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ISSUES IN HEALTH PROJECT
SUSTAINABILITY

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EXECUTIVE SUMMARY

The purpose of this paper is to review the lessons learned from AID's health programs. Based on a review of AID literature on health programs and on reports over projects from other large donors, the paper aims to summarize what is known and what is not yet known in the field of international health.

Summary

The theme of the paper is project sustainability. However monumental or costly the efforts going into starting a health program, if there are no lasting benefits the effort can be considered a failure.

AID, and other large donors such as the UNICEF, UNDP, and the World Bank have had experiences similar to those of AID. Although there is an intellectual commitment to projects with long term sustainability, the bureaucracy provides no internal rewards to personnel based on the long term results of the project. Personnel are rewarded for starting projects, and for keeping them on schedule, not for measurable reductions in morbidity or mortality rates ten years later.

Short-term thinking in project planning and implementation results when few personnel, either with AID or with host country ministries of health, see projects through the long run. Personnel change, national project directors are transferred, sympathetic host country ministers are replaced by unsympathetic ones. Few people see the project through from conception and planning to implementation, much less from implementation to long term sustainability.

AID was created in 1961. Prior to that time U.S. efforts in international health were mostly large scale programs with specific objectives. U.S. had no policy on and limited experience with international health. Projects were motivated by humanitarian concerns and located according to post-war political expediency.

With the creation of AID, a new era in international assistance began. For the first time the concept of development played a large role in international assistance. Loans replaced grants and health programs were seen as a part of overall economic development. Healthy people are more productive workers and economic development hinged on productivity.

The economic benefits of health was a theme that carried through the late 1960's and 1970's when small was beautiful and integration was stressed. Health programs were integrated with efforts in agriculture, education, and housing. The primary health care (PHC) model stressed the small, community-based, integrated service approach.

During the 1980's, when the first experiences with small-scale integrated PHC programs began to be assessed, it was found that many programs try to do too much with too little. While the multi-service program is still an ideal, in fact only a few select program types have demonstrable effects. Proving the impact of integrated programs has been difficult, especially during the short-run of the AID project cycle.

AID today stresses improved health planning at the national level, research and training in sounder health care financing for developing countries and a few select interventions which are known to be effective: oral rehydration, vector control, immunization, and vaccine development. Where earlier health programs had stressed economic development, programs of the 1980's have stressed saving children's lives.

While we have little research on the components of sustainable health programs, the one unequivocal issue is that of financing. No program can survive without a sound financial base. The financing of health programs continues to be a difficult problem to solve. Host countries may have official policies in support of PHC but unofficially there is often little understanding of PHC or no support for it. Because of a history of free health care in many countries, it is politically unpopular to begin to recover some of the costs through user-fees or other fund raising schemes at the delivery level.

Health care in developing countries tends to be available only in the urban areas and then to the more affluent. Making health care available in rural and other underserved areas is costly and government officials may find it is not worth the effort politically. There is generally low public interest in primary health care. People want, and are willing to pay for, curative services. They seek out costly private practitioners even when free care is available. But, few poor can allocate money for activities from which they see no benefit and the results of prevention are invisible.

Planning for recovery of recurring costs of a program has presented enormous problems in developing countries. Partly it is because no one had much experience in estimating what costs would be down the line. Partly, too, it was because there was no way to predict changes in foreign exchange or to cope with the extraordinarily inflation rates in some countries.

Financing country wide health programs requires a sincere commitment from the government toward PHC and toward providing services in the rural areas. It requires a continuity of policy, if not personnel, and it requires a reallocation of budgets away from urban, hospital oriented, care toward rural PHC.

Community financing is a way to provide for the recovery of some costs. Selling drugs, community labor, raffles, income generation, and other schemes have been successful in raising

money to cover some of the costs of specific activities such as building a clinic, digging a trench for a water pipe, or for immunization campaigns. However, the health services must include substantial curative services to generate broad financial support. Community financing may be part of the answer in financing programs but rarely will communities be able to finance sustainable programs on their own.

Fees-for-service represent a more practical way to finance services. Charging a fee for a service discourages nonessential use and enhances the perceived value of the service. Paying for a service makes more sense to many people than pre-payment, insurance, and other risk-sharing arrangements.

Few health programs take advantage of the full range of existing health care providers. These include private physicians, traditional healers, midwives and traditional birth attendants, pharmacists and other drug sellers, and herbalists. The limited experiences reported of programs which incorporate existing health care providers has been successful if designed to protect the dignity of the individuals. While working with private physicians has not worked well, largely due to their curative approach, programs to train traditional birth attendants and drug sellers (social marketing) have been successful.

An alternative to paying for services after they are used is to join a risk-sharing, pre-payment plan. Various types of insurance and health maintenance organizations in developing countries are now being studied. Preliminary results show that such schemes can provide health care for that part of the population which is salaried. The successful programs have been carried out in countries such as Chile where the government supports private sector involvement in health care, where the population is affluent enough to support the idea of paying in advance for care and where there are enough personnel to manage the finances of such organizations.

Development projects in all sectors conventionally place great emphasis on community participation. In health programs, that participation is usually some variation on a committee. There has been little examination of the concept of participation and whether committees are inherently representative or effective. In most cases the role of the committee is prescribed and limited to making decisions about the hours the clinic will be open and choosing health workers.

When committees are charged with making more substantive decisions they often lack the skills to do so. Ordering drugs, carrying out financing schemes, and managing health posts are often beyond the experience of any committee member and projects rarely provide committee members with little training in how to carry out their responsibilities.

Self-help projects are often confused with participation. When community members come on a weekend to assist in the construction

of a clinic, they may have had little role in deciding whether they want a health project or what form it takes. True participation means that the people themselves make all the decisions. Since almost all development projects are designed and financed by some agency or organization outside the community, few projects have true participation. It is important that the roles of members of the community be defined and the amount of participation not over-estimated. The main reason to encourage participation is its link with community financing of some of the recurrent costs of the program. People are more apt to contribute to programs they perceive to meet their needs.

Health programs are sometimes characterized as categorical or integrated programs. Categorical programs are those which target a specific cause of morbidity or mortality. Such programs often operate on a wide geographic scale. Oral rehydration, vitamin A, malaria control, and immunization campaigns are examples of categorical programs. Categorical programs are often called vertical programs because they are managed from the top, often under the guidance of special sections of the ministry of health. Integrated programs have wider objectives and attack health problems from several directions.

Categorical programs are easier to plan, manage, and implement because they target very specific conditions with well understood, effective technology. The impact of such programs are usually immediate and predictable. If so many children are vaccinated, so many deaths will have been averted. If so many acres of malaria breeding grounds are sprayed, then the incidence of malaria will drop by a predictable rate.

Integrated programs are difficult to plan, manage, and implement because health conditions in each community differ and traditional beliefs about the cause of illness must be overcome. They try to provide first aid, referrals to clinics, health education, nutrition, peri-natal care, and environmental sanitation programs with inadequate human and financial resources. And, most importantly, the results of integrated programs are not always immediately obvious. While the nutritional status of children can be monitored over time that may not tell the full story of illnesses prevented and human suffering minimized.

Both categorical and integrated programs have strengths and weaknesses. Categorical programs are easier to design and have clearer measurable impact. They are costly if they have their own management systems and are not integrated with other programs. While integrated programs are preferable, they end up doing many things poorly rather than a few things well. Integrated programs are most effective when they start with a few limited services and add activities as community support and health workers skills grow.

The main management problem is how to make limited resources provide a range of services in inaccessible places. Developing

countries have acute problems with a shortage of personnel, difficult transportation systems, lack of availability of drugs, and poor communication. Evaluation reports routinely report serious management problems in health programs. At the same time, many programs continue to provide services and to have some measurable impact. AID is placing great emphasis on improving management systems.

An information loop which includes data on morbidity, mortality, referrals to clinics, services performed, and health worker effectiveness is important to maintaining a health program. The more extensive the system, the more important a good feedback and communication system. Almost all evaluations of health projects discuss the weakness of the information system within the project. It is evident that some projects succeed even with very poor information and management systems in place. Increased efficiency of the system leads to a streamlining of management and finance, however. While projects do not necessarily flounder with a poor system, they are much more economical and efficient when management and information systems are stronger.

If there is a central question concerning project sustainability it has to do with long term financing of the project. Host country policy and budgets must make a strong statement in favor of primary health care and in support of cost recovery through a variety of community financing, user-fees, and prepaid health services. They should tap into the existing health care provider systems, particularly in training drug sellers and traditional birth attendants. Improving management and information systems will be an on-going process. There are many roles for members of the community to play in sustaining their health system. As citizens learn more about health care management, it is to be hoped that their role in the decision making process would increase. It is when PHC becomes popular that politicians will strengthen their own support of a policy of health for all.

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CHAPTER ONE

Introduction

As recently as fifty years ago, famine and pestilence were the norm in both industrialized and non-industrialized countries. Because of efforts by the international health community, and because of increased interdependence and communication, dramatic strides have been made in improving the health of the world's people. While malnutrition and disease still exist, increasingly technology and a other resources find ways of minimizing the crippling social and economic consequences of illness.

AID health programs have addressed the problems of health in developing countries since 1945. The major trend during those years has been the increased emphasis on the prevention of illness and away from expensive curative and hospital based care. Along the way, AID has learned a great deal about what works and what does not work in health programs. More importantly, it has discovered some of the more effective roles an agency of its size and resources can play. Depending on local resources and health care priorities, the most effective role for AID may vary by country and by region. Fortunately, AID has accumulated a body of literature documenting both successes and failures. From that literature can be derived some generalizations pointing to the most cost-effective interventions.

A. Purpose of the Paper

The purpose of this paper is to review the lessons learned from AID's world wide experience with health programs with an aim of providing some guidelines for the planning of future programs and for the evaluation of present programs. The paper is based on a review of both internal and external project evaluations and critiques of AIDs health programs. For comparison, information on the health programs of other large organizations, such as the World Bank, UNICEF, UNDP, and WHO are included.

The methodology has been to review secondary and tertiary sources of information on AID and other health programs. Existing literature was reviewed including, particularly, reports and studies which reviewed more than one AID project. This completed document is intended to review AIDs experience in health and to provide a frame of reference for a general health program review being conducted by AID/PPC/CDIE.

B. Sustainability

A project without lasting impact has no real consequences for development. The effect of vaccinations campaigns last only until a new wave of children are born. There are always diets to be improved, mothers to be educated, and births to be controlled. No matter how effective a program is at accomplishing its aims, if it terminates when the funding cycle ends, the long term effects will be inconsequential.

Although development planners recognize, intellectually, the importance of project sustainability, the actual emphasis among the larger scale development organizations such as AID, IBRD and the UN (WHO, UNICEF, etc.) is on getting projects started and keeping them running rather than on long term viability. Sometimes, too, the emphasis has been on sustaining the infrastructure rather than sustaining the benefits of the program.

Almost all development projects face problems of sustainability over the long run, when the donor agency has moved on to other projects or other communities. Within AID, two of the reasons for a lack of sustainability in projects are a rapid turnover of staff at all levels and a lack of institutional rewards for staff who pursue long term sustainability.

Rapid staff turnover among AID project managers, national project directors, supervisory sector chiefs, host country ministers, deputy ministers and project directors leads to rapid changes in priorities and a lack of follow-through on projects. "Some projects that had had high hopes of achieving sustainability when they were among the then ministers and/or the director's top priorities may be weakened and their sustainability threatened by the lesser interest of their replacements" (Development Associates 1985:17).

A second reason for a lack of sustainable projects is the AID project managers relationship with the project during and after the funding cycle. There is a consensus that projects fare better when the project manager takes a positive and constructive role in project implementation (Development Associates 1985:18). AID project managers, however, are not rewarded for what happens to the project when funding ends.

There are no institutional rewards for AID staff whose projects sustain their impact beyond the term of funding. The rewards within the Agency go to those who initiate projects (i.e. spend money) and who keep the projects on schedule. AID staff are held

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accountable for the process of getting the project moving rather than for the results it produces over the long run. Most projects are funded for a three-year period. What happens after the third year is theoretically of interest but sustainability is not built into the project cycle beyond funding.

A recent review of the impact of AID projects in five countries (Morocco, Senegal, Colombia, Korea, and Tanzania) indicates that sustainability is a problem with AID health projects. "Virtually every evaluation raises questions about the long-term viability of AID health projects. Problems appear likely in relation not just to financing (admittedly a critical ingredient) but also in relation to shifting political support, weak community participation, inappropriate technology, dependence on imported commodities and foreign specialists and other factors" (Stinson 1986:10).

Over the past year, the sustainability of projects has become a point of discussion within the development community. Concern has focused both on the sustainability of project infrastructure (personnel, management structure, office space, vehicles, and equipment) but also on the impact of the project.

In health, the central sustainability issue is the long range viability of preventive services. Because their utility is much more obvious, government, local communities, and end-users are much more willing to pay for curative health services. In some places poor families are paying up to 30% of their income for health care. In the long run prevention is less costly and prevents not only illness but the terrible human costs of mental retardation, physical handicaps, blindness, and death. Programs aimed at education and the prevention of illness, however, are much more difficult to sustain.

This paper focuses on lessons learned from health programs. It excludes a review of the large body of literature on certain types of programs such as water and sanitation, PL480 food, family planning, and nutrition except in so far as these activities are part of primary health care (PHC) programs. Some of the most successful community based PHC projects have been carried out by the private voluntary organizations (PVOs) but these activities are not discussed here. A major study of PVO efforts in health is underway by Management Sciences for Health and will cover some of the strengths and weaknesses of these smaller, longer term health programs.

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C. Overview of this paper

AID's policy stresses project sustainability. "The basic objective of AID's health programs is to help developing countries become self-sufficient in providing broad access to cost-effective preventive and curative health services directed at the primary causes of mortality and morbidity in LDCs (AID 1982:4).

