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A FAMILY HEALTH CARE REPORT

Planning for Health and Development:
A Strategic Perspective for
Technical Cooperation

Volume I
Main Report
(Findings and Recommendations)

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

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PLANNING FOR HEALTH AND DEVELOPMENT:
A STRATEGIC PERSPECTIVE FOR
TECHNICAL COOPERATION

Volume I
Main Report
(Findings and Recommendations)

Submitted to:

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OFFICE OF HEALTH
Bureau for Development Support
Agency for International Development
Washington, D.C. 20523

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FOREWORD

Objective of the Study

The objective of the Family Health Care (FHC) contract with AID's Office of Health/Bureau for Development Support was to review and assess AID and other international experience in designing, implementing, teaching, and institutionalizing national health planning and its linkages with national development planning in developing countries. The research and analytical activities undertaken in this study were designed to provide AID with current background information, and assessment of state-of-the-art and resources, against which to develop an AID program in support of national health and development planning in developing countries over the next five to ten years.

The workplan for the project, which began in February 1979, included the following specific activities:

1. A survey of the experience of each of AID's regional bureaus and the DSB relating to central support, program design, field experience, personnel training, and institutional development in the field of health planning. What is the current stage of development of such programs in developing countries? What has been the influence of the AID program on development of self-reliance in planning for health?
2. An assessment of developing countries' experiences in design, process, and outcome (irrespective of AID support). How many countries actively engage in multisectoral planning for health in

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- association with a development planning commission? What national planning systems seem to be working as measured by influence on national policy and implementation? What progress is there towards establishing self-sustaining systems/institutions?
3. A review of the World Health Organization's experiences in implementing "country health programming", including an assessment of that method's process, training components, outcomes, and future plans. To what degree does CHP complement or overlap with AID programs? Is CHP a short-term instrument or does it have serious long-term potential for institutionalizing the planning process?
 4. An assessment of the status of training for health planning in the United States and in overseas institutions. Is the current design, curriculum content and multisectoral exposure appropriate to needs of the next decade? To what degree is exposure to major non-health sectors such as education, rural development, public administration, and political science being incorporated into training? What is the career record of trained health planners? Where are potential institutions overseas which might serve as bases for developing multisectoral training?
 5. The convening of a panel of consultants to formally review progress made during the conduct of the study. These consultants would have had extensive experience in intersectoral planning structures and processes, particularly in the developing countries, which have focused on health improvements.

The Project Team

To carry out the intensive series of activities required for the study, FHC put together a well-balanced, multidisciplinary project team which combined both theoretical and practical experience in many aspects of health planning in the developing world. The project team was composed of the following professionals:

Stanley C. Scheyer, M.D., Chairman of the Board, FHC (Project Director)

Jeremiah Norris, Director, FHC International Division

Alan W. Fairbank, M.P.A., Health Economist, FHC (Project Manager)

Ronald B. Epstein, President, FHC

Lawrence E. Williams, Treasurer, FHC

David W. Dunlop, Ph.D., FHC Consultant

David A. Parker, M.P.A., FHC Consultant

Natalie Pishock, M.P.A., AID/W Intern, Office of Health

Gayle Gibbons, Resource Librarian, FHC

Patricia H. Davis, Administrative Assistant, FHC

Project Approach

The project team focused its initial activities on intensive collection of preliminary data. These activities included the drafting of an assessment framework which described and rationalized an approach to guiding the collection of data and the conduct of interviews, and a series of field visits to selected countries and to WHO central and regional offices. The draft assessment document, together with tentative findings and recommendations, were presented at an early stage to a

Review Panel made up of a broad range of professionals from disciplines concerned with health and development issues.

The results of the discussions of the Review Panel, which met in Washington, D.C., on May 3-4, were then used as input into a revised draft document, which also reflected the results of further visits to the field during May.

The revised draft report then became the subject of a workshop on planning for health and development, which was held in Washington, D.C., on June 4-5. The reactions and comments of the health and development planning professionals at the workshop helped to finalize the findings and recommendations which appear in this report.

Field Visits and Interviews

Much of the information about the practical realities of health planning in developing countries was obtained through field visits. In addition, extensive interviewing and consultation with professionals located in the Washington, D.C., including those at the World Bank, the Inter-American Development Bank, and the Pan American Health Organization, area added invaluable insights to the final product. An appendix to this volume includes a list of persons interviewed and the composition of project teams which made the field visits. The places and dates of the field visits were as follows:

Field Visit To:

WHO/Geneva

WHO/SEARO/New Delhi

Dates of Field Visit

March 8-14, 1979

April 2-3, 1979

WHO/WPRU/Manila	April 16-18, 1979
WHO/EMRO/Alexandria	May 23-26, 1979
WHO/AFRO/Brazzaville	May 28-31, 1979
PAHO/Washington	June 6-7, 1979
Nepal	April 4-10, 1979
Korea	April 10-18, 1979
Guatemala	May 14-17, 1979
U.S. Training Institutions	May 1-31, 1979
European Training Institutions	May 17-28, 1979

Review Panel and Workshop

The participants in the May 3-4 Review Panel, and the June 4-5 "Workshop on Planning for Health in Less Developed Countries", were essentially consultants to the project. Of the professionals who appear below, an asterisk indicates that they were participants in both the May and June sessions held at the Pan American Health Organization in Washington, D.C.:

William Bicknell, M.D., M.P.H., Health Policy Institute, Boston University, Boston

Henry Bienen, Ph.D., Woodrow Wilson School of Public and International Affairs, Princeton University

*Thomas Bossert, Ph.D., Office of International Programs, School of Public Health, Harvard University

*Richard Cash, M.D., Harvard Institute for International Development, Harvard University

Sol Chafkin, Officer-in-Charge, Social Development, Ford Foundation, New York

Susan Cole-King, M.B.B.S., D.T.P.H., Institute for Development Studies, University of Sussex, United Kingdom

Abraham Drobny, M.D., Inter-American Development Bank, Washington, D.C.

*David W. Dunlop, Ph.D., University of North Carolina, Chapel Hill

Tomas Engler, M.D., Director, Adult Education, Ministry of Health, Panama City, Panama

Kenneth Farr, Ph.D., Office of International Health, DHEW, Washington, D.C.

Dale Gibb, Dr. P.H., Health Officer, USAID/El Salvador

Frederick Golladay, Ph.D., Economist, Office of Environmental & Health Affairs, World Bank, Washington, D.C.

*Robert Grosse, Ph.D., School of Public Health, University of Michigan, Ann Arbor

Davidson Gwatkin, Visiting Fellow, Overseas Development Council, Washington, D.C.

Susi Kessler, M.D., Associate Executive Director, International Health Programs, American Public Health Association, Washington, D.C.

*Robert Kudrle, Ph.D., School of Public Administration, University of Minnesota

Paul Lawton, Assistant to the Director General, World Health Organization, Geneva

Ted Marmor, Ph.D., Committee on Public Policy, University of Chicago, Chicago

Kartar H. Notaney, Ph.D., Planning Officer, WHO/SEARO, New Delhi, India

Chong Kee Park, Ph.D., Secretary General, National Health Secretariat, Korean Development Institute, Seoul, Korea

Hyung Jong Park, M.D., M.P.H., Ph.D., President, Korea Health Development Institute, Seoul, Korea

Susan Ueber Raymond, Ph.D., World Bank, Washington, D.C.

William A. Reinke, Ph.D., Department of International Health School of Hygiene & Public Health, John Hopkins University, Baltimore

Dragan Stern, M.D., Health Planning Advisor, WHO/WPRO, Manila, Philippines

Carl Stevens, Ph.D., Department of Economics, Reed College, Oregon

Paul Zukin, M.D., Kaiser Foundation International, Oakland, California

Representing the U.S. Agency for International Development, Washington, D.C.

*Stephen C. Joseph, M.D., M.P.H., Deputy Assistant Administrator for Human Resources Development

From the Office of Health, Development Support Bureau

*Lee M. Howard, M.D., Dr. P.H., Director

*Clifford Pease, M.D., Deputy Director

*Donald E. Ferguson, Ph.D., Health Delivery Systems

*Irving Taylor, Chief, Health Planning Division

*Theresa Lukas, M.P.H., Health Planning Advisor, Health Planning Division

From the Bureaus

*Barbara Turner, M.P.H., Near East Bureau, Acting Chief, Health, Population and Nutrition

Don MacCorquodale, M.D., Deputy Chief, Asia Bureau, Health, Population and Nutrition

*Thomas Georges, M.D., Africa Bureau, Chief, Health, Population and Nutrition

*Charles DuBoise, Ph.D., Development Resources, Africa Bureau

*Barbara P. Sandoval, M.P.H., Latin American Bureau, Chief, Health, Population and Nutrition

*John Massey, M.P.H., Deputy Chief, Health and Nutrition, Latin American Bureau

In addition, the FHC team would like to extend its appreciation to Henrik L. Blum, Ph.D., Professor of Health Planning, University of California at Berkeley, for his review of FHC's first draft paper; to Carl Taylor, M.D., and William Reinke, Ph.D., Department of International Health, Johns Hopkins University, Baltimore, for their written critique of that draft paper; and, to Kerr White, M.D., Deputy Director, Division of Health Sciences, Rockefeller Foundation, New York, for his review and comment on the FHC's second draft paper.

This study was commissioned by the Office of Health, Development Support Bureau, AID/W. Its Director, Lee Howard, M.D., Dr. P.H., has provided much of the staying power and direction to AID's investment strategy in the health sector during the past ten years. It is now at a point where it represents the largest single donor involvement in primary health care throughout the world. He participated actively in this study to determine what works and what does not work in health planning as it has been conducted during his tenure as office director. And he thought it just as important to understand the latter's contribution to knowledge as the former's temporal capacity to provide the appearance of truth. Programming in the health sector is a minefield of uncertainties. The FHC project team would be pleased if this study commissioned by Lee Howard serves to reduce the uncertainties for AID as it moves into the 1980s.

Organization of the Report

This report of the study has two components:

Volume I: Main Report (Findings and Recommendations)

Volume II: Technical Background Papers

The "Main Report" contains summary statements of the assessment frameworks of the rationale and assumptions underlying planning for health and development, and of the findings of the field visits, interviews, and research activities. Most of the material in the "Main Report" comprises the necessary documentation and reasoning which lead to the conclusions and recommendations.

The "Technical Background Papers" include the full documentation and explication of the project's approach, methodology, and assessment findings. In this volume there is included a thorough analysis of the theoretical and empirical justifications for a multisectoral approach to health and development programming and planning; the principal author of this section was David A. Parker. This volume also includes an empirical analysis of health planning concerns and activities in 27 countries of Africa, Latin America; the principal authors of this analysis were Holly Caldwell, David W. Dunlop, and David A. Parker.

Executive Summary

The U.S. Government is the largest contributor for health development assistance to developing countries. AID ranks first and foremost among donors lending specifically for primary health care, a key to achieving "health for all by the year 2000".* In recent years, AID expenditures on health have increased, and, if current trends continue, the prospects are that the total health investment during the decade of the 1980s will be in the range of \$1.5 - \$2 billion. Thus, the expectations and perceptions generated by the scale of this investment program cast AID into an international leadership role; the sheer momentum of it propels AID into a position of global responsibility.

The magnitude of that responsibility began to take on definition when the U.S. Government committed itself to the primary health care goals set forth in the Alma-Ata Conference in 1978, and to the resolution on achieving "health for all by the year 2000" adopted by the 1977 World Health Assembly. Now, AID is undertaking a review of multisectoral planning for health and development within the context of its health sector strategy. AID thus joins the World Health Organization in focusing attention on the need to approach technical cooperation in health from a multisectoral perspective.

However, the capability to undertake a coherent effort in a social policy area that cuts across traditional institutional lines of authority

* "New Directions in International Health Cooperation", The White House, Washington, D.C., Spring 1978.

(agriculture, industrial development, the private sector, etc.) is weak, within AID, the donor establishment, and the recipient community. The donor capacity to systematically provide legitimacy to a new policy initiative (multisectoral planning) through appropriate program research and evaluation is untested. Donors have a major influence on allocating resources to new programs in LDCs but only a limited ability to understand the implications of their actions over an extended period of time.

The readiness of the donor community in general, and of AID in particular, to apply resources toward improved and expanded primary health care (PHC) in LDCs is examined in this study. The PHC program initiative is seen to depend on the establishment of new, multisectoral methods for planning for health. While AID has been involved in support of "health planning" for ten years, a multisectoral approach constitutes a new departure. Past experience has shown that new program initiatives by AID must successfully meet three critical tests:

1. The political character of the agency means that new initiatives in health need effective U.S.-based political support; but political constituencies are more easily found for some parts of AID's portfolio (population, agriculture) than for others. Political support for longer-term, more speculative investments of high (though uncertain) potential return is a continuing problem for AID.
2. Many program initiatives are based on incomplete information and minimal empirical justification (e.g., prepaid health care for the poorest of the poor; comprehensive, integrated health services for

rural residents;) but are launched when they are theoretically sound and meet an expressed need or demand; and

3. The brief time perspective of AID programming means that some new initiatives must serve short-run, event-forced needs of a particular Administration.

AID has generally sought to design its assistance programs so as to make one or more of three types of contributions:

- To transfer financial resources to support a subsector which could not get financing from alternative sources;
- To encourage more effective use of the recipient's own resources in project implementation; and/or
- To convey insights and knowledge gained in other developing countries to the country being assisted (replicability).

Since the end of World War II, there have been several changes in the composition of health expenditures of AID and its predecessor agencies. First, associated with the steady shift in focus from categorical diseases to health care systems was an increase in clinical funding to provide for the treatment of diseases. Public health measures were maintained but there were few significant initiatives. Second, there was acceptance by AID of a major responsibility for financing health care for certain groups within LDCs (the poorest of the poor). As living standards rose and health care became more specialized, technology-oriented, and costly, equitable access to treatment became a salient issue. In turn, as central governments' financial investments in treatment increased within the LDC community, a search for measures of quality and cost control began. The role of the donor community in helping to finance "equal access" to health care (treatment) services,

however, is according to one view, not entirely supportive of donors' stated objectives of improving health status.

This apparent gap between rhetorical and programmatic thrusts of donor assistance has raised questions about the efficacy of past investments: is there greater improvement in population health status from development of a "disease-care" system (curative medicine) or from development of a "health-care" system (preventive medicine/public health)? Some have argued that it is infinitely more cost-effective to apply scarce resources to attacking underlying causes of diseases, rather than to treating their effects. Others have been more persuasive that neither approach can be effective in isolation from the other. Indeed, the rationale underlying the "primary health care" strategy explicitly addresses the need to improve access to integrated services for both "disease-care" and "health-care" in the peripheral areas of LDCs. However, the administrative and analytic capacity of LDCs to plan and to implement the necessary programs is woefully inadequate at present.

This study has determined that there is a gap between the U.S. Government's commitments at Alma-Ata and the World Health Assembly, and its capacity to make good on that pledge by the year 2000. The one hope for bridging that fateful gap lies in our fragile capacity to try and realize the ideals which have been conceived at these world conclaves, to strive to attain what we are theoretically capable of attaining. It would not be helpful to argue that, in order to meet these commitments, AID must first be in possession of a full-fledged arsenal of professional and fiscal resources.

While there is a gap between capacity and need, one does not create

the former by invoking the latter. There is no doubt about the need for each citizen of the world to be able to lead a socially and economically productive life by the year 2000, but there can be little confidence that it is in man's ability to make this happen. If only the impossible will bring health to those AID serves in the LDC community, then those populations will not be healthy, ever. But, with the essence of life itself at stake, one must deal with possibilities without probing too rigidly at the probabilities.*

In all the vast sweep of human history, man has moved into the future as a result of decisions, not as a result of plans. An important source of bad decisions is the illusion of certainty. The great danger is that the product of planning (the "plan") frequently produces an illusion of certainty simply because it is dressed up attractively and is seen as the work of professionals.** Multisectoral planning for health, however, is much too complicated to be considered a near-term LDC programmatic objective; rather it is a strategic perspective (focused now on the PHC strategy) which offers a conceptual framework for understanding important concepts and tools needed by policymakers for the process of resource allocation among all sectors of the economy. As the multisectoral health perspective begins to gain acceptance among decisionmakers and program managers, greater certainty and wider knowledge can progressively become the basis for health investment decisions.

* Seth Tillman, "Human Nature and International Community: Thoughts on the Lower Instincts and Higher Capabilities," **Worldview** (no date).

** "Our Third Century: Directions. A Symposium," Committee on Government Operations, United States Senate, February 4, 5, and 6, 1976, Washington, D.C.

The central issue of this study is caught in a delicate web between a philosophic confrontation with the constructs of multisectoral planning and the urgent need for donor cooperation to transform its underlying theory into an implementable program of action. The significance and value of multisectoral planning for health lies less in what its proponents say it can do for the attainment of "health for all by the year 2000" than in the incipient forces it can marshal for the provision of new forms of organization toward that end. Goal-setting is one such force. The multisectoral process has both a driving and a drawing power of its own. Change itself is an energizing force, opening up new opportunities for new sources of economic, political, and intellectual power throughout the LDC and donor communities. And, human values, those which are shared and those opposed, also serve to fuse motion to substance. At times these forces may polarize or even paralyze the decisionmaking process, but for both their drawing power and driving strength, they hold high potential for galvanizing donor sensitivities to LDC needs.

An awareness of the critical need for linkages between the planning process and project implementation has shaped the thinking about these recommendations. The wide spectrum of linkages needed between support for multisectoral programming of health assistance and support for its implementation in the field suggests the necessity for AID to develop a portfolio approach in this area. Such an approach would recognize that support of the long-term goal of multisectoral planning for health need not require a distinct programmatic initiative naming "better planning" as its theme and objective. Rather since AID support of multisectoral

planning can be advanced by the achievement of several quite distinct and separate objectives across development sectors of an LDC economy, there should be a variety of different (though related) investments in the AID portfolio. Different criteria should be used to manage and evaluate each, and different returns should be expected from each. More effective policies and institutional arrangements can be devised if the value of such diversity is accepted.* The recommendations made at the end of this report suggest modifications of existing arrangements, and these modifications recognize the incentives and disincentives that shape AID's current technical assistance policies.

Even as modifications, few of the recommendations proposed will be easy for AID to accept or to implement. They all imply change and this is generally threatening in that it involves changes in existing structures, relationships, and habitual ways of doing business. But change is essential and we must be on its side; otherwise, our rhetoric at Alma-Ata and the World Health Assembly will be out of step with our capacities to deliver, and our stated objectives out of tune with public opinion as expressed through the U.S. Congress.

* "The Federal Investment in Knowledge of Social Problems, Study Project on Social Research and Development," Assembly of Behavioral and Social Sciences. The National Research Council, National Academy of Sciences, Washington, D.C. 1978.

the FHC team encourages AID to proceed as a participant with its other colleagues in the world community to begin, conjointly with the LDC community, the collaborative and cooperative design of projects which provide a step-by-step approach to incremental improvements planning for health from a multisectoral perspective. There is a critical need, though, to temper enthusiasm with humbling amounts of pragmatism as we set off into the future. The year 2000 will be reached; and though it will not bring in its wake the millennium of health services to all, we may all have been ennobled to have been part of the quest.

I. BACKGROUND

I. BACKGROUND

During the past several years, there has been a significant change in the focus and in the scope of international concerns about health in the developing world. This change was reflected in the 1977 World Health Assembly and in the 1978 Conference on Primary Health Care at Alma-Ata. The 1977 World Health Assembly adopted a resolution that the main social target of member governments and of WHO in the coming decades should be "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."¹ The Alma-Ata Conference declared that "primary health care" constitutes the "key to attaining this target as part of development in the spirit of social justice."²

The widening scope of concerns about health among development policymakers, program officials, and health professionals is chiefly the result of a changing perspective among them on the social dimensions and prerequisites of development and on the role of health in development processes. An increased awareness that health is both a cause and an effect of socio-economic development has made health an important component of development strategies for meeting "basic human needs".

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1. Resolution WHA30.43, WHO Official Records No. 240, Part 1, 1977, pg. 25
 2. "Declaration of Alma-Ata", International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

With this general global agreement that "primary health care" is the best strategy for achieving "health for all by the year 2000" and that it is the umbrella concept under which technical cooperation will be undertaken, there is now a need to fashion global agreement on the appropriate steps required for implementation. Toward this end, the principles and concepts of "primary health care" as enunciated at Alma-Ata are an explicit endorsement of significant social and political changes which many Third World nations should aim at, with or without large-scale international cooperation. In order to promote self-determination and self-reliance, LDCs must implement efforts to address:

- (1) the need for individual and community participation in decisions affecting their own health;
- (2) the need for application of health technologies which are socially and economically appropriate to the country;
- (3) the inequitable distribution of health resources; and
- (4) health promoting elements of non-health activities, e.g., strategies of meeting "basic human needs."

