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**INTERNATIONAL AID IN THE HEALTH SECTOR:
PROGRAM, PROJECT AND RESEARCH INVESTMENTS**

Part II: Considerations in Assessing Effectiveness

by

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PART II: CONSIDERATIONS IN ASSESSING EFFECTIVENESS*

INTRODUCTION

In this section of the paper I propose a framework for examining the effectiveness of three different forms of aid, project, program, and research investments. For the purposes of this presentation, I do not distinguish between different types of aid within categories such as sector adjustment lending, sector lending, institution building, etc.

My original intention was to focus simply on effectiveness, and specifically on measures or attributes which could be used to evaluate forms of aid. As I thought about these issues, however, it seemed much more useful to set up an analytic framework for considering the forms of aid. The basis for this framework is the assumption that different actors on the aid stage have different perspectives. It does not make sense to talk about the effectiveness of different forms of aid without consideration of each actor's point of view.

In the literature which I reviewed for this paper, and in the conversations I had with individuals at the World Bank and A.I.D., and with development economists and individuals involved in development work in health and agriculture, differences in terminology and perspective were apparent. "Effectiveness" means different things not only to aid professionals but also to different interest groups within recipient countries. Clarifying these perspectives should help us to define much more precisely the implications of each form of aid for investments in health.

*The assistance of Brad Barham, Ph.D., Paula Braveman, M.D., M.P.H.,

In this discussion, each form of aid-- project, program, and research investments, will be considered separately from two broad perspectives, donor and recipient. Within the donor category, I focus on the World Bank, AID, and non-governmental organizations (NGOs). From the recipient perspective, I discuss the public sector (which in our case will often mean, the Ministry of Health), the private sector, and the population. I decided on the latter term because I wanted to use a broader term than the poor, or women and children, or the industrial workforce, even though I realize that each of these groups may have different criteria for effectiveness.

For donors and recipients, effectiveness criteria will vary depending on whether they are viewed internally and organizationally or externally and politically (the institutional environment). Internal and organizational aspects of effectiveness refer primarily to bureaucratic characteristics and needs such as staffing, flexibility, etc. The external political environment raises issues of national agendas, ideology, and accountability.

Measures of effectiveness are considered separately, since they vary for different types of donors and recipients. They range from more easily evaluated process outcomes or health indicators to sustainability and quality which may be difficult to capture.

Last I talk about constraints on effectiveness of the different forms of aid. Constraints are defined as those features of aid, or the actors, or measures which make it difficult to evaluate effectiveness.

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This is not a perfect framework. Some issues cut across categories or cells, while some cells are empty. Perhaps the discussion today will help to refine the framework so that it can be a useful tool for evaluating forms of investments in health.

PROJECT AID

For the World Bank, AID, and non-governmental organizations, the primary form of investment in health has been through projects (1,2). As Figure 1 shows, on the internal, organizational side, both the Bank and AID are constrained by the need to disburse funds and to use staff efficiently (2). NGOs can be more flexible in how and to whom funds are distributed (3), but all three function as bureaucratic structures. Project aid can strain recipient capacity at the ministerial (2) and the health system levels. On the other hand, it may involve and build commitment at a local level (4).

All donor organizations depend on other agencies for sources of funds, and therefore do not completely control their own agendas. Nor are donor agendas controlled by recipients (5) except in rare cases. Donor agendas may be blurry, or may conflict with the agendas of recipient countries and organizations. For the recipient ministry, aid can either build credibility or create conflict, depending on the source and form of aid. The private sector may experience direct or indirect effects from donor organizations. Indirect effects may flow from changes in the public sector and/or changes in the economic

or institutional climate. Donor agendas may respond more to the donor's own national political climate than to population needs (5,6).

From the donor perspective, project aid is fairly easily evaluated using conventional quantitative measures of effectiveness (2,7). How many people were treated? How much improvement has there been in disease rates? What proportion of the target population has this intervention reached? Sustainability (8) is more difficult to measure since long-term follow-through frequently does not occur and donor programs shift tracks (5).