This paper is organized around the theme of project sustainability even though there is no agreement about the attributes of sustainable projects. The issues discussed here, financing, host country policy, program type, resource allocation, communication, and community participation, are among the frequently mentioned attributes of a sustainable projects. The truth is that we do not yet know what contributes to sustainability. Each project is, to some extent, unique and there may be no single variable which determines the long term viability of a project.

Chapter Two reviews AID's health policy. It describes in general terms, the path AID has taken in the journey to its present policy. That chapter, also, describes some of the factors which determined the course of the journey.

The viability of a health program is based on its affordability and its desirability (Blumenfeld and Pipp 1985:20). Programs may be financed in a variety of ways including local government contributions, community contributions, and fees for service. The use of private sector physicians, insurance programs, and health maintenance organizations may defray some program costs. **Chapters Three** is a discussion of some of the problems in health care financing. **Chapter Four** looks at some of the solutions to those problems.

Chapter Five discusses communities involvement in their health programs and discusses the issues relating to community participation in health programs.

Health programs are often dichotomized as categorical or integrated programs. Categorical programs, also referred to as vertical programs, have very specific objectives and are often nation-wide campaigns aimed at reducing morbidity or mortality from a specific disease or deficiency. Malaria, schistosomiasis, and onchocerciasis programs are typical categorical programs. Immunization campaigns, vitamin A and oral rehydration programs are also examples of categorical or vertical programs.

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Integrated programs, by contrast, have multiple objectives and are more apt to be responsive to local conditions and constraints. The relative advantages of categorical and integrated programs are discussed in **Chapter Six** where some of the unresolved issues are highlighted.

A sustainable and effective health program uses appropriate, low-cost technology and delivers services through appropriately trained and supervised staff. Discovering the least expensive technology and the most effective delivery system are activities with which AID has considerable experience and within which there remains controversy. The issues relating to resource allocation are discussed in **Chapter Seven**.

Central to the effective management of a health program is an efficient method of record keeping and information management. **Chapter Eight** discusses the role of communication and program responsiveness in the context of sustainability.

While a program is unlikely to be sustainable unless it rates high on the five factors discussed here, which are the most important? Are there other issues of importance? **Chapter Nine** reviews what is known about project sustainability and the "lessons learned" in each of the topic areas. Some controversies remain. These are discussed along with some recommendations about future research in the concluding chapter.

CHAPTER TWO

A Short History of AID's Health Programs

This chapter highlights some of the major trends in AID health policy and budget expenditures. In reviewing policy statements and budgets for the past twenty-five years, four themes emerge.

1) Even before AID was formally created, U.S. international health efforts have placed a constant emphasis on malaria eradication. In the early days following World War II, the emphasis was on spraying and drug distribution. Later, when these methods were found to be creating resistant strains of mosquitoes and malaria, the focus switched to environmental control and the search for an effective, low-cost vaccine. Spurred on by the success of the small-pox vaccine, AID has also worked in other vector control programs but in none with the consistency and endurance of its thirty-year battle against malaria.

2) The premise of the US effort in international health programs has gone from health for health's sake during the pre-AID years to health for economic development's sake during the 60's and 70's to health for the children's sake in the 80's. In the early years national and international organizations had little experience with international health efforts and carried out programs without much policy or experience to guide them. When AID was created as a branch of the State Department, it was at a time when "development" was a new idea and when economic growth in developing countries was a high priority. Since healthy people are more productive, health programs were often integrated with agriculture and other economic development programs.

During the late 70's and early 80's Americans began to see pictures of starving African children on their televisions as drought conditions in the Sahel worsened. By this time AID had enough health experience to recognize that the worst killers of children were not exotic, difficult to pronounce, tropical diseases but simple dehydration and common childhood diseases such as measles and whooping cough. Programs focusing on children's survival are politically popular and are relatively easy to design and carry out. The diseases are well known, the cures are at hand and they require little technology to disseminate.

3) AID has come full circle in its swing from categorical to

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integrated and back to categorical programs. AID's earliest programs were categorical efforts (mainly malaria control, immunizations, and food distribution/nutrition programs). During the 70's and early 80's there was a strong emphasis on integrated programs. Health programs were integrated with education and economic development programs. The standard model for a health program was the integrated, community-based primary health care program offering simple curative and preventive services through a network of community health workers.

The integrated PHC program remains an ideal but reality has shown that few developing countries have the resources, personnel and political commitment to maintain such programs. As a result, AID of the mid-80's has gone back to more centrally-funded, focused, categorical programs.

4) AID's earliest programs were large, centrally funded programs which involved several countries and relatively large outlays of capital and personnel. During the 60's and 70's when small was beautiful and grass-roots development was the mode, the stress was on smaller programs tailored to the needs of individual communities. However beautiful or effective such programs are, they are difficult to manage. At a time when AID's personnel were being reduced, each staff person had to handle more and more projects. Small, grass-roots projects are very labor intensive from AID's perspective. It is more effective for staff to manage a few large programs than dozens of smaller ones. Also, small programs do not require the large outlays of money AID has committed for health programs. In order to get large amounts of money into developing countries in a given fiscal year, larger projects are needed.

Because AID health expenditures have been presented in some detail in the references cited in this chapter, actual budget figures are presented only in the most general terms. Budget figures are presented in either actual or "current" dollars according to the year of the budget and the year of the report. Because of the difficulty of translating figures into comparable terms and because the trends are clear from gross budget figures, little budgetary detail is presented here.

It is, furthermore, difficult to sort out AID health expenditures over the years because many health related activities are in Agriculture or other sectors and the costs are hidden in the budgets of other programs. Also, many US Agencies funded by AID have significance for health. These include the U.S. Public Health Service, U.S. Department of Agriculture, The Departments of Labor, Interior, and Commerce, the Veterans Administration,

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the Smithsonian Institution as well as private institutions such as chemical and pharmaceutical companies, engineering and construction firms, foundations, professional organizations, voluntary organizations, universities, and hospitals (HEW 1965).

AID health resources are concentrated in the politically unstable areas and as such a history of AID expenditures mirrors the international political situation. During the 60's most health funds and personnel were in S.E. Asia. The political importance of Africa was growing and AID health expenditures there began a steady increase. After the Vietnam war, most money has gone to the Middle East, particularly to Egypt. That AID is a branch of the State Department is, not surprisingly, reflected clearly in the budgets and policies of the agency.

A. Health for health's sake: The pre-AID years

Prior to World War II there was little activity in the field of international health. The Pan American Sanitary Bureau, under the direction of the Surgeon General of the U.S. and the International Health Office in Geneva were the two organizations concerned with international health. Both were small and served as information centers rather than carrying out programs.

During this period, most international health efforts were carried out by private organizations such as missionary groups, and by commercial companies such as United Fruit Company, Firestone and Standard Oil (C. Pease 1985:1-2).

The only foundation working overseas was Rockefeller Foundation which has successfully carried out programs for hookworm prevention in the U.S. and had taken their programs overseas. They also carried out programs for the control of yellow fever.

In 1940, Nelson Rockefeller was appointed Coordinator of Inter-American Affairs. After the war began, he suggested that a cooperative health service be established to improve health in Latin America. Although the U.S. was motivated by an interest in procuring strategic materials for the war effort, eighteen Latin American ministries of health began programs for the construction of hospitals, clinics, training, disease control, and environmental sanitation. The Institute of Inter-American Affairs, as it was called, carried out its programs with great difficulty because of the shortages of materials (C. Pease 1985:2). The Institute lasted from 1943 to 1953 and carried out 1,500 health projects with a budget of about \$100 million (HEW 1965).

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The end of the war saw the beginning of a florescence of interest in international health stimulated by two important events: the establishment of the United Nations and the development of the Marshall Plan for the reconstruction of Europe in 1947.

UNICEF was created in 1946 along with the UN. In 1948, the Office of International Health became the World Health Organization and the Pan-American Sanitary Bureau (to) became the Pan American Health Organization (PAHO).

The Marshall plan had few direct health programs but as the first major U.S. commitment for sustained foreign assistance to any part of the world, it represented a major policy shift which was the forerunner of today's development assistance programs (C. Pease 1985:3).

Health services in the Far East began with a survey of health conditions in the Philippines in 1946. An extensive health program (\$5 million) stressed improved malaria eradication, smallpox immunization, maternal and child health services, health education, and health training centers (HEW 1965).

In 1946, the U.S. provided 72 percent of the funding for the establishment of the United Nations Relief and Rehabilitation Agency (UNRRA). This sponsorship established the U.S. as a major force in international health (HEW 1965).

In 1949, the concept of sustained assistance was expanded to a world-wide program known as the Point IV program. Based on the model of the Institute of Inter-American Affairs, the programs mainly offered technical assistance for health programs to Asia, Africa, and the Near East. Drawing resources from U.S. universities, especially schools of medicine, nursing, and engineering, the programs stressed disease prevention, health center development, disease control, institutional development, water and sanitation, and health education (C. Pease 1985:4)

During the 1950's a number of health related activities were being undertaken by the U.S. government. The passage of Public Law 480 in 1954 called for U.S. agriculture surplus to be sold overseas and the proceeds to be used for humanitarian needs. Although PL480 assistance was not earmarked for health programs, much of the local funds it generated went into health, nutrition, and, later, research (C. Pease 1985:5)

In 1955, a major international effort to eradicate malaria was undertaken. Involving a world-wide effort (except for Africa)

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multilateral, bilateral, and national programs, stressed insecticide use and drug distribution (C. Pease 1985:4). The program did lower the morbidity and mortality rates in some places but in the process created insecticide resistant strains of mosquitoes and drug resistant forms of malaria. The attempt to control malaria has been a major theme of AID's health programs until the present.

In 1960, the Public Health Service Research Act permitted the U.S. Public Health Service to support bilateral agreements for exchange programs in science and technology with other countries and for the use of PL480 funds for research in those countries with a surplus of currency (C. Pease 1985:5).

B. Health for development's sake: AID 1961-1970

The creation, in 1961, of the Agency for International Development from the old Foreign Aid Program marked a significant departure from earlier program styles. The stress on technical assistance and grants was gone. The new program emphasized development and loans (C. Pease 1985:6).

During AID's first years water and sanitation projects were underway in 45 countries, with a professional, technical, and administrative staff of health professionals of 366 people and budget of approximately \$85 million a year. In FY 1963, over half the funds for health were in the form of loans rather than technical cooperation and development grant funds (HEW 1965). Even in the earliest days, AID health efforts stressed large scale projects in PHC, child survival, water supply and sanitation, nutrition, disease control, population and family planning, and biomedical research (C. Pease 1985:6).

In 1963 it was decided that future AID support in health would be determined by the degree to which health problems, malnutrition, and population growth inhibited economic and social development. Priorities would be based on assisting in the promotion of political objectives. Target countries would be those, such as Vietnam, where the elite were healthy but the poor are lethargic from illness. The objective was to contribute to the economic and social development of a country by improving the physical strength, energy, and morale of the people. Such programs would also demonstrate U.S. humanitarian interests (Lee 1964).

Although health services were expensive, at this time it was perceived that economic and social development cannot take place where people are ill. Health services in the early and mid-

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sixties were also seen as forestalling insurgency especially in southeast Asia. When political motives determined the type and location of the programs, designing programs with a self-sustaining infrastructure was not a high priority. The emphasis was on reaching large numbers of people or on reaching politically important segments rapidly.

AID's earliest and most innovative efforts during the 1960's were in population. A separate Office of Population was created and Title 10 of the Foreign Assistance Act earmarked funds for family planning programs (C. Pease 1985:6). The Latin America region was the first to establish a population unit and provide regional funding for population projects.

In 1965, an increase of 50 percent in health personnel were needed to carry out health programs in Vietnam, Thailand and other Asian countries. In 1965 there were 51 AID supported health personnel in Africa. The Near East and South Asia had 76 while Latin America saw a reduction in staff to 39 as resources were diverted to the politically sensitive areas of Asia and Africa (Lee 1964).

In 1967, with an AID health budget of \$109 million, President Johnson declared a massive attack on hunger, disease, and ignorance. The two main tools were to be agricultural development and health education. The major drive to eliminate malaria and smallpox continued (HEW 1967).

In Africa, specific diseases were targeted along with urban water supply and waste control, health education and training. In Latin America, in addition to planning and expanding national health services, AID programs targeted malnutrition in pre-school children (HEW 1967).

1968 marked the beginning of a major family planning effort with \$20 million allocated to population programs. Of 59 new health projects, 42 were for population programs. Other priorities included environmental health and malaria programs (HEW 1969). The budget for population programs went up to \$50 million in FY 1969 (HEW 1970).

1968 also saw the beginning of the "grass roots" development programs with a major policy change away from large, infrastructural programs toward ones which increased the participation and strengths of private resources in the development process (HEW 1969).

In FY 1969, 90 percent of all country program funds went to 15

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countries: India, Pakistan, Turkey, Bolivia, Brazil, Chile, Colombia, Dominican Republic, Peru, Tunisia, Indonesia, Korea, Laos, Thailand, and Vietnam. Thirty-four percent of all AID health staff overseas were in Vietnam.

C. The prevention of illness: AID during the 1970s

During the 1970's the focus was on basic human needs and a strong concern for the urban and rural poor. The early 1970's were the time of the Alma Ata conference, a tremendous force for primary health care, and the World Health Organization's "Health for All by the Year 2000" program. The "small is beautiful" movement of the time translated into a rejection of high technology and an embrace of appropriate technology and rural health services (C. Pease 1985:7).

The emphasis was on private enterprise, individual initiative, and greater use of technical assistance. Increased sharing through multilateral channels, food production, and population programs were priorities. By 1970, of the 45 countries receiving bilateral aid, 22 had started official family planning programs and appropriations for family planning programs increased 64% over the previous year.