It is evident that the predominant emphasis on an multisectoral approach to health development programming and implementation has a number of far-reaching implications for the way in which development resources are channeled and applied. For less developed countries, the resource allocation to non-health sectors must become more responsive to national health goals, particularly in peripheral areas. At the same time, services provided through the health sector must be redirected toward community-oriented health promotion, protection, and prevention

activities. Donor technical cooperation must also change in terms of the establishment of priorities and in the methods by which they program and disburse financial and technical assistance.

The level of resources, both financial and technical, that will be required to adequately implement the global strategy is substantial. However, country-specific implementation plans which define resources and policies needed and programs to be pursued must be developed based upon that country's unique characteristics, conditions, and development goals. No one donor can provide adequate resources by itself to any one country. Moreover, no particular donor or agency possesses the range of knowledge and resources needed for such an effort. Thus the more developed countries will need to coordinate their efforts globally, based on a clear enunciation of policies and programs to be supported in country-specific and country-level efforts.

Since varied social and economic conditions and highly diverse health situations and health care systems preclude the creation of a single formula for implementation of the global strategy, each country subscribing to the global goal and PHC strategy will have its own view and interpretation of the meaning and relative importance of key concepts, and will need to adapt ongoing efforts and past investments. Further, the additional resource requirements and imperative of involving other sectors in health development programming give added importance to the strengthening of planning capacities.

On a global scale, the question of overall program priorities within an overall strategy for technical cooperation in health development

cannot be adequately determined without improved planning capacities both among the donor agencies and the less developed countries.³ However, there are different issues for donors and recipients of financial and technical assistance in this cooperative process. For donor and technical agencies, the effectiveness of their participation depends on their ability to better plan a coordinated effort.⁴ For recipients, the achievement of national health goals will depend upon an ability to better plan all development efforts so that overall population health status is improved.

The purpose of this document is to assess the capacities and needs of less developed countries for planning of health investments and improvements; to examine the existing capacities and policies of donors and technical agencies in technical cooperation for health development; to chart a reasonable framework by which future planned participation should proceed; and to articulate an appropriate role for AID to play as a major donor of resources for health development.

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3. See discussion and similar conclusion in "Formulating Strategies for Health for All by the Year 2000: Guiding Principles and Essential Issues", Preliminary Document of the Executive Board, A32/8, 15 February 1979, Provisional Agenda Item 2.6, 32nd World Health Assembly, Geneva, World Health Organization.
 4. Initial efforts in coordination were reported in "WHO Report on Meetings on Extrabudgetary Resources for Health," held in Geneva, 20-24 November 1978, WHO Document CPD/ERH/78.15, Geneva, World Health Organization, 1978.

II. DEFINITIONS

- A. General Terms
- B. Programming Terms

II. DEFINITIONS

Before introducing the analytical framework designed for assessing health planning efforts in developing countries, it is helpful to precisely establish how certain terms, words, and phrases are used.

A. General Terms

1. "Development"

In a sense, the definition of this term in the past was determined by conventional theories of its principal determinants and by economic measures of its achievement. Rate of growth in per capita income has been a traditional yardstick for measuring, and thus defining, the speed with which a nation or population group was achieving "development." The shortcomings of this measure and its implied definition have become evident. First, some countries with rapid growth rates in average (per capita) GNP have continued to experience constant or worsening conditions of poverty for substantial portions of their populations, while other nations have achieved high rates of growth and of capital formation while narrowing income differentials within their populations. Second, conventional measures of average output exclude the value of household production of non-marketed goods and services which clearly add to consumption (and investment) and to utility. Third, some output increases cause a decrease in overall social welfare (or utility), such as irrigation schemes spreading disease or increased road traffic causing pedestrian deaths. Finally, rising average income can mask falling median income, hiding an increasingly inequitable distribution of the gains from economic growth. From the point of view of social welfare,

any definition of development which excludes consideration of social benefits and costs of economic growth is considered an inadequate definition. "Development" should specifically include the concept of social welfare advancement, and it is so used in this assessment.

2. "Health"

"Health" is a multifaceted phenomenon with many varied underlying determinants. Thus, it is difficult to arrive at a definition that captures all facets, that provides a clear and accurate conceptual picture, and that is also amenable to purposes of measurement. The concept of "health" in any particular society is based in the socio-cultural structure and belief system of that society. These structures and systems vary greatly.

As a result, definitions of "health" which are conceptually inclusive tend toward the ideal and have little practical use as a goal or a measure of activities that aim at "improved health." For example, the WHO defines "health" as:

"A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

Henrik Blum offers an alternative formulation:

The capacity of the organism (1) to maintain a balance appropriate to its age and social needs, in which it is reasonably free of gross dissatisfaction, discomfort, disease, or disability; and (2) to behave in ways which promote the survival of the species as well as the self-fulfillment or enjoyment of the individual.⁵

Blum condenses this concept into a shorter version:

A state of being in which the individual does the best with the capacities he has, and acts in ways that maximize his capacities.⁶

It is easy to see that "health" as a concept does not lend itself to being measured or quantified in a single composite statistic, either for an individual or population group. The search for a single health status indicator has led to a body of evidence that a complex of aggregated elements or factors making up "health" offer a more practical useful set of measures for goal formulation, program design, and evaluation than can be attained via one measure.

5. Henrik Blum, **Planning for Health: Development and Application of Social Change Theory**, (New York: Human Sciences Press, 1974), p. 93.

6. Ibid.

For purposes of measuring the concept of "health," studies have constructed indices in which various functional states are postulated "well-being" and "death." For example, Warford and Saunders identified a total of 11 states,⁷ and Culyer et al constructed an index reflecting degrees of pain and restriction of activity.⁸ These "states" are characteristics of individuals, which, when aggregated, provide summary characteristics for population groups. Goldsmith traces the span of definitions or concepts of health over into the derivation of indicators which can be used for purposes of measurement.⁹ Fanshel and Bush¹⁰ constructed more advanced formulations, which together with Goldsmith's¹¹ work formed the basis for Blum's own conclusion that separate scales (eight of them) must be used to measure the separate aspects of "health" of individuals: (1) prematurity of death; (2) disease; (3) discomfort; (4) disability or incapacity; (5) internal satisfaction; (6) external satisfaction; (7) positive health; and (8) capacity to participate. These eight health scales are later converted into indicators for assessing health status, which can then be used as measurable goals.

7. R.J. Saunders and J.J. Warford, **Village Water Supply: Economics and Policy in the Developing World**, (Baltimore: Johns Hopkins University Press, 1976), p. 55.

8. A.J. Culyer, R.J. Lavers, and A. Williams, "Social Indicators: Health," **Social Trends**, 2 (1971), pp. 31-42.

9. Blum, *op cit.*, p. 63

10. S. Fanshel and J.W. Bush, "A Health-Status Index and its Application to Health-Services Outcomes," **Operations Research**, 18 (November/December 1970), pp. 1021-1066.

11. Seth B. Goldsmith, "The Status of Health Status Indicators," Department of Health Services Administration, School of Public Health and Tropical Medicine, Tulane University, New Orleans, July 1971, mimeographed, cited in Blum, *op. cit.*, p. 93.

It should be recognized that there are conceptual problems in converting scales for measurement of individual health status into scales for measurement of population health status, except in the case where aggregations are disease- or problem-specific. Over large groups of people, the number and variation of health problems is so vast and complex that measurement in a single variable can be truly misleading.

There are measures of the levels of certain illnesses or problems within a population, e.g., incidence and prevalence of morbidity from specific causes, which can be used for various measurement, goal specification, programming, and evaluation purposes. These data should be recognized as "reported" figures, not "actual" figures, and be treated accordingly for the probable error involved. One should also be careful to recognize subtle differences between both concept and measurements of morbidity, infirmity, debility, disability, and incapacitation.

Because of its terminal nature, mortality should be seen as defining an altogether different conceptual dimension of "health." Mortality as an aggregate figure fails to reveal important information about causes of death and age-specific death rates unless it is disaggregated in such a way. Since death can be prevented for only so long, it is helpful to keep in mind that predominance of "premature" death is a more significant reflection of health conditions than the actual rate (relative to population size) of its having occurred. As a result, whether predominant causes of death are preventable and whether the predominant age at death is fairly young are important factors in determining the importance to attach to mortality data as an indicator of health status. Thus, although mortality data are typically the most easily identified,

quantified, and reported of all feasible health status indicators, in most societies the reduction of mortality is a priority distinct from a reduction of infirmity.

3. "Nutrition"

"Nutrition" status is as difficult and complex a concept to define as health status. Conceptually, health and nutrition status are closely related because their levels and changes are mutually determined. Direct measurement of nutrition status is usually accomplished through various types of anthropometry, such as birth weight, weight for age, height for age, and weight for height. Nutrition status cannot be determined without reference, in fact, to other physical characteristics of an individual or population group, the principal ones being age and height. These and many other indicators have problems in interpretation, especially when used as aggregate summary data for large population groups.¹² More precise use of indicators can be accomplished by using population subgroups for reference purposes, such as pregnant women, lactating women, and children by age group.

12. James E. Austin, et al, **Urban Malnutrition: Problem Assessment and Intervention Guidelines**, (Cambridge: Harvard University Press, 1976), pp. 121-123.

B. Programming Terms

1. "Planning"

Julius Nyerere, the well-known president of Tanzania, once said that "to plan is to choose." Such a characterization goes beyond the dictionary definition (Webster's Dictionary defines "to plan" as being "to devise or to project the realization or achievement of.") To Webster, "to plan" is more "to design" or "to intend" than Nyerere's definition, which appeals to the formulation of a more encompassing definition of the term than that which emanates from the dictionary.

Nyerere's definition takes the term from the passive and incorporates a dynamic or active component of not only engaging in the act of designing but also incorporating the acts of decisionmaking (about allocation of scarce resources) and of implementing those decisions. In contrast to dictionary or textbook definitions, e.g., Blum's characterization of "planning" as those activities "devoted to directing and attaining social changes of a specific and desired nature,"¹³ Nyerere's explicit invocation of the necessity to decide by making choices gives life to the concept and to the dynamic processes involved.

13. Blum, op. cit., p. 14.

In Nyerere's Tanzania, as in other developing countries, the social goal of choices made in "planning" is typically that of "development." And "planning" comprises all those activities which are involved in specifying goals and objectives, designing alternative means of achieving them, estimating probable consequences of those alternative means, and facilitating the implementation of the decision and the assessment of results. The activities that are entailed in this process are numerous and varied; they are difficult to define abstractly. There can be, in fact, many operational meanings of planning, depending on the range of processes or steps being defined and on goals, structural characteristics, and the tools it adopts. It is not sufficient, however, to define "planning" merely in terms of one aspect of all activities it involves. Thus, "planning" cannot be adequately defined only by its concerns, nor only by the administrative structure by which it takes place, nor only by the tools or methodologies which it uses. Conceptually, it is most usefully defined as a complex of acts and activities which centrally involve analysis for decisionmaking (alternatives and consequences) but which broadly comprise participation in setting goals and making decisions as well as participation in implementing those decisions and assessing the results. This all-inclusive and dynamic definition of "planning" as a broad set of activities is the way it is used in this assessment.

2. "Planning Health Services" vs. "Planning for Health"

The juxtaposition of these two phrases is intended to facilitate a conceptual contrast for illustrating how differences in perspectives can lead to vast differences in the definitions of "planning" in the field of

health. Although it may be somewhat artificial to dichotomize the various kinds of perspectives into two categories, the scope of "planning health services" (typically labeled "health planning"), is narrower than that of "planning for health." Differences between the two phrases go beyond differences in perspective, and include differences in the inclusiveness of goals, scope of policies and programs relevant to achieving those goals, and operational requirements for implementation and in breadth of conceivable impact or result. The implications of these differences are important and are subsequently addressed in this assessment of health planning.

According to the dichotomy applied here, "planning health services" is defined simply as "activities devoted to analyzing alternative ways of organizing and delivering health services and in forming decisions on health services development." "Planning health services" assumes a narrower goal framework than "planning for health"--health services being the focus of the former and health status being the focus of the latter. The assumptions of the "planning health services" approach has distinct implications for the dimensions of the "health planning" structure, process, and outcome, and they reflect a narrower perspective on "health."

Comprehensiveness in approaches to planning for health becomes necessary if the policy planner is to have sufficient scope to direct changes in all areas which constitute major inputs to health and well-being. These major input areas can be classified in a number of different ways. For definitional purposes it is sufficient to point out that comprehensive multisectoral planning for health ("planning for

health") concerns itself with those factors and events (social, cultural, political, and economic) which have both direct and/or indirect effects on health through one or more intervening variables. "Planning health services" concerns itself largely with the effects of disease and only minimally with the direct causes of morbidity and mortality. The indirect causes of illnesses are beyond its scope of concern.

"Planning for health" is often termed "multisectoral" planning because of the necessity to involve many non-health sectors. Limitations faced in trying to implement "planning for health" have been usually due to the fact that it is administratively difficult to involve non-health sectors in health-related interventions. However:

Health planners can no longer avoid the background (indirect) inputs to health if they are to protect the investment of their efforts at the (direct) level of morbidity and, equally important, if they are to exert any control over the kinds and quality of morbidity with which they will be confronted.¹⁴

14. Elizabeth Jolly, "A Model to Put Comprehensiveness into Health Planning and Health into Comprehensive Planning," School of Public Health, University of California, Berkeley, 1970, mimeographed, cited in Blum, *op cit.*, p. 112.

For purposes of our assessment, a distinction between "health planning" and "planning for health" is maintained. "Health planning" will be used to refer to conventional concepts generally implying "planning health services"--activities which are limited to addressing the direct, immediate effects and circumstances of morbidity. The term "planning for health" will be used to refer to the broader concepts of "comprehensive multisectoral planning for health" or planning activities which include attention to causes and circumstances of poor health, especially predisposing factors and background conditions. This dichotomy of usage, of course, will not be rigorously adhered to because the more commonly used term "health planning" does, in some instances, include the broader set of concerns in its specific connotation.

3. "Basic Health Services"/"Primary Health Care"/"Integrated Health Services"

It can be shown that these phrases, which are commonly used in the literature of health/development programming, have closely related if not overlapping meanings. To some analysts, these phrases can be used almost interchangeably because they all seem to embody about the same degree of imprecision. To illustrate the problem of defining these terms satisfactorily, examples of definitions cited in the literature follow.

A recent joint study by the WHO and UNICEF on "Alternative Approaches to Meeting Basic Health Needs in Developing Countries" discussed the concept as follows:

An adequate approach to meeting basic health needs must provide, inter alia: sufficient immunization; assistance to mothers during

pregnancy and at delivery, postnatal and child care, and appropriate advice in countries that accept a family planning policy; adequate safe and accessible water supplies, sanitation, and vector control; health and nutritional education; and diagnosis and treatment for simple diseases, first-aid, and emergency treatment, and facilities for referral.¹⁵

The "Declaration of Alma-Ata" adopted by the delegates to the September 1978 International Conference on Primary Health Care declared that "primary health care" (among other things):

Includes at least: education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supplies and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunization against the major infectious diseases, prevention and control of locally endemic diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs.

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15. V. Djukanovic and E.P. Mach, eds., "Alternative Approaches to Meeting Basic Health Needs in Developing Countries," A joint UNICEF/WHO study, (Geneva: World Health Organization, 1975), p. 9.

AID's Office of Health's draft report entitled "United States Policy and Programs on International Health as Related to Development Assistance" defined its concept of "low-cost integrated health delivery systems" as being synonymous with the WHO concept of "primary health care" adopted by the 1975 World Health Assembly. According to the draft report, this concept included the ideas of: (1) participation by the served population; (2) health provider functions being performed by a person from the community to be served; and (3) a network of referral services into which the majority of people have access through the entry point of the most peripherally-located village health worker.¹⁶

This AID draft report also said that "'integration' refers to the combination of elementary health, population, and nutrition services at the household level."¹⁷ In other places, "integrated health services" is used to refer--either explicitly or implicitly--to the combining of previously "vertically" administered categorical disease control programs into ongoing health care services, or to the combining of various activities of non-health sectors with health services (beyond the population and nutrition services mentioned above).

16. Lee M. Howard, "United States Policy and Program on International Health as Related to Development Assistance," mimeographed draft report, (Washington, D.C.: USAID Office of Health, Development Support Bureau, February 1, 1978), p. 96.

17. *Ibid.*, p. 101.

As can be discerned from the above confused state of definitions and use of multiple terms for the same set of services, this analysis suggests that: (a) the term "integrated health services" be abandoned; (b) the Alma-Ata definition of "primary health care" be recast as a statement which defines the minimum set of inputs into the health status production function and (c) the terms "primary health care" and "basic health services" be melded into one term (the former, "PHC") defining individually consumed preventive and curative health services which can be provided by minimally trained health care workers at the periphery. The definitional and conceptual recastings form the basis for future use of these terms throughout this analysis.

4. "Linkages"/"Synergism"/"Complementarity"

For a detailed discussion of these programming terms, see Volume II, "Technical Background Papers", Section I, where they are more extensively used.

III. ASSESSMENT OF EXPERIENCES IN PLANNING FOR
HEALTH IN LESS DEVELOPED COUNTRIES

A. Assessment Criteria

B. Assessment Findings

III. ASSESSMENT OF EXPERIENCES IN PLANNING FOR HEALTH IN LESS DEVELOPED COUNTRIES

A. Assessment Criteria

1. Methodology and Approach

The development of appropriate criteria for judging efforts in planning for health is difficult because the phrase is imprecise; it connotes a broad range of activities and concerns. Problems in this regard were discussed somewhat in Section II ("Definitions"); but by choosing a precise definition for our purposes, one still cannot make uniform the widely divergent perceptions and uses of the term by those on whom one must rely for information. The conceptually broad connotations of "planning" in theory seem to narrow considerably in practice when applied to "health". As previously noted, the common constraining focus is typically on "health services" rather than on "health status".

The tasks of gathering and classifying the kinds of information needed to assess efforts in planning for health are not standardized across countries. How these planning efforts can be and are carried out, the quality with which activities are executed, and their ultimate results are all influenced by the social, economic, and political climate in which they take place. The importance of any particular activity or process can vary greatly from country to country, and it depends for example, on administrative structure and capacities, technical capabilities of planning personnel, and/or the degree of integration of planning for health with overall development planning.

For a study such as this one, limited as it is both by time and resource considerations, it is not possible to design and implement an elaborate evaluation methodology. The assessment methodology is a two-dimensional framework which is partly descriptive and partly evaluative. (A detailed presentation of the research framework and its results is given in Volume II.)

In the empirical assessment framework, a general categorization of areas and functions of the process for planning health catalogues the specific activities that characterize the process in each particular country covered in the study. Moreover, social, economic, demographic, and health indicators are collected for each country to define the overall development context in which the planning of health is being carried out. Analyses are conducted using cross-tabulations and other statistical techniques to determine whether and how specific characteristics of the process of planning for health is related to the larger social and economic framework in which it is conducted.

In the qualitative assessment framework, analyses are conducted of the operational dimensions of planning for health. These analyses are based upon indepth assessments of health planning efforts in specific countries visited by the project staff. The purpose of this assessment framework is to make judgments about the manner in which planning for health actually is carried out in less developed countries. Criteria are developed, and judgements made, in three general areas: (1) the political/administrative structure by which priorities are set, alternative programs considered, and decisions taken; (2) the process by which the technical/analytical functions of planning are carried out; and

(3) the mechanisms by which policy/program planning functions [(1) and (2)] are linked to implementation, monitoring, and evaluation functions. This characterization is shown schematically in Figure 1.