For the public sector, criteria of effectiveness include efficiency, coverage, and range of services (2), the development of human resources (8) and of infrastructure (8) and for both public and private sector, the creation of financial self-reliance (9), although this may be illusory (6).

It seems to me that the bottom line measure of effectiveness for the population is, Did this project alleviate poverty (7) by giving the local community, including women and the poor, more involvement in and control over the conduct of their lives (3,4,7)? This measure of effectiveness is often at odds with the agendas of large bilateral and multilateral organizations (5,6).

Constraints on the effectiveness of project investments include, from the donor perspective, accountability and the need to control costs, and ideological agendas which collide with community beliefs and practices. From a more methodological

perspective it may be difficult to to tease out the real variables from a range of social, economic, and environmental predictors which have produced certain outcomes (3). Sources of data may be poor. Also, for donor organizations, the need to be politically accountable to their own constituencies may drive project content and structure to easily evaluated outcomes (for example in the Child Survival program).

From the recipient side, ministries of health are often very weak, making it difficult for project implementation to proceed smoothly (2). Also, within the public sector there may be conflicts between urban-rural or primary-tertiary care interests (2). The development of one project may have intrinsic and negative consequences for a second project, because health sector resources are stretched thin (10). Although much of AID's recent efforts have been directed towards privatization (11), the capacity of the private sector may also be insufficient for added services (5,6). Finally, from the population's perspective, projects may have little social and cultural relevance (3,5), or may actually destroy indigenous community efforts towards solving a development problem (12).

PROGRAM INVESTMENTS

Figure 2 presents the framework for program investments. They are attractive in a period of recession because they contain a number of mechanisms for influencing policy in an era of recession (13) but they also may be relatively cost effective for donor organizations since they reduce preparation time and staffing needs (7). For recipients, program investments often

force reallocation of resources (14) which results in service cuts (13,15) but it also believed to impose efficiency and strengthen management (7). Program aid has been linked with privatization (13) and may raise profits for the private sector (7). The social costs of adjustment are high (4,13,14,15) as program investments generally raise the costs of health and welfare services (4,7) and diminish use (4).

For the donor agencies, program aid is frequently driven, overtly or covertly, by political agendas (5,6). Because of the macroeconomic context of program investments (13), accountability may be more diffuse than with project aid. With the drive towards program investment, greater coordination and cooperation among donors becomes important (15), especially if a program goal is to preserve some basic health and welfare necessities for the poor (4). [This conference is a good example of this process.] Since the time frame for measuring effects is crucial with program aid, it is not clear whether in the long run the public sector will suffer or benefit. In the short run, the public sector is apparently weakened by program investments, at least until strengthened by managerial efficiency. Consequences of program investments for the private sector are also unclear (6).

Outcome measures of the consequences of program investments differ for the long and short terms (4,7). From the donor perspective, the large investments involved make economic output measures (5) and linkages among investments and their relation to development policy (10) important. For the recipient, concerns are much more proximate. How has the level of services

been affected by program investments? What are the consequences for access to and adequacy of services (4,15)? How cost effective are measures taken as a result of program investments (14)? Degree of community participation in health programs should be a measure of effectiveness from the population perspective (3,4). Also, epidemiologic surveillance data, and short and long term health and social indicators will enable the recipient to determine the extent to which it is a net gainer or loser as a result of program investments, and where services should be targeted. This suggests attention to the creation and maintenance of sound data bases. Priorities should be determined at the local level (4).

Constraints on program investments from the donor perspective include the need for donor coordination (7), useful, sound, and accurate policy analyses (16,17), a need for "hard", quantitative data on economic indicators (5), the need to prioritize to protect the poor (15) and to maintain political credibility, and the inadequacy of existing economic models (15). For example, if effects are measured only for formal sectors of the economy, and the informal sector is ignored, benefits to the population may be overestimated. For a correct assessment of program investment effects, it is also critical that the unit of analysis be correctly specified-- the household level (15).