A major thrust during the 1970's was to assist in developing national health plans. Only one of AID's target countries had such a plan in 1972. By 1979, 36 countries had such plans or were receiving technical assistance in the development of a plan (J. Pease 1980). The Bureau for Population and Humanitarian Affairs was created in 1972.

From the late sixties, development aid for Africa had steadily increased. In 1971, 20 countries were chosen for special emphasis. Budget allocations for health in Africa in FY 1971 were triple the 1970 obligations because of an increase in population activities and loans for health programs (HEW 1972).

A presidential directive in 1971 divided foreign assistance into three types of aid: development assistance, security assistance and humanitarian assistance. Program emphasis was on agriculture, rural development, population, health, nutrition, education and manpower development. Ninety-three percent of the Security Assistance funds went to Thailand, Laos, Cambodia, Vietnam and Jordan (HEW 1972).

In 1973 and 1974, AID began to lose staff. From a high during the mid-sixties, total staff numbers dropped by 44 percent. At

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the same time, the total funds decreased from over \$1.9 billion in FY 1973 to \$865.8 million the following year. Although over all funding levels were down, the budget for health, population and nutrition doubled (\$41.8 million in FY 1972, \$83.2 million in FY 1973, and \$104 million in FY 1974) (HEW 1975).

The mid seventies saw the beginning of the recognition of the problems of desertification in the Sahel and African assistance emphasized food, animal feed, medicines, medical supplies, emergency shelter, and blankets for rehabilitation and emergency assistance (HEW 1975).

The eradication of smallpox in 1977 demonstrated that international cooperation and a focused program could have profound implications. The success attracted world-wide attention and stimulated interest in other categorical programs, particularly in immunization. Research was stepped up in finding vaccines for the common childhood illnesses and vector-borne illness (C. Pease 1985:7).

D. Health for the children's sake: AID during the 1980s

The early 1980's saw a shift in health policy at AID which placed greater emphasis on community based PHC projects. Within the agency, also, there was (a) also an increase in centrally (rather than by the regional bureaus) funded projects. Although the first formal commitment to primary health care came in the 1974 amendments to the Foreign Assistance Act, AID had no agency wide health policy until 1980 when it strongly endorsed integrated, community based, primary health care.

Since 1979, the Near East Bureau has received by far the greatest amount of funding for health. It has, in fact, received more funding than all other bureaus combined, receiving an average of 50 percent of all health funds between 1979 and 1985. Egypt receives a significant amount of that money.

After 1982, the number of projects started increased considerably. Centrally funded projects increased the most followed by the Latin America and Africa Bureaus, both doubling the number of projects initiated. The Asia Bureau also doubled its number of projects though it still has less than half as many as Africa. The Near East Bureau has maintained a fairly consistent number of projects over the decade but has had a substantial increase in budgets. Projects are larger rather than more numerous (Pipp 1985:6).

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With increased experience in PHC projects and with incoming data on the early PHC projects, three trends emerged which affected later programs.

- o While AID had always encouraged project self-sufficiency in the early days of PHC programs, AID supported local government's efforts to provide free, comprehensive health care to all. Such policies were found to be unsupportive and inefficient.
- o Fielding personnel and equipment to remote rural areas for health care services proved to be difficult and it was found that a collaboration between private and public sector in rural areas enables more involvement of the community, and promotes further self-sufficiency.
- o Integrated, comprehensive projects are complex to design and administer. Given the difficulties of implementation with scarce resources, AID found that selective intervention, oral rehydration and immunizations in particular, are more effectively carried out (Pipp 1985:8).

There has been a definite trend toward funding selected interventions. Pipp (1985:6) compared the data for different projects project types for the periods 1975-79 and 1980-85. She found that there was a relatively stable distribution of projects in the earlier period but that in the later period there was a clear preference for PHC, immunization and oral rehydration programs. Latin America, in particular, had a proportionally high number of PHC activities.

AID's most recent policy statement incorporates the lessons from the earlier experience and stresses increased cost-effectiveness of projects through better management, design, and implementation. Progress toward self-financing is stressed as is bio-medical research particularly in the development of vaccines.

The data on AID's expenditures are summarized elsewhere (cf. Pipp, J. Pease, et al.). Measured in current dollars, however, AID's expenditures in health have risen approximately eight and one half times over the past ten years - from \$61 million in FY 1975 to \$521.2 million in FY 1985. The increase in constant dollars is less, an increase of only four and one half times (Pipp 1985:4).

AID's expenditures in health have increased from \$85 million in 1961 to \$550 million in 1985. As a proportion of total

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development assistance, in 1961 health budget constituted nine percent of the total aid package whereas today it is 15 percent. In 1961, there were 366 personnel administering programs in 45 countries. In 1985, 90 health staff administer programs in 44 countries (HEW 1965; Ferguson and Pease 1985).

Four trends have been traced in this short history of AID's health programs.

- o AID's thirty-year long effort to decrease the effects of malaria;
- o the evolution of health for it's own sake of the pre-AID years to health as economic development during the 1960s to health to save children's lives in the 1980s;
- o the movement from categorical to integrated and back to categorical, vertical, and centrally funded programs;
- o the shift from large programs in the early days of AID to small programs of the mid-1960s and 1970s back to large programs in the 1980s; and

Those who have lived through much of AID's health policy history could, no doubt, tell us much more about the human and bureaucratic forces which went into the major trends as well as the smaller fads which change with the Presidents. It is unfortunate that the "unofficial" story has not yet been written.

CHAPTER THREE

Financing Health Care: The Problems

In the discussion of health project sustainability, no issue is less controversial than the importance of assured financing beyond the scope of the sponsoring agency's commitment. The overriding policy question is the distinction between public and private health care. What are a government's responsibilities in the sector and what can or should be handed by the private sector? Related issues are the problem of cost recovery and financial sustainability over the long run.

Projects have two types of costs: start up costs and recurring costs. Both are usually underestimated. Start-up costs, the initial investment in training, equipment, staff, and offices are usually underwritten by the donor agency. Recurring costs, the annual cost of maintenance, salaries, supplies, and replacement, are assumed to be the responsibility of the host country. Estimating such costs is very difficult, budgeting for them even more so. Some costs can be covered with internal budget allocations. Other costs must be recovered at the point where services are used such as various types of user fees or community health fund schemes.

A. Host country policy

Most developing countries are working to extend their health care services into previously underserved areas. The primary health care model of community health workers guided by a community health committee has served as a goal for most countries. However, it is very difficult for health workers to focus on primary care when there is no back-up curative care. Their time becomes taken up with medical emergencies, and the treatment of wounds, respiratory illness and gastro-intestinal problems. For this reason, many primary health care workers spend most of their time as outreach workers for the curative system and have little time left for carrying out education programs, vaccination campaigns, and organizing environmental improvement efforts.

The degree of commitment a country has to PHC and prevention of illness is reflected in its official policy, its unofficial policy and its budgets. Most countries have some official stand in support of PHC and health for all. Whatever their policies, however, they are sometimes constrained by political considerations and a lack of resources.

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In developing countries, the government usually supports both hospital based and PHC. While they have embraced the principle of PHC, few have worked out a feasible implementation strategy. Since PHC is often seen as a separate system (some countries even have separate ministries to deal with primary or rural health care), they do not take advantage of the complementarities and infrastructure offered by existing systems (AID 1982:6)

Although it is an enormous drain on resources, many developing countries remain committed to providing free health care for all citizens. Even where health care is free, people still spend a significant portion of their income on private-sector health care and medicines which they perceive to be more effective and more efficient than care they receive at government clinics. While AID supports government subsidies for health care, it supports cost recovery through user fees or in-kind payments for health care (AID 1982:7).

Where free health care is the policy, services are usually available only to a few and then in the urban areas. Once a country has a free health program, it is politically very unpopular to begin charging user fees. Yet developing countries lack the resources to build up an extensive network of rural health posts and personnel without finding ways to substantially increase their health budget.

In their eagerness to provide services to a larger number of people, governments may expand their health programs too rapidly and fail to consider the investments required and recurrent costs of existing and new programs. As a result, many community health workers were trained but not provided with the supplies they need for their work or receive little supervision (AID 1982:7).

The UNDP has found that in developing countries, senior and middle-level officials responsible for planning and implementing programs do not fully understand PHC. They think of PHC as merely an extension of the health system to improve coverage in the rural areas. "Policy makers and planners need to realize that the goal is rather a fundamental reorganization of the health care system, based upon a new way of thinking about health care and a redistribution of functions, involving a high degree of inter-sectoral co-ordination and an important role for communities" (UNDP 1983b:14).

The discrepancy between policy and resource allocation is particularly acute in Africa where resources are so limited. "In many African countries, commitment to the Declaration of Alma Ata

needs to be demonstrated by policy reforms which support the allocation of resources to the development of cost-effective primary health care services. Investments in health must be promoted as integral components of socioeconomic development" (AID/Afr n.d.b:11).

B. The priority given to rural health care

AID's policy in health care financing has been to urge developing countries to reorient their spending and develop primary health care systems which would complement their curative system. The objective is to disburse health care to low-income populations and to rural communities.

In spite of AID's efforts, however, "priority continues to be given to urban services, usually in hospitals and clinics, since it appears to be politically difficult for most LDC governments to cut back on urban services in order to redistribute limited funds to rural and peri-urban areas." The problem is compounded by the commitment to (or history of) free health services. While the government should underwrite certain public health measures which pose a threat to the community, users should pay for personal health services (AID 1982:7).

AID works with government so help them reallocate their resources. "Where government policies concentrate investment and operating funds in health on sophisticated clinic and hospital-based facilities, predominantly in urban areas, AID will engage in policy dialogue with officials to encourage reallocation of public resources within the health sector, or among government supported sectors, to support primary health care services" (AID 1984:5).

C. Failure to plan for recurring costs

To maintain existing PHC projects and move into the next phase, of maintenance and expansion, senior government officials in developing countries are having to rethink their policies and the allocation of resources.

Because of limited resources, developing countries can not effectively plan for system expansion as well as budget for recurring costs of their health care systems. As a result, many community health workers do not receive the supervision, back-up support, and follow-up training they need to be effective. Priorities are given to urban programs and then mostly to

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hospitals and clinics. Developing countries cannot easily cut back on urban curative services to redistribute limited resources for prevention and rural services (AID 1982:7).

By not developing complementary primary and secondary systems, the alternative systems of PHC drains already limited resources. "The programs are often poorly designed, and the resources needed for continuation, much less expansion of the system, are not anticipated; economies of scale and transportation and communication bottlenecks are not considered" (AID 1982:6).

AID's Latin American and the Caribbean Bureau has found that in most countries in that region "existing health resources are not allocated efficiently within the public sector. The high capital and recurrent costs of the hospital-based curative system limited to urban populations consume a major part of the public sector health budget..." (AID/LAC n.d.:2).

Although Latin America has the most sophisticated health care systems of the regions in which AID works, the problems of planning for recurring costs is well known. "Financial resources for health services and water systems in LAC countries are limited and not likely to increase over the short term. LAC countries are not likely to significantly increase the proportion of their budgets allocated to the health sector, particularly given the high demand which agricultural and industrial development place on limited government resources. In addition, existing health resources are not allocated efficiently within the public sector. The high capital and recurrent costs of the hospital-based curative system limited to urban populations consume a major part of the public sector health budget in LAC countries. Primary health care services, while less costly per capita, nonetheless generate considerable recurring costs for manpower, facilities and vehicle maintenance, vaccines and drugs, and transportation which cannot be met as long as the majority of LAC governments maintain policies of providing health services "free" to the public. Without user charges and/or other forms of revenue generation, resources will remain insufficient to expand and/or improve primary health care services" (AID/LAC 1983:2).

Similarly, in a review of eight PHC projects in Africa, AID found that host governments have difficulty financing PHC projects because the costs of supervision and vehicle maintenance are high. "Private sector implementing agencies in Zaire are more capable than the government to assume the recurring costs of PHC in Zaire. Without continued assistance, the Government of Niger would not be able to continue training of health workers or infrastructure support for supervision at current rates" (AID/Afr

n.d., a.:3).

Continuity of senior officials can also be an important aspect of sustainability of policy, programs, and budgets. "Changes in host-country government personnel and policies that are beyond AID's control may severely affect the appropriateness and ultimate acceptance of a project design. By the time a project has been approved and activities have begun, it is quite possible that the key government officials will have been replaced" (Parlato and Favin 1983:89).

The large donor agencies such as the UN, World Bank, AID, and government development agencies from other countries have often provided funds for the start up of a PHC system, particularly for rural areas. Most of these programs failed to consider the high recurring costs of maintaining such programs nor did they consider fluctuations in foreign exchange and the extraordinary inflation in some countries.

Both AID and local ministries of health lack experience and data for estimating the costs of health projects. Foreign exchange rate adjustments, increasing fuel costs, a lack of data on usage and program costs has lead to a serious underestimation of program costs (Parlato and Favin 1982:77).

D. Low public interest in primary health care

Even when official policy supports primary care, budgets often show true priorities to be elsewhere. "A disturbing paradox in most developing countries is that, while in policy terms national health planning tend to give high priority to primary health care, the lion's share (often more than 50 percent) of MOH expenditures actually goes for hospitals" (UNDP 1983a:3).

People want health care when they are sick. When they are not sick, it is not a high priority. Although there is ample evidence that prevention is less costly than a cure, not to mention the savings in human and social costs, the value of prevention of illness has never been widely accepted even in developed countries. In countries where poverty is an overriding issue, paying for health education, vaccinations, and other preventive measure seem less important than food, clothing, or even luxury goods.