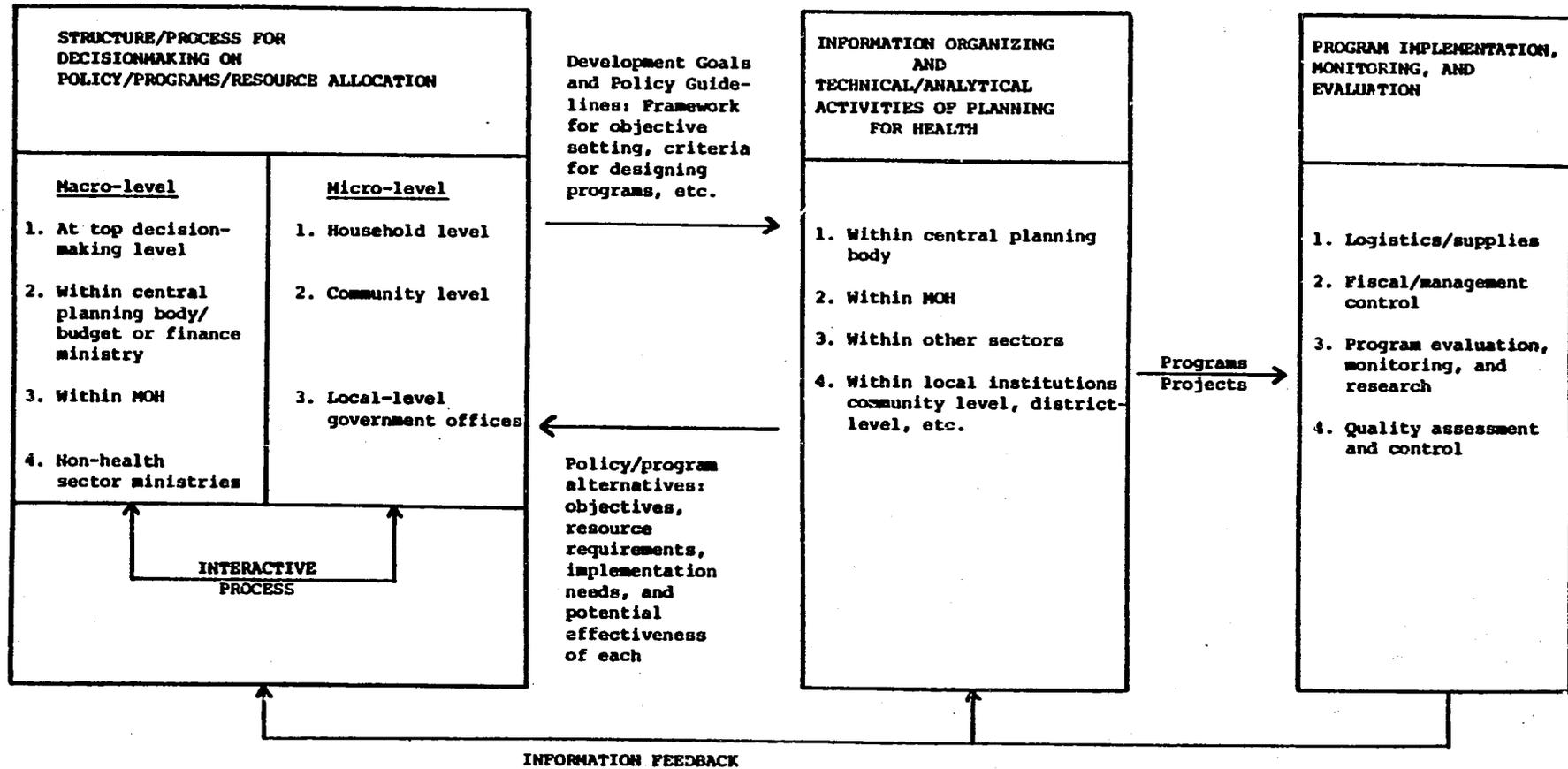
Since it is rather difficult to develop clear distinctions between these elements or activities when looking at any particular country's planning process, it is conceptually helpful to view these three elements of planning as representing, in some sense, a continuum of activities ranging from the setting of overall development goals and broad policies at one end to the carrying out of specific mundane tasks at the other. Planning activities are those which aim to give direction in all steps of the continuum. To categorize these activities into three areas, as is done in Figure 1, provides some focus to the making of judgments about the ways in which the activities are conducted and about their results.

The three-category classification illustrated in Figure 1 is a broad-gauged systems perspective of the planning process. While the complex processes and structures in some countries may require a more detailed and sophisticated systems classification framework, this three-part framework was a reasonably helpful way to classify the project team's data gathering effort in the countries visited and facilitated subsequent judgments and conclusions about observations that were made.

In addition to developing this framework, the project team also articulated an associated set of value statements against which the findings were assessed. Judgments about planning efforts in particular countries, and generalizations about the set of countries looked at in depth, reflect the team's process of seeking answers to a set of specific questions (implied by the assessment framework) and of applying certain values to the answers.

Figure 1

Schematic Characterization of Qualitative Assessment Framework:
Areas, Foci, Elements of Activities and Concerns Involved in Planning for Health



2. Value Judgments: What is "Good" Planning for Health

Planning when applied in the field of health is especially difficult to assess when criteria are to be applied to a broad definition of "health" linked so closely to the overall process of "development." Among the 40-50 less developed countries whose efforts at "planning for health" might be assessed, there exists a wide range of historical experience in health system development which can imply uniqueness for each case. There are divergent concepts, structures, processes, and techniques of planning, and there are different concepts of the scope of planning concerns deriving mainly from different concepts of "health" and how it is to be provided to the population. Generalizations in judgments are thus likely of dubious validity unless qualified and put into proper context. Nevertheless, when approaching the assessment of a particular country's planning for health efforts, it is necessary to have in mind a framework of values and set of criteria against which to judge the observed planning activities. It is for this purpose that the following values and norms are stated. It is these criteria which have formed the basis for the information gathered about country-specific efforts at planning for health. Judgments made on the basis of these criteria and the data that have been gathered are reported in the next section (III.B, "Assessment Findings"). These judgments, when combined with the rationale and premises for planning for health in Section IV, are the basis for conclusions and recommendations about the current status and future needs for planning for health in LDCs (presented in Section V and VI).

(a) STRUCTURE DEFINING PROCESS OF SETTING GOALS/PRIORITIES

(1) Whatever the structure or processes for resource allocation/policy/program decisionmaking, the concept of health to be addressed by planning for health should be broad enough to require consideration of:

- health impacts of all development projects and activities;
- the importance of particular non-health sector investments and of intersectoral coordination in improving population health; and
- the limited role of personal curative services in affecting health status relative to the role of behavioral and socio-economic characteristics of the population in determining the causes of ill health.

(2) Satisfying the expressed political demand for personal curative services, while it is legitimate in its own right, should not be confused with satisfying the political demand (albeit unexpressed in many countries) for better health.

(3) The structures and processes for resource allocation/policy/program decisionmaking should effectively connect the various levels and sectoral agencies of government around the issue of better health.

(4) One of the major prerequisites for effective planning for health is that key decisionmakers at the top level and in key non-health sectors (e.g., water and sanitation ministry) understand and support the focus on a broader concept of health. Thus, planning for health cannot be effective without the opportunities for face-to-face discussions between health sector representatives and top-level

planners/decision-makers on the one hand, and between health sector representatives and other sector representatives on the other hand.

(5) Where planning for health emphasizes the need for community-based primary health care delivered by community health workers, then decentralized structures and processes for programming, resource allocation,, and decisionmaking are required. Moreover, the central ministry of health requires effective administrative/management and logistics/supply support mechanisms, that may indeed be linked to other sectors.

(6) Appropriate structures and processes (i.e., those that support planning for health approaches and activities) are necessary, but by no means sufficient, for effective planning. What is necessary is that key decisionmakers believe in the potential effectiveness of approaches, concepts, and activities of planning for health, since to support them requires application of scarce administrative and political resources.

(7) A trained professional planner in the central planning body, one well-versed in the approaches and concepts of planning for health, is necessary in order that multisectoral investments toward improving health receive adequate consideration at the top political decisionmaking level. This professional should have training in planning for health, not merely training in social sector or human resources planning.

(8) The structure and processes for decisionmaking concerning policies and programs for better health are pertinent for their effect on the outcome of planning for health at all levels of government and in all successive sequential stages of alternative program/policy design and

implementation. Connections between policy/program decisionmaking and the budgeting and project implementation processes are required.

(b) INFORMATION ORGANIZING AND TECHNICAL/ANALYTICAL ACTIVITIES IN PLANNING

Information Organizing

(1) Data produced through the network of official (government) health services should be used as only one segment of the overall information base of the process of planning for health. Official health statistics should be recognized as having substantial weaknesses in indicating the overall health situation, health problems, and nature of demand for health services.

(2) New sources and kinds of information need to be developed in order to support a multisectoral effort in planning for health; this information must be developed so that it helps to communicate common understanding of health problems and the dynamics of their causes and effects throughout all sectors and levels of government.

Setting Objectives for Planning for Health

(1) The setting of objectives must be consistent with overall development goals and take place within a context that permits the consideration of the political, social, and economic feasibility of implementing the subsequent programs.

(2) The setting of objectives of programming for health must be articulated in a political/administrative context that makes possible not only the estimation of potential effects of alternative means for

achieving those objectives, but also the measurement of whether subsequent implementation leads the system toward stated objectives.

Identification of Problems

(1) The identification of health problems should be approached from the perspective of what combinations of factors cause the perceived patterns of ill health and how the dynamic epidemiology occurs.

(2) The identification of health problems should involve the participation of those in need of health care--both consumers of services and those currently without access to services.

Analysis of Constraints and Design of Program Alternatives

(1) The analysis of constraints and design of program alternatives should be an iterative process in which there is close and continuous collaboration among planners and program implementors.

(2) Resource constraints analysis should include consideration of the full spectrum of resources to be required--from financial to professional/technical manpower to managerial/administrative resources.

(3) Realistic analysis of constraints is central to any plan that is to be feasible of implementation; particularly crucial is identification of local and national financial resources that are (both now and in the future) available for discretionary allocation according to plans for the future.

(c) PROGRAM IMPLEMENTATION, MONITORING, AND EVALUATION

(1) All plans must include, at some point, a detailed management

plan which outlines the procedures and means by which the program and projects will be implemented. Without this having been completed, line managers can have no idea how new programs relate to existing ones and administrators will lack realistic guides to day-to-day decisionmaking.

(2) Monitoring and evaluation capacity is critical to long-term progress in developing a planning capacity. Without improving and expanding the knowledge base for informing decisionmakers of the consequence of their decisions, there can be little hope for increasing effectiveness of the process for making sound policy and designing effective programs.

B. Assessment Findings

1. Experiences of Less Developed Countries

A large number of less developed countries have instituted efforts at health planning during the past 10-15 years. Many of these efforts have received stimulus and assistance from major international donor agencies, mainly AID, and from the Pan American Health Organization and World Health Organization. In conjunction with these efforts, there have been a number of efforts organized to train health planners in various methodologies and curricula focused on techniques of health planning, many of them emphasizing the planning of health facilities and manpower development. The expansion of health services to cover more and more of the population has been the priority concern of many of these methodologies, and it has reflected, in part, the interests of major donors to the health sectors of developing countries in insuring the effective use of the increased amounts of aid they have made available.

The following assessment findings on experiences of LDCs in health planning are not based on a thorough, on-site field investigation of structures, processes, and results. However, the project team visited several developing countries, read plan documents, and consulted with officials of the WHO and other major international donors in health before deriving these preliminary conclusions. Members of the project team have also drawn upon their extensive collective experience and knowledge of a number of other countries than those visited specifically for this project. The stated findings represent a melding of the results of both the empirical and qualitative assessment frameworks which are reported in detail in Volume II.

SUMMARY FINDINGS

(1) Processes and activities in health planning efforts are only rarely connected with decisionmaking on resource allocation or with national development policymaking. The budgeting and actual expenditure of funds appear to continue to follow traditional (i.e., non-planned) priorities.

(2) Health planning activities usually do not go beyond technical or methodological exercises leading to a plan document, which focuses on numerical targets generally unassociated with specific consideration of implementation tasks required and organizational changes needed.

(3) Health planning activities are heavily oriented toward donor-inspired priorities which usually find articulation in exercises dominated by outside consultants, typically from WHO. While some countries have greatly reduced dependence on consultants, the donors' influence on articulation of priorities (not to say implementation of stated priorities) is still strongly evident in the rhetoric of plans.

(4) Health plans tend to become blueprints which ministries of health then follow in constructing a health system. These blueprints satisfy donors' needs for giving aid in the context of a comprehensive plan but do not necessarily represent the best basis for deciding how to program better health.

(5) Health planning is largely oriented toward analysis and solution of problems in the supply of health services (i.e., facilities,

manpower) and is uninterested in analysis of the demand of those services by the population (e.g., the problem of underutilized, understaffed, but costly-to-build rural clinics).

(6) Most health planning efforts so far have failed to adequately analyze long-term implications and requirements of programming options and decisions. Particularly important and relatively easy to perform are long-term cost and employment projections of certain programming directions. More difficult to conduct, but not less important for improving planning effectiveness, are analyses which begin to relate program implementation with effects on health status.

(7) Health planning efforts are perceived too often as static, short-term, time-limited exercises, rather than long-term ongoing processes which should be integrated into the whole institutional process of decisionmaking and budgeting. WHO's "country health programming" (CHP) to some extent fostered this notion, but its evolution is moving now in the direction of supporting the institutionalization of planning/programming/budgeting procedures.

(8) Comprehensive multisectoral planning for health has not generally been tried in LDCs primarily because political decisionmakers have little inclination or incentive to view health as an intrinsic part of socio-economic development.

SPECIFIC FINDINGS

(1) STRUCTURE DEFINING PROCESS OF SETTING GOALS/PRIORITIES

a. Existing structures and processes for decisionmaking in LDCs are generally not receptive to either the broad concept of health or to the various activities required in effective planning for health.

- Top policymakers and decisionmakers in budget/finance/planning ministries and in non-health ministries still perceive health as implying personal, curative services (usually hospitals) and an area of responsibility that is exclusive to the ministry of health.
- Planning activities in general, and those for health in particular, are incompatible with the generally short-term outlooks of most political regimes, and are not effective in guiding resource allocation decisionmaking for two main reasons: first, government revenues are difficult to predict and traditional budgeting mechanisms often retain tight control over allocations; second, donor interests, priorities, and funding processes are seldom coincident with a particular country's multiyear planning cycle.
- Planning activities are time-consuming if they are to be effective, and few LDCs can afford the opportunity costs of allocating already hard-pressed managers and program officials to planning tasks.
- The broad concept of health implies the need for a capability (i.e., the multisectoral, comprehensive programs required) of mounting complex administrative and managerial enterprises that are costly and require long lead times to prepare and long gestation periods to pay off: few LDCs have anything approaching this kind of capability and few can afford the large investment required.
- Economists in top policy positions often do not perceive government health spending as potentially productive nor classify such investment under human resources development; politicians in top policy positions do not see political benefits of providing much more than expanded ("low-cost") personal, curative health services within the government health program.
- No one government agency or unit is responsible for reviewing or assessing the long-term cost implications of certain fixed investments in building facilities and training manpower trends in both private and public sectors.

b. The traditional prerogative of the ministry of health over health matters tends to narrow the scope of any planning for health;

- On the one hand, the ministry of health naturally claims a preeminent role in designing any health plan because it possesses the technical expertise required.
- On the other hand, political leaders tend to view the ministry's role as that of a "social services/welfare provider" thus delimiting any wider expectations that it might have a potential for leadership in more than the technical/medical sense.
- The health ministry's own narrow medical perspective and its image among other parts of the government serve as disincentives to the employment of first-quality professionals in planning positions.

c. A wide variety of activities in non-health sectors and in the private sectors are often carried out which have health impacts, both intended and unintended, but these diverse and extensive activities are quite beyond the control, influence, or often even knowledge of the ministry of health.

- Local health services are often the responsibility of ministries of interior/home affairs, which carry on such activities frequently independent of the ministry of health.
- Government-supported health/medical insurance schemes are often independent of the ministry of health.
- Health manpower training is often the responsibility of the ministry of education, which has caused, in some cases, waste of resources and conflict with the ministry of health.
- Government agencies responsible for environmental conditions (e.g., water, sanitation, sewage disposal, etc.) are frequently controlled by ministries other than the ministry of health.

d. Efforts to coordinate and integrate comprehensive, multisectoral planning and programming in the social sector (which might address the above problems) are generally quite weak within central planning bodies, and health is only sometimes represented by trained professional(s);

- Where health planning sections in the central planning body do not exist, the MOH's health planners and the central planning body's social sector planners each lack appreciation of the other's perspective: the health planner sees the central planner as too "money-minded" or "resource-oriented" while the central planner sees the health planner as too "technical" and "naive about resource constraints"; thus the central planners tend to ignore the usefulness or potential effectiveness of whatever health planning methodology may have been applied in arriving at the health plan.
- Even where central planning bodies employ trained health planners in a health planning section, the arguments in support of programs in the health plan produced by the health ministry tend to be based more on humanitarian appeals than on cost-effectiveness or potential economic benefits of particular program investments; this tendency limits the political influence of the central health planning section even if it is inclined to use resource-based arguments for increased investments toward health (this is true even where CHP methods have facilitated group processes among planners, programmers, and decisionmakers).
- Non-health sectors' consideration of health impacts of their activities or projects are virtually non-existent.

e. The decentralized political/administrative mechanisms permitting and encouraging local participation in decisionmaking for local development goals and priorities (including health goals and priorities) are absent or weak in most LDCs.

- District or community-level political representatives or planners are rarely consulted in the design of health plans.
- The centralized, hierarchical, top-down method of organization and decisionmaking remains the dominant style in most LDCs.

(2) INFORMATION ORGANIZING AND TECHNICAL/ANALYTICAL ACTIVITIES

a. Existing data bases and sources of information tend to bias the use of planning methodologies and the setting of program objectives toward achievement of measurable access targets rather than of health status improvement objectives; this bias has two general manifestations:

- o reportable diseases and cause-of-death data translate into the identification of problems by specific levels of morbidity or mortality according to disease or disease classification (the fact that these data are only reported statistics may lead to faulty conclusions of actual patterns within the overall population); and
- o facilities, manpower, and services data translate into identification of problems by reference to specific geographic, specialty, or service gaps or inadequacies.

b. Despite frequent references to the importance of eliminating the causes of disease (in environmental pollution, poverty, lack of education, etc.), health plans generally focus most attention on the need to expand the supply of medical services (curative or preventive, personal or community).

- o When objectives are then generally set in terms of manpower to be trained, facilities to be constructed, and/or services to be provided within a specified period of time, there is seldom parallel reference to the expected demand for service to be met by such services or to the levels and sources of resources which would be required to meet specific future levels of demand.
- o The neglect of analyses of the demand for specific services, and the factors underlying such demand, creates the large potential for misplaced and/or underutilized/understaffed facilities.

c. Inadequate attention to financial resource constraints, is

often characteristic of LDC planning for health.

- Existing allocation of resources within the health sector are seldom examined for potential cost-saving or cost-effective adjustments to programs and projects.
- Additional financial resources required by a health plan are typically assumed to constitute a "shopping list" for the benefit of donors (one made attractive in the context of a comprehensive plan).
- Future implications of partial funding, or of skewed funding, say, toward training or toward facilities construction, are seldom specifically addressed.
- Resource-use impact of future demand for services, or the potential of user co-payment schemes, are sometimes but not often considered.
- Future implications of present-day capital construction investment spending are more common but sometimes inadequate.

d. Attention to absorptive capacity of the health sector, or of the government, for multisectoral comprehensive planning is often inadequate, or not even referenced, in LDC health plans.

- The need for organizational development both within the ministry of health, and in sectors and agencies coordinating with the ministry of health is often ignored for its key to long-term progress in multisectoral comprehensive planning for health.
- The potential contribution of local communities in mobilizing management and other resources for their own health is often underestimated or ignored in health plans.

e. Programs and projects of the health plan are often predetermined by the political process, leaving the planners merely to justify the decisions with data and arguments.

- This process, which is inevitable to some extent under any circumstances, is aggravated in some countries by "competition" among donors to make grants and loans in health; this process

invites the recipient country to parlay the planning process into one that articulates the priorities which donors most wish to support.

- The result of this phenomenon in practice is to make health planning units into "post box" operations which receive policy guidelines and program decisions from above, data and project reports from below, and then "fill in the blanks".
- Some health planning sections of ministries of health function more as "donor program brokers"--matching donor interests with "needed" projects, making reference, say, to a 15-year plan created by outside consultants some years earlier.

(3) IMPLEMENTATION, MONITORING, AND EVALUATION

a. Implementation of health plans is generally quite weak, particularly where large-scale construction of facilities or rapid build-up of manpower is contemplated. The attention and energy of leadership are drawn more to the conceptualization of a national health plan than it is toward designing an implementable program of action. The gap between the former and the latter continues to widen and fosters national plans in health which depend on central administration and support.

b. Evaluation of health planning and of the implementation of resulting programs has been very intermittent and inconclusive.

c. Feedback from the monitoring and evaluation of health planning efforts and of the programs making up that effort have generally little, if any, effect on future planning. Usually this is so because the implementing agency, the ministry of health, has a political stake in the outcome. Careers are threatened by projects that fail to demonstrate what was intended. The result is that knowledge about what went wrong,

and why, in a health demonstration project, have currency neither among planners in the ministry nor often among planners in the donor community.

2. Assistance Efforts of The World Health Organization

("Country Health Programming")

It is hazardous to generalize from the large variety of country-specific CHP experiences; the WHO 1974 "Working Guidelines" have been liberally adapted and altered to fit country preferences on many occasions. Moreover, regional emphasis has varied in respect to their encouragement of adherence to the guidelines. Although there has been little formal evaluation of CHP, nevertheless, some conclusions can be articulated from the 5-6 years' of experience of CHP exercises/processes. It should be kept in mind that the 1974 "Guidelines" is the basic reference document for these conclusions. They are based on observation of many recent and current experiences and discussions with numerous WHO staffers in Geneva and the regional offices. Many of the questions, reservations and criticisms of the CHP process are likely to be addressed in the revision of CHP which is currently being undertaken by WHO/Geneva in order to adapt it for use in devising national "primary health care" strategies.