The effects of recession and program lending may be confounded, making it difficult to trace the consequences of

program investment at the country level (15). A weak infrastructure (3) or corruption (6) may mean that program aid does not work in the economy in intended ways. In-country planners may represent elites who are out of touch with the needs of local communities (5) or whose priorities are bureaucratically determined, and therefore decisions concerning program priorities will not be participatory (15).

RESEARCH INVESTMENTS

Figure 3 provides the framework for research investments. They are a long-term commitment, and therefore from a donor perspective, are probably more relevant to NGOs such as foundations and universities or to bilateral agencies like AID than to multilateral investors whose time frame tends to be short. Conversely, research investments for the recipient are not effective without long-term commitment from the donor.

The advantage for donor organizations is that research investments have high good will value, are less politicized, and have lower conflict potential than other forms of investment. Both the health (4) and education (18) sectors are attractive areas for research investment, although World Bank data for education indicates that the highest income and largest borrowers receive the most funds for education.

For the recipient, conflict may emerge over competition for resources (19) within the public sector, or between the public and private sectors. Also, the selection of the sector or area of research investment may depend more on the donor's agenda than on locally determined needs. Research investment's effects

on the population are indirect, may be long term (for example, in the development of a local pharmaceutical industry), and may ultimately reach only the elite rather than the poor. Again, it seems to me that the focus of research investments needs to be determined on a participatory basis and to be determined by the needs of the poorest and least healthy sector of the population, rather than by a scientific elite.

Thus, from the population's point of view, measures of the effectiveness of research investments might be their long term effects on income distribution and social and cultural effects (including the creation or exacerbation of social conflict). From the donor perspective, more conventional measures of the effectiveness of research investments might be, in the short run, numbers of trainees, numbers of courses, course enrollments, and in the long run, sustainability and scientific output. Cost effectiveness should also be a criterion from the donor's perspective and may determine such basic issues as where training takes place. From the recipient's perspective, research output might be measured by numbers and types of research or training institutions, the development of specialized organizations, the growth of scientific infrastructure (19), and manpower distribution. In the area of research investments I see less potential conflict between donor and recipient in measures of effectiveness than with project or program investments.

A major constraint on the effectiveness of research investment appears to be the source of the aid, with foundations and universities in a stronger position than bilateral organizations who have historically been unsuccessful in this area (7,8). This should not be surprising since domestically, at least in the United States, scientific research is also dominated by the universities and foundations (with the exception of intra-mural research in some government agencies like NIH). Research investments require diverse but complex and interrelated inputs (19), and strong feasibility analysis and sound policy research (18). NGOs may be better positioned to provide this.

On the recipient side, the success of research investments will be constrained by access to resources and information (unless these are provided as part of the investment) (19), and the motivation, quality, and skills of scientific personnel. The recipient must be able to sustain recurrent costs (19). Last, the research investments should be socially and culturally appropriate and acceptable to the local population (3,19).

CONCLUSION

This section of the paper has presented a framework for examining the effectiveness of project, program and research investments. The framework is driven by the question, effective for whom? Aid has a number of constituents. The constituents are bilateral and multilateral donor organizations, recipient public and private sector institutions, and the population of the recipient country. The relationships among these

constituents are those of power and control. Investment agendas and the form investments take appear to be determined by political and bureaucratic agendas on both recipient and donor sides. The themes of social and cultural relevance and community participation in decision making for use of investments and development priorities are present, particularly in the literature on "adjustment with a human face" (4,20,21). But the evidence that aid is shaped by population rather than donor needs is lacking.

Because health is a most critical basic human need and because the world-wide recession may be driving fragile health attainments into eclipse, the participants in this colloquium have the opportunity to drive this population perspective to the top of the aid agenda for the 90's. In that case, we will be able to answer the question, "effective for whom?" in a very different manner at the end of the 90's than we are able to do at the end of the 80's.

