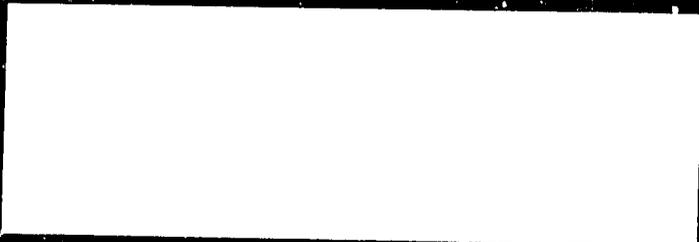
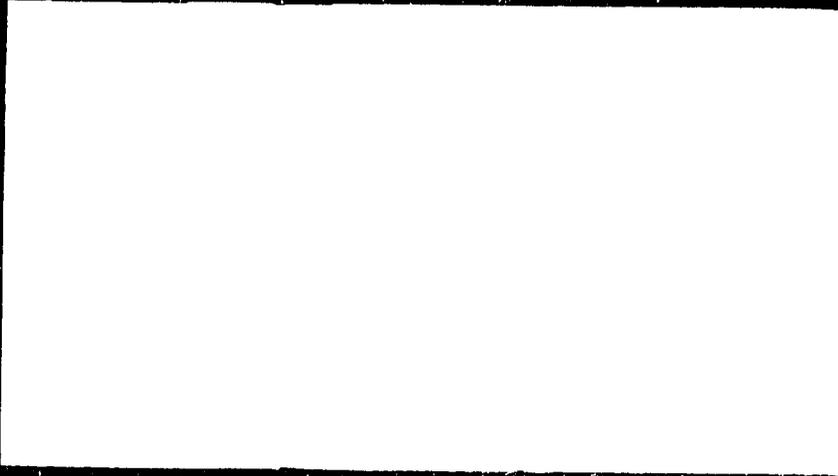


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**COST RECOVERY FOR CHILD SURVIVAL
PROGRAMS:**

Recommendations to Build Sustainable West
African Health Projects

Measures to Enhance the Sustainability of A.I.D.
Health Investments in West and Central Africa

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BUILDING SUSTAINABLE WEST AFRICAN HEALTH PROJECTS RECOMMENDATIONS

A four person team organized by University Research Corporation reviewed the status and prospects for donor-sponsored health projects in West Africa and made the following recommendations to A.I.D.'s Regional Economic Development Support Office in Abidjan. Team members included:

- Eckhard Kleinau, M.D., Harvard University
- Donald Shepard, Ph.D., Harvard University
- Wayne Stinson, Ph.D., University Research Corporation
- Ronald Vogel, Ph.D., University of Arizona.

This work was undertaken between December 1989 and August, 1990. In addition to this summary and recommendations, team members prepared a detailed strategy statement, profiles of health care financing in 20 West and Central African countries, and an annotated and computerized bibliography of 80 items. Copies of each may be obtained from URC. Items annotated for the bibliography will be retained by REDSO/WCA in a special library to be maintained for this purpose.

Recommendations are grouped below under the following topics:

- country selection
- project design
- project management
- social financing
- user fees
- operations research
- REDSO/WCA followup.

A. CONSIDER SUSTAINABILITY IN COUNTRY SELECTION

Principles

Severe economic and administrative constraints in West Africa make sustainable projects the exception rather than the rule. Sustainability prospects for child survival, family planning, and AIDS prevention generally rest on the Ministry of Health's ability and willingness to manage and finance them, in most cases leaving lesser roles to the private sector and to direct user payments. The Ministry of Health's ability depends greatly on policies and practices relating to user fees for curative care in hospitals and on its overall

managerial capacity, while its willingness reflects the degree to which politically influential constituencies perceive significant benefits from a given activity.

Recommendations

1. Sustainability should be a central criterion in selecting countries for A.I.D. assistance. A.I.D. should continue, of course, to work in countries where sustainability is doubtful, but it should be explicit in each case about its reasons for doing so.
2. Country Development Strategy Statements that suggest future A.I.D. health work should indicate whether benefits from proposed projects are likely to continue at least three years after major funding ends. If this goal is thought achievable, the Statement should analyze possible constraints and suggest a specific plan of action for overcoming them. This plan should include a series of mutually reinforcing A.I.D. activities lasting up to ten years. If sustainability is unlikely, Country Strategy Statements should cite and justify reasons for proceeding anyway. These might include satisfying some time-limited need, or a plan for very longterm donor assistance.