WHO's health planning efforts in the Americas, which were devised and implemented by the Pan American Health Organization (PAHO) and are not based on CHP, are not evaluated in this section. The U.S. Government, which funds 62 percent of PAHO's operating budget, has played an important role in fostering the continued development of this organization during the past seven decades. Findings based on a field visit to Guatemala and on interviews at PAHO headquarters in Washington are included as input to general findings in the previous section. As

both an independent organization (founded in 1902 some forty years before the creation of the WHO) and as a regional office of the WHO, PAHO has played a unique, pioneering role in the development of health planning methodologies. Its PAHO-CENDES methodology, which has been criticized for overemphasizing epidemiological determination of planning goals, has been taught, applied, evaluated, and revised over the years. PAHO has now abandoned the idea of adopting a single methodology for planning, opting rather for promoting a series of different planning procedures. Because PAHO has a close working relationship with the Inter-American Development Bank, which finances many health facilities projects on which PAHO acts as executing agency, it has a critical role in the development of health care systems in Latin America. It is beyond the scope of the present study, however, to assess PAHO's efforts.

SUMMARY FINDINGS

(1) "Country health programming" (CHP) has a series of purposes, postulates, and theoretical processes that are compatible with the general thrust of (comprehensive, multisectoral) planning for health as outlined in this assessment. In its implementation in specific countries, CHP has brought some benefits to programming for improved health. However, virtually all observers agree that there is a considerable gap between theory and practice with regard to how the CHP process envisioned is actually implemented in most countries. Accordingly, benefits expected to result from CHP frequently are not realized.

(2) CHP provides beneficial instruction to participants in its processes, techniques and methodological procedures for designing programs and establishing priorities. However, it is felt by many that CHP focuses too narrowly on planning health services because of its focus on producing a health plan of, by, and for the ministry of health.

(3) Frequently, LDCs undertake the CHP process for the following primary reasons: CHP provides a means of (a) drawing technical assistance from WHO, and (b) attracting increased external support for the ministry of health from the international donor community. In many or most LDCs there is little felt need for comprehensive planning for health. Given the traditions and mandates of WHO and ministries of health, it is difficult for them to assume leadership of all sectors within a country in undertaking comprehensive, multisectoral planning for health.

(4) The confusion over whether CHP is a "single-shot exercise" or "on-going, continuing process" (which it is called in those countries that started doing CHP 5-6 years ago) highlights the ambiguity of CHP contribution/relationship to the development and institutionalization of planning for health.

(5) Because CHP is often regarded by LDCs as a process/method oriented largely toward creating reasonable bases for requests for external support, it creates incentives for political leaders to inflate health targets that are incorporated into the CHP document in order to maximize the opportunities/options for external support.

(6) Despite CHP's rhetorical commitment to broad-scale health and development programming on an intersectoral basis, the CHP process tends

in many countries to perpetuate the medical orientation and bias toward health services delivery that characterize the perspectives of ministries of health; there is a corresponding lack of focus on organizational development needs, implementation requirements, and program-related research and evaluation needs for determining the actual impact of specific program activities at the community level relative to community needs.

(7) There is some evidence that CHP as a planning process may be too complex and demanding for the limited planning resources of the poorest LDCs.

SPECIFIC FINDINGS

(1) STRUCTURE DEFINING PROCESS FOR DECISIONMAKING ON GOALS/PRIORITIES

a. The structure and process for decisionmaking have been little affected by the implementation of CHP except in countries where there have been attempts to "institutionalize" it as an "ongoing process". In these countries the structure/process changes have usually been limited to minor adjustments in the way the ministry of health makes decisions internally.

b. The organization of the CHP processes reflects its original "exercise" orientation and imparts an air of unreality to the programming decisions arrived at.

- Programs are designed as components of a "plan" usually without the creation of an overall strategy and without specific reference to the availability of resources to carry them out.
- Having been conducted outside the framework of the nation's

political decisionmaking process, CHP does not carry political weight beyond that brought to it by the ministry of health (a relatively weak ministry in most LDCs often headed by a "junior" minister).

- Participation by non-health sectors in CHP is usually voluntary and its value (to planning and program design) depends upon the personal commitment to the process by the professional representatives assigned.
- Participation by non-health sectors in CHP design is rarely followed by meaningful participation in subsequent program implementation, since extrabudgetary resources that may have been attracted (from donors) by CHP are almost always controlled by the ministry of health.

c. Most of the limitations of CHP's ability to develop political understanding and acceptance of comprehensive, multisectoral planning for health are caused by WHO's own structural limitations.

- As an international agency, the WHO is accredited specifically to the member states' ministries of health, who constitute, in aggregate, the WHO's sole constituency as members of the World Health Assembly.
- Many of the WHO's staff and consultants, themselves, come from ministries of health, and are personally and professionally committed to the traditional perspectives of such ministries.
- The limitations of the scope and mandate of ministries of health to a large extent are mirrored in the restricted scope and mandate of the World Health Organization.

d. In some countries, where there has been meaningful participation of the central planning body and non-health sector representatives in the CHP process, there has occurred a group dynamic which has led to cross-fertilization of the concepts and processes of CHP into other levels and sectors of government.

- CHP has fostered innovative, informal mechanisms and has developed interpersonal skills in key professionals in a manner that has promoted improved understanding of the dynamic

cause-and-effect relationships of health and development variables, and thus an improved (if informal) process of planning and programming.

- Specific applications of CHP's problem-solving approach through systems analysis and operations research have led in some countries to significant instances of improved program design.

e. CHP has facilitated communication among the component departments of ministries of health (and among parts of the health sector generally) about the appropriate goals, mission, and objectives of their collective and individual activities, and about the nature and causes of the most pressing health problems faced by the population.

- This benefit has sometimes led to a clear improvement over traditional methods of programming and budgeting within the ministry of health, even though conventional perspectives of the ministry's role still often predominate;
- Where this benefit has led to improved organization and management procedures, there have been occasions where the effective use of donor assistance has been enhanced.
- CHP's sequential consideration and articulation of health information, problem priorities, health policy, and program alternatives has sometimes increased the knowledge and insights of policymakers, program managers, and providers within the ministry into the dynamics of the country's health problems.

f. The methods and techniques embodied in CHP, and the technical assistance WHO offers to countries wishing to learn and use them, can be rendered only under circumstances agreeable to the requesting country; potential benefits of CHP are thus not realized when inappropriate timing and inadequate preparation characterize the conduct of the "exercise" or "process".

- CHP has sometimes been conducted by countries without coordinating the timing with multiyear planning cycles.

- In some cases, the scope of the programming part of CHP is deliberately delimited to those areas in which a country may be seeking to find donor financing, leaving out assessment of ongoing ministry of health programming (to some extent this was encouraged in early CHP exercises by a deliberate design of early CHP--which focused on trying to identify outstanding gaps and inadequacies in the existing health system).
- In most cases, the CHP process focuses on mastery of technical methodologies and processing of data, with insufficient emphasis put on establishing an understanding and a receptivity among top political decisionmakers for the results of the methods.

(2) INFORMATION ORGANIZING AND TECHNICAL/ANALYTICAL ACTIVITIES

a. Introduction to CHP is through a series of intensive workshops over a period of several months during which a number of outside consultants teach CHP methods and processes and collaborate with nationals in producing a CHP document. Although experiences vary and naturally evolve through successive exercises or institutionalization of the CHP processes, CHP documents can take on an definitive flavor, an implication of finality, that are inappropriate to the short time spent and to the heavy reliance on consultants whose knowledge of the country and its health situation can be little more than superficial.

b. CHP's "problem-oriented" approach to planning and programming is a decided improvement over the "facilities/manpower-oriented" approaches of the past. However, because adequate attention is rarely paid to organizational and managerial requirements of implementing the programs designed to attack the target problems, the results of the whole process, in terms of the activities and expenditures of the ministry of health, are much the same.

- To save time, CHP relies on existing data bases and sources of information which are often of dubious validity for extrapolating the importance of particular health problems across the population (limited numbers of reporting sites, mostly urban clinics and hospitals, mean bias in the reported statistics).
- Reliance on existing data, specifically morbidity and mortality data, leads to a disease-specific identification of health problems; while this may be a good foundation for identifying needed single-purpose, categorical programs, it is not helpful in improving the overall system, programming improvements in health, or for developing a network of basic health services.
- The "problem-oriented" approach seems invariably to focus on health and medical problems, rather than on the administrative/political/management weaknesses and resource constraints that may underlie many of the identified health problems.

c. The particular methods CHP uses for constraints and resources analyses are sometimes not very thorough or accurate because the orientation of most CHPs has been toward assuming minimum constraints, particularly financial constraints, in order to maximize the choices and options from which interested donors could select for support.

- WHO has encouraged countries to undertake CHP by representing it as an opportunity that may lead to increased external support of the country's health sector.
- CHP is not designed to give comprehensive, overall direction either to bilateral donor behavior or to the behavior of the many levels of government and non-health sectors whose resources need to be coordinated in the "total approach" CHP claims to represent.

d. Because CHP has been evolving rapidly as a result of experiences in application and as a result of changing WHO, national, and donor perceptions and priorities, CHP is not perceived or conceptualized, by those who have consulted to the process or participated in it, in an entirely consistent manner; some describe it rather narrowly ("just

methods", "project systems analysis techniques applied to problem-solving in health") while others describe it broadly (e.g., "a continuing process"). While CHP was first seen as a "single-shot" exercise, its adherents/practitioners now show greater appreciation of the need for a continuing planning and programming process.

e. Despite this evolution, CHP remains in practice more medically-oriented, and more ministry-of-health oriented, than its purposes and design indicate. Processes and methods used are highly supportive of centralized administration and decisionmaking and there are virtually no mechanisms for soliciting or factoring in the views and needs of individuals and communities on their health care needs.

(3) IMPLEMENTATION, MONITORING, AND EVALUATION

a. Implementation of specific CHP-designed programs and projects has on occasion been impressive if particular donors pursue them. However, successful and timely achievement of targets is quite rare, primarily because determining implementation needs and following up on execution of required steps receive low priority in the overall CHP process.

- Implementation often depends on assumptions of donor assistance availability and of particular government agencies carrying out tasks which they may be neither prepared nor inclined to undertake.
- Conventional administrative and technical methods are difficult to change and usually left untouched by CHP.

b. Successful implementation often requires technical assistance

and tailored training for administrators, managers, community health workers, which many donors are not anxious to support. Rather than assisting in expanding managerial and absorptive capacity, donors tend to concentrate support toward tangible aid, like commodities, vehicles, and buildings--assistance that frequently causes more harm than good over the long-run and is not critical to successful implementation of CHP programs.

**3. Assistance Efforts of The U.S. Agency for
International Development ("Health Sector Assessments", etc.)**

(1) Programmatic involvement by AID in health planning over the past decade may be characterized as sound and reasonable in theory, but inconsistent and fragmented in practice, apparently resulting from lack of an agency-wide program strategy and of a definitive priority within AID's health assistance efforts.

a. Policy statements, internal memoranda, and interviews with agency staff document a continuing recognition of the importance of health sector planning and analysis in an overall strategy for development assistance.

b. A number of comprehensive, country-specific health planning studies have been undertaken by AID. The Syncrisis series, prepared by the Office of International Health, DHEW, contributed over 30 background studies of country health conditions and inventories of health resources. The "Health Sector Assessments" (HSAs) performed by AID through its regional bureaus provided some 15 comprehensive country health sector analyses. These are discussed in further detail below.

c. The AID regional bureaus have included health planning components in many health projects, as well as in certain projects in related sectors, such as nutrition and education.

d. Other AID health planning activities include an ongoing program of technical assistance to host country health ministries upon request; support of training programs for health planners from LDCs; and

collaboration with WHO health planning efforts, although rarely has there been significant collaboration between AID and WHO on specific CHP exercises.

(2) Multisectoral planning for health has long been a nominal element in the AID health development strategy, but it has at most a limited record of successful implementation. Few, if any, countries can be identified whose present health planning capability can be attributable to AID assistance in this area.

a. Health and health planning have had relatively low priorities within AID so that an organizational structure for the promotion and coordination of health planning has never been developed. The lack of a strong constituency in support of health planning has led to difficulties in mobilizing resources within the agency, as well as to disagreements over the locus of responsibility for AID programming in health planning.

b. Over time, multisectoral planning for health has tended to receive a wide range of interpretations both by the Office of Health and by the regional bureaus.

(3) "Health sector assessments", as the major formal effort and centerpiece of programs supporting health planning, did not prove to be an effective tool for comprehensive planning for health.

a. As originally designed, the HSAs showed promise as a means of identifying useful health projects and establishing health priorities for individual countries. The HSAs were to produce documents serving these purposes; in addition they were to institute or add to local health planning capacity, facilitate the acquisition of planning skills by host

country nationals, and improve coordination between the host country, AID, and other parties.

b. In practice, however, the HSAs were implemented inconsistently, and rarely met the objectives set for them. There is evidence that actual local participation was limited, and that country support for the HSAs never occurred on a significant basis.

c. Collaborative activities with other health planning programs, including WHO "country health programming" (CHP), were never very extensive and showed no practical results. Although there was ongoing exchange of information through working groups, presentations, and seminars, and some joint use of resources, the differences of approach and purpose between these two efforts were such that there was very little activity in common and no cases of mutually conducted planning/programming exercises. (AID personnel have, however, participated in a few CHP exercises.)

d. Operational support of the HSAs by AID, especially among the regional bureaus, has declined over time. This has been due to the lack of central coordination of HSA activities, and a general inability to effect the integration of macro-level findings and outcomes with local planning activities in the field. There have been few country requests for the HSAs, and the program has been discontinued.

(4) The current AID approach to health planning reflects a basic continuation of the conditions discussed above, even though current policy documents maintain the following formal objectives: (a) a multisectoral approach to health planning, (b) coordination among all

participating and affected agencies, and (c) research into the interrelationships between health and other sectors.

a. Central administrative support for health planning within AID remains mixed. There is no guiding or overall Agency policy for health planning, nor is there a long-term commitment to it. Office of Health recommendations over the past decade for an expansion of health planning efforts have not been followed up with action, and those staff members who actively support health planning continue to be in a minority.

b. The regional bureaus provide only limited support for health planning. The strategy was adopted that each region would undertake a separate program of health planning activities to suit its own needs, with the goal of a cross-fertilization of ideas and methods. Only rarely, however, was more than one or two regions involved in health planning at any given time, and few ongoing projects were identified to which a health planning component might usefully be added. Current regional activities concerned with health planning show a wide range of funding levels and degrees of technical staff involvement.

c. In place of the formal health sector assessments, health planning exercises being performed at the present time are primarily short-term, less costly preliminary assessments. These studies are most often conducted only in relation to specific projects and identified areas of health need, and consist largely of targeted data collection activities. Efforts are not being made to institutionalize a planning capability within host countries as a result of the assessments, nor is there significant utilization of local personnel. The effectiveness of this type of assessment, and their future, are not clear.

4. Training Programs in Planning for Health and Development

The following is a summary of the complete report on training in health planning for less developed countries which is contained in Volume II (Section II.8.4). These findings are based upon interviews with academicians at eleven training institutions in the U.S. and with those at four such institutions in Europe.

(a) Findings About Health Planning Training

There is an increasing awareness in AID that the optimal locus of health planning training activities is in Third World countries, preferably in the country where acquired knowledge is to be practiced. This approach is warranted when there are economies of scale in training programs that can be captured by country-specific programs. The logic of this training locus rests on two fundamental premises:

- (1) that the levels of technology and resource endowment in Third World countries are so different from those in the U.S. that nonreality-based training, i.e., that which does not take into consideration the technical and economic constraints on the system in these countries, is ineffective; and
- (2) the political, social, and cultural constraints on planning for health and implementing a given strategy are equally understood by all students.

Where economies of scale in training do not warrant country-specific programs, the potential of regional training centers offers an important

option to be evaluated. While regional training has several benefits, including potential geographical and philosophical similarities and possibly language similarities, there are some potential difficulties. It is an approach that has been undertaken in the past by regional offices of WHO. Cadres of health planners have been trained in regional centers in Latin America and the Pacific, but the training provided has generally been considered incomplete, with most of the training focusing on narrowly defined technical skills. Basically, the training tended to (a) be quantitative in orientation, (b) focus on the supply side of the market for health care services, (c) focus solely on benefits provided through the health care providing delivery system, and (d) provide few implementation skills to health planners.

Another important aspect of the present state of health planning is that it has not often been well integrated into general development planning activities, despite individual country efforts to do so. In most countries health planning has been an isolated effort and not well articulated with respect to overall goals and strategies for social and economic change.

Finally, many prior health planning training programs have not focused on the realities of project design, project management, information systems, and project evaluation. Further, the notion that health impacts of other sector activity must be carefully documented and incorporated into the planning process of the health sector has not been fully implemented.

While these problems have indicated to many observers within AID that most training for health planning should be undertaken in the Third

World, there is a rationale for a certain set of international health planning activities be undertaken in the U.S. The rationale for U.S.-based training of health planners includes the following, but not exclusive, reasons:

Trainers of health planning practitioners require more formal training and experience background than practitioners. If such health planning training is to become institutionalized in developing countries, such activities require more highly skilled and experienced persons. It is often argued that this training can be most easily implemented in the U.S. where cross-fertilization can occur due to the diversified student population of U.S. institutions. It is often not acknowledged that this alleged benefit could be realized in other parts of the world. A second potential reason is that economies of scale can be realized in training trainers. Finally, there may be some economies of scale in the development and transmission of new knowledge about health planning and attendant problems. Given the university heritage of the U.S., perhaps such economies can be realized in the short run by involving U.S.-based institutions.

(b) Structure of Programs in "International Health Planning"

Three of the 16 universities on which information has been obtained have specific departments in international health. These include: Johns Hopkins University, The University of Illinois at Chicago, and the University of California at Los Angeles (UCLA).

Most of the other programs in international health are not formalized with a departmental structure. They cross departmental lines

either within a school of public health or throughout an entire university. These cross-disciplinary programs act in much the same way as area studies centers of the 1960s operated, in the sense that where the program has its own resources, it pays a portion of a teacher's salary to obtain the expertise embodied in that individual's disciplinary focus. There are eight universities with cross-disciplinary programs in international health. These are coordinated through offices of international health or some other cross-disciplinary coordinating board. This level of university commitment is significantly less than a formal departmental organization; however, it has been instrumental in initiating programs operated by Harvard, the University of North Carolina, Tulane University, the University of Wisconsin, Michigan State University, and several others.

Several universities have operated with even less commitment than that for a specific program. These include the University of California at Berkeley and the University of Washington at Seattle. Both are willing to allow their university faculty to engage in international health programs and projects, but in an individual consulting fashion or through consortia. The consortium arrangement, however, tends to be a "last resort" mechanism, since the university is clearly indicating by such an approach that the issue of international health in general, or health planning in particular, is not of sufficient intellectual concern nor of long-term academic interest to scholars.

There are eight universities with persons or institutional strengths in international health planning and related disciplines: Harvard, including the Harvard Institute for International Development (HIID),

Tulane University, University of Wisconsin, University of North Carolina, and possibly Michigan State University and University of Pittsburgh, besides the University of Michigan and Johns Hopkins. The other universities, while having certain expertise and skills in international health, more generally do not have sufficient strength to launch a training program at this time in health planning and related activities. The criteria used to make this judgment are based on an assessment of a nucleus of individuals with substantial interest, experience, and multidisciplinary concerns embodied in the faculty which has been drawn together in either several research endeavors or through some formalized programs or department in order to engage in training and research related to health planning. Important disciplinary backgrounds of faculty include economics, sociology, health services research methods, political science, as well as community medicine, nutrition, pediatrics, and internal medicine.

(c) Issues and Problems Related to Training in Health Planning for Less Developed Countries in U.S. Institutions

By virtue of the changing concerns within USAID, particularly with the increasing concern about implementation problems and recognition that training should be located in Third World countries, there are several issues that must be dealt with in order that a full partnership between U.S. universities and AID can be effectively pursued in the future.

First, it is important to recognize that universities are now less capable of taking financial risks than they have been for a number of years. The twin problems of inflation and cutbacks in appropriations

from states, or the impact of shrinking endowments and general foundation support, have meant that universities are increasingly concerned about the financial implication of their activities.

Second, there is a general concern within U.S. institutions that, as a consequence of a fairly rapid turnover in the Office of Health, and in AID generally, an historical sense and perspective on the part of AID to development problems, particularly in the health area, are lacking. Finally, there is a general concern about the level of expertise embodied in present AID personnel.