Where curative care is free, there is little incentive to prevent illness. Only when the cost of curative care becomes prohibitive, has it has in the United States, does the cost-

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effectiveness of prevention become apparent to the public.

Only when there is a cholera or typhoid outbreak or some other health crisis is there strong public support for illness prevention. Many people in urban areas see environmental sanitation, potable water, and public health services as a responsibility of the government and issues over which they have little control.

The problem of lack of support for primary health care is most obvious in the area of financing. As we will see in the next chapter, cost recovery through user fees and other community financing plans often fail because of the lack of public support for preventive care.

In summary, the sustainability of a PHC program in a developing country hinges, not only on an explicit policy in support of primary care, but on a reallocation of resources away from curative care. It also calls for a redistribution of health resources from the urban to the rural areas.

In order to accomplish an improvement in and redistribution of health resources, governments must increase their health budget and they cannot continue to provide free health care. However politically unpopular, some type of fees must be charged to users to generate more resources. But, as we already know, people are not willing to pay for primary care because the benefits are not obvious to the poor.

CHAPTER FOUR

Financing Health Care: Cost recovery

AID strategy for the promotion of self-sustaining programs is a combination of analysis of recurrent cost requirements, innovative financing mechanisms, and creative private sector involvement in health care. "The objective is a mix of host country public and private resources which, as part of an integrated system, delivers services most cost-effectively" (AID 1984:7).

There is little doubt that additional research on cost-analysis of health programs is needed. Several studies recently published or about to appear discuss the problems of defining key cost term, linking costs to project outcomes, and of assessing the economic advantages of using private sector providers (cf. de Ferranti 1984; SUNY-Stony Brook 1986; APHA 1986).

A. Community financing

One option in recovering the cost of health programs is to increase the contribution made by the individuals and groups who benefit from the programs. The standard model for a community based primary health care project includes community contributions at several levels.

To defray one-time or recurrent costs of health programs, communities may undertake many types of activities. These are of varying financial dependability and effects on service delivery and use. Certain problems or benefits occur more commonly with certain community financing schemes than with others. Stinson (1982) carried out an important study of community health care financing. Some community financing schemes he discusses include:

- o Drug sales
- o Personal prepayment
- o Production based pre-payment
- o Income generation
- o Community labor
- o Individual labor
- o Donations and ad hoc assessments
- o Festivals, raffles, etc.

Because cash can be used to purchase drugs and is welcomed by

health workers as compensation, the most versatile schemes are those which generate money. Mobilizing labor or in-kind payments are less versatile but can marshal relatively abundant resources. Community labor, donations, ad hoc assessments, raffles, and festivals are usable chiefly for one-time costs, especially construction, equipment purchase, and the creation of drug revolving funds.

Community labor is best applied to construction; drug sales are most easily used to cover costs of restocking supplies. Service fees are most appropriate for compensating community health workers. Systems based on service fees and drug sales are vulnerable to interruptions of drug supplies; prepayment and income-generating schemes are sensitive to market prices for the commodity. Donations, fairs, raffles, etc. are based on an acceptance of the programs objectives and their revenue potential is sensitive to economic conditions.

Almost all community financing schemes are subject to mismanagement and technical error. It is important to be able to estimate use rates and forecast demand in order to make budget forecasts. Where records are poorly kept, and staff unskilled in health management, such problems are common. Funds raised on an ad hoc basis are difficult to budget around and protect from corruption.

One of the main problems of cost recovery of PHC projects is payment of the community health workers. Poor or irregular pay leads to high worker turnover, high training costs, and reduced quality of service. In the American Public Health Association's (APHA) study of 52 AID projects, they found "efforts to keep costs of PHC programs low by transferring responsibility for certain recurrent costs to the community have been partially successful. A number of projects have been successful in getting communities to finance drugs, but of the 28 projects that use community financing to compensate community health workers (CHWs), none has a satisfactory method of obtaining local support" (Parlato and Favin 1982:77).

Another report over the same study found that "there is no ideal method for worker payment.... Communities and especially individuals, tend to be interested primarily in personal curative services, not in the full range of primary health care activities.... Direct payment methods do nothing to help the poor or persons without access to family wealth. Service fees can be adjusted for income but often are not, and drug prices must normally cover replacement costs and are difficult to adjust. Communal production, where feasible, may be a good

financing method but health programs have to adapt to existing social and political structures. If government payment is feasible, ways of using it to reward preventive work should be considered" (Stinson 1982:36-37).

The Sine Saloum Primary Health Care project in Senegal offers an interesting case of a project which suffered from most of the standard problems -- lack of financial support, lack of supervision and support for community health workers, an inadequate drug and transportation system. Started in 1977, the 1980 evaluation found the program fraught with problems following which, the project was substantially redesigned. A 1984 study (Bloom 1984) found that the program had made a remarkable turnaround and now serves as a rare example of a self-financed community health program.

In the Sine Saloum project, community health workers are remunerated differently in different communities. They either sell drugs, are paid by a "donation" from each household, or they sometimes receive payment, cash or in kind, from clients. Each community constructs and maintains a "health hut" made from locally available materials and supplied with modest furnishing. The success of the Sine Saloum project is laid to two aspects of the program: financing and managing the program at the village level. Each of 378 communities has a health committee with the following responsibilities:

- o Ensures that the health workers are responsive to villagers felt needs.
- o Ensures that financial records are kept for health hut receipts, that drug supplies are replenished, and that funds are not misused.
- o Holds periodic meetings to review health hut management problems and community health problems.
- o Selects community health worker candidates.

The program focuses almost entirely on curative health services because the community is not willing to support preventive services for which they have no perceived need. While the program is still struggling with some problems, it has become "one of only a handful of primary health care programs in the world that are successfully managed and financed by users at the village level" (Bloom 1984:24). Since the services offered are curative, the case probably best serves to illustrate the point that people are willing to pay for curative services but not for

the prevention of illness.

On one hand, community financing is an untapped resource. It can be a catalyst for community development by using local labor and local produce for community self-reliance. On the other hand, community financing of health programs places the burden of health care on the poor who are least able to afford it. Health care, it is argued, is a public good and should be paid for from general revenue. The APHA study of 52 health projects found that "in many countries, persons in rural areas are asked to pay for PHC, while those in urban areas have access to free care. In most of these rural programs, villages must pay for drugs, and in approximately one-half of the projects, communities are being asked to finance their CHWs. This inequity is an issue which most of the governments have not addressed (Parlato and Favin 1982:77).

The use of community volunteers has not been found effective over the long run. Volunteers can be effective in short-term campaigns but not for sustained delivery activities (UNDP 1983b.) Some individual projects, however, have had some success with volunteers. The Community-Based Delivery Health and Family Planning Project in Oyo State, Nigeria uses volunteers to carry out educational and preventive services. It has been suggested that the reason for the success of the program is a strong community organization and active participation by individuals in the project. They also found that in some areas where stipends were given early in the project, it was not possible to switch to voluntarism. "Once incentives are given, they create difficulties when stopped" (Weiss 1984:4).

Stinson (1982:41) found that community financing schemes may be a partial answer but that most have not been rigorously evaluated and there has not been enough experimentation with alternative schemes. Community contributions are good for one-time costs such as construction but there is no experience of community financing paying for supervision, logistical support or referral linkages, all of which are critical to the maintenance of the system.

B. Fees for service

AID policy states that "private contributions for health services should be encouraged. These may take the form of fee-for-service, cooperative health organizations, or, where feasible, private insurance schemes" (AID 1982:10).

In Latin American and the Caribbean, "primary health care services, while less costly per capita, nonetheless generate considerable recurring costs for manpower, facilities and vehicle maintenance, vaccines and drugs, and transportation which cannot be met as long as the majority of LAC governments maintain policies of providing health services "free" to the public. Without user charges and/or other forms of revenue generation, resources will remain insufficient to expand and/or improve primary health care services" (AID/LAC n.d.:2).

Stinson found a number of alternatives in the fee-for-service approach. Fees may be set by the individual health care provider, by the community, or by some unilateral professional or government decision. Payment may go to the health worker directly or to the clinic or health center. The success of such schemes depends on the patient's willingness and ability to pay and there are few studies to quantify ability and willingness to pay. Also, in the design of projects there is little consideration of total revenue requirements or likely usage levels.

Some projects have tried a sliding scale for certain types of patients or certain diseases. However, if community health workers are pressured to give free treatment to the poor and to the influential, they attempt to make up the difference by overcharging others. In a Nigerian community health project, while the community agreed to a small service fee from clients, "the community health workers did not collect fees from their relatives -- a significant portion of their clients" (Weiss 1984:4). Exemptions are best handled by a community committee, removing the responsibility for decisions about fees from the health worker.

Charging a fee for service discourages nonessential use and enhances the perceived value of the service. On the other hand, in some cases it has encouraged patients to demand drugs at every visit if they are not charged for separately.

The United Nations Development Programme (UNDP 1983b:7) has found that fees for service and profits from drug sales tend to be unsatisfactory ways of providing incomes to community workers since they involve support only by ill people and not the entire community. Such fees place the emphasis on providing curative services rather than preventive care. Using the profits from the sale of drugs, furthermore, depends on regular supplies of drugs, a condition that is not common in developing countries and particularly in rural areas.

The concept of social marketing has been reasonably successful in the distribution of some types of contraceptive devices. Social marketing takes advantage of private sector retail skills, advertising, and distribution networks to disseminate contraceptive supplies. By setting fees appropriately, more expensive supplies (the pill) can be subsidized by the less expensive ones (the condom, often). For supplies which require no medical supervision (including oral rehydration salts, vermifuges, vitamins) social marketing is low cost, provides wide coverage, and may encourage use of the products (AID/CDIE 1985)

D. Private sector physicians

One source of medical expertise which few developing countries incorporate into their planning is private physicians. Although they are scarce in some countries, they do represent a public investment in their training. Private practitioners have the advantage of being able to provide one-on-one services and relatively high quality care. They do tend to cluster in the large cities, however, and they are sometimes too specialized to serve the general population. Also, most private medical practitioners emphasize treatment rather than the prevention of illness. In Korea, for example, private sector physicians, fearing a decline in business, were able to terminate a major primary health care effort.

Regardless of the formal health care services available at no cost, as much as 80% of the population continues to seek personal health services from private physicians, by self-medication of over-the counter drugs, consulting private drug-sellers or by seeking out folk remedies. People commonly go for public sector health care only when other sources have been exhausted (AID 1982:9).

In Egypt, a government study indicated that 60% of health care spending still comes from individuals and families rather than from free government health services. Similarly, in Turkey, a study found that 80% of personal medical expenses come from private sources (UNDP 1983a:4).

Since the private sector is not organized in any manageable way, the government may have had difficulty collaborating with professionals who are not under its immediate control. Although it is large and absorbs a large number of people and a substantial amount of money, the private sector is not easily managed by national governments. Also, most private sector services are curative and cater to the more affluent. All the

special programs to deliver services to rural and disadvantaged people, all organized preventive services, and all training and research is carried out by public bodies and, to an increasing extent, by the PVOs (UNDP 1983:5).

The Africa Bureau is actively seeking ways to increase private sector involvement, including the indigenous private sector. They urge program planners to make better use of private practitioners (both traditional and modern) including midwives. (AID/Afr n.d.b:10)

D. Midwives and traditional birth attendants

In a review of 45 ongoing projects funded by AID in 1979, 18 were using or planned to use traditional birth attendants or traditional healers. In general, there has been more success in training traditional birth attendants or midwives than in incorporating other kinds of traditional healers into the health care system. Traditional birth attendants are generally amenable to training to upgrade their skills and at the same time they have the confidence of women in the community. Traditional midwives often provide a gamut of marital counseling services to women and advise them on birth control and general issues of health for mothers and their children. They are often willing to stay longer with a new mother, help with housework, and provide moral support which formally trained women have no time or inclination to provide (Pillsbury 1979).

The World Health Organization (WHO) has taken the lead in encouraging developing countries to mobilize traditional medicine and its manpower for PHC. UNICEF has been supporting training for traditional birth attendants for over twenty-five years, especially in Africa and Asia. At least twenty countries, universities or governments have established institutes of traditional medicine for research and treatment (Pillsbury 1979:27-29).

The UNDP (1983b:10) also supports the training and integration of midwives and traditional healers, many of whom have been compensated for generations with in-kind or non-cash payments. Therefore, creating a system of such care providers would not involve recurrent costs on the national health budget.

"Private practitioners - midwives, pharmacists, and traditional birth attendants, as well as physicians and nurses - can be retrained to provide a range of primary health services. Where private providers currently are functioning, it may not be

necessary to train a new cadre of health workers, although measures to ensure better access to health providers by low-income groups may be warranted" (AID 1982:9).

E. Pharmacists and private drug sellers

Pharmacists, pharmacy workers, and small shopkeepers are primary sources of health care in developing countries. In addition to preparing and selling drugs, they also diagnose illnesses and prescribe medications for customers. Because of most people equate drugs with medical care, and because pharmacies are much more widely distributed than clinics, many people rely on self-medication or medicines suggested by the shopkeepers.

People spend a substantial part of their money on drugs. Although the pharmacists are not always qualified to diagnose illness and the medications may be given in incorrect dosages, people are willing to accept "free" medical advice for the price of the pills or injections (APHA 1986:85-86).

Private drug sellers have stalls in virtually every large urban market where they sell expired prescription medication from Europe and the United States. These stall owners frequently are non-literate and know nothing about the powerful medications they offer for sale. Laxatives are sometimes touted for worms. When the feces contains visible worm segments, people think they are being cured. In fact, the laxatives serve only to weaken the body and do nothing to cure the worms.

With training and technical assistance private drug sellers and pharmacists can provide an important health service but governments need to crack down on the sale of dangerous medications on the streets and by vendors who are unfamiliar with the products (and their side effects) they sell.