The remainder of this summary deals only with countries and projects where sustainability is an explicit objective.

3. Country assessment and/or project identification teams should include at least one specialist in sustainability analysis. At the initial assessment stage, it is more important that this person be experienced in project design, implementation, or evaluation in West Africa than that he or she be a technically trained financial analyst or economist.
4. In identifying potential projects, A.I.D. should attempt to address sustainability and financing issues sectorwide rather than solely in the context of child survival, family planning, and AIDS control. Projects of this nature address hospital activities as well as primary health care because sectorwide projects offer the greatest potential for both improved efficiency and cost recovery.

B. DESIGN SUSTAINABLE PROJECTS

Principles

While acknowledging sustainability, most project designs do not analyze constraints in detail nor plan for the policy changes and infrastructural development likely to be required. Both the process and the content of project designs influence sustainability. Projects promoting relationship with multiple government units, national institutions, and donors are more likely to be supported after A.I.D. funding diminishes than imposed projects and those not fully integrated into established program structures.

Recommendations

1. Project designs should explicitly state their sustainability goals, targets, and plans of action. While goals should reflect country resources and interests, project outputs should generally be expected to continue at least three years after major A.I.D. funding ends. Intermediate targets should be set for technical performance, local financing, and personnel development.

2. A.I.D. should choose a different strategy for countries with adequate resources to adopt more aggressive cost recovery and set higher targets for sustainability than for countries with little economic potential. Not only should the technological level of services be adjusted to the resources available, but A.I.D. officials should also accept the fact that some countries will require long run assistance beyond typical project durations of five years.

3. A.I.D. should encourage integration of child survival into curative services, especially primary care, and avoid absorbing scarce resources into vertical child survival programs.

4. Specific plans should be made for the three-year period after major A.I.D. funding ends, showing how project benefits will be maintained, if necessary through limited non-project assistance. Operations research and continuing education may especially require post-project aid. Contingencies should be established for projects which show reasonable success but which due to various constraints cannot be managed entirely by host country institutions.

5. Cost and financing analyses required for project design should be performed by an experienced financial analyst or economist.

6. Projects should be designed collaboratively with national officials, without imposition of A.I.D. strategies on reluctant host country personnel.

C. DEVELOP SUSTAINABLE MANAGERIAL SYSTEMS

Principles

Effective management and stable personnel are just as essential for sustainability as is financing. Particularly important are skills in financial and economic analysis, in management information systems, and in both the collection and management of user fees. Skills are required at both the national and regional levels, particularly where planning and financial management are decentralized. Both short (one to three month) and long term (one or two year) international courses are available, but participation in carefully selected workshops and conferences may be less disruptive. Training and technical assistance may be accessed through a variety of centrally funded contractors and universities.

Recommendations

1. USAID should strengthen the capacity of Ministries of Health to perform financial analyses. Technical assistance, training, as well as sending qualified interns to work in offices of NGOs or ministries, can all help facilitate this.

2. Where necessary, A.I.D. should pay to train Ministry of Health staff in economic and financial analysis. A.I.D. should try to finance more than one participant per institution to help create a critical mass of trained personnel. Supervisors should be required to commit themselves to use trainees' skills after their return.

3. Training of district and lower level staff is critical for the implementation of decentralized user fees and financial management. A.I.D. should support such training wherever feasible.

4. A.I.D. should provide technical assistance to improve financial management and cost recovery by incorporating performance indicators, cost and budget data into existing management information systems. They should help host country governments develop performance-based resource allocation.

5. In choosing consultants and contractors, A.I.D. should seek practical hands-on experience more than theoretical refinement. Formal training is offered through Boston University, Management Sciences for Health, and several universities in England, while consultants are available through the Health Care Financing and Sustainability Project and other mechanisms.

D. ENCOURAGE SOCIAL FINANCING FOR CHILD SURVIVAL, FAMILY PLANNING, AND AIDS CONTROL ACTIVITIES

Principles

Sustainability for preventive care, family planning, child survival, and AIDS control depends on government and other forms of social (as opposed to individual) financing. Fees may discourage use of preventive services, especially for women, children, and the poor, and in any case, resources available to A.I.D.'s target population will never suffice to fully cover recurrent costs. The success of A.I.D.'s sustainability strategy for West Africa depends on convincing governments and, in some cases, private-for-profit groups, to maintain project financing; it requires also that A.I.D. assist with policy changes and technical guidance so that governments and the private sector may generate the necessary resources.