In addition, given the rather important changes in the general political life of this country over the last decade, there have been some significant changes in priorities as they relate to development assistance. These changes have had the effect of reducing the agency's ability to make long-run commitments to any particular programmatic endeavor, whether with U.S. universities or any other developed and developing country institutional mechanisms. With the exception of the long-run commitments to Johns Hopkins University, the University of Hawaii, and UCLA, only short-run commitments have been made.

It has been pointed out by a number of academicians that in order to make any impact on health care delivery and health in general within developing countries, a major investment over a considerable period of time is required. The three- to five-year commitments commonly embodied in AID projects are not sufficient to make any significant improvement. Thus, U.S. institutions and academicians are not surprised to find that most projects are left wanting when it comes to identifiable impacts on the longer run goals and objectives of development assistance.

Another aspect of the problem of the relationship between AID and U.S. universities is that, from the point of view of the university, there must be some concrete benefit to be derived from it for the institution itself, such as an important departmental program, improved student-body mix, or a seat of new knowledge yielding worldwide recognition. Further, in order to provide incentives to individual university faculty to make the commitment to engage in a life of teaching and research in the area of international health, a commitment by some group to long-run support must be forthcoming in order that AID training objectives and research requirements be met. Thus, increasingly, training grants per se will not attract the most qualified and intellectually stimulating academicians in any discipline to spend a significant amount of time in health planning. In order that the resources of the academic community be engaged to the purposes of the foreign assistance program, particularly those in health and health planning, it is essential that AID and the federal government be cognizant of the basic reward structure facing individual scholars in the academic profession today. Given the increased pressure of intensified competition for tenured slots in universities, without an immediate research pay-off to the individual scholar, the incentives to faculty and particularly young faculty for participation in AID projects are almost non-existent.

In order for U.S. institutions to make a significant impact and provide the assistance necessary to develop Third World institutional capabilities to engage in their own teaching and research programs in the future, it is essential that the relationship between developing countries' institutions and U.S. academic institutions develop over a

long period of time with a variety of interchange mechanisms at work, e.g., student and faculty exchanges, collaborative research and evaluation efforts, and educational programs. In discussing the Danfa program with people who were intimately involved, for example, it was pointed out that only after eight years were there strong identifiable benefits emanating from that relationship.

A fourth aspect of this set of problems is that the U.S. cadre of experienced, young professional people with expertise in the field of health planning and international health is limited. An investment in the self-renewal function of a cadre of highly skilled and experienced scholars and experts has not been made, given the demand pattern that is emerging from U.S.-based institutions, multilateral organizations, and financial institutions. Without a reasonable set of programs and efforts within U.S. institutions, this lack of renewal is likely to continue with the probable result that the first problem identified above (namely, the lack of highly experienced and well-disciplined health program officers within AID) will be unresolved.

The final problem identified by U.S. institutions is that in-country training is often perceived by Third World participants as "second-class," that is, inferior to U.S.-based training. This issue has been brought up repeatedly within the context of medical schools' curricula and in the population field. Exactly how to address this issue is not clear, but it must be considered in determining the role of U.S.-based training.

(d) European Institutions' Programs in International Health and Health Planning

United Kingdom

The Institute for Development Studies (IDS) was established about thirteen years ago as a national center for teaching and research on development problems, particularly those relating to poverty, employment, and income distribution within Third World countries. The IDS is largely funded by the Ministry of Overseas Development of the British Government; it is located on the campus of the University of Sussex, which jointly with IDS offers a M.Phil. degree in "development studies." The IDS itself does not confer academic degrees, but rather sponsors four-to-six week study seminars, study groups, and short courses for professionals working on development problems. A recently created "Health Group" of three research fellows has developed an interdisciplinary research and teaching program that seeks to explore the health policy issues spanning the four problem foci of the Institute: human resources, international relations, planning and government, and rural development.

Within the past year, the Ministry for Overseas Development has funded a new program of research and teaching on issues of evaluation and planning of health care, especially at the district level, in developing countries. This program, which will reportedly be implemented through two different British institutions, is currently in the formative stages. One center will be located at the Ross Institute of Tropical

Hygiene of the London School of Hygiene Tropical Medicine; the other is to be administered at the Nuffield Institute of Comparative Medicine at the University of Leeds.

The Netherlands

The Royal Tropical Institute in Amsterdam has recently completed the fifteenth "International Course in Health Development" (ICHD). This course, given this year to seventeen students from developing countries, is sponsored jointly with the Prince Leopold Institute of Tropical Medicine and Hygiene in Antwerp, Belgium. It is given alternatively at each institution, and in French or English in alternate years. The course, which is open to qualified M.D. s from the developing world, prepares for a master's degree in public health. (Several students from Holland or Belgium or other developed countries are permitted to take the course each year, as long as their professional interests are in working in the developing world.)

The course was organized by the Netherlands Universities Foundation for International Cooperation (NUFFIC) under the responsibility of the Board of Trustees in which several Belgian and Dutch institutes and organizations are represented. Dutch and Belgian governments provide fellowships to a majority of the students accepted for the course.

The general objective of the course, according to the catalogue, is "to enable medical doctors to deal adequately with problems in the field of management and planning of health systems in the context of a comprehensive development." The degree requirements include the writing of a thesis on some issue of health and development policy and

programming in the developing world. Most students focus on a particular subject relevant to their own country, but there is no field work in a developing country context.

The medical faculty at the Catholic University of Nijmegen sponsors an Institute, "Medical Care in the Developing World," which was established in 1972 and is the first such institute in a Dutch medical faculty. The Institute has a relationship with five hospitals in the Mwanza region of Tanzania, where Nijmegen medical students can take four-month internships to satisfy full credits for "community medicine." The Institute also sponsors a research program focusing on the training of medical auxiliaries, medical anthropology, appropriate technology, and basic issues in medical development. It conducts lectures, seminars, short courses, and credit courses, mostly for students at the university and from other institutions in the area.

The institutional resources available in the above locations of the United Kingdom and the Netherlands offer a source of knowledge, experience, and interests which are significantly compatible with the health and development perspective of planning for health. Collaboration with U.S. institutions in the areas of program-relevant training, research, and evaluation is both possible and potentially fruitful.

IV. PLANNING FOR HEALTH: ELEMENTS OF A STRATEGIC
PERSPECTIVE FOR NATIONAL HEALTH DEVELOPMENT

- A. Rationale for Comprehensive Multisectoral
Planning for Health
- B. Premises of Effective Planning for Health
- C. Policy Guidelines: A Strategic Perspective
for National Health Development Programming

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IV. PLANNING FOR HEALTH: ELEMENTS OF A STRATEGIC PERSPECTIVE FOR NATIONAL HEALTH DEVELOPMENT

A. Rationale for Comprehensive Multisectoral Planning for Health

The rationale for pursuing (comprehensive, multisectoral) planning for health in developing countries is based on the concept that a population's health status is a function of a dynamic interaction of many factors. While this is largely a theoretical concept, there is an increasing amount of empirical evidence to support it. A few of the principal determinants of health status are under the purview of ministries of health, but, perhaps more importantly, many other determinants fall under the jurisdiction of other activities of governments, such as in agriculture and education, or in the establishment of macro-economic policies. The number of private sector decisions may also be important, particularly where urban pressures and stress result. Given an improved understanding of these multiple dynamic factors which affect health status, it is theoretically possible to develop programmatic interventions which can contribute to its improvement.

The theory of multiple sector health promotion rests on the validity of three sets of relationships: (1) between the assured health promotion factors and health; (2) between program-specific interventions and their targets; and (3) on the organizational and implementational capacity of the responsible entities. As a basis for program design, the cause-and-effect operation of these relationships can be conceptualized for their separate short- and long-term significance and for both direct

and indirect effects. It is also important to distinguish between the dynamic interaction of factors at the micro level (household) and at the macro level (national).

The pace, pattern, and direction of changes in the health of a society are affected by the relationships among many social characteristics which determine and are determined by the social and economic system. There are at least three important variables which affect and are affected by health status and the larger social and economic environment. These variables include: (1) nutritional status, (2) educational status, and (3) present fecundity and results of past family formation efforts. Finally, the relationships between these variables are determined by the sum of both direct and indirect effects. The direct effect is the extent to which one variable changes, in one direction or another, as a consequence of a change in one other variable, whereas the indirect effects are the result of the one variable's impact on all other related variables which in turn affects the variable under consideration. (A detailed discussion of the relevant theoretical models and empirical evidence supporting them is included in Volume II.)

As a consequence of the potential synergistic interaction between these variables, increased consideration has been given to programming interventions which can simultaneously effect all of these variables thus leading to a larger overall impact. Further, it has been suggested that if any one variable is not addressed simultaneously with the others, then the possibility exists that its effects will be to dilute the efforts in affecting all the others. To quote Taylor and Hall:

In the dynamic equilibrium between the...major components of

this matrix (of human resource program interaction), optimum progress occurs when all elements move forward together, the general objective being improvement of the quality of life...The social components of a better quality of life are benefits in themselves but, more importantly, they can be used as instruments of change or as means of increasing productivity.¹⁸

Despite the development of theoretical linkages between the variables and a limited empirical basis for such hypothetical relationships, the empirical knowledge base for determining what can or should be done programmatically is virtually unknown. Thus, while the theoretical basis for certain intervention strategies coalesce around "a composite package approach to the delivery of nutrition, health, and family planning services in rural areas," (there is) no consensus on (specific) policies and programs that will be most effective in mounting an assault on poverty...(since) choice of strategies raises complex issues and is as much a political as an economic question."¹⁹

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18. C.E. Taylor and M.F. Hall, "Health, Population, and Economic Development," *Science* (August 1967), p. 657.
 19. B. Johnston and A. Meyer, "Nutrition, Health and Population in Strategies for Rural Development," *Economic Development and Cultural Change*, Vol. 26, 1 (October 1977), p. 13.

B. Premises of Effective Planning for Health

Prior to stating the study's conclusions and recommendations about the role of external assistance in general, and of AID in particular, in support of LDCs' activities toward planning for health the project team drew up a list of premises which begin to define the context which can be expected to permit effective matching of donors' interests/responsibilities with country needs through planning for health. Based on the project staff's assessment to date, these elements--which can be articulated as hypotheses about necessary and sufficient preconditions--will characterize the future if effective planning for health is to take place. These assumptions have been deduced from background documents, recent field trips, and the past four years of FHC project experience with AID projects in Korea, Pakistan, Tunisia, Syria, Colombia, the Phillipines, the countries of the Sahel, Portugal, Botswana, Lesotho, Swaziland, Malawi, Zambia, Kenya, Senegal, and Tanzania.

In the spirit of collaboration among donors and recipients in implementing goals that all have mutually agreed upon, these assumptions are articulated using the verb "will". The use of "will" is not intended to imply "should" or "shall", but is intended to convey an acceptance of the seriousness of purpose which LDCs have implied by their endorsement of the ambitious health goals for their countries. The future is, of course, difficult to predict. But predictions have been attempted in this section of assumptions--based on the one big assumption that the ambitious goals of better health will be reached and that they will be reached through better planning for health.

1. COUNTRY PRIORITIES

(1) Within a time frame of five to ten years, individual country priorities on a global basis will shift toward health development strategies which invest the greatest proportion of marginal increases in available resources at the base, i.e., household, village, community, the periphery, etc. (In this context, the periphery applies both to rural and urban areas rather than to a geographic proximity to central administration.)

(2) The top political decisionmakers in the less developed countries will find it in their own self-interest to withstand the competing pressures for scarce resources. Instead, these resources will be allocated in a manner which supports the implementation of base-level strategies. For example, the decentralization required of the process of planning for health will proceed through a basic and fundamental administrative reform of the existing public health system, and a recognition on the part of national leadership that all health workers in the system need not and must not necessarily be included in, or accountable to, the formal public health system as government staff.

(3) Decisionmaking processes of planning for health will take place at the highest political level in a socio-economic and political context that is much broader than has traditionally been the case for health planning. This will require that the political leadership acquire both the conceptual and analytical understanding of the long-term health implications of existing patterns of development, of alternative and

proposed development decisions, and of alternative health investment strategies.

2. DONOR PRIORITIES

1. The current trend of donor investments in health development will continue to place priorities on supporting country-specific plans to provide better health to ever greater proportions of LDC population groups. Increasingly, emphasis will be focused on ways to assist LDCs to reach those segments of the population which do not now have access to the health system.

2. Donor support in time will shift from project assistance to general program assistance in underwriting the recipient countries' shift toward priorities of national health development strategies which seek to improve capabilities for implementing programs which target peripheral populations and which support local participation in planning and program implementation.

3. Due to the long-term cost implications of investing in health development efforts, donors will, on a country-by-country basis, begin shifting toward multi-donor funding arrangements. Although they will resist long-term commitments to fund recurrent expenditures, donors will be asked by LDCs to accept the responsibility for having caused ever-increasing recurrent expenditures and staffing requirements of past high-cost infrastructure projects.

C. Policy Guidelines: A Strategic Perspective for National Health Development Programming

Planning for the health of a nation requires consideration of how to define the dynamic interaction of social, cultural, economic, and political factors determining health status at both the macro and micro level. Health services planning, for example, is only one small part of this process of planning for health.

1. Micro-Level Planning

(a) The single most critical determinant of successful, future planned interventions at the micro-level is planners' understanding not of the epidemiology of diseases, but the "epidemiology" of communities; that is, planners will need to understand the dynamic interactions of communities' health status with the range of variables determining development processes and standards of living: community institutions, environmental conditions, and socio-economic status; individual behavior; cultural practices and beliefs; and social perceptions and responses to disease. In the short-term the highest probability of improving health status through planned interventions will occur from modifications or re-orientations of existing patterns, relationships, and behaviors. For example, to achieve the objective of an improved diet by adding new crops, the highest probability for change occurring lies in knowing what community response will occur from the introduction of new crops under particular conditions and using approaches which are designed to prepare for and obtain acceptance of the changes. For each intervention, the

decisionmaker/planner must understand the health implications--negative, positive, or neutral --of whatever change is contemplated.

(b) Achieving this understanding, however, can usually best take place through trial-and-error, a process of combining the pragmatist's ability for seizing opportunities for change with the researcher's ability to discover what causes the subsequent results. In the most pragmatic sense, this is what multisectoral planning requires--that planners combine the results of micro-level program-oriented research/evaluation activities with seizing opportunities for change. In this way, they can assist decisionmakers to understand that even under the best of circumstances or intentions, results will be what one observer has called "disjointed incrementalism".

(c) Change in the health development systems of peripheral populations, as desired, will be a long-term process. For example, the "ujamaa" movement in Tanzania; the incremental thirty-year process of improvement in health services in China; the plan to cluster dispersed households around basic new structures in Tunisia, i.e., primary school, dispensaries, small stores; and the affiliation of rural hospitals with hospitals in industrial complexes in Korea.

(d) The training of the manpower supportive of planning to assist communities make choices, can, therefore, best be done in indigenous training institutions. Whatever re-orientation or modification they wish to make in their existing patterns of interventions is best defined by the countries themselves.

(e) The future training of health planners will be less in

institutions and more "on the job". Programs will increasingly combine training and service development. This implies that the future cadre of "planners" and "implementors" will emerge from those who have demonstrated their skill in initiating and carrying out successful operations at the peripheral level.

2. Macro-Level Planning

(a) Planners for health in the future will have to make extremely difficult cost-benefit decisions. Competing demands for available financial resources are increasing. The capital and recurrent cost implications of the rapidly expanding personal, curative health care service technology will usurp all available resources unless expenditure limits are defined and informed trade-offs are made in resource allocations.

(b) The marginal benefit relative to marginal cost of expanding high technology, personal curative health services is questionable. Future national planners, although faced with the demand from some segments of the population to invest in the most advanced technologies, will be required to resist these demands in order to establish equitable and efficient basic health services to the largest portion of the population. Much of the demand for technology will be generated by the professional medical community in urban-based settings.

(c) The planning of national and sub-national sectoral support activities will be derived from the aggregated definition at the macro-level of what micro-level interventions are to be implemented, in what sequence, and at what scope. Areas for interventions will likely include:

- (1) The planning of administrative and logistical support;
- (2) The definition of technical skills and the training requirements;
- (3) Commodity requirements; and
- (4) Manpower training.

(d) Planning health (for all by the year 2000) will involve the continuing evolutionary development and refinement of specific tasks and activities (complexes of tasks) which, if implemented, can have the greatest impact on health status for a given resource cost.

(e) Theoretically, it is assumed that the simultaneous implementation of programs for improving nutrition, the safety and quantity of the drinking water supply, literacy and hygienic practices, sanitation and waste disposal facilities, and general environmental conditions, has the largest health impact. Further, it is thought that the effectiveness of this program approach is optimized when opportunities are available for local participation in deciding priorities and in implementing them.

(f) Empirically, there is little conclusive evidence about the marginal benefits (relative to marginal costs) of specific programs, or about combinations of programs. But the available evidence suggests that:

- (1) The precise definition of a cost-effective program package is

less important for ultimate impact than the development of a process encouraging community participation in planning and programming improvements in their own health.

(2) Of all the factors influencing health status, personal curative health services generally provide the least marginal benefit relative to cost particularly when the focus is on treating effects and not causes.

(3) The empirical evidence suggest that those countries with similar economic status which have been the most successful in improving health status have:

- Implemented national schemes to ensure the availability of an adequate diet. These schemes have placed emphasis on local self-sufficiency for local consumption with a minimum guarantee through national distribution schemes;
- Achieved a high literacy rate within the population;
- Organized and carried out successful schemes to reduce environmental risks;
- Provided safe potable water to people on a wide-scale basis, accompanied by mass education programs aimed at behavior modification.

V. CONCLUSIONS

- A. The Role of Planning for Health in National Health Development
- B. The Role of Donor Assistance in Support of Planning for Health
- C. Constraints on the Role of AID

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V. CONCLUSIONS

A. THE ROLE OF PLANNING FOR HEALTH IN NATIONAL HEALTH DEVELOPMENT

1. The underlying causes of ill health in less developed countries are generally unaffected by improved access to medical treatment of disease. Serious levels of preventable diseases, moreover, are often aggravated by food and nutritional deficiencies and/or high rates of population growth. The need to develop short- and long-term solutions is constrained by the extreme scarcity of necessary resources.
2. There is widespread agreement that improved social welfare should be the goal of development, and that improved health is a central element of improved welfare. Increasing theoretical and empirical evidence supports the belief that there are mutually reinforcing effects of health and welfare, and that these potential effects form the basis for global strategies of development and health improvement through meeting "basic human needs," and providing "primary health care."
3. There is a universal need for better planning to improve health; this need is underscored by a growing awareness of the magnitude of the Third World health problems, of the complex dynamics of determinants of health and development, and of the severe resource limitations (including the lack of relevant knowledge).
4. There are sound reasons for concluding that "comprehensive multisectoral planning for health" (CMPH) (as defined and discussed

in this document) is the most appropriate strategic approach to planning to improve health. The most important reasons for CMPH include:

- (1) its framework for programming is based on an understanding of the multiple determinants of health status;
- (2) linkages and complementarities among those activities in various non-health sectors aimed at improving population health comprise the basis for program development; and
- (3) issues of financing and resource allocation related to health services/facilities/manpower and to health-related programs can be cast in a broader policy framework.

5. By orienting programming in non-health sectors toward health improvement objectives, governments can realize significant health benefits for the population, particularly in rural/peripheral areas. Planning for health, however, has considerably more benefits in the determination of how to decide what ought to be done than it provides in the determination of what to do and how to do it.
6. The concepts on which planning for health is based can be translated into effective programs for social change by progressive, incremental improvements in the requisite component elements. Such an iterative, continuous improvement of discrete components required by the planning process is not often advanced through production of a static, multiyear "plan." Rather, incremental progress for better planning for health can be judged by whether a particular initiative leads to a better understanding among policymakers of the variety of alternative policy/program options, and of their requirements and potential costs and benefits.
7. Effective implementation of planning for health requires minimum

competence in a number of key areas within the continuum of activities and processes which comprise the cycle from policymaking to project implementation. These areas include:

- sound sector management and administration;
- sound processes for linking decisionmaking on development strategies and policies with resource allocation, budgeting, and program implementation;
- decentralized mechanisms for participation of local communities and for channelling central support for local initiatives; and
- training, research, and evaluation capabilities that serve to increase policy- and program-relevant knowledge about the impact of specific programs.

8. Despite the theoretical merits of planning for health, intercountry variations are great, both in terms of social, economic, and political contexts for planning and in terms of technical and administrative capabilities needed for undertaking the required activities and processes. It is difficult to generalize about the feasibility of implementation for at least two reasons.

First, the conceptual understanding of the interrelationships between health status and social and economic development (which underlies the rationale for planning for health) does not extend to an adequate knowledge base about the direction and magnitude of specific interrelationships and does not translate into an all-purpose, general prescription for operational programs. The optimal mix of policies and programs will vary from country to country, and even within countries.