REFERENCES

1. Agency for International Development. Program Sector Assistance Guidance. State 246904, August 30, 1983.
2. Measham, Anthony R. Review of PHN Sector Work and Lending in Health, 1980-85. PHN Technical Note 86-14. Population, Health, and Nutrition Dept., The World Bank, March 1986.
3. Justice, J. Social Science and Medicine, 1987.
4. Jolly, R. The crisis for children and women. What can be done?, Journal of Development Planning (15), 1985: 99-112.
5. Justice, Judith. Policies, Plans, and People. Culture and Health Development in Nepal. Berkeley, Ca: University of CA Press, 1986.
6. Shepherd, Philip L. The case of the invisible aid. Nacla. Report on the Americas 22 (1), January/February 1988:31-40.
7. Cassen, Robert. Does Aid Work? Report to an integrated task force. Oxford: Clarendon Press, 1986.
8. Agency for International Development. Institutional Development Policy Paper. March 1983.

9. Agency for International Development. Recurrent Costs Policy Paper. May 1982.
10. Schiavo-Campo, Salvatore and Hans Singer. Perspectives of Economic Development. Boston: Houghton-Mifflin, 1970.
11. Agency for International Development. Implementing A.I.D. Privatization Objectives. Policy Determination-14. PN-AAQ-167. June 16, 1986.
12. Ekblad, Robert. Elbowing out initiative. Nacla. Report on the Americas 22 (1), January-February 1988:34.
13. Cornia, Giovanni Andrea. Adjustment policies 1980-1985: Effects on child welfare, pp. 48-72 in Cornia, Giovanni Andrea, Richard Jolly, and Frances Stewart. Adjustment with a Human Face. Volume 1. Protecting the Vulnerable and Promoting Growth. Oxford: Clarendon Press, 1987.
14. Mosley, W.H. and R. Jolly. Health policy and programme options: Compensating for the negative effects of economic adjustment, pp. 218-231 in Cornia, Giovanni Andrea, Richard Jolly, and Frances Stewart. Adjustment with a Human Face. Volume 1. Protecting the Vulnerable and Promoting Growth. Oxford: Clarendon Press, 1987.

15. Huang, Yukon and Peter Nicholas. The Social Costs of Adjustment. CPD Discussion Paper No. 1987-8, The World Bank, March 1987.
16. World Bank. Education Policy Note. Policy Based Lending. May 13, 1987.
17. World Bank. Education in Sub-Saharan Africa. Policies for adjustment, revitalization, and expansion, 1988.
18. Johanson, R.K., W. Haddad, M. Hultin. Review of World Bank Lending Operations in Education and Training. Fiscal 1984-85. Discussion Paper. Education and Training Series. Report # EDT28, The World Bank, June 1986.
19. Auerhan, J., S. Ramakrishnan, R. Romain et al. Institutional Development in Education and Training in Sub-Saharan African Countries. Discussion Paper. Education and Training Series. Report # EDT22, The World Bank, November 1985.
20. Cornia, Giovanni Andrea, Richard Jolly, and Frances Stewart. Adjustment with a Human Face. Volume 1. Protecting the Vulnerable and Promoting Growth. Oxford: Clarendon Press, 1987.
21. United Nations Children's Fund (UNICEF). The State of the World's Children 1988. New York: Oxford University Press, 1988.