Recommendations

1. Every project design should thoroughly analyze projected recurrent costs and require gradually increasing local financing. Where government funding is projected, analyses should specify the budget heading from which resources will be drawn and indicate the steps likely to be necessary to make the resources available. Contingencies should be spelled out for circumstances in which governments are unable to meet their commitments to assume local costs.

2. A.I.D. missions should conduct policy dialogues with ministries of health, finance, and planning, regarding the financial sustainability of health services. In many cases, other donors and international agencies - especially the World Bank and the International Monetary Fund - will have already introduced this subject. A.I.D. can help this process by:

- working with the Ministry of Health to develop a financial profile of the health sector
- supporting training in financial analysis
- helping ministries to quantify their needs as a result of new projects.

3. While emphasizing government or private institutional financing for child survival, family planning, and AIDS control, A.I.D. should, nevertheless, encourage cost recovery

at all levels of the health system, starting in hospitals. Governments should be reminded through policy dialogue, application of funding conditions, and specific technical assistance, that quality improvement and geographic expansion of services will be difficult without fee-derived revenue and the efficiency improvements that usually result.

4. Where necessary and desired, A.I.D. should provide technical assistance to enable governments to establish cost recovery strategies and procedures for the hospital sector.

5. While opportunities for health insurance are initially limited, A.I.D. should, nevertheless, keep abreast of possibilities and finance pilot schemes where they appear feasible. Facilities such as government referral hospitals or mission or private hospitals, which offer a good quality of care and have adequate administrative capacity, can be useful bases. Countries in West Africa that already have some useful examples, such as Zaire, should be encouraged to replicate these successes in other sites and to host visitors from other countries.

E. ENCOURAGE USER FEES AND SOCIAL MARKETING WHERE DEMAND FOR CARE IS ADEQUATELY ESTABLISHED

Principles

Though user fees cannot fully cover costs, they can usefully supplement other resources and create significant incentives for managerial efficiency. Demand for pharmaceutical products, injections and childbirth care is sufficiently established to permit private sales as well as small user charges at public facilities. Provided responsibility is decentralized, staff may be motivated to collect such fees and apply them for quality improvements and other local needs. There is growing experience in West Africa in cost recovery for child survival and family planning activities.

Recommendations

1. Cost recovery should be promoted even in child survival and family planning projects through user charges for ORS packets, contraceptive supplies, immunization cards, and pharmaceuticals. Most project designs should include technical assistance and operations research to promote this objective. Where necessary, policy research may be supported as well. Appropriate steps should be taken to reduce fees for those unable to pay and to avoid them altogether for activities with predominantly public (as contrasted with private) benefits.

2. The well-established demand for curative care and drugs should be used to finance prevention, by linking the two types of activities and encouraging cross-subsidization (i.e., the transfer of surpluses from profitable to underused services). Preventive and curative service should be managed together and fees raised on the curative side used to facilitate such transfers.

3. A.I.D. should actively encourage decentralization of revenue generation and financial management and thus motivate local personnel to manage scarce resources wisely. A.I.D. can further this process by conducting policy dialogues with governments, by requiring policy changes as a condition for grants, and by training mid-level staff.

4. A.I.D. should encourage the private sale of ORS packets and contraceptives through social marketing programs.

F. USE OPERATIONS RESEARCH TO GUIDE POLICY CHANGE

Principles

User fees are politically contentious in many countries and may produce a backlash if introduced without adequate trial and public explanation. Several years, perhaps up to a decade, may be required to change urban dwellers' expectation of subsidies and to work out acceptable prices, exemption policies, and financial management systems. Often, local personnel and political elites must discover facts themselves, even when international experience should suffice for key operational procedures.

Recommendations for operations research are consistent with the recent findings of a major international commission, which calls for building national research capacity, performing "essential national health research" to improve program operations (among other objectives), and expanding financing for health research (Commission on Health Research for Development. Health Research. New York: Oxford University Press, 1990)

Recommendations

1. A.I.D. should fund and encourage policy analyses and operations research to guide steady improvements in revenue generation, quality assurance, and management of health services. A.I.D. should explicitly discourage precipitous implementation of politically unpopular fees, or schemes that devolve responsibility to untrained personnel, until such schemes have been refined and tested through pilot studies.

2. In the area of revenue generation, operations research and policy studies may be particularly required to:

- analyze household willingness and ability to pay for specific health and child survival services, including family planning, other preventive care, pharmaceuticals, outpatient and inpatient hospital care
- determine the unit costs of each major type of health service at each type of facility
- set user fees based on the above
- test exemption procedures
- implement and evaluate pilot projects
- determine what forms of risk-sharing have been the most successfully implemented in low-income countries.