F. Other traditional healers and practitioners

Traditional healers and practitioners form the first line of health care for about 90% of the world's rural population. Although traditional healers are most frequent in rural areas, they are also found in urban areas. Rural people and the urban poor often feel more comfortable consulting traditional practitioners than getting treatment from practitioners trained in modern or Western medicine.

The UNDP found the absence of relations with traditional healers

to be one of the most pressing problems for PHC projects. "In most of the developing countries studied, traditional practitioners and traditional birth attendants (TBAs) play a large part in the primary health care of the people. Yet - with some exceptions for TBAs and in one country for general healers - the policy in the countries reviewed is to ignore these personnel and hope that provision of modern health services will lead eventually to their disappearance. The soundest policy toward traditional healers may be subject to debate, but Ministries of Health that simply ignore their existence are missing an opportunity to exert influence on the nature of health services used by millions of people" (UNDP 1983a:30-31).

Traditional healers are less intimidating than modern health care providers. They know folk beliefs about the causes and cures of illness and misfortune. Traditional ideas about illness and its causes may be very different from Western medical theory. Health care providers trained in modern medicine often seem cold, disinterested, or superior to the poor and uneducated. Also, traditional or folk healers work on a sliding scale basis, knowing the resources of the family and charging accordingly. Many traditional healers do not charge for their services but only accept gifts for helping out when they can (Pillsbury 1979).

Traditional healing beliefs may be divided into three categories. Those which are harmful, such as cutting the umbilicus with a dirty knife or cauterizing it with cow dung, expelling "bad blood" or withholding liquids from children with diarrhea. Those which are neither helpful or harmful (many ritual cures, harmless herbal teas) and those which are helpful (herbal medication, presence of a midwife at births, psychological counseling).

It has been found that traditional healers and midwives are often eager to learn more about their trade if they are approached with respect. Pillsbury (1979:17) points out that, as with any profession, some individuals are more competent than others. In a profession where there is no licensing anyone can set themselves up as a healer or curer. Folk healers do not last long in their trade unless they have a satisfied clientele. Those who are successful often are known very widely.

The difficulty of working with traditional healers, bonesetters, herbalists, and shamen is that without substantial research it is not easy to distinguish harmless from harmful and beneficial treatments. Although anthropologists and pharmacologists have carried out a substantial body of research on traditional healing practices, that knowledge has not been widely disseminated and many health planners dismiss all the services of the traditional

healers rather than try to sort out those treatments which should be encouraged from those that should be discouraged.

In those parts of Asia where ancient medical traditions have been formally institutionalized and legitimized through schools, licenses and institutes, there may be a clearer understanding of which treatments are helpful. Practitioners usually are quick to pick up the most effective aspects of Western medicine, particularly injections and pharmaceuticals.

Research is now underway in Brazil on the use of traditional healers to distribute oral rehydration packets. Earlier research indicated that mothers seek out traditional healers as their first source of care. Mothers experience long waits, extensive travel, and expensive or improperly prescribed drugs when they attempt to use the modern health care system (PRICOR 1985).

Spiritualists have been found to be as effective as modern psychiatrists in treating mental problems. While it is difficult to provide them with additional training, where they are successful they may provide a valuable mental health service. Some training to enable them to identify physical problems and make referrals to other types of healers can be valuable.

G. Health maintenance organizations

In financing schemes discussed so far, individuals pay for goods and services as needed. The sick pay the most, the healthy pay little or nothing. An alternative is to pay for all services in advance of need and share costs equally (or based on actuarial risk) among all group members regardless of individual use. These approaches are called "risk sharing" and differ largely by the degree to which they link payments and services.

Alternative risk sharing systems include prepayment, insurance, or health maintenance organizations (HMOs). With insurance, for example, the insurer bears the cost of overuse so the provider has no incentive to be economical. With HMOs, on the other hand, the provider bears the risk of overuse leading to parsimony in service delivery.

In Stinson's review of financing schemes, he found that most of the 31 prepayment schemes studied are combined with a fee-for-service co-payment and most also charge for drugs. Prepayment may be based either on individual or household payments. Cash or in-kind resources are collected directly from beneficiaries or a

levy, payroll tax, or the surplus from an economic enterprise is used to subsidize the payment of health workers.

The ideal way to finance such programs is where money is raised from some cooperative or productive scheme with the profits going to support the community health program. However, the organization and management of such schemes has proved difficult.

In subsistence economies, prepayment schemes are vulnerable to economic misfortune and projects, to be sustainable, need a back up reserve. In Indonesia, the Dana Sehat is based on a communal credit union. Surplus funds go into the credit union and the credit union loans money to make up for short-falls. Others rely on external sponsors to make up for deficits.

Prepayment schemes work much like health maintenance organizations in the developed countries. AID's Latin America and the Caribbean Bureau has focused particularly on social insurance, social security mechanisms, and the development of HMOs.

The Africa Bureau now supports research into alternative ways of mobilizing public and private sector financing of PHC services. This includes the use of PL-480 funds, the establishment of user fees and the development of pre-payment schemes.

Alternative financing schemes are the subject of a number of applied research projects financed by AID. In Benin and Zaire, fee-for-illness is being compared with fee-for-visit, fixed consultation fee and variable fees for drugs. Revolving drug funds are being studied in Thailand and the Dominican Republic (Tinker In Evans AID/S&T 1985:36-37). Management Sciences for Health is investigating alternative schemes in Haiti while PRICOR has carried out a number of such studies. The results, which are just beginning to come in, will assist in future project designs

A number of countries have expressed interest in mechanisms such as HMOs and other pre-payment schemes. Assistance has been provided in the Philippines, Yemen, Tunisia, Turkey, and other in Latin America in their quest for large scale financing alternatives (Tinker IN Evans AID/S&T 1985:39).

Chile has a growing nation-wide HMO which suggests that pre-paid health care can work in a developing country if certain conditions are met. These include:

- o A strong government policy supporting a new conceptual model of health services delivery.

- o A government which is eager to curtail its health care expenditures.
- o Physicians who support the HMO concept and who are willing to work in a structured system.
- o A market of interested employers and employees.
- o An increasing number of physicians who are competing for patients and who are therefore receptive to new forms of delivery and payment.
- o A population which is familiar with the concept of pension funds and social security and who are used to the concept of paying in advance for care.
- o Competition between traditional insurers and the HMO.
- o A significant population base to support the HMO.
- o Incentives to encourage local and foreign investment and tax incentives for investing in HMOs.
- o An economy which allows effective cash flow management such as prepayment "floats."
- o Expertise in effective data management for financial and management decision making.
- o Management skilled in finance, cost control, budgeting, marketing and negotiation.
- o Marketing expertise, especially where the HMO concept needs to be communicated to a new audience.

The Chilean HMO covers about 10% of the population including employees of a large bank, the armed services, and over a million private subscribers. One reason for the success of the Chilean project is that the government requires that a portion (6% in 1984) be withheld from employees salaries to pay for health care. The employee can choose the national health care system or the private HMO.

A formal study of the Chilean experience was carried out by Health Central International for AID/PRE (Rice 1985). Also, Group Health Association of America carried out a study of HMOs in Latin American and the Caribbean (GHAA 1985). There is

disagreement as to whether the government should act as the HMO. While it is clear that political stability and strong government support are critical to the success of the HMO, some senior HMO officials in this country believe that private enterprise is more efficient and cost-conscious and therefore better equipped to manage HMOs both in the U.S. and abroad (Group Health News 1986).

While the evidence is still coming in on HMOs for developing countries, it would appear that they can provide high quality health care to the more affluent 10 to 20% of the population in middle-income countries. Since most HMOs depend on salary deductions as a source of revenue, and since most poor people do not hold salaried jobs, it is unlikely that HMOs will ever resolve the health problems in developing countries. They may, however, take some of the strain off government health budgets or allow more public health services for the poor as the more affluent subscribe to private pre-paid care.

The proper role for AID and other donors in the promotion of HMOs has yet to be worked out. On one hand, HMOs do promote private enterprise; on the other hand, they do not serve the poor who are the mandated target of AID programs. AID's strategic approach encourages studies and project designs which utilize alternative consumer financing schemes (AID 1984:7).

CHAPTER FIVE

Community Participation

The standard model for PHC projects is one which places a strong emphasis on community participation. A community health committee is responsible for the selection of community health workers, managing the health center, identifying community health problems, and making decisions which affect how the program will be run.

There are few concepts in development so undefined, yet used so frequently, as community participation. In the classic community development view, all projects begin in the community with a realization of some pressing need, an inventory of resources available and needed to resolve the problem, and then some alternative solutions discussed until one is agreed on.

In fact, in most development projects, participation takes the form of a committee. An organization (the Ministry of Health or a PVO perhaps) decides to start a health (or education, etc) project in a community. The organization has already decided more or less what form the project will take. A committee is chosen to rubber stamp the decisions made by the implementing agency. The committee is usually allowed to make some minor decisions but the overall framework of the project is handed down from the government or the development organization.

This model of development assumes that a committee is some natural form of social organization and that it has some inherent quality of representativeness. In fact, the committee is a very Western (democratic) mechanism of decision making and one which is alien in many autocratic or lineal societies. Forming a committee with individuals who actually represent the diverse interests of the community may be a major sociological task in itself. In those cultures where committees are an alien form of social organization, it may take years for the committee members to learn the give and take required for committee effectiveness.

In most traditional societies, the very idea of participation is foreign. Decisions are made by government officials or lineage elders and passed down. Helping people understand that they need not be passive victims of illness and that they can work together to resolve some of their problems is not accomplished overnight.

Committee members are frequently asked to perform tasks for which

they have no training and take responsibility for activities with which they have no experience. Health committees are asked to raise funds, supervise health workers, manage revolving drug schemes, monitor receipts and medical supplies. Yet they rarely have experience in these tasks and they receive little training or assistance.

The other kind of "participation" in most development projects is self-help. Community members "volunteer" to construct the health post, dig drainage canals, or lay water pipe.

There is an inherent contradiction between true participatory development and that imposed by an agency. Projects undertaken by AID and other donors (including many PVOs) are top-down projects no matter how many committees and self-help components are added. True participation takes much longer than AID has to plan and implement projects.

Participation, in its classic definition cannot be mandated as part of a project plan. Project plans can assign certain roles to certain individuals or groups within the community. Confusing participation with including citizens on some aspects of the project can lead to problems. As Parlato and Favin (1982:34) point out, "it often seems as if project planners expect participation to develop spontaneously. Generally, insufficient attention is given to the significant effort and deliberately slow pace required to gain a community's trust and support."

In their review of 52 PHC projects, Parlato and Favin (1982) found that few communities were even asked whether they wanted the projects. They rarely have any role in defining the major features of the program. Few have any experience with PHC programs and can offer little in the way of ideas for overall design.

Community involvement in the health care system is an integral part of the PHC model. Although project plans always give prominence to community participation, it is not easily achieved. "Communities sometimes contribute land for health centres or health posts, or even some labour, but this tends to be all. Local "health councils" may be organized to oversee health affairs, but they seldom function. In Benin, health councils have been organized at several levels - local, district, and province - but after initial enthusiasm, interest dwindled" (UNDP 1983a:18).

"In many projects, these general objectives of popular participation have not been translated into clearly defined

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activities on which project staff can focus and which can be verified and evaluated. Although certain expected forms of participation (e.g. the selection of health workers and the formation of health committees) are well-defined, neither communities nor project personnel may have precise ideas about what they should do or what they should expect from general community participation goals, such as communities' actively seeking solutions to health problems" (Parlato & Favin 1982:29).

"Project evaluations reveal a definite pattern of results from community participation. Generally, community support of specific and concrete functions and activities (e.g. health hut construction or provision of labor for water projects) has been successful, but other kinds of activities have not. Communities tend to support activities but not initiate them" (Parlato & Favin 1982:29).

The most effective program design for community involvement is to begin with a request from the community for some type of program. Then, the community should be involved in specific activities and decisions where possible. They can set health post hours, advise on project priorities, select sites for health posts, for example. However, community involvement is a progressive activity which develops as individuals skills in program design and management grow. Committees are not necessarily the best way to monitor the project. There may be more culturally appropriate forms of management. The more responsive the program is to community needs, the more quickly and effectively will community members find ways of supporting it.

The importance of participation to project sustainability depends on the program model being implemented. For vertical, categorical programs such as immunization programs, vector control, and oral rehydration there is ample opportunity to people to participate in the implementation of the project but most plans are probably made at higher governmental levels.

For the classic integrated primary health, community participation is essential in both the implementation and planning of some aspects of the program. It is important that programs begin with those health problems people perceive to be a problem, moving through health education to those components which may not initially be seen as problems.

The central issue in participation is has to do with cost recovery. People are more apt to contribute (through user-fees, or community financing projects) when they see the services as being valuable and responsive to their needs. The only way to

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determine what they need and want is to allow them a voice in setting priorities and determining some of the methods of implementation.

Further research on the roles community health committees can effectively play is needed. Also, culturally appropriate alternatives to the committee need to be identified and expatriate health planners taught to design projects around existing social systems rather than assuming that Western models will work.

There are many roles community members may play in carrying out a health program. Individuals and groups can learn more about management and assume greater roles in the decision making process but inevitably, major decisions will be made outside the community.

CHAPTER SIX

Categorical vs. Integrated Programs

A. The issues

There is a trend away from general health intervention toward programs with more direct methods and objectives. Community based PHC aims to improve health with a multifaceted intervention of nutrition, education, environmental sanitation, and education. The new Child Survival Program (CSP) offers a more limited package of services.