Second, the potential effectiveness of the implementation of planning for health depends on the willingness and ability of

policymakers and political leaders to mobilize social, political, and bureaucratic support for changing goals, policies, and programs.

9. Solutions implied in the identification of problems through a multisectoral approach can be most effectively implemented where there is meaningful participation in the process by beneficiaries and where multiple resources and interventions can be applied on several levels by several different sectors at once. The experiences of less developed countries suggests that these two critical elements of the process are far from being adequately developed.

- (a) The development of participatory, interactive processes both within local communities, and between communities and government agencies, is necessarily linked to broader processes and mechanisms for political participation and decisionmaking; the decentralization of authority to support local initiative, especially at the periphery, is not far advanced in some countries and is not a political goal in others.

- (b) The orchestration of simultaneous or sequential application of the interventions of several sectors or agencies is a difficult process. It is tremendously complicated to maintain the breadth of vision required, and even more complicated to assert the minimum necessary management and bureaucratic control of multisectoral program operations, and few LDCs have the capabilities required for attempting such efforts.

10. Thus, while a national capability to plan multisectorally for a people's health is a laudable ideal, especially in light of the primary health care strategy, developing the **operational** capability to plan multisectorally is probably not a realistic goal for most LDCs at this time.

(a) Despite the existence of health planning units in ministries of health and national planning bodies, in some LDCs, there are very few countries where the capacity of these units for planning the health sector alone can be considered to be successfully institutionalized or effectively implemented; in the course of this study, no "exemplars" were found, even for "health planning."

(b) The creation of health "plans" has not often been accompanied by an ability to implement the "planned" programs.

(c) The training of health sector personnel in health planning technologies has received more attention than the creation of opportunities for those personnel to use their knowledge and techniques for decisionmaking on resource allocation and policymaking.

11. Nevertheless, improved country-specific capabilities to plan for health should be a long-term overall programmatic goal, and it should be approached by the realization of two objectives:

(a) to create a process whereby decisionmakers obtain a clearer understanding of policy and program options for health development and of the potential requirements and consequences

of those options; at the very least, decisionmakers will need greatly improved knowledge and understanding of the multiple determinants of health and its links to overall socio-economic development--the rationale of planning for health; and

- (b) to create an improved capability to implement policies and programs for health development (some of which may be intersectoral in nature).

Benefits from the achievement of these objectives could be:

- a. (1) Adoption of development strategies and policies with reasonable and realistic programmatic targets for health and welfare improvements; and
 - (2) Orientation of the activities of non-health sector ministries to support health goals.
 - b. Incremental improvements in the indigenous knowledge, skills, attitudes, and institutional strengths needed to better plan health and development.
12. The priority need to set up, in developing countries, an analytical process that involves top decisionmakers and program administrators in examining key health development policy issues can be realized through any number of various catalytic activities. These activities can be called programmatic "entry points" for the long-term development of perspectives, principles, and procedures embodied in planning for health. Typically, donor involvement in the design of external assistance in any particular health-related

effort provides an opportunity for such catalytic efforts in collaborative consultations with political leaders. Thus, "entry points" to assisting the process of planning for health need not initially be training in planning technology, the development of planning units (although this is typically a first step), nor the creation of a multiyear or multisectoral plan. Other entry points, which under certain circumstances offer opportunities for the beginning of a planning process (by analyzing health development policy issues), are:

- research and evaluation;
- training;
- information systems development;
- organizational development; and
- program management and administration.

13. The design and execution of implementable programs for improving a population's health should result from prior efforts to design country-specific health development strategies--the basis of efforts to promote planning for health in LDCs. National health development programming which takes place in the context of this conceptual framework can incrementally learn what programs impact in what way on health status and progressively improve the capability for implementing such programs. Examples are:

(a) National Health Policymaking:

The multisectoral framework provides a broad perspective within which to assess the varying impacts of all governmental activities in health and of the interaction of private sector health activities and public health services, and to analyze resource implications of various investment strategies. Particularly important for some LDCs is the need to rationalize the role of the ministry of health within the government vis-a-vis the health role of the ministry of social welfare/interior and the health role of the ministry of education. In general, applying a health-oriented approach to development policy means, on the one hand, taking steps to eliminate the adverse health impacts of development policies and projects, and on the other hand, taking measures to enhance the positive health impacts of development, for example, through a basic human needs strategy which guarantees social justice, distributive equity, and minimum levels of food, shelter, and clothing.

(b) Decisionmaking Process and Structure:

The multisectoral framework provides a perspective for looking at problems across sectors and thus stimulates thought on instituting processes and mechanisms for taking decisions and implementing policies and programs in nontraditional ways. In this framework, it is possible to develop organization and management in ways that adapt and advance a country's capability to develop more communicative interaction between (a) "top and bottom," (b) government and community, and (c)

policymakers and program implementers.

(c) Knowledge and Skill Development:

The multisectoral framework is appropriate for developing knowledge and skills among political leaders, programmers, and providers about the health-specific outcomes of certain policies and programs. Since this knowledge is to a large extent undeveloped for specific country situations and conditions, its development is best pursued as an iterative process within each country through training, research, and program evaluation activities that are designed around real problem identification and problem-solving actions. The role of outside consultants and donors must be truly collaborative to efficiently use resources applied.

(d) Health System Development:

Basic health services can be developed for fuller coverage of the population in a way that both improves the specific services provided and multiplies real health effects if the framework within which programs and policies are developed is multisectoral in its approach to problem identification and problem solving at the local level.

B. THE ROLE OF DONOR ASSISTANCE IN SUPPORT OF PLANNING FOR HEALTH

1. The predominant focus of health planning efforts to date in LDCs has been on the development of planning units and on the creation of health plans. This emphasis on developing a technical capacity to plan has had some influence on the pattern and level of donor investments in health in some countries, but has had little apparent influence on improving the knowledge base of decisionmaking for health improvements nor on improving the capacity to implement programs and projects.
2. Donor support of health planning in LDCs has generally been through health planning projects and/or programming exercises which typically have involved a focus on technical methodologies for determining priorities, setting targets, and designing projects. The relative neglect of projecting costs (against anticipated effects or benefits) as an important element of resource allocation decisionmaking, and of identifying the instruments and tasks required for implementation, have been the major failures for realizing the full benefits of planning.

(a) WHO's "Country Health Programming" constitutes a sound conceptual basis for a systematic planning approach, but its application needs to emphasize greater attention to three major areas:

- cost and resource considerations need to be applied early in the process of setting project priorities in order to serve the needs of resource allocation decisionmakers;

- health problems need to be identified more broadly in terms of social, cultural, economic, or behavioral problems that underlie patterns of diseases, rather than in terms of the severity of morbidity and mortality due to specific diseases; and
- ministries of health who adopt CHP methods must give close consideration to the limits of their implementing the possibly multisectoral programs. Although CHP may identify program needs whose implementation is external to the ministry of health, the ministry's jurisdiction frequently does not extend beyond organizing and directing its own managerial and administrative resources.

(b) AID's future support of planning for health in LDCs must be based on a more comprehensive programming perspective than its past support of health planning, which has been generally characterized by support of training, by support of planning units, and by the execution of various health sector assessments, which were frequently conducted without collaboration with professionals of the country of study.

3. A prerequisite of any future AID support of planning for health will be the strengthening of AID resources in two currently weak areas:

- AID field officers in health are generally unfamiliar with and unsympathetic to the AID approach to, and efforts in, health planning as it has been conceived by AID/Washington; these officers must continue to respond to short-term

programming needs and to the obligations of programming the U.S. bilateral assistance program; this factor leads to wasteful and unproductive work throughout the agency; and

- Neither AID's health planning projects nor its regular health assistance programming has sufficiently emphasized the need for follow-up support to participant trainees who have gained health planning degrees or training in the U.S. or third countries, nor the need for complementary health and development programming. This has reduced the relevance and impact of the substance and orientation of the training.

3. Among the variety of international, multilateral, and bilateral agencies involved in providing health assistance to LDCs, WHO and AID have major roles and responsibilities. Each has a distinct and separate contribution to make toward improved planning for health, but an acknowledgement of appropriate roles and more collaborative efforts needs to be achieved on a country-by-country basis.

(a) WHO exercises international leadership in technical/medical matters and can draw upon its broad-based technical resources and experiences in advising LDCs in health matters. WHO, however, is handicapped by its charter which restricts its representation and consultative functions to ministries of health of member states, making it difficult to participate in broad-scale health/development programming. It is also without access to financial resources for assisting member states to supplement the available professional/technical consultative

services it can provide.

(b) AID operates as the largest bilateral donor in health assistance to LDCs. Its potential contribution in this area is enhanced by its ability to program health assistance in the context of overall development programs and processes. The financial resources made available through AID programming processes, however, are generally unguided by any use of, or reference to, the general principles of planning for health.

There are at least two reasons for this:

- The compartmentalized single-sector approach to health characterizes both overall U.S. Government activities and AID health assistance activities; there has been inadequate attention to multisectoral perspectives on health in AID's internal policymaking and programming processes.
- Few AID health officers have backgrounds or experience in multisectoral or multidisciplinary problem-solving, programming, or planning for health, and none face incentives which encourage them to adopt that perspective.

4. There is little evidence to suggest that LDCs are convinced of the value of health planning or planning for health, beyond its function of facilitating donor assistance. LDCs participate in "collaborative" exercises in health planning typically because it is a "condition precedent" or a preparatory step to receiving donor assistance. The benefits of planning for health will need greater articulation and more effective advocacy as part of any program to

advance capabilities for planning for health.

5. The tremendous magnitude of resources and of efforts required in health development in LDCs over the next decade makes it imperative that international donors and technical agencies now focus on coordinated multidonor programs for individual countries. AID's leadership role as a bilateral donor in health must necessarily shift toward a new role as a cooperating and collaborating participant in a modified process. Its support of better planning for health, as suggested in the next section, would constitute a worthy contribution toward this evolving process of change.

C. CONSTRAINTS ON THE ROLE OF AID

1. AID experiences lengthy lead times in getting its present health sector projects underway, as well as delays in project execution. Projects are seldom started up or carried out according to schedule. It may be assumed that similar delays will be experienced in projects supporting multisectoral planning for health. These delays could even be lengthier than those of conventional projects. The time span for a multisectoral project to become fully functional could be considerably longer for the following reasons: ²⁰
 - a. Added to the larger number of people and the various layers of bureaucracy that must participate in the decisionmaking process within AID, there would also be a large number of participants in the recipient country's decisionmaking process owing to the multisectoral nature of the project and to community participation;
 - b. Due to the complexity and novelty of multisectoral development, to the lack of basic data, and to the frequent need for a research and development phase, the technical, financial, economic, and other analyses of project planning and evaluation could require more time than conventional health projects;
 - c. Lack of adequately functioning administrative and managerial processes in the health ministries;

20. Source: "Aid for Health", Norman C. McEvers, January 8, 1979. Washington, D.C., Mimeographed.

- d. Institutions in the recipient country must be coordinated multisectorally; and
 - e. There will be an increased demand for local currency financing from the recipient government in order to meet recurrent costs.
2. The project design system currently used by AID consists of detailed planning, years in advance, by staff (resident and consultant) who will not be responsible for project implementation, or, for that matter, even involved in it. Success or failure in multisectoral projects will depend largely upon the effectiveness of management in overcoming obstacles to implementation. Insuring continuity of project inputs is one of the biggest problems facing AID.
 3. The implementation of multisectoral planning for health projects is a long-term process which entails distributive and institutional reforms in the health sectors of LDCs. Therefore, it is not necessarily attainable by a given set of specific projects. Investment in multisectoral planning cannot be truly viable without a revision of the health services system in terms of its resource distribution and the technology it uses. The national sovereignty of recipient countries severely limits the extent to which AID, and other donors, can succeed in getting them to undertake distributive reforms in health which are inherent to multisectoral planning projects.
 4. While these constraints are serious, they need not preclude AID from a programmatic activity in planning for health. Projects can be

planned and implemented more quickly if structural changes are made in the way AID does its business (see recommendations I, II, and III), these would do much to increase the credibility of AID among those in the LDC community.

VI. RECOMMENDATIONS

- A. AID Leadership of a Collaborative Global Approach to Health and Development Planning
- B. AID Program Support of Planning for Health and Development
- C. The Role of the U.S. Academic Community in Supporting Planning for Health in LDCs
- D. The Role of the U.S. Private Sector in Supporting Planning for Health in LDCs
- E. The Implementation of Self-Reliance by AID
- F. Sensitizing U.S. Policymakers to the Need and Potential Benefits of Planning for Health

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VI. RECOMMENDATIONS

Introduction

The analysis which has preceded this portion of the study has examined the past and current status of health planning in LDCs and has explored the need for, and potential of, approaching planning for health on a more comprehensive, multisectoral basis. It is a major conclusion of this study that AID should strongly support the goal of improving LDC capability to plan for health in this broader prospective. The central principle of the recommendations to follow is that this goal of improving planning for health and development provides a strategic perspective which links AID programming in health assistance to the needs for technical cooperation in health development activities among AID, other donors and agencies, and the developing countries. Requirements of instituting this goal as a strategic perspective are suggested in the series of six recommendations. These recommendations should be seen as targetted on the development of a policymaking and programming framework within which AID's role in global technical cooperation in health will be conducted. There is not within the recommendations an intent to support a separate and distinct AID program in "planning for health". Rather, the recommendations address some key institutional, policymaking, and programmatic constraints which at present are found to inhibit faster progress toward health and development improvements in the developing countries.

Recommendation A offers some ideas for eliminating the duplication of effort, lack of communication, and institutional competition among the

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various partners for technical cooperation in health in LDCs. AID is encouraged to capitalize on its leadership position in health and development programming and to initiate bold steps toward necessary collaborative efforts with the WHO, PAHO, and other donor agencies.

Recommendation B suggests a number of specific ways in which AID health programming can be adjusted and augmented to give greater support and impetus to the broader scope of health development programming within the strategic perspective of planning for health.

Recommendations C and D address the imperative need to harness and direct the resources of the U.S. academic community and private sector in supporting planning for health and development in LDCs.

Recommendation E highlights the enormous opportunity that AID currently faces to assist "graduate" countries in applying their experience and expertise to the global effort in health and development.

Finally, Recommendation F offers specific suggestions for organizing an effort to galvanize and inform a domestic constituency to support the urgently needed financial and technical support for the cooperative worldwide goal of "health for all by the year 2000".

In this moment, "health for all by the year 2000" is an elusive goal. Though this goal carries with it a power and persuasiveness beyond substance in its present form, it stands as a rhetorical affirmation of high principles, one which holds the possibility for generating among disparate sectoral interest groups a momentum for propelling previously agreed upon strategies toward a common end. Instituting planning for health and development may be as elusive a goal as "health for all", even

though there is eminent sense in prescribing the former as the means to the latter. But as a strategic perspective for the technical cooperation needed in any event, principles of planning for health and development provide a framework for frontally addressing the question: how does AID give meaning and purpose to the U.S. commitments at Alma-Ata and the World Health Assembly?

The recommendations suggest an approach to this question, not as an endorsement of planning for health as a programmatic activity for AID, but rather as a confirmation that many useful initiatives can flow from its strategic perspective. It provides a framework for understanding important concepts and tools needed by policymakers for the process of resource allocation among all sectors of the economy. AID's decisionmakers and program managers must begin at some point to obtain wider knowledge and confidence in this subject area. Thus, these recommendations argue for incremental investments in knowledge, and they argue for drawing from experiential program activities the basis for progressive, larger-scale funding commitments in selected program areas supportive of health development planning, as acceptance of the concept takes root within the donor and recipient community.

Whether one wishes to call it health planning or planning for health or health development planning, "planning" best occurs through lessons learned from the past. For this compelling reason (see Recommendation A.1 below), the study team recommends that AID fund a composite of activities designed to support country-specific initiatives in planning for health in only one country in 1980. This will permit the fundamental assumptions of the concept to be tested, and it will begin the

compilation of a practical body of knowledge through which planning and project implementation may take place. Concurrently, of course, numerous other agency-wide and regional program activities will be designed to fit the strategic perspective and to begin the task of building a knowledge base for the future.

**A. AID LEADERSHIP OF A COLLABORATIVE GLOBAL APPROACH TO HEALTH
AND DEVELOPMENT PLANNING**

Efforts to improve country capabilities in multisectoral planning for health will require support for management, organizational, and analytical skill development which exceeds by several orders of magnitude that which currently exists for the design and implementation of unidimensional health service delivery projects. Presently, neither AID nor any other donor agency has the capacity to undertake a multisectoral planning and implementation activity. The U.S. Government and all the ministers of health from WHO member states have committed themselves to achieving the goal of "health for all by the year 2000."

The operative mechanism for achieving this goal was articulated as "the initiation of national multisectoral strategies." It is stated elsewhere in this paper that the goal itself has significance and meaning beyond immediate programmatic concerns of the donor and recipient community. Certainly AID, as one donor, can exert influence on the LDCs in support of these complex planning processes, but the return will be as uncertain as it has experienced during the past ten years of investment in health planning. The best opportunity for AID to impact directly on a positive movement toward the goals established in "health for all by the year 2000" is through active participation with other donors. Inasmuch as principles of planning for health and development constitute a framework for a developing country's own policymaking and programming processes, they also comprise a fundamental strategic perspective for technical cooperation in health. The recommendation for close

collaboration is a pivotal one: all the recommendations which follow it are keyed to the success of this idea in benefitting from the strategic perspective of planning for health and development.

It is recognized that the prescription of improved and increased collaboration is an easy recommendation; like the oft-repeated endorsements of coordination, cooperation, and integration, an encouragement of collaboration is unlikely to result in real structural changes unless accompanied by actual changes in the incentives or decisionmaking processes of the parties involved. Changes that are both feasible and potentially effective, however, are difficult to design; but the following four suggestions offer some concrete steps to create an environment where institutional actors will see it in their interests to collaborate.

1. Collaborative Program and Project Design

AID should reorient its internal procedures (both centrally and regionally, and at the country/mission level) to design programs collaboratively with the WHO and other interested donors within the framework of host country institutions. Such collaboration and cooperation should become a requirement of all programming for health and development in host countries. While specific programs selected through this process may not be directly supportive of comprehensive improvements in planning capacities (e.g., development of planning units, training of planners, etc.), collaborative design efforts should be premised on the long-range goal of improving some requisite element of planning for health and should seek incremental progress toward that end within the

specific context of the limited, defined program objectives. For example, the processes involved in collaboratively planning (i.e., designing, implementing, and evaluating) a specific health program (e.g., expanded basic health services) or health and development program (e.g., rural sanitation) can increase knowledge and skills applicable to planning for health quite apart from the direct benefits of the program itself.

AID should stipulate that all health (and development) programming be:

- (1) Collaborative with host country institutions and in concert with their development policies;
- (2) Collaborative with the WHO and other donors; and
- (3) Conducted in a commonly understood framework for overall health and development goals.

While the details of implementing such a requirement will vary from one country to the next, AID will need to establish an agreement with the WHO on a common methodological framework within which to conduct collaborative national health and development programming in LDCs. The WHO's "country health programming" provides a good starting place; both AID and WHO would benefit from the negotiation of mutually agreed guidelines.

The collaborative design of multisectoral programs cannot take place overnight, and it cannot be, of a sudden, all-encompassing and comprehensive in nature. Nonetheless, in the interest of demonstrating measurable progress toward this end, specific, achievable goals to test this assumption and to begin the compilation of a practical body of knowledge can be undertaken in one country in 1980. This would allow

time for donor staff capacity in multisectoral planning for health to increase, and for program managers to document the process by which a policy choice has been implemented. Then, in 1981 and subsequent years, expansion of cooperative design efforts could be permitted in other countries.

2. Coordination of Donor Policies and Programs

Because multisectoral planning for health cuts across well-established institutional lines of bureaucracies in both the donor and LDC community, a structure is needed to coordinate this complex undertaking (multisectoral planning) on a global scale, and to provide it with sustained coherence over a long-term period. In this context, coordination means: (a) advice and counsel on matters pertaining to donor health investments; (b) monitoring of resource flows in health; (c) policy guidelines development; (d) determination of political accountability; and (e) a catalyst for the development of strategies through which multisectoral planning activities can be pursued. This central, coordinating body must have the power to wield symbolic authority, and a capacity to communicate common goals simultaneously to the public and private sectors of developing and developed countries. It must also be able to transcend the everyday minutia of political bargaining in country-specific health sectors and secure the attention of all parties to commonly agreed goals and objectives in multisectoral planning for health.

The findings and conclusions of this study indicate that the institutional mechanism(s) selected for this global mission should have

the following capabilities:

1. Be in a position to assist in articulating specific goals and objectives that both donors and recipients wish to attain;
2. Be able to monitor the level and rate of flow of funds into multisectoral health planning activities and determine if this resource flow is consistent with the capacity of LDCs to absorb effectively in light of implementation capabilities;
3. Be in a position to assist in establishing institutional processes and outcome guidelines for accountability and objectivity with respect to results;
4. Be able to determine who gains and who loses (within the host country) as a result of any donor investment in multisectoral planning for health (ministries of agriculture, home affairs, health, the expanding private sector, etc.); and
5. Be able to advise on the institutional mechanisms requisite for ensuring political accountability by the donor community and for facilitating bilateral and multilateral decisionmakers' attention to results.