3. For improved management, we recommend studies to:

- analyze the cost-effectiveness of alternative supervision systems, transport methods for rural areas, drug procurement and distribution, immunization service delivery, health education techniques, and potential interventions for maternal health
- identify wastage in health facilities and develop better management to reduce losses
- analyze the feasibility of low cost procurement and supply systems for essential drugs
- understand why NGOs, such as church-mission facilities, have been so successful in: (a) achieving managerial efficiencies; (b) charging fees; (c) procuring pharmaceuticals; (d) providing what is perceived to be better quality of care than in government facilities.

4. Operations research will also be useful in improving the quality of family planning, child survival and AIDS prevention activities, and thus their potential for revenue generation. Studies may specifically be required to analyze the costs of improving quality of care.

G. REDSO/WCA SHOULD SERVE AS AN INFORMATION CLEARINGHOUSE AND SOURCE OF TECHNICAL GUIDANCE

Principles

Governments and A.I.D. missions in West and Central Africa need the benefit of each other's experiences as well as technical guidance to devise local plans of action. Continuous assistance from Abidjan is likely to be more effective than episodic visits by different U.S.-based personnel. Intensive followup work over the next several years will be needed to implement this strategy statement.

Recommendations

1. A.I.D. should organize a workshop where the results of this study can be presented and discussed with both U.S. and host country personnel from West and Central Africa. Country-specific strategies and plans of action with regard to sustainability should be developed during this workshop. Participants should also be introduced to the bibliographic data base. Similar workshops should be financed at the country level where appropriate.

2. REDSO/WCA should maintain and update both the country profiles and the bibliographic data base developed through this work order. Missions staff should be encouraged to request both literature searches and reprints on specific subjects, and REDSO/WCA should ensure that it has the capacity to respond.

MEASURES TO ENHANCE THE SUSTAINABILITY OF A.I.D. HEALTH INVESTMENTS IN WEST AND CENTRAL AFRICA

The goal of the A.I.D. Regional Economic Development Support Office (REDSO/WCA) is to ensure the sustainability of family planning, child survival, and AIDS control activities initiated in West and Central Africa through A.I.D. project assistance. REDSO/WCA also seeks to make health care affordable and geographically accessible to the poorest of the poor in the countries in which it supports projects. Sustainability, affordability, and accessibility are A.I.D.'s overall health development goals as well as the goals of this strategy statement.

To achieve sustainability for the relatively low cost services that it supports, A.I.D. must:

- build host-country commitment from the start through collaborative design, implementation, and evaluation, and through effective integration within established program structures
- develop strong and demonstrably effective technical and managerial systems
- train host-country staff at all levels and encourage continuity of senior managers
- help governments, communities, and private institutions develop sustainable financing systems based on increased government allocations for primary health care and limited (but significant) cost recovery from users
- create lasting changes in family health behavior.

Increased host-country financing of primary health care, together with expanded private care, are essential preconditions to sustainability, accessibility and equity. This financing should derive from multiple sources, including public taxation, employment-based or other insurance, and direct user payments. The latter, while helping to defray costs, should not be seen as the most important potential financing source for A.I.D.-supported population groups or for child survival/family planning services. A central goal of A.I.D.'s sustainability strategy for West and Central Africa is, thus, to convince political leaders and government officials that primary health care programs merit longterm government financing.

This strategy statement concentrates on financing aspects of sustainability through enhancement of government commitment to primary health care and through such new sources as user payments, employment-based health insurance, other prepayment schemes, and community financing. The statement highlights: (a) policy issues to be discussed with governments, (b) issues to be addressed in the design of new A.I.D. projects, and (c) other followup recommendations for both REDSO and A.I.D. mission staff.

Specifically, this statement recommends:

- realistic goals for A.I.D.-sponsored health sector cost recovery in West Africa
- basic strategies and methods of approach that A.I.D. should pursue in the region

- types of health financing and sector development actions that A.I.D. mission staff should promote at the country level
- actions that REDSO staff and consultants should take to assist A.I.D. missions.

I. ASSESS SUSTAINABILITY PROSPECTS DURING COUNTRY APPRAISALS AND PROJECT IDENTIFICATION

A.I.D. should concentrate its assistance in countries where sustainability of project activities and benefits is either likely or reasonably achievable through project inputs. Sustainability prospects should thus figure highly in both country appraisals and project identification. Factors affecting potential sustainability should also be regularly assessed during the life of projects.