Integrated or horizontal programs are usually managed by several different individuals within the Ministry of Health. Horizontal organization requires great effort to coordinate ministerial units at the national level but it reduces problems of coordination in the field. Integrated programs have specific objectives but hope to achieve them through a multi-faceted approach. Most PHC projects target women of child bearing age and children under five. The CSP is a program of stepped up funding for those categorical programs which seem to have the greatest impact on infant mortality.

Management problems in working with integrated, community based programs is not limited to AID's programs. The UNDP also finds that broad multi-purpose types of projects "are proving to be the most problem-ridden and difficult to manage" (UNDP 1983b:14).

Community based programs are difficult to manage and are most successful when carried out by the smaller development organizations (PVOs) who have the staff and inclination to work with communities over several years to provide health and management training and, most importantly, establish the program in the community. The most successful and sustainable projects have been relatively small in scope and placed great emphasis on community involvement in both planning and implementation of the projects.

Because staff have the confidence of their clientele, have close contact with individuals in the community, and their projects are small, PVO programs seem to work better than large-scale government programs. At the same time, there have been problems of duplicating PVO projects or expanding them beyond their immediate scope (Development Associates 1985:23).

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Categorical, or vertical, programs are usually much larger in geographical scale (frequently nation wide) than integrated programs. They target a specific cause of morbidity or mortality. With vertical programming, a single unit of the Ministry of Health has its own budget, personnel, and logistical services. Common categorical programs include vector control (malaria, onchocerciasis, and schistosomiasis), immunization campaigns, water and sanitation, family planning, oral rehydration and, growing in popularity, are the Vitamin A programs.

In developing countries where Ministries of Health are underfunded, disorganized, highly politicized or held in low esteem, vertical programs are easier to manage and the effectiveness of the program easier to assess. On the other hand, too many vertical programs can waste resources by duplicating efforts.

In fact, the distinction between the two types of programs is not as discrete as the literature sometimes suggests. Categorical programs are often carried out through existing primary and curative health programs. Some PHC programs focused on two or three areas such as immunizations, oral rehydration, and environmental sanitation even before the recent CSP initiative.

The large body of literature on the pros and cons of integrating family planning programs with other health care programs is not reviewed here. The issues are the same as those arguing for and against the integration of immunization, vector control, and other "vertical" programs.

B. AID policy

"AID believes that it is preferable, at the outset, to aim at institutionalizing more universal coverage with a minimum PHC package, and then to expand the content of the program as resources permit" (AID 1982:4)

The "minimum PHC package" includes:

- o growth monitoring, nutrition education and the promotion of breast feeding;
- o supplementary feeding for the severely malnourished;
- o prenatal screening for high risk mothers and supplementary feeding if appropriate;
- o oral rehydration programs;
- o family planning programs;
- o basic immunization of infants and children;

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- o Emergency treatment for injuries, and first aid; and
- o medicines and supplies to carry out these services.

"In some circumstances, disease control programs that are separate from PHC activities may be warranted; however, to be effective, these programs should be sustained rather than isolated campaigns and clearly linked with planned or existing PHC programs.... Other elements of a more comprehensive health program, such as water and sanitation, should be included only when financial resources and support systems are adequate." (AID 1982:5).

Since the mid-1970s, many developing countries have started PHC programs. UNICEF (1984:13) reports that PHC is official policy in 78 of 122 countries surveyed by the World Health Organization. "Nor is the commitment to the idea purely rhetorical: India has trained 340,000 health guides and volunteers, for example, and Thailand has trained 384,000 health communicators. In Tanzania, almost every village now has one health post attended by a trained person; in Botswana, 80% of the villages have village health committees; in the Republic of Korea, 2,000 community health practitioners will be available to two-thirds of the population by the end of 1985. In Burma, 13,000 community based health workers are being trained in five years."

But, there is discouragement with the general PHC program. There is some feeling that most PHC programs try to do more than they can realistically accomplish with community health workers and limited support resources. For these reasons, AID health programs now include more categorical programs.

Current AID Health Sector Strategy (1984:1-2) retains the emphasis on a "basic package of proven, cost-effective technologies delivered in primary health care programs. The agency encourages immunizations, oral rehydration therapy, family planning and nutrition monitoring as the most immediately available, effective means to reduce infant and child deaths. Transfer of cost-effective technologies to control major communicable diseases, particularly malaria, is also a strategic priority to enhance labor productivity. In many settings, water supply and sanitation may promote both health and productivity...." The new AID strategy emphasizes

- o immunization
- o oral rehydration
- o family planning
- o nutrition (with growth monitoring and use of PL480 food).
- o control of infectious disease

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- o health education
- o water and sanitation (AID 1984:1-3).

In a study of 47 AID projects completed in 1984, of 27 health projects, the purpose of the project was as follows:

Bureau	Africa	LAC	Asia	Near East	Total
PHC	6	7	2	0	15
water & sanitation	1	1	1	3	6
inst. development	1	3	0	1	5
research & training	1	2	1	1	5
onchocerciasis	1	0	0	0	1
malaria	1	0	1	0	2
vaccination	1	0	0	0	1
population	0	8	1	1	10
ORT	0	0	1	0	1
blindness	1	0	0	0	1
Total	13	21	7	6	47

These data (Development Associates 1985:44-50) indicate that of AIDs programs, only 32% are integrated programs. Some categorical programs are carried out in conjunction with existing integrated programs.

C. Impact

In Stinson's (1985) study of impact evaluations in five countries, he found a lack of evidence to indicate whether selective interventions such as ORT and immunizations has a greater impact than a comprehensive PHC program. A Moroccan supplemental feeding program had a demonstrable impact but for most projects there was a lack of evidence or a lack of controls to show causality.

This raises the problem of measuring impact. In classic PHC programs, the communities are often also beneficiaries of agriculture, small-business, and other development activities. Measuring program impact is difficult. Baseline studies are difficult to carry out, routine data collection may or may not be reliable, and there may be a lack of controls for comparison. Political and economic conditions may change during the life of the project. Even in those cases where impact can be reliably demonstrated, it is difficult to say which intervention caused the change in morbidity or mortality. The impact of a nutrition or education program may be subtle or not measurable for years.

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Blumenfeld and Pipp (1985) have reviewed the issues in AID's health sector evaluations. They have recommended a systems approach to evaluation and have set forth a protocol for evaluating AID health programs which would make them more comparable across countries.

AID's search for the "magic bullet" by which the quality of life may be improved with minimal resources continues. Integrated programs can be frustrating. They require relatively high start up costs and measurable impact is slow in coming and frequently hard to measure. On the other hand, categorical programs are more discrete and impact more measurable. Formulae are available by which the number of lives saved or the incidence of illness reduced for the number of children vaccinated, the number of acres sprayed with insecticide, or the number of "acceptors" of a family planning programs. For this reason, categorical programs are more appealing. Within AID and in terms of budget justification to the Congress, categorical programs can demonstrate impact with greater confidence than integrated programs.

D. Community based primary health care

"Few worthwhile studies have been conducted concerning the effects of health service on health, and those that exist are difficult to evaluate. In some cases, concurrent improvements in water supply, sanitation, or housing have not always been fully taken into account, or nutrition may have improved but its effect has not been identified" (World Bank 1980:27).

As long ago as 1978, the National Academy of Sciences warned AID that integrated PHC projects while "internationally fashionable" were not practical. A committee of international health professionals "was not aware of any strong evidence that this approach has been demonstrated to be clearly cost-effective and ready for widespread and relatively rapid replication." (Rogers et al. 1978:9-10). At that time the committee recommended that categorical programs continue to play a key role in AID's health programs.

"The development of a system directed toward multiple objectives vastly increases the complexity of the task while sharply reducing its probably successful implementation.... In the committee's judgement, it may make sense in some situations to develop an operative structure for the execution of one or two functions, gain experience, and the trust of the recipients, than

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add an additional function, and later yet another." (Rogers et al. 1978:11).

In terms of integration, the argument may have to do with demographics as much as other variables. One strong opponent of integrating family planning with other health services argues, with respect to family planning programs that "when there is a population of high density guaranteeing a numerical important demand for specialized services, 'verticalism' will be the most efficient response.... In the extreme perimeter where population is scarce and demand very small and an effort is made to establish contact with those human nuclei, the focus must be horizontal. It would be ridiculous to travel five hours going and as many returning to talk for ten minutes about contraceptives and to distribute a few cycles of pills and a dozen condoms" (Trias 1980:40).

The World Health Organization (1978:11) has urged that the control of acute diarrheal diseases should be integrated with an overall health strategy. AID's CSP is an effort to focus primary health care on specific interventions to reduce mortality among children. Twenty-five million dollars was allocated in FY85 for the Child Survival Program. The program places great emphasis on Oral Rehydration Therapy (ORT) (about 35 percent of the funds) with other funds going for nutrition (18 percent) and immunization (21 percent). The remaining 26 percent goes for family planning, treatment of respiratory infections, vector-borne disease control, and water and sanitation. The Child Survival funds aim to give AID's health programs a "sharper focus" (AID 1986).

The CSP is new and there is no evidence of how effective it will be. The program is accompanied by a three-tiered evaluation system where all projects collect data on some basic indicators, a smaller sample collects data on a wider range of indicators and a few carefully chosen projects will have intensive evaluation components (AID 1985).

E. Vector control

"Serious vector-borne diseases are endemic throughout whole regions of the developing world. Malaria, which has experienced a resurgence in many countries, is a major factor contributing to death and disability. Approximately 850 million people live in areas where malaria is a threat in spite of malaria control efforts; another 345 million people live in areas where malaria is endemic but control efforts are ineffectual or nonexistent.

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Trypanosomiasis (sleeping sickness) has once again become a serious problem in Africa; the Latin American variant of trypanosomiasis (Chagas' disease) remains endemic in Central and South America, and there is no satisfactory treatment. Onchocerciasis, endemic in West Africa, is responsible in part for the abandonment of fertile lands and inhibits cultivation in potentially productive areas. Finally, schistosomiasis (snail fever), a gradually debilitating disease found in varying forms in many parts of the developing world is believed to afflict 180 million people in LDCs. Schistosomiasis spreads rapidly in areas with irrigated agriculture, sapping the energy of the very population that [it] is intended to benefit...." (AID 1982:2)

Malaria is particularly a disease of the rural poor and uneducated. It is relatively easy to treat and is sometimes considered to be a mild illness. Malaria control may be a low health priority for those who fail to understand the seriousness of its consequences. It is difficult to convince uneducated people of the cause-effect relationship between the mosquito vector and the onset of symptoms. Consequently, it is difficult to explain the rationale for using a variety of mosquito control measures. Successful malaria control, however, must be based on a combination of spraying, environmental measures to eliminate breeding sites, and the acceptance by patients of anti-malaria medication (Foster 1982:16).

Programs for the distribution of chloroquine for malaria prophylaxis were initially successful. Incidence of malaria in Sri Lanka dropped from 1 million in the 1950s to only 17 in 1963. Then, malaria made a comeback as mosquitoes evolved into forms carrying chloroquine resistant strains of malaria. Sri Lanka reported 150,000 cases in 1984 and the actual number was probably four times that. Some of the most lethal forms of malaria are now chloroquine resistant. Fansidar, the drug used for chloroquine resistant strains is losing its effectiveness in some areas where it has been used widely. Vaccines are forthcoming for malaria but the best solution to mosquito control are insecticides, larvicides, biological control agents, breeding site reduction, mosquito nets, and other solutions which will not lead to further spread of drug-resistant strains (AID 1986:39).

River blindness, onchocerciasis, affects one out of five adults in some parts of West Africa. This blindness is spread by black flies. Aerial spraying has brought it under control in some areas. Like other type of vector control programs, onchocerciasis programs are often vertical and based on a combined use of chemicals and behavior modification.

G. Immunizations

The smallpox immunization program began in 1967 and, because of its success, was an inspiration for all later immunization programs. Within ten years, the disease was completely eliminated. One reason for the success of smallpox eradication is that the freeze-dried vaccine does not need refrigeration. This enabled health workers to vaccinate people who lived in very isolated areas without concern for the "cold chain."

The cold chain is an ever-present problem in most vaccination campaigns (in addition to assuring the supply of vaccine on the needed dates). Keeping the vaccine at the proper temperature is essential to its effectiveness. Vaccines differ in stability and refrigeration requirements so that keeping it at the required temperature from the factory to health centers and storing it in places without refrigeration can be major logistical problems.

In 1974, the World Health Assembly of the World Health Organization voted for the establishment of a permanent Expanded Program of Immunization (EPI) as a component of all primary health care programs. A later resolution by the same body called for immunization of all the children of the world by the year 1990 as a milestone towards "Health for All by the Year 2000."

The objectives of the EPI are to

- o reduce morbidity and mortality from diphtheria, pertussis, tetanus, measles, poliomyelitis, and tuberculosis by vaccinating every child in the world by 1990.
- o promote countries' self reliance in delivering immunization services in the context of a comprehensive health program.
- o promote regional self-sufficiency in vaccine production, quality control and distribution.

EPI activities, according to the World Health Assembly, should be carried out in the context of an established PHC structure, where such care exists (de Quadros 1983:7).

AID lends major support to the EPI program through contributions to WHO and other international agencies as well as providing funds for immunization programs in more than 50 countries. "Immunization projects need to pay much more attention to the demand side of the equation. Existing services are underutilized

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and could probably handle double or triple the vaccinations they are now giving if they were upgraded (for example, with more reliable means of keeping vaccines cold) and became more aggressive in recruiting clients" (AID 1986:16).