The recommended activities of coordination for this body are: ²¹

21. "The Federal Investment in Knowledge of Social Problems, Study Project on Social Research and Development," Assembly of Behavioral and Social Sciences. The National Research Council, National Academy of Sciences. Washington, D.C. 1978.

a. The Oversight Activity

The fragmented character of donor funding activities in health assistance to LDCs has created the need for effective oversight. Because health sector funding is compartmentalized, both within and among donors, the donor community has generated little systematic review of problems or issues which cut across the jurisdictions and professional perspectives of multilateral and bilateral agencies. Furthermore, few attempts are made to bring different donors together into cooperative, mutually reinforcing enterprises. Too little attention is paid to resource allocation, management, or evaluation of results in a global context, i.e., effective oversight is consistent with an emerging policy initiative of unknown costs and uncertain consequences. The incorporation of more cross-cutting perspectives in the political bargaining process between donors and recipients prior to and subsequent to the implementation of multisectoral planning for health and development is of prime importance to decisionmakers.

b. Setting A Research Agenda

The acceptance by LDCs of programming national health development through multisectoral planning for health will depend, ultimately, on the building of a sound body of knowledge in support of theory. There is now little systematic planning of research priorities within the community of donors and recipients. Frequently the focus and the direction of a donor's research agenda simply emerge from a variety of interests and forces which influence the selection of particular projects. Establishing research priorities jointly with host country institutions

can be a distinct and conscious aspect of the administrative processes of recipients and donors that support the acquisition of knowledge for multisectoral planning for health and its implementation in LDCs.

e. ~~Program~~-Supporting and Policy-Forming Activities

Donor and recipient countries should be encouraged by the coordinating agency to establish an explicit management process that connects program and policy planning to project planning and implementation activities. These connections should build into the planning of health research agendas a strong sense of the program or policy audiences that will benefit or be influenced by the results of the research.

d. ~~Problem~~-Exploring Activities.

The donor community should be stimulated by the coordinating agency to plan more problem-exploring activities. Yet, the compartmentalization of research management in various donor agencies often acts as a barrier to designing a research effort that cuts across the interests of a number of donors or is within the clear province of none. Setting agendas for problem-exploring activities is often a task beyond the means of a single donor, yet common problems in program implementation often serve to inhibit multiple donors from achieving their objectives within LDCs.

e. ~~Activities~~ To Disseminate and Apply Research Results

There are many different audiences to whom the results of donor-supported knowledge activities might be pertinent, including the

private sector in LDCs, and ministries other than health, i.e., agriculture, interior, etc. Yet, there is little reason to believe that information will be received and used in the same way by each of them. If knowledge is to influence the policies, programs, and practices that are implemented to cope with health problems, it must be presented to potential users in forms that are appropriate to the needs of LDC policy makers, program managers, field practitioners, etc. The key to dissemination and use of knowledge intended to aid in program support and policy formation is the close coordination of research planning with program and policy planning. A "demand-pull" model of use, with policy makers and program managers calling for the information they need, is much likelier to succeed than is a "supply-push" model, with research administrators in the donor community trying to promote the results of particular work they have supported.

The coordination of donor policies and programs should not be a WHO function for the following reasons:

- as an international agency, the WHO is accredited specifically to the member states' ministries of health who constitute, in aggregate, the WHO's sole constituency as members of the World Health Assembly;
- many of the WHO's staff and consultants, themselves, come from ministries of health, and are personally and professionally committed to the traditional perspectives of such ministries;
- the limitations of the scope and mandate of ministries of health to a large extent are mirrored in the restricted scope and mandate of

the World Health Organization.

Because of the limitations, the WHO is constitutionally and politically accountable to the ministers in member states in the exercise of programmatic activities. It is thus in a compromised position, both in respect to developing and developed countries, to perform a coordination role for donor policies and programs.

3. Collaboration Between AID and WHO

AID and WHO should establish a new partnership for unified support of health and development. Collaboration should focus on the following two elements:

- (a) AID and WHO should agree upon a common method or set of guidelines by which national health development programming should be approached collaboratively with Third World countries. WHO's new "country health programming" guidelines provide an advanced starting point. CHP exercises conducted over the past seven years in a number of LDCs have led to the accumulation of a large body of experience and data; they have also prompted recognition of problems that still need to be addressed by any such overall prescription for national health development programming (WHO is currently revising its CHP guidelines and many of the problems faced so far are being addressed in the new guidelines). For its part, AID has a wealth of field experience in the application of resources to specific problems and programs, experience that has to be tapped for the development of an agreed-upon procedure. The most critical issue requiring agreement is the methods for matching the technical

leadership needed for problem identification and project formulation process with the political leadership needed for the subsequent direction of organizational and administrative resources needed for project implementation. Within any multisectoral effort, the role of the ministry of health (among the various levels and agencies participating) will have to be rationalized and specifically defined in each country situation.

- (b) In both AID and in the WHO, the locus of bureaucratic control of resources and program decisionmaking is decentralized. The emphasis of collaborative efforts should be focused at regional levels of both organizations. While AID's organizational structure has the regional offices located centrally, there still exists substantial opportunity for detailed collaborative mechanisms to be structured on a regional basis. The actual geographic span of regions in the two organizations is congruent enough for this kind of process to make sense. Closer regional collaboration should be one foundation for closer country-level collaboration. Those professionals and officials who are closest to the realities of field implementation of technical and financial assistance are best situated to negotiate realistic and beneficial modes for collaboration around specific country needs and categories of health problems.

4. Intra-Agency Cooperation

AID/W has to provide incentive mechanisms for its own staff charged with the design and implementation of multisectoral projects. These suggestions are offered:

- (a) AID's Office of Health should take a leadership position in fostering agency-wide collaboration with WHO by making deliberate and widely-publicized efforts at joint action at the highest, central level.
- (b) AID's Office of Health should involve the technical health personnel in the AID regional bureaus in all phases of the collaborative activities, and should see that these personnel have increased contact with, and information about, WHO/Geneva.
- (c) AID's Office of Health should devise, in collaboration with the regional bureaus, ways to reward country directors and health officers in the field who successfully design and implement programs in collaboration with the WHO Program Coordinator.
- (d) AID's Office of Health should elicit WHO's participation in a series of joint mutually-prepared seminars on the needs for, and benefits of, planning for health and development in relation to assistance needs of implementing the primary health care strategy. These seminars could be conducted on a regional basis, and would involve all country-level as well as regional-level health development programming staffs. Although activities of this nature have occurred in the recent past, they have all come to naught. It is not evident from the record that any follow-through was exacted or that the seminars led to on-site programmatic interventions.
- (e) Whenever the Deputy Assistant Administrator for Human Resources Development or the Director, Office of Health DSB, travel to WHO/Geneva or any of its regional offices, or to such meetings

sponsored by OECD/DAC in Paris on international cooperation in health programming, there should be, on a rotating basis, representation of health/population/nutrition officers from AID Bureau staff.

B. AID PROGRAM SUPPORT OF PLANNING FOR HEALTH AND DEVELOPMENT

AID should provide the necessary mandate and technical support to country missions (field offices) to enable them to initiate/participate in a dialogue with other donors and with the host country government regarding appropriate health policies and programs within the overall context of socioeconomic development strategy. The USAID country director and health officer, working together with host country officials and other donor representatives, need to galvanize a process in which better planning for health and development becomes the strategic perspective for technical cooperation in the health field.

In order for AID to develop an institutional capacity to meet this need, it must undertake two sets of activities:

- (1) A series of seminars and workshops for country directors and health (and health-related) sector field officers designed to orient them to the concepts and perspectives of planning for health and development and to familiarize them with methods for elevating to the attention of top decisionmakers and development planners the urgent policy issues of programming health development from a multisectoral perspective.
- (2) A comprehensive set of linked activities which taken together vastly improves AID's ability to provide the requisite knowledge, skills, and technical support to LDC efforts to plan for health improvements within overall development.

These two sets of activities should include the following:

1. Orientation Workshops

AID's Office of Health should develop and implement a series of regional workshops for country directors and field officers in health and health-related areas to orient them to the implications of this initiative in better planning for health and development. A general framework for the subject matter to be imparted during the seminars would include three basic areas:

- determinants of health and development and the rationale for a multisectoral approach;
- the need and significance of a multi-donor approach to improving planning as the perspective for determining modes and content of technical cooperation in health;
- nature and availability of AID technical support capabilities in the area of better planning for health and development, i.e, the existence of new initiatives in the following areas.

2. Research and Evaluation

AID should develop and undertake a substantial, long-term program of research and evaluation in several high-priority policy-related and program-relevant aspects of planning for health and development; e.g., through national strategies of "primary health care" development. Specific elements of this program should be designed and implemented in collaboration with LDC research institutions and should focus on finding out what programs and projects work well, and why and how they do. The research agenda should be cast with a long-range view of the interplay of needs and results (ten years minimum), should aim at the acquisition of new knowledge about the health impact of specific health and non-health development programs, and should seek to develop indigenous institutions able to carry on program-relevant research and evaluation activities.

Among the research areas deserving priority attention are:

- economics of health and development;
 - resource implications of alternative patterns of health investments;
 - cost-effectiveness of alternative project formulations for a given program objective;
- health impact of alternative modes of expanding basic health services;
- health impact of experimental, small-area demonstration project implementing principles of planning for health and development;
- health impact of specific, health-oriented tasks/activities of non-health sectors; and
- effectiveness of alternative modes/processes of planning for health (a specific proposal for research needs in this area is included in Volume II, Section II.A.4.).

A research question of special importance to AID is one that would critically assess the application of primary health care at the village level. The term "primary care" is frequently viewed as being synonymous with the skills of a newly trained village health worker. This concept is derived from, among others, an extensive health delivery program in rural areas of China in which health services are provided by "barefoot" doctors. China and other countries that have implemented national health development strategies to distribute health care through peripherally-based, self-selected, marginally trained health workers are beginning to reassess the effectiveness of this approach. What works and what does not? At what cost? Since the concept (primary health care) is the programmatic foundation of a number of projects being planned, or that are in the process of being implemented by AID, WHO, and other donors, it is imperative that the assumptions underlying the concept be tested. The research must focus specifically on the socioeconomic

changes which might occur at the village level if behavior was modified in the existing environment. That is, what behavioral changes in the way people presently live and work in villages impact positively on their health, and what effects are external to the clinical setting and to the village health worker?

Many research and evaluation activities complement needed activities in training, which offer opportunities for development of professional research/evaluation skills, such as data analysis, operations research, system analysis, research design, etc.

3. Training

AID should develop and undertake a program of training professionals and government officials from less developed countries in the knowledge and skills required for their particular roles in relation to planning for health and development. For the larger countries whose size can justify the investment, AID should support the creation of "Health Development Centers" which would have the institutional capacity to provide training as well as research, evaluation, and consultative support to efforts in planning for health and development (as the World Health Organization has proposed).

The knowledge and skills which are central to any training program relevant to planning for health are represented by:

1. Economics and public policy analysis,
2. Management/public administration/organizational development,
3. Epidemiology and bio-statistics, and

4. Principles of cause-and-effect interaction of health, population, and development variables

This quartet of knowledge and skills should be a constant that runs through each type of training, whether it be a short course, certificate course, or degree course.

Appropriate candidates to receive training can be categorized as follows:

- (1) Top-level political leaders and development planners;
- (2) Senior political and administrative leaders of non-health sector ministries;
- (3) Health sector leaders/planners/managers:
 - a. Senior political/administrative leaders;
 - b. Directors of operational units or of geographical divisions;
 - c. Planning and analysis staff (central and district-level).

It is imperative that the type and content of training to be offered be designed deliberately to address real country-specific problems. They should be tailored not only to the job responsibilities of the persons to be trained, but also to the particular program or project with which the training requirements might be integrated. Generally speaking, three levels of training/education should be offered, although the site, duration, and context of the training would no doubt vary greatly from one country to the next:

- (1) Short Course (2-4 weeks)
- (2) Certificate Course (3-5 months)
- (3) Degree Course (1-2 years)

Short Courses would be appropriate for senior political and administrative decisionmaking personnel (health and non-health) whose time constraints are severe. Such a short course could involve participants from multiple countries, or just one country, be done in one place or as a travelling seminar with carefully selected field visits. The goals of the short course must be clear to faculty and participants well before the fact. Specific issues to address include:

1. the consequences of alternative investment strategies in health,
2. alternative approaches to improving the population's health,
3. strategies for changing resource allocation patterns, and
4. implementation problems and managerial skills required for successful investments.

The seminar could be usefully organized around a health investment case study in the host country. This exercise could show vividly what current investment patterns are and what their probable consequences may be, where there are critical gaps in information, where the decisionmaking process in the public sector is inadequate, and where, with a different orientation vis-a-vis the presentation and analysis of data, major improvements in decisionmaking and implementation can occur.

The **Certificate courses** could be for individuals working in senior

positions in government and possibly individuals working in the private sector or in para-statal organizations that effect and impinge upon health or resource allocation related to health. Here one would begin to get into specific techniques and methods that could allow better planning and analysis to take place.

Degree courses would fill the need for advanced or indepth training in policy analysis, program design, research/evaluation or other planning-related skills. It could provide promising junior and mid-level staff with a solid conceptual and technical basis for careers in planning, public administration, and policy-analysis that appropriately recognize health as an integral part of overall development strategies.

Where it is feasible to collaboratively develop an institutional resource such as a "Health Development Center" (ideally joining or supplementing existing institutions with training programs and faculty in public management and administration, development planning, public policy, business administration, and public health), AID should give its technical and financial support to such an effort. A long-range goal of such a Center could be to develop degree-level training, although the primary efforts should focus on short courses and orientation courses, and on corollary consultative and research/evaluation activities that would help to slowly build a knowledge base and an opportunity for growth. Degree-level training should be at existing institutions of higher education offering the pertinent multi-disciplinary programs. Currently, most of these institutions are in developed countries.

4. Information Systems Development, Organizational Development, and Program Management/Administration

AID should give urgent attention to the development of a capacity to improve the ability of recipient countries to implement the programs and plans in which AID (and other donors and agencies) are cooperating partners. Most of AID's primary efforts in collaborative program design, training, and research and evaluation will come to naught if absorptive capacity and program implementation are not simultaneously improved, particularly in the areas of information systems development, organizational development, and program management/administration.

Besides the development of program support capacity (which requires an upgrading and expansion of existing AID programming approaches), AID should improve its ability (either in-house or contractor) to provide process consultation to governments/ministries of health so that programming initiatives, technical and financial support, and planning for health and development can be designed to be mutually supportive activities. This process consultation capability must combine social and cultural sensitivity to the country being served with a broad practical knowledge of how to effect and stimulate appropriate social change for health and development. The context for most process consultation would be the planning of collaborative/cooperative programs for health and development. Further skills in program design are equally important to the effort.

5. The Procurement Process

AID's capacity to implement the soundest of policies in the health

arena is seriously constrained by the procurement process. This process serves domestic interests first, and the foreign policy interests of the government second. If AID is to move into a new area such as multisectoral planning for health, and conduct this activity in concert with other donors and collaborating host country institutions, then a review of current procurement policies must be initiated. The outcome has to be one which applies the technical and professional resources of this country in a manner fully consistent with the normative values of the societies AID purports to serve abroad.

C. THE ROLE OF THE U.S. ACADEMIC COMMUNITY IN SUPPORTING PLANNING FOR HEALTH IN LDCs

In the absence of useful role models for multisectoral planning for health, the academic community in the United States, for the most part, is not now institutionally prepared to restructure curricula to the needs of multisectoral health planners (both indigenous and expatriate), particularly given the vicissitudinous history of AID-funded program support to universities.

This is a distinct loss for AID. The academic community has, to date, been among the most notable of those involved in the promotion of health activities abroad. Though they seem hesitant to become public advocates and have offered little commentary to congressional hearings in support of AID health efforts, they do constitute a formidable, persuasive force which could respond favorably if asked to join in a new partnership with the agency.

The academic community is reluctant to harness its resources for the training of multisectoral health planners without a concomitant long-term AID commitment to a strategy of investment supporting both research and evaluation components in the teaching program. Universities need a commitment of this nature over the long term (five years at least) in order to justify commitment of the institutional resources required.

Closely tied to the research needs of the university is the difficult question of faculty support. That is, if the universities are to be involved in training or technical assistance programs for AID, they want to have an identifiable research component built into the project.

Staff promotion within the university system, especially for young faculty members, is closely associated with research projects which are publishable. Without prospects for such research, the attractiveness of the project to the university is diminished considerably.

On the other hand, AID feels that as a development agency it is supposed to target its assistance to LDCs, not to support faculty in the U.S. While some universities have been able to obtain faculty support from AID, notably in the agriculture sector through consortia arrangements and 211d contracts, AID's health budget is moving away from these arrangements, which in any case, have only gone to a few universities. Still, the critical determinant of AID budget assistance to universities is the Congress. Given the scale of AID investment required to fund an institutional effort which combines training (teaching), research, and field evaluation in multisectoral planning over a five-year period, it is unlikely that the Agency will find itself in a position to offer the university community the kind of package deal it is requesting.

In order to be supportive of capabilities for planning for health capabilities in LDCs, training, research, and evaluation capabilities of appropriate personnel must be taught and developed in the context of real-world situations. In this setting, there is a close relationship between learning and doing; these capabilities can be most effectively developed in the country requesting particular AID assistance in its health sector. It is recommended, therefore, that AID and the university community seek accommodation around issues which will give the Agency what it needs operationally and give the university community what it

needs institutionally. These recommendations are offered:

Since field operations are the sine qua non of AID, universities will have to adjust their interests in that direction somewhat more than they have in the past. Many projects are designed and implemented within LDC health sectors which require the kinds of expertise found in a university and other U.S. organizations. There are AID projects which reflect the special capabilities that the academic community can offer a LDC. On a selective basis, some of these projects should be set aside for universities in terms of both project design and implementation. Pre-qualification procedures should be used in the procurement process, and the final selection of a university can then derive from a short-list of applicants. Furthermore, the criterion of selection should be based on the applicant's technical proposal. The cost proposal should be negotiated with the selected applicant and if terms cannot be reached, the AID contract officer can then invite in the next bidder.

Because of the university's participation in the project design stage, research and evaluation activities can be incorporated into the project if there is agreement both by the country involved and by AID. Naturally, political bargaining will take place and this should not be construed in a negative sense. The political process allows divergent interests to be settled in mutually satisfactory ways. However, a pre-condition to qualification should be the expressed willingness of the university to participate in the project through the faculty system rather than as consultants to

AID. (That is, many academic staff who work with AID do so as free-lance consultants. They do not, for instance, work under the direction or control of the Dean, or are they accountable to him for their performance on the contract. When they participate through the faculty system, they do so through their respective Deans' offices, and they are accountable to the Dean, and the Dean to the University.) This would help to ensure accountability of project staff to AID, USAID, LDC program managers, and, most importantly, to the university itself.

- Develop highly specific contractual relationships between AID and a particular university. This contract should spell out clearly the role of each party, and it should hold both parties fully accountable to its terms. Annual reviews should be held by the participating university and AID so that each side could state its case for compliance or non-compliance on items which were previously agreed upon. Such a process would assist both sides to amend the contract, given implementation conditions not foreseen when the implementation was signed, and permit the orderly participation of newly assigned project management staff to the project.
- If it is in the interest of the U.S. Government to involve universities in technical assistance programs abroad, then it cannot expect AID to be the sole funding agency for long-term institutions' arrangements in the health sector. Essentially, funding of this sort is pre-investment infrastructure development. The extensive faculty support needed by universities is properly the domain of other government agencies (DHEW, for instance). It is suggested

that AID request the Congress to provide budget support, through DHEW, to universities which are programmatically involved in LDC health development programming. Surely, of the \$600 million authorized by the Congress for health manpower training programs in 1978, DHEW and AID should be able to state the case for faculty budgetary support to universities collaborating with the U.S. government's foreign assistance program in health.

D. THE ROLE OF THE U.S. PRIVATE SECTOR IN SUPPORTING PLANNING FOR HEALTH IN LDCs

The private sector plays an important role in the international health arena. While U.S. Government funding of overseas aid ranks 12th among 17 OECD countries in terms of proportion of gross national product, U.S. private sector funding overseas (about \$1 billion in 1975 according to OECD) ranks third behind Sweden and Switzerland (Overseas Development Council, 1977). Major private sector groups include private voluntary organizations (PVOs), labor organizations, universities, foundations, management consulting firms, and corporations. They engage in research, education, training, and delivery of health services.