A. Country Appraisals

Prospective sustainability assessments should review government policies and operational practices regarding:

- financing of child survival, family planning, and AIDS prevention services
- the role of the private sector in service delivery
- pharmaceutical procurement, distribution, and financing
- personnel hiring, promotion, transfer, and remuneration
- user fees in government hospitals and primary health care facilities.

Country strategies will review and assess critical macro-economic, policy, and infrastructural assumptions affecting sustainability as well as the role of other A.I.D. projects and international donors in policy coordination and implementation. Findings from these analyses should influence both policy dialogue with potential implementing agencies and the types of possible A.I.D. projects that are eventually identified.

A suggested scope of work for financing appraisals is included in Appendix A.

B. Policy Dialogue

Country appraisal missions should initiate policy dialogue with governments as a means of identifying the appropriateness of A.I.D. assistance. A.I.D.'s ability to influence negative policies may be greatest prior to project commitment. The themes emphasized below should be discussed throughout implementation as well.

Most countries spend a predominant share of their health resources on curative care and urban hospitals, while A.I.D. emphasizes low cost and potentially more effective child survival, family planning, and AIDS prevention measures. Substantial policy dialogue is often needed to convince policymakers of the feasibility, effectiveness, and acceptability of non-traditional interventions, and sustainability prospects are enhanced if this conviction is well-established before project design. Measures to encourage it may include:

- sharing of experiences in similar settings (facilitated by the REDSO resources center)
- computerized demographic and effectiveness projections based on country-specific data
- support for small-scale pilot studies or analyses of existing data
- brief study tours for key personnel.

Finance ministries often determine long-term project financing and must be involved early on.

A.I.D. staff should encourage the availability and continuity of key host country staff as a fundamental condition for sustainability. While continuity cannot be assured, many project designs require the appointment of qualified counterpart staff as a "condition precedent" for disbursement of funds. Regarding financing and cost recovery, a number of principles should be reiterated:

1. Promote government financing for child survival, family planning, and AIDS prevention services

A.I.D.'s policy is to encourage maximum feasible government financing for services with significant social benefit, while also seeking reasonable user cost-sharing. The tactics for achieving this goal are to convince policy makers of the feasibility, effectiveness, and public demand for new services, and to extend modest technical assistance for reducing costs and improving revenue generation in the high cost hospital sector. Policy dialogue, while supporting the need for user cost sharing (especially for drugs and curative care), must reinforce the centrality of longterm government financing for most A.I.D.-supported staff and commodities.

2. Promote User Charges for Services with Significant Personal Benefits

Users everywhere (including in West Africa) have long demonstrated willingness to pay for what they consider high quality curative care, including drugs, injections, and tradition-based healing. Direct payments are made for goods and services and for transport to providers, and indirect costs incurred through income foregone while seeking care. Willingness to pay has been strongest for goods and services bringing immediate personal benefit. While ability to pay has been less evenly distributed, few governments have made adequate use of the beneficiary payments that could be readily available.

A.I.D. mission and regional staff should promote cost recovery concepts through policy dialogue and research, through project design processes, and through application, where appropriate, of grant "conditions" to encourage specific government actions.

Political support for "free" health care remains strong in West Africa, making it difficult for governments to abandon long standing promises and institute user charges. Analyses in most countries, nevertheless, show that:

- Promises of "free" health care made at Independence cannot be achieved and are delusory; in practice, "free" health care disproportionately reaches only better off city-

dwellers.

- Donor and government commitment to equity and efficiency in health care requires new resources. Governments will only sustain A.I.D.-sponsored Child Survival programs if they generate new funds or reduce the high costs of hospitals. New tax-based resources are highly unlikely.
- Cost recovery enhances quality of care, by increasing staff motivation, financing dependable drug supply, and forcing service providers to respond to user needs.
- Sensitively administered cost recovery also enhances equity by financing service extension to underserved populations.
- Direct charges increase efficiency, by reducing unnecessary use of services and drugs and encouraging use of lower level facilities.
- People worldwide already pay substantially for health care - through private drug purchases, through hidden fees at government centers, through use of private healers and doctors, through transport charges, and through worktime lost in queues. User fees often reduce real costs and increase utilization by ensuring drug and service availability at convenient locations.