"One method of integrating immunizations into primary health care has been the simple addition of immunizations to the list of tasks which primary health care workers are expected to perform. Experience from the field shows that this facile and superficial approach does not work. Successful broad coverage immunizations on a continuing basis (as new infants enter the population) are more complex to organize than many planners realized. Besides sophisticated logistics and substantial supervisory requirements, they require disease surveillance and record-keeping to ensure successful completion of immunization series" (Sabin and Stinson 1983)

In a study of eight PHC projects in Africa, "Mali's planned [immunization] activities in Koro Health Center and through the mobile team were cancelled due to late arrival of UNICEF equipment. In Mauritania, 3/4 of the AID health project budget is for vaccination and coverage of children fully immunized is 30% in the major region of project coverage, the highest in the country (AID n.d.a:2).

In Afghanistan, vertical programs for smallpox eradication, malaria control, and the training of traditional birth attendants were more successful than integrated programs. Efforts to integrate the immunization program into a system of basic health care was unsuccessful (O'Connor quoted in Sabin and Stinson 1983:25).

Colombia vaccinated 800,000 children during one National Vaccination Day. Brazil vaccinated 2 million children on two separate National Vaccination Days (UNICEF 1984: 7-9)

For rapid coverage immunizations, vertical programs are the most efficient and effective. Over the longer term, however, immunization programs must be integrated with other health services because few developing countries have the resources to maintain personnel and support for one health activity.

CHAPTER SEVEN

Program Implementation and Resource Allocation

Programs cannot be sustained without the skilled personnel to manage, plan, and carry them out. The lack of economic and human resources plagues health programs in all countries.

When a country with limited economic resources, few trained personnel, a stagnant or inefficient bureaucracy, and limited infrastructure (roads, communication, supplies) undertakes to provide health services to those poorest people who live in the most inaccessible regions, it is inevitable that it will be difficult to plan, implement, and maintain the program. Such a situation is exactly what is happening in many developing countries.

Over the past ten years, AID and other donors have urged developing countries to place more emphasis on primary health care and the model based on community health workers was adopted widely. In countries where PHC was encouraged, AID assisted with start up costs and technical assistance for planning. Both AID and host country personnel usually seriously underestimated the recurring costs for maintaining extensive networks of community health workers, secondary and tertiary referral systems, transportation and communication.

Management problems are inevitable when a program is planned both from the top and the bottom and most PHC projects are run exactly that way. On the one hand, the PHC model value community participation calls for local committees to manage their own PHC programs. On the other hand, community health workers require logistic support, supervision, and backup from a national network of clinics, hospitals, and physicians who have little interest in primary care and where decisions are passed down from policy makers and managers at senior levels of the ministries involved. When decisions about programs are made at the top by curative-oriented ministry of health officials and at the bottom by unsophisticated community health committee members, conflicts do occur.

Given the circumstances under which most PHC programs are attempted, it is perhaps surprising that they have been successful at all. It is not unexpected that they will have problems both with the allocation of limited resources and trained personnel and with the decision making process.

A. Program planning and management

The UNDP (1983b:10) finds almost all health programs in developing countries suffer from weak health system management. Over-centralization of decision making and trained personnel, lack of an effective incentive system for rural service, counter-productive personnel policies, inadequate information and data flow are some common problems. In addition, there is a lack of coordination and cooperation between ministries of health, agriculture, sanitation, and other health-related government organizations. Poor logistics hamper the distribution of drugs and other supplies. Because of a shortage of fuel or maintenance parts, vehicles are often disfunctional.

Similarly, the World Bank has found that "it is now evident that the most persistent problems in improving health do not result from the complexity of medical technology, and only partially from the scarcity of financial resources; rather, they derive principally from problems in the design and implementation of policy, management, and logistics. The obstacles most frequently encountered by the Bank in its lending for health components are:

- o Lack of sound, long term-planning, particularly for the financing of recurrent costs, and for the coordination of program elements.
- o Limited capacity for implementing new programs.
- o Inconsistencies between new health programs (especially for training paramedical workers) and existing laws and regulations.
- o Inadequate methods of procurement, distribution, and control of drugs and pesticides.
- o Insufficient and poorly managed transport.
- o Poorly designed curricula for training health manpower and insufficiently prepared procedures for clinical care" (The World Bank 1980:8).

AID has found that the "major factors contributing to poor management and administration include: hasty deployment of health workers before adequate managerial systems are installed; a widespread shortage of personnel trained to undertake various management functions; and institutional inflexibility and

reluctance to adopt new management functions and approaches" (AID 1982:5). As a result, AID policy is to provide technical assistance in the effective management, supporting in-country training programs in management and planning as well as training for trainers in management (AID 1982:5).

The current Health Sector Strategy (1984:6), AID calls for the development of better management capability for the design and implementation of better PHC programs. Health programs are not to be approved by AID unless management needs have been adequately assessed and actions identified to resolve deficiencies. AID provides technical assistance in planning and project design, financial management, supervision, logistic support, and information and evaluation systems.

Stinson's (1985) review of health and nutrition impact studies in five countries found that "virtually every" evaluation indicates significant problems in internal organization and management, particularly in relation to the development of health systems. Problems of logistics, supervision, information collection and use are universal. Programs, Stinson found, suffer from lack of clear, measurable objectives.

The background statement for AIDs health programs in Africa indicates similar problems. Health programs in Africa are constrained by the following:

- o lack of effective management, local financing, infrastructure, logistics, communications, and referral systems, cold chain and planned targeted interventions.
- o inadequate planning and poor management.
- o lack of trained manpower
- o lack of research on cost-effective methods of preventing and treating common communicable diseases (AID/Afr n.d.b:5)

The serious management problems have not rendered all programs ineffective, however. A review of eight PHC projects in Africa found that "even a minimum of health infrastructure can deliver the simpler health technologies, OR, and immunizations, to many persons previously underserved" (AID/Afr n.d.a:1).

AID Latin America and Caribbean Bureau reports that "management problems continue to impede effective health and water service

delivery. Adequate systems of planning and management, transportation, logistics and drug supply, supervision, referral, and data collection are frequently lacking in LAC health systems" (AID/LAC 1983:2)

One response to the problems of managing the delivery of health services in developing countries has been an increase in operations research and systems analysis. Primary Health Care Operations Research (PRICOR) has carried out 49 studies of management problems in health delivery systems overseas and they anticipate an additional 50 studies over the next three years. Such research enables program planners to identify weaknesses in program delivery systems and recommends culturally appropriate ways of strengthening the system. A summary of PRICOR's findings to day is in preparation.

The APHA review of 52 AID projects found that support services to projects were a major problem. Programs often do well in the first years as health posts are constructed, health workers trained, and initial supplies provided. However, governments often underestimate the costs of maintaining the system. With limited national funds, they may be needed elsewhere. "Government management capabilities generally are weak to begin with, since in many countries the administering agency for the PHC project has too few trained management personnel" (Parlato and Favin 1982:15).

The study found that the main management and support problems are a deteriorating economic situation which affected governments' ability to fund fuel, drugs, and other program costs.

- o implementation of programs through a highly centralized administrative structure making change and the implementation of new programs difficult.
- o lack of basic infrastructure in rural areas such as roads, communication, lack of suitable housing, banking, and other services, and shortages of personnel who are willing to work in rural areas.
- o dependence of programs on vehicles but with poor maintenance systems, poor road conditions, and difficult geographic and climatic conditions and rising fuel costs.
- o weak systems for the supply and management of drugs due to lack of personnel, inefficient logistics systems, and transportation problems.

- o lack of supervision for health workers which affects the quality of care they provide, leads to high attrition rates, and extra training costs. Low quality care leads to a lack of community confidence in the program and lack of community support can lead to many other problems (Parlato and Favin 1982:15).

B. Appropriate technology and the private sector

AID programming guidelines call for AID to assist in expanding host country PHC services through the transfer and further development of selected, cost-effective technologies. AID emphasizes immunization, oral rehydration, contraceptives, PL480 food supplements, vector control and water and sanitation as areas within which low-cost technology is available and should be used.

One project which incorporates technology transfer with AID's emphasis on private enterprise is Health Link. Health Link works with health technology companies in the U.S. and other countries to transfer products, processes, and know-how to private manufacturers in developing countries. Initial funding was 1.5 million dollars over two years by AID/PRE with Child Survival funds.

Health Link negotiates joint ventures, assists with licensing, financing, production staff, obtaining equipment, and helps with auditing and marketing as needed. With initial projects only in Indonesia and Thailand, Health Link is carried out by The Program for Appropriate Technology in Health (PATH). At the end of the first funding period, they have supported joint ventures in the manufacturing or distribution of larvacides, hepatitis B vaccine, weaning food, rabies vaccines, low-cost eye glasses, x-ray equipment, intra-ocular lenses and a potential antibiotics production project is awaiting approval.

Such a program helps to eliminate some of the problems identified in Latin America where "comparatively little has been done in the utilization of research methodology to develop drugs, vaccines, or diagnostic methods for the highly prevalent diseases of the developing world" (AID/LAC 1983 2).

C. Human resources

In the industrialized world, the physician and the hospital form the core of a network of other skilled health personnel - pharmacists, technicians, sanitarians, and so on. In developing countries, a variety of traditional healers, herbalists, bone-setters, midwives and shamen fill the health needs of the population. Only in the last few years have physicians trained in modern medicine been available outside the capital cities of developing countries.

In the U.S. there is one physicians for every 600 people. In Malawi there are 49,000 people for each physician. In some Egypt, Turkey, and the Dominican Republic, the ratio of physicians to the population is relatively high for developing countries because of government policy to train great number of physicians. However, such figures can be deceptive when most physicians still practice in the capital cities and large rural populations may be completely unserved by physicians.

Other technically trained health personnel in developing countries includes nurses, midwives, sanitarians, and various types of technicians (lab workers, pharmacists, etc.). Even with government programs to train large numbers of health care workers, most countries still suffer from a serious shortage of health workers and a problem of distributing those personnel throughout the country.

AID/Latin America and the Caribbean bureau reports that the absence of appropriately trained manpower in sufficient quantity delays the implementation of key interventions. Planners, managers, and health workers at all levels are scarce and unevenly distributed in LAC countries. Training, for the most part, continues to be in curative medicine rather than prevention and social issues (AID/LAC 1983:2).

"Specifically regarding human resource development for PHC, the numbers of health personnel of all types in relation to population are inadequate, complicated by maldistribution of those which do exist. Lack of clearly defined functions of the different categories of personnel, based to the extent possible on written job descriptions, creates problems in their training and functioning (UNDP 1983b:10-11).

In some countries, physicians or other health workers are expected to serve one or two years in the rural areas in return for support during their schooling. However, the quality of the care given by these unwilling rural physicians is frequently

subject to complaint. The physicians are often unsupervised and fail to keep clinic hours. They make long visits home and take little interest in the health problems of the rural people whom they feel to be ignorant and dirty. The quality of care that the rural people get from such physicians depends entirely on the character and skills of the physicians.

The young physicians are often directly from the classroom and lack practical experience, particularly with general medicine in a rural area. They see their time as something to be endured in penance for their medical training.

Almost everywhere, there is a shortage of nurses and midwives. The response has been to train relatively larger numbers of assistant nurses or assistant midwives. These are drawn from lower income and rural families. They tend to work for longer years and to serve willingly in rural areas, but their technical skills and knowledge are bound to be limited.

A common problem, too, of all health care training in developing countries is that it is hospital based where curative medicine is taught. Physicians and nurses rarely have any formal training in prevention or the social aspects of health. Therefore, even when trained personnel are available for PHC projects, they have difficulty working in prevention and many programs drift into more and more curative care (UNDP 1983a:7-13).

Efforts are underway to design curricula for medical and nursing schools which teach the elements of prevention and principles of PHC design and implementation. Even at that, teachers with a preventive orientation are hard to find and teaching materials on health education and prevention are limited.

CHAPTER EIGHT

Feedback and Communication

A dynamic system of feedback and communication within a health project is critical to its continuation and to obtaining the maximum benefits for the limited resources. Health supplies, personnel, transportation, and other support are expensive. A good evaluation and communication system can help maximize the projects benefits and keep costs minimal.

An evaluation system helps project managers determine how effective their project has been and which approaches are the most cost effective. For example, an evaluation system can help determine what the trade-off costs are of taking vaccinations door-to-door (costly but effective) and organizing campaigns to bring children to health posts for vaccination (less costly but not necessarily less effective). Similarly, a system of feedback from hospital and clinic referrals can measure the accuracy of health workers diagnoses or identify areas for further training.

A. Communication systems

Health programs, more than other sector programs, need a system of internal controls, records, and feedback. For drugs to be ordered, estimates of usage must be made. For personnel to be located strategically, it is important to know how often and what types of services are needed at health posts. Monitoring the performance of community health workers involves checking the amount of medications they are dispensing, the referrals they are making to clinics and hospitals, and the other services they are performing. Costs of various activities must be calculated so that future activities may be planned.

Communication needs to flow both up and down vertically as well as horizontally. Program planners need to have a continual flow of information from the delivery level so that supplies can be ordered, training arranged, and management decisions made. At the same time, health workers need to know what their colleagues in other health posts are doing and have some feedback on the quality of the service they are giving.

Data must be routinely be collected on certain minimal measures of health (in PHC programs this is usually weight for age of children under five years old). Records of referrals, supplies

used, and services performed are all essential. At the same time, if too much paper work is required, its importance is diminished and the quality of the information slips. It is not tabulated or analyzed. One of the greatest weaknesses in health information systems is in getting the data back to those who can use it to improve the system. But it is a delicate balance between the collection of enough information for decision making and collecting so much that it is not used.

Where there is a shortage of staff, bureaucratic inefficiency, weak supervision, and shortages of supplies and vehicles, the maintenance of a dynamic and efficient information management system is difficult.

In a study of eight PHC projects in Africa, five had explicit health information system components. Design of forms and training in their use was considered successful. "Feedback of information to the field was weak. In one country, Mauritania, information was used to redesign a major project component. In Somalia, multiple systems were developed by different donors and departments of the MOH" (AID/AFR n.d.a:3).