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Figure 1
PROJECT INVESTMENTS

<u>Perspectives</u>	<u>Internal/ Organizational</u>	<u>External/ Political</u>	<u>Measures</u>	<u>Constraints</u>
Donor:				
World Bank	Need to disburse funds	Accountability	Coverage, quantifiability (how many, how much, to whom); focus on target; Quality; Sustainability(8)	Cost control; accountability; Ideological agendas; Difficulty teasing out predictors(3);
AID	Staffing; Need to disburse funds	Match w/ nat'l agenda; Clarity of nat'l agenda;		Evaluability drives project
NGOs	Flexibility (3); Ease of management			
All	Bureaucratic structures	Conformity among donors(5)		
Recipient:				
Public Sector		Builds credibility or creates conflict; Builds dependency	Efficiency, coverage range of services(2); Human resources, infrastructure(8); Financial self- reliance(9)	Lack of power (3,5) Conflicts (urban-rural, primary-tertiary) (2); Ministry of Health capacity(2); Project interdependence(10)
Private Sector		Indirect effects from impact on public sector		Sufficiency of capacity(5)
Population	May involve & build commitment @ local level (4)	Popularity of targeting population needs	Poverty reduction(7); Involvement of women, local community(3,4,7)	Cultural & social relevance(3,5)

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Figure 2
PROGRAM INVESTMENTS

<u>Perspectives</u>	<u>Internal/ Organizational</u>	<u>External/ Political</u>	<u>Measures</u>	<u>Constraints</u>
Donor:				
World Bank	Reduces staffing & preparation needs(7)	More diffuse; Accountability; Long pipeline keeps disbursements distant(10);	Long & short run outcomes (4,7); Utility of policy analyses; Large investments drive economic output measures (5); Linkages among investments as they affect development policy(10);	Need donor coordination(7); Depth & accuracy of policy analyses(16,17); Need to focus on hard data(5); Inadequate methodologies(15); Donor size (10); Vulnerability of poor(15); Inadequate existing economic models(15); Misspecification of unit of analysis(15)
AID		Political agendas may drive program(5)		
NGOs	Flexibility(3,5); High costs(10)	Involves cooperation w/ other donors(14)		
Recipient:				
Public Sector	Strengthens management; Imposes efficiency(7); Service and wage cuts(7); Affects resource allocation (14)	Short-run weakening?	Adequacy of and access to services(15); Cost effectiveness(14); Maintenance of basic services(4)	Need to disentangle effects of recession & program(15); Differences in long & short term outcomes(4); Insufficient infrastructure(3)
Private Sector	Raises profits(7)	May generate leadership, commitment(14)	Same as above	Same as above
Population	Raises costs (4,7); Diminishes use(4)		Degree of community participation(3,4); Short & long term health & social indicators(4);	Need for community input & participation(3,4); In country planners elite, bureaucratic(5);

Figure 3
RESEARCH INVESTMENTS

Perspectives	Features		Measures	Constraints
	Internal/ Organizational	External/ Political		
Donor:				
World Bank	Short time horizon of bank lending; Builds donor institution	High good will value; Low conflict potential; High priority for health & education(4,18) Favors higher income borrowers(18) Ideology may determine investment	Short run: # of courses, # of trainees, enrollments; Long run: Sustainability, output; Cost effectiveness; Scientific product.	Complex--requires diverse interrelated inputs(19); Complexity of policy research requirements(18); Lack of feasibility analysis(18); Historical lack of success (7,8)
AID			As above.	
NGOs	Long term approach congenial; Close to organizational mission	Attractive to donors	As above.	
Recipient:				
Public Sector	Builds capacity; Needs institutional commitment	Can create power conflicts (19); May affect relations w/ private sector;	Manpower distribution; #s and types of institutions; Development of specialized organizations; Growth of infrastructure (19)	Personnel dependent; motivation, quality, skills Need access to resources & information(19); Need social/cultural appropriateness; Ability to sustain recurring costs(19); institutional weaknesses(19)
Private Sector	As above.	As above,	As above.	As above.
Population		Very indirect effects; May only reach elite	Social & cultural effects; Long term impacts.	Social & cultural acceptability(3,19)

Figure 2
PROGRAM INVESTMENTS cont'd

Epidemiologic &
surveillance data(4);
Serendipitous & spill-
over effects(14);
Social and cultural effects(4);
Quality of services(5)