In 1973, Congress stated that private organizations should work more closely with government agencies to improve U.S. effectiveness in international health.²² This statement represents explicit congressional recognition that the private sector could perform a useful role in foreign assistance.

However, the workings of the marketplace often place private sector groups at cross-purposes to each other and they often view themselves as competitors in the implementation of AID projects abroad. While much of this is healthy, most of the opportunity for different private groups to

22. 93rd Congress. December 17, 1973. S. 1143. Foreign Assistance Act of 1973. Public Law 93-189. 87 Statues 714.

work as collaborative partners with AID is overlooked. For instance, the operational resources of a private group could be melded with the institutional strengths of a university to bring together a highly experienced project staff with diverse skills. Private groups are particularly efficient in project administration and management, and public groups in training, research, and evaluation. Together, this public-private team could prove an economical investment in terms of time expended, positive results, and ultimate costs.

Moreover, it provides both the AID mission directors and LDC program management officials with the option to change the mix of project inputs, depending on the problems encountered in on-site implementation. That is, if more management/administration components are needed in, say, year three than were anticipated when the project was first designed, then the private side (management consulting firm) of the team could take on this added responsibility without AID/W having to issue a new RFP for these services. In a similar vein, if new research questions arose as a result of implementation problems, the LDC and Mission Director would then have the option of contracting for these services with the public-private team already on-site. This may mean that new funds would have to be put into the contract, though it would not always be the case. More often, the public-private team could shift line items around within their original budget. The point is that neither the LDC nor AID have this option with a unidimensional contractor now. They are each stuck with the other for the duration of the contract, frequently three to five years. And, it is known by all concerned how infrequently projects are executed in the field as they are designed in the Project Agreement.

Other areas of collaboration for private-public sector groups that are recommended include the following:

1. Consortia arrangements for the conduct of complex multisectoral planning projects in the field;
2. Consortia arrangements for providing technical assistance to "graduate" LDCs as they strengthen their own institutional capacity toward self-reliance and, possibly, toward joining the donor community at some time in the future.

E. THE IMPLEMENTATION OF SELF-RELIANCE BY AID

Whatever images AID and the LDCs have of each other as a result of past experiences, both need to take account of new circumstances in development assistance. Some developed countries (Korea, Taiwan, Brazil) were LDCs, and AID policies and programs helped to make this progress possible. There have been substantial shifts in world conditions since the founding of AID; the ties between political and economic systems, the spread of technology, the scramble for dwindling world resources--these are just a few of the factors which are transforming relationships between nations. If AID is to continue to operate at the cutting edge of development assistance, it must respond in the 1980s to demands generated by new international realities. One of these realities lies in the opportunity AID has to work with "graduate" countries in bridging the gap from bilateral to multilateral assistance through a program of technical cooperation with the World Bank.

The old donor-recipient relationship may well exhaust itself completely in the decade ahead. Equality, mutuality, and reciprocity are becoming more than slogans: they are rapidly becoming the standards used by developing-country policymakers to judge the sincerity of donors on such often used catch words as "technical cooperation" and "self-reliance". Self-reliance, however, modified by policy or circumstances, will continue to be a key principle in the national plans of LDCs and, consequently, in all forms of development cooperation.

If U.S. statements about building a community of nations dedicated to economic development are to be taken seriously, those countries

considered as "graduate" LDCs must then be included in this endeavor -- not as beneficiaries but as fellow-builders; for some are taking on that role anyway. This government, through bilateral and multilateral development assistance programs, has much to gain from continuing and strengthening the ties it has built up during the past two decades.

In the short-term, the most relevant experiences in "re-orienting" national health care delivery capacity and in creating the receptivity of political leadership to the implementation of a multisectoral approach to planning for health will be the exposure of LDCs to successful efforts in "graduate" countries with like socio-economic development conditions. Future global or regional planning must include and facilitate this "peer" interactive process.

It is recommended that AID in collaboration with the World Bank undertake a major study to determine:

1. The impact of new directions in global relations on development assistance in the health sector;
2. The current roles of development agencies, and their effectiveness in accomplishing stated objectives;
3. The major policy issues to be addressed if development assistance is to be more effective in the health sector; and
4. The kind of development assistance "graduate" countries are prepared to provide to LDCs in the region, and the nature of assistance needed from donors for them to undertake this role initially.

In regard to item (4), this point is significant enough in its own

right to be considered separately. Therefore, it is recommended that AID and the World Bank provide technical assistance to "graduate" countries for the development of an indigenous capacity to:

1. Institutionalize in-country capability through which technical assistance in multisectoral approaches to planning for health can be offered to LDCs in their respective regions, as well as other places whose cultural and socioeconomic conditions favor acceptance.
2. Assist in the setting of criteria and guidelines for "graduate" countries in which self-reliance could be fostered. A few "graduate" countries could become donors and begin the provision of technical assistance in planning for health to countries within their respective regions. More importantly, some of these same countries could turn the tables on the donor community and themselves issue "RFPs", on a loan basis, for donor funding. Thus, donors would have to reorient their own strategies if they hope to be selected for participation in indigenous development schemes.
3. Make available loan funds for strengthening institutions in-country so that they could develop their own capacity to respond to the technical assistance needs of LDCs. If "graduate" countries wanted to use loan funds for the purpose of purchasing university resources from the U.S. or other countries to strengthen or build an institutional capacity, this should be considered an appropriate activity on the part of AID and the World Bank.

There are three important reasons why AID and the World Bank should give support to this recommendation:

1. It would provide an incentive for LDCs to strive toward self-reliance objectives;
2. It would capitalize on past investments made by AID which materially assisted "graduate" countries to become technical assistance donors;
and
3. It would provide the framework for bilateral (AID) and multilateral (World Bank) coordination in technical assistance.

F. SENSITIZING U.S. POLICYMAKERS TO THE NEED AND POTENTIAL BENEFITS OF PLANNING FOR HEALTH

Given the findings of this report, it is evident that AID is in a position to render only partial support to the U.S. Government's commitment at Alma-Ata and the World Health Assembly for "health for all by the year 2000". The scale and complexity of the undertaking dwarfs the investment program AID initiated in the mid 1960s to launch its global population program and the funding now needed to maintain the momentum it has generated.

Neither the fiscal nor professional resources are presently available to begin the design and implementation of programs supporting multisectoral planning for health at a level consistent with this government's pledge at Geneva, nor with the time frame given to carry it through to the goal. The risks for this venture are so formidable, and the consequences of failure so clear, that to set off into this great uncertainty in social programming independent of a political base of support within the United States is unwise in the extreme.

AID is a participant in this massive, global endeavor. It must act in concert with its partners, and this act has to be interpreted by them as one emanating from a broad constituency of domestic support and understanding. The central problem AID has in meeting the U.S. Government commitments is to shape and embody enough of the public will at home to support what it has been mandated to do in implementing health policy abroad. Therefore, in order to bring coherence to the preceding recommendations, there is a need to create a national forum where

knowledge about the complex interrelationships of health and development can be disseminated, and where policy analysis can be applied in support of better planning for health and development in LDCs.

Because many of the issues to be addressed (most of which involve AID) require a neutral setting for consideration, it is recommended that AID take the leadership role in the creation of this forum, but that it be established outside its own institutional environment. This forum should be broadly representative of public and private groups in the U.S. which can mobilize public opinion toward an understanding of the resource (human and fiscal) requirements needed to support a broad program of technical assistance in planning for health activities in LDCs.

Thus, possible areas for focusing this forum's activities should be:

1. Providing a focus for bringing decisionmakers in the U.S. to a better understanding of the needs for and benefits of planning for health in LDCs, and development for mobilizing their active support. In order to improve communications and understanding among all partners engaged in this undertaking, the mandate of the forum should be closely coordinated with the missions assigned to Recommendation I (above), and to the WHO-proposed National Health Councils and National Health Development Centers in LDCs.
2. Working with multilateral institutions and development banks in the setting of goals and objectives in macroeconomic planning for health investments.
3. Improving the relationship between AID and the Congress as planning for health and development is undertaken in coordination with other

donors abroad. Given the multifaceted implications of this new initiative, there is a need for AID to interact with many more donor agencies and their policies and regulations, some of which may be at variance with the Congressional mandate.

4. Initiating policy studies on total resource flows to and within the health sectors of LDCs, and the implications of these investments on the stated goals and objectives of both donors and recipients.
5. Sponsoring policy seminars for AID staff, Congressional staff, OMB staff, and other institutional groups within the U.S., the donor community, and in LDCs. The signal purpose of these sessions would be to sensitize selected individuals to a better understanding of the interaction between health and economic planning on the part of those engaged in the development planning process and the social policymaking process.

APPENDIX

APPENDIX

A. Project Team Field Visits

World Health Organization

Office Visited	Team Member(s)	Dates of Visit
WHO/Geneva	Stanley C. Scheyer Ronald B. Epstein	March 8-14, 1979
WHO/SEARO	Alan W. Fairbank	April 2-3, 1979
WHO/WPRO	Alan W. Fairbank	April 16-18, 1979
WHO/EMRO	Ronald B. Epstein Lawrence E. Williams	May 23-26, 1979
WHO/AFRO	Ronald B. Epstein Lawrence E. Williams	May 28-31, 1979

Countries

Country Visited	Team Member(s)	Dates of Visit
Nepal	Alan W. Fairbank	April 4-10, 1979
Korea	Jeremiah Norris Alan W. Fairbank	April 10-18, 1979
Guatemala	Jeremiah Norris Thomas Bossert	May 14-17, 1979

Institutions

Institutions Visited	Team Member(s)	Dates of Visits
University of California Los Angeles	Stanley C. Scheyer David W. Dunlop	May 16
University of California Berkeley	"	May 17
University of Washington School of Public Health	"	May 21
Johns Hopkins University School of Hygiene & Public Health	David W. Dunlop Jeremiah Norris	May 11
Harvard University School of Public Health	David W. Dunlop	May 10
Tulane University School of Public Health	"	May 15
University of Wisconsin Medical School	"	May 24
University of Illinois School of Public Health	"	May 25
Michigan State University Department of Community Medicine & Geography	"	May 28
University of Michigan School of Public Health	"	May 29
University of North Carolina School of Public Health	"	June 1
Ross Tropical Institute London School of Hygiene & Tropical Medicine	Alan W. Fairbank	May 17
Institute for Development Studies University of Sussex United Kingdom	"	May 17-18
Royal Tropical Institute Amsterdam, Netherlands	"	May 21-22
Institute "Medical Care in the Developing World" Catholic University of Nijmegen Nijmegen, Netherlands	"	May 23

APPENDIX (con.)

B. Persons Interviewed by Project Team

World Health Organization

Geneva

- J. Cohen, M.D., Special Assistant to the Director General
D. Tejada-de-Rivero, M.D., Assistant Director General
C. Vukmanovic, M.D., Chief, Country Health Programming
P. Lawton, Administrative Officer, Cooperative Program for Development
J.L. Kilgour, M.D., Director, Division of Coordination
R.H. Henderson, M.D., Director, Expanded Program of Immunization
H.E. Fillmore, R.N., Chief, Nursing Unit

New Delhi/SEARO

- Thaineua Mali, M.D., M.P.H., Director, Comprehensive Health Services
M.S. Rahman, M.D., Director, Planning and Coordination
Kartar H. Notaney, M.D., Planning Officer
George Cumper, Ph.D., Health Economist
C.R. Krishnamurthi, Consultant
James Veney, Ph.D., Operations Research Specialist

Manila/WPRO

- Francisco J. Dy, M.D., Regional Director
S.T. Han, Director, M.D., M.P.H. Manpower Development and Family Health
Remigio D. Mercado, M.D., M.P.H., Director, Health Services and Planning
Dragan Stern, M.D., Regional Adviser, Health Services Development
George Dorros, M.B.A., Program Management Officer

World Health Organization (con.)

Alexandria/EMRO

A.H. Taba, M. D., Regional Director

R.L. Manning, M.D., Public Health Adviser, Health Program Development

E.K. Westenberger, M. D., Director, Support Program

F. Partow, M.D., Director, Communicable Disease Control, and his staff

G.E. Rifka, M.D., Director, Strengthening of Health Services

A. Robertson, M.D., Director, Health Manpower Development

M.O. Shoib, M.D., Director, Program Management

Brazzaville/AFRO

C.A.A. Quenum, M. D., Regional Director

S.H. Siwale, M.D., Director, Program Management

A.M. Geller, M.D., Director, Program Development

J.P.E. Jardel, M.D., Director, Program Development and Evaluation

A. Franklin, M.D., Director, Health Manpower Development

Countries

Nepal

Tara Dev Bhattarai, M.A., Secretary, Ministry of Health

Pushpa Lal Rajbhandari, M.B.B.S., D.P.H., D.C.H., Chief, Health Planning Section, Ministry of Health

B.N. Baidya, M.D., M.P.H., Assistant Chief, Health Planning Section, Ministry of Health

Raymond Chical, M.D., WHO Representative

Peter Hornby, Health Planning Adviser, Ministry of Health

Duane Smith, M.D., M.P.H., Project Director, USAID Integrated Health Services Project

William Oldham, M.D., M.P.H., Chief, Office of Health, Population, and Nutrition, USAID/Nepal

Countries (con.)

Korea

Jae-Ik Kim, Ph.D., Director-General, Bureau of Economic Planning,
Economic Planning Board

Sei-Jin Pyo, Ph.D., Chief, 4th Investment Division, Economic Planning
Bureau, Economic Planning Board

Chong Kee Park, Ph.D., Secretary General, National Health Secretariat,
Korea Development Institute

Ha Cheong Yeon, Ph.D., Senior Fellow, Korea Development Institute

Jaesung Min, M.A., Chief, Health Planning and Policy Division, Korea
Development Institute

Hyung Jong Park, M.D., Ph.D., President, Korea Health Development
Institute

Shyn-Il Joo, M.D., M.P.H., Senior Fellow, Korea Health Development
Institute

Kilbyoung Yoone, Director Manpower Development Division, Korea Health
Development Institute

Kong Hyun Kim, M.P.H., Senior Researcher and Field Officer, Korea Health
Development Institute

John Huh, M.D., M.P.H., Ph.D., Dean, Graduate School of Public Health,
Seoul National University

Chang Dong Min, M.D., Director, Medical Affairs Bureau, Ministry of
Health and Social Welfare

Alexander M. Rankin, M.D., Representative, World Health Organization

William Paupe, M.P.H., USAID Representative

Guatemala

Carlos Estrada, M.D., Health Unit, National Economic Planning Council

Jaime Solorzano, M.D., Director, Office of Programming, Ministry of
Health

Eliseo Carrasco, USAID Mission Director

Scott Edmonds, USAID/Guatemala Health/Population Officer

Institutions

Harvard University

Richard Cash, M.D., M.P.H., Institute Fellow, HIID; Lecturer, Department of Tropical Public Health; and Coordinator for the Office of International Health Programs

Joe E. Wray, M.D., M.P.H., Director, Office of International Programs; Lecturer, Department of Maternal and Child Health; and Head, Department of Population Sciences

James Kocher, Ph.D., Institute Associate, HIID

James Austin, Dr. B.A., Professor of Business Administration

Gretchen Berggren, M.D., Assistant Professor, Department of Population Sciences; Coordinator, Office of International Health

Roger Nichols, M.D., Irene Heinz Given Professor of Microbiology

University of North Carolina

Bernard Greenberg, Ph.D., Professor and Dean of the School of Public Health; Kenan Professor in Biostatistics

Barry Popkin, Ph.D., Assistant Professor, Department of Nutrition

Sagar Jain, Ph.D., Professor and Chairman, Department of Health Administration

Tulane University

James Banta, M.D., Dean and Professor of the School of Public Health

James Carter, M.D., Chairman and Professor, Department of Nutrition

Claudio Schuftan, M.D., Assistant Professor, Department of Nutrition

William Bertrand, Ph.D., Associate Professor, Department of Biostatistics and Epidemiology

Ramiro Delgado, M.D., Professor, Department of Applied Health Sciences

Athol Patterson, MBCHB, Professor, Department of Applied Health Sciences, British College

James Wyllie, I.D., Assistant Professor, Department of Health Systems Management

Institutions (con.)

University of California, Los Angeles

Stewart Blumenfeld, Dr. P.H., Lecturer, Division of Population, Family and International Health

Irvin Lourie, M.D., M.P.H., Lecture, School of Public Health

Alfred Neumann, M.D., M.P.H., Professor, School of Public Health and Coordinator, Danfa Comprehensive Rural Health and Family Planning Project, Accra, Ghana

University of California, Berkeley

Andrew Fisher, Ph.D., Assistant Professor and Head of the Health Education Program

Henrik Blum, M.D., M.P.H., Professor of Community Health Planning, Department of Sociology and Health

Nick Marlet, Associate Dean, School of Public Health

G. Nicholas Parlette, M.P.H.

University of Washington

Jacques Faigenblum, Ph.D., M.S.E.E., Assist Professor, Department of Environmental Health

Thomas Bice, Visiting Professor, Department of Health Services

Robert Day, M.D., Ph.D., Dean, School of Public Health

William Richardson, Ph.D., Acting Dean, School of Public Health and Community Medicine

Don Riedel, Ph.D., Professor and Chairman of the Department of Health Services

Institutions (con.)

University of Wisconsin

Barbara Wolfe, Ph.D., Assistant Professor of Economics and Preventive Medicine

Ralph Andreano, Ph.D., Professor of Economics and Director of Health Economics Research Center

Rockwell Schulz, Ph.D., Director of Programs in Health Services Administration

James Bjorkman, Ph.D., Assistant Professor of Preventive Medicine and Political Science

Edwin Wallace, M.D., M.P.H., Assistant Clinical Professor of Preventive Medicine and Director of the Office of International Health

University of Illinois

George Saxton, M.D., M.P.H., Professor of Community Health Sciences

Nail Ozerol, Ph.D., Assistant Professor of Community Health Sciences

Wadie Kamel, M.D., M.P.H., Professor of Community Health Sciences

Swaillem Hennein, Ph.D., Associate Professor of Community Health Sciences

University of Michigan

Robert Grosse, Ph.D., Professor of Health Planning

Oscar Gish, M.Phil., Lecturer, Department of Health Planning and Administration

Kenneth Warner, Ph.D., Associate Professor, Department of Health Planning and Administration

Institutions (con.)

Johns Hopkins University

William A. Reinke, Ph.D., M.B.A., Professor of International Health Services and Administration and Biostatistics

Timothy Baker, M.D., M.P.H., Professor of International Health and Health Services Administration

Carl E. Taylor, M.D., M.P.H., Dr. P.H., Chairman and Professor of the Department of International Health

Cecile De Sweemer, M.D., D.T.H., Dr. P.H., Assistant Professor of the Department of International Health; Research Scientist

Michigan State University

Carl Eicher, Ph. D., Professor, Department of Agricultural Economics

Michael Abkin, Ph.D., Assistant Professor, Department of Agricultural Economics

John Hunter, Ph.D., Professor, Department of Economics

Institute for Development Studies, University of Sussex

Susan Cole-King, M.B.B.S., D.T.P.H., Research Fellow, Health Group

Royal Tropical Institute, Amsterdam

A.S. Muller, M.D., Director Department of Tropical Hygiene

Institute "Medical Care in the Developing World", University of Nijmegen

V. Van Amelsvoort, M.B.B.S., Director

London School of Hygiene and Tropical Medicine

Patrick Vaughan, M.B.B.S. D.T.P.H.

Agency for International Development

Lee Howard, M.D., Dr. P.H., Director, Office of Health, Bureau for Development Support, AID (April 25, 1979)

Irving Taylor, Chief, Health Planning Division, Office of Health, Bureau for Development Support, AID

Kenneth Farr, Ph.D., Office of International Health, DHEW, HRA/DHEW, (May 10, 1979)

Joe Davis, M.D., M.P.H., Health Planner, Bureau for Health Planning, HRA/DHEW, former Chief, Health Planning Division, Office of Health (AID) (May 9, 1979)

Barbara Sandoval, M.P.H., Chief, Health, Nutrition, and Population,, Latin America Bureau, AID (April 27, 1979)

Marie Kirby, Africa Bureau, AID (May 10, 1979)

Julius Prince, M.D., former Chief, Health, Nutrition, and Population, Africa Bureau, AID (May 31, 1979)

Others

William J. Towle, Economist, The Analytic Sciences Corporation,
Reading, Mass.

Scott Loomis, Analyst, The Analytic Sciences Corporation, Reading,
Mass.

Frederick Golladay, Ph.D., Economist, The World Bank, Washington,
D.C.

Peter Hall, Project Officer, The World Bank, Washington, D.C.

Jose Barrenechea, Department of Health Planning, PAHO, Washington,
D.C.

Abraham Drobny, M.D., Health Sector, InterAmerican Development Bank,
Washington, D.C.

James Potts, Health Planning Section, PAHO, Washington, D.C.