The conflict between donor needs and project managers needs has created problems for many projects. Where donors have rigid systems of reporting, or worse where there are multiple donors each with different systems of reporting, such conflict taxes already fragile information systems.

The problem of information management is not unique to AID programs by any means. UNDP found "proper management also requires a flow of information on the operation of health programmes - information on patients seen, services provided, problems encountered, etc. Seldom do such information systems function efficiently. Sometimes there are printed forms to be used, but they are not filled out. In some higher-level offices receiving such forms, they pile up but are not analyzed" (UNDP 1983a:32).

Management information systems are important to the efficiency and effectiveness of PHC projects. Designing an effective system requires a careful analysis of the project to see who needs what information and the elimination of unneeded information to keep paperwork minimal. A system must be in place for the analysis and interpretation of the information so that it is both timely and accurate.

B. Monitoring impact and progress

Impact monitoring and evaluation are ideally built into the routine management information data collection. In addition, some donors require major community surveys as baseline studies early in the project. Baseline surveys are costly, time consuming, require a large number of skilled personnel to construct questionnaires, collect data, analyze and interpret computer print-outs. In communities with a low level of education, the quality of the data may be low. In most baseline studies, the data are never fully analyzed and the results are not used in designing the program.

A more economical, more responsive method, if a questionnaire must be used, is to carry out "mini-surveys" on very limited subjects (a questionnaire of one page or less) at a time within the project when the data can be analyzed and used most effectively. Even more preferable, is the use of alternative data collection methods. Anthropologists have a large repertory of such methods and their use in health care projects is increasing (Buzzard 1984).

Stinson (1983) prepared a manual on health information systems which discusses in detail the issues, problems, and uses of information collection systems. He points out that whenever possible, data should be analyzed by those who will use them since they have the strongest motivation for accuracy and completeness. Record keeping does take staff time and those at the delivery level (community health workers) sometimes see time spent on records as time taken away from their clients.

Data should be checked for accuracy. Programs may inadvertently encourage workers to over or under report certain activities in order to gain supervisory approval. A sample of records should be routinely checked or health workers observed to see whether their reports are accurate.

A major issue is whether personal health records should be kept by the family or kept at the health center. Where patient education is a factor, as with growth monitoring cards, it is best for the family to keep their own records so they take responsibility for their own health care and so that they can see progress as their children improve nutritionally. Where education is not a factor, it is sometimes best to keep records at the clinic where they are less apt to be lost and where health workers can check on appointments and progress.

Some have argued that mothers cannot keep their children's

records, that they get lost, dirty, or unreadable. However, health clinic records get lost, dirty, and unreadable, too. If patients are supplied with a small plastic bag to keep the records in, they usually can keep them safely. Giving mothers their children's records also shows confidence that the mother can take an active role in the child's health (Stinson 1983:44-45).

In the APHA study of 52 PHC projects, Parlato and Favin found that "although provision for an information system is made in almost every project plan, during implementation the system rarely functions as intended and rarely provides the desired data. The information system either breaks down or produces information that is never used. Because it is more detailed than is necessary, produced too late to be of value, or inappropriate given the decisions that must be made, information is often not used. Even useful data may be ignored by those managers who only trust their personal experience or who make decisions for political reasons (Parlato and Favin 1982:74).

Parlato and Favin found that AID procedures and close congressional oversight often constrain or delay project approval. Then, AID bureaucratic procedure for project planning are too often inflexible or inappropriate. Because the AID planning process is followed pro forma to justify what has been decided and because bureaucratic procedures and not the project become the focus, constraints and host-country realities may be glossed over (Parlato and Favin 1982:37).

C. Project flexibility and mid-course corrections

The collection of impact data and management information is of little use unless the project has the flexibility to discontinue activities which are unproductive, experiment with solutions to problems, and build on successful approaches. No amount of prior planning can successfully eliminate all the problems which may occur. A financing scheme, vaccination campaign, or mother's club that worked very well in one community may not work at all in a neighboring community. There must be a continuing process of change as a program develops and settles in.

Projects need the flexibility to use the information they collect to make necessary changes in the program. Technical assistance is often ignored or unused because the procedures for making basic changes are so cumbersome. Conflict between technical advisors in the field and AID staff are common. The quality of evaluation and monitoring systems varies considerably. "The need

to define better the respective monitoring roles of the AID mission, the technical assistance teams, and the host governments seems obvious, as does the need for additional health staff in the missions" (Parlato and Favin 1982:90).

In summary, health information systems are difficult to establish, maintain and use. Ideally, a monitoring system should chart project activities and impact as part of a routine information collection system. Too often, however, separate monitoring systems, baseline studies, and conflicting requests from donors bog down an already fragile system. Yet a system that allows communication vertically and horizontally within the system is essential to the maximum use of available staff and other resources.

CHAPTER NINE

Conclusions

The purpose of this paper has been to identify lessons learned from AIDs extensive world-wide experience in health programs. The methodology has been to review existing documents, mostly secondary sources, which review a number of projects. Working from original evaluation reports and project papers would have been interesting but time consuming. While working from secondary sources has its limitations, the agreement among the sources suggests that the issues emerge as clearly in this method. If anything is missing from the paper, it is more anecdotes and examples from specific projects to illustrate the points made here. But, that would have lengthened the paper and made it less useful.

The theme of this paper is the issue of project sustainability. To have a long-lasting impact on health, a program must last beyond AID's period of sponsorship and be managed, financed, and carried out entirely by local ministries and communities. Although there is no consensus about what aspects of a project contribute most to project sustainability, a review of the literature indicates that at least six aspects of a project are important both to its short term success and its long term sustainability. These are financing, community participation, a host country policy in support of preventive care, appropriate program design, effective allocation of human and other resources, and an effective system of information collection and use.

There may be other factors which contribute to the sustainability of projects. Which of those listed is more or less important may vary by the country or the project. A study of the attributes of projects which continue, both in their infrastructure and their impact, would be a welcome. Until the results of such research are available, those issues which emerge from a review of the literature must serve us.

A. Financing

Without question, a health program cannot be sustained without assured long-term financing. Yet, developing countries are short of capital and the cost of health programs, particularly the recurring costs is routinely underestimated and methods of

recovering costs from end users have not been politically popular.

Lesson: In project financial planning, consideration of changes in foreign exchange rates, local rates of inflation, and all recurring costs should be carefully calculated in advance so that realistic budget planning can take place.

When a country is working with limited money for health, they must either raise additional revenue through user-fees, re-allocation of money within the government, or underwrite part of the expenses by funds raised in the community. A reallocation of funds within the budget involves political considerations. It is difficult to start charging user-fees when free health care has been available.

Lesson: People are not willing to pay user-fees for primary health care services, but they are willing to pay for curative services. Even when free health care is available, people often spend money on private practitioners. Charges for curative care will likely have to be high enough to subsidize preventive care.

Raising money within a community in support of a health care system has not been successful on a long-term basis. Communities do make an important contribution through labor, land, and volunteers services but there has been no effective way of sustaining payments for community health workers unless they work in curative as well as preventive care.

Lesson: If community financial support is needed for the health care system, curative services must be available.

Lesson: Community financing of health programs is a way to recover some program costs. However, it is unlikely that user-fees or community income-generating projects will sustain a project over time.

Research is needed to find a better way of evaluating community financing schemes, and more experimentation with alternative methods is needed.

The use of private sector physicians, midwives, and traditional healers is a potentially cost effective way of delivering many PHC services to the rural and underserved areas.

Lesson: Experiments in using traditional healers, midwives, and and the social marketing of supplies and vitamins, has

generally been successful though such programs have been small and further research is needed on how best to design programs which include the existing health care system.

Lesson: Efforts to incorporate private physicians into PHC systems have not been as successful. This is largely because few physicians are trained in prevention and many see PHC systems as cutting down on their business.

Lesson: The costs of quality primary and secondary care are so high that providing services to people in rural areas strains the budget of developing countries. All possible care givers should be incorporated into the health system. This would include traditional healers, private physicians, traditional birth attendants, and drug sellers.

Health maintenance organizations (HMOs) are being tried in some of the more advanced developing countries. They seem to offer a private pre-paid health care system for the more affluent segment of the population, particularly those who are in salaried positions. As yet, they have not been able to incorporate the poor into their systems. As more countries try prepaid health plans, it is important that their experiences be documented so that experiments for reaching the poor can be designed.

B. Community participation

Community participation is very difficult to achieve in the short time most projects have to get started. There is an inherent contradiction between the idea of participation and the top down design of most health projects.

Lesson: It is important that community members have roles in making some of the decisions about health care in their communities. However, participation cannot be mandated. Training in health management for civic groups, and an effective health care program will increase the participation of individuals in the program. Mechanisms for increasing the decision making powers of the community can be built in so that as the skills of the citizens improve, their role in the program will also grow.

The effectiveness of community health committees has been mixed. Alternative forms of decision making (other than the committee) needs to be investigated. More documentation of the process of the establishment of successful committees is needed.

More research is needed on the importance of community participation in the sustainability of health care systems. Specifically, different models of participation need to be identified, and documentation of the more successful ones carried out.

C. Host country policy and budgets

Host country policy in support of PHC and of dispersal of care throughout the country is important. At this point, many developing countries have policies in support of country-wide prevention programs but still place greatest priority on curative services and health care in urban areas.

Lesson: Host country policy must be matched with an aggressive program to carry out that policy. That means cutting off free health care, re-allocating financial and human resources, and looking into ways of incorporating private enterprise into the health care system.

D. Categorical vs. integrated programs

While the idea of a community based PHC system is sound, developing countries lack the human and economic resources to set up and maintain such programs, especially in the more remote parts of the country. Also, developing the community support for such programs takes a long time.

Integrated programs are fuzzy. They have many objectives but few resources and personnel to carry them out. In attempting to do everything, they sometimes do nothing well. Information keeping systems are often poor and impact is either unmeasurable or only is significant after years or decades of work. The recent Child Survival initiative is an effort to focus the old generalized health care programs on four areas which are known to have the greatest health benefits.

Programs focused on a specific disease or deficiency are tidier than integrated multi-service programs. The targets individuals or regions are clear cut, the funding for supplies, personnel, and vehicles can be estimated with more precision. Because there are formulae for calculating how many lives are saved for number of children vaccinated, or acres sprayed, the evaluation of categorical programs is crisper. When the only available personnel have little schooling and resources for training are limited, programs with limited objectives are both easier to

manage and more effective. Results may be measurable in weeks or months.

Demographics may play a part in determining whether integrated or categorical programs are preferred. Because it is too expensive to have separate programs, in isolated, difficult to reach areas programs in PHC should include family planning, vaccinations, vector control and other services. In more densely populated areas where large numbers of people can be reached with vertical programs, they may be preferable.

Program type also has to do with the level of economic development of the country. In a country (such as most Latin American countries) where the Ministry of Health is reasonably well managed, where poverty is not abject, and where health problems are not devastating then integrated programs may be appropriate. Where poverty is extreme, certain targetable illnesses evident, and where the local government is not capable of managing an integrated program, vertical programs of immunization, vector control, or oral rehydration may be most effective.

Lesson: Both categorical and integrated programs have strengths and weaknesses. Categorical programs are easier to design and have a clearer measurable impact but they are often costly if too many of them are undertaken as each must have its own management system. Integrated programs are preferable but often undertake too much with too few resources. Integrated programs are most effective when they start with a few limited objectives and add services as community support and health worker skills increase.

E. Management and resource allocation

The health care system in every country is short of human and financial resources. In the developing countries, the problems are acute. There are not enough trained health personnel of all types (physicians, nurses, midwives, pharmacists) and those available are trained in curative rather than preventive care. There are shortages of vehicles, spare parts, and fuel. Roads are impassable, vaccines unavailable, and communication poor.

In spite of serious shortages of money, personnel and with noteworthy management problems at all government levels, many health programs do seem to work and they do seem to have some impact. This raises the question of just how bad the management has to be and how few the resources have to be for a program to

have no effect.

It is difficult to make generalizations about health care management because each program is organized somewhat differently, works under different constraints and with differing resources. However, it would appear that many programs are over-managed. Since all programs seem to suffer from management problems, **research is needed to identify the most critical areas of management in a health care system and make distinctions between those parts of the system which must function and those which contribute to its efficiency but are not vital to its continuation.**

Lesson: In spite of serious management problems and limited resources, most health care systems continue to function, provide some services and have some impact. Improved management and resource allocation makes them more efficient but poor management does not necessarily render them ineffective.

F. Feedback and communication

An information loop which includes data on morbidity, mortality, referrals to clinics, services performed, and health worker effectiveness is important in maintaining a health program. The more extensive the system of useful information, the more effective and economical the program can be. A minimal information system would allow for the ordering of supplies, monitoring of the services provided, and some assessment of impact.

Unfortunately, when resources are limited, staff overworked and supervision weak, the feedback system suffers. Donors often request special reports or types of data, a problem compounded when the project has multiple donors. Information which is collected is not analyzed or the results not used.

There is more information on the problems of information systems than on solutions to those problems. **Documentation is needed on programs where an effective, minimal information system has been worked out.**

Lesson: Record keeping systems should be worked out early in project planning, training in record keeping should be an integrated part of any training and health workers should be given time to complete their reports. Regular revisions of forms and systems should take place to keep all paper work

Chapter Nine/Conclusions

to a minimum and to be sure that information collected is presented in a useful form those who will make decisions based on it.

IN SUMMARY this review of the literature shows that AID policy and practice has been responsive to the lessons learned from its experiences in twenty years in PHC. It has been shown that the general model of a community based primary health care project is a goal which is best reached with more targeted programs. The lessons AID has learned from its own projects have been mirrored in the experience of the other large donors such as UNICEF, the World Bank, WHO and UNDP.

NOTES

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