ASIA:

Philippines	Nutrition Population
Nepal	Population
Pakistan	Expansion of Population Plannir
Korea	Population
Thailand	Population Planning
Bangladesh	Population/FP

LATIN AMERICA:

Chile	Child Nutrition
Colombia	Nutrition Loan
Costa Rica	Demographic Education
El Salvador	Family Planning and Population
Guatemala	Population and Family Health
Haiti	Nutrition Improvement
Honduras	National Nutritional Development
Jamaica	Family Planning
Nicaragua	Family Planning Nutrition Loan
Panama	Health and Population
Paraguay	Population

NEAR EAST:

Afghanistan	AZGA Clinic Expansion
Morocco	Family Health Training
Tunisia	Family Planning
Yemen	Health/Nutrition OPG

\*These listings for 1977 programs are estimates made in August, 1976.  
Joint AID and host country decisions may alter the listings.