3. Promote Change Systemwide, Starting with Hospitals

Inequity and inefficiency in health care are most evident in hospitals, and this is where effective cost reduction and recovery should start. Hospital services, while obviously necessary, disproportionately serve better-off city dwellers, and divert scarce public resources from primary care and prevention. Most governments are already committed to hospital fees but neither adjust them regularly for inflation nor collect them effectively. Willingness to pay for hospitals is well-established, and many users have the resources to pay much more than they now do.

A.I.D. only rarely works at the hospital level but can make effective hospital fee collection a condition for A.I.D. financing of Child Survival activities. The rationale for this is that governments will not be able to sustain Child Survival programs unless they are able to reduce costs and generate revenue from higher cost activities. A.I.D. may also encourage hospital cost recovery by helping ministries of health develop reform plans and by extending limited technical assistance to strengthen fee collection. Donor collaboration is essential where A.I.D. itself lacks direct influence on the hospital sector.

All mission staff, including on occasion the ambassador, should participate as needed in policy discussions with the government.

C. Prioritizing Assistance Needs

The feasibility and constraints of longterm sustainability should figure highly in project identification and design, especially in countries where continuation of A.I.D.-initiated activities may be in question. Key issues include the types of projects to be developed and selection of implementing agencies.

1. Encourage Sector Development Projects Where Feasible

A.I.D. project inputs may be most sustainable over the longterm in the context of comprehensive health sector reform, including both cost reduction/recovery and technical improvements in the hospital sector. Projects of this type require major technical and financial resources as well as day-to-day "hands-on" mission support, but may be feasible where these are available and where A.I.D. has a history of effective collaboration with government. Elsewhere, A.I.D. should collaborate with the World Bank and African Development Bank to encourage effective linkage of project activities with broader health sector reform.

2. Include Cost Reduction Elements in Every Project Design

Cost reduction and more effective use of existing funds is just as essential to sustainability and expansion as is cost recovery. A.I.D. staff should employ operations research and technical assistance to identify and reduce internal program costs, while conducting policy dialogue to encourage reallocation of funds to the most efficient uses.

Specific actions to improve efficiency may include:

- Measures to reduce drug costs: e.g., competitive bulk procurement of generic drugs, restriction on high cost and/or ineffective treatments, support for essential drug programs
- Measures to reduce inappropriate drug use: e.g., development of standard diagnostic and treatment regimens, drug education for users and providers, treatment "audits", etc.
- Measures to reduce inappropriate use of services: e.g., minimum charges for all curative care, price incentives to attract users to lower cost facilities
- Measures to improve hospital efficiency: e.g., reduction of non-health personnel, referral systems to increase appropriate use of lower-level facilities
- Efforts to redirect government spending from hospitals to primary prevention and treatment.

3. Encourage Others to Develop Revolving Drug Funds; Provide Selective A.I.D. Assistance Only Where Prospects for Success Are Good

Properly established and managed, revolving drug funds have great potential for both reducing pharmaceutical inefficiencies and recovering one of the most significant costs of health delivery. Demand for drugs is well-established and helps pull supplies through otherwise non-functioning logistics systems. Drugs have concrete value and can be more easily priced than services; in commercial societies, potential commodity and revenue managers may be relatively easy to find. As UNICEF has found in implementing its Bamako Initiative, revolving drug funds may also form the centerpiece for community participation.

Revolving drug funds can be extremely useful adjuncts to system development and management improvements of this nature, but for cost recovery alone they may be problematic. Depending on project objectives, the management effort to start and sustain revolving drug funds may be either worthwhile or a diversion from more crucial activities. A.I.D. should collaborate respectfully with government and donor officials involved in the Bamako Initiative and other revolving funds but should limit direct involvement to projects with a significant logistics management or essential drugs focus.

4. Include Health System Support Within District Development Projects

An adjunct to reallocation of central revenue in many countries may be the strengthening of decentralized revenue generation and management capacity, both within the health sector and beyond. This may be particularly critical for certain child survival interventions and for primary health care generally. Multi-sectoral, geographically-focussed projects may be particularly useful for increasing local tax generation and cost recovery efforts and for convincing local leaders to spend an appropriate portion of revenue on locally managed child survival, family planning, and AIDS prevention activities.

5. Support Private Sector Initiatives

Private health care practitioners have a long tradition of self-financing, while drug sellers provide a badly needed service in areas which the government cannot effectively reach. One of the most effective means of strengthening health sector financing and quality of care is to develop more appropriate private roles while focussing scarce governmental resources on those requiring public support. Care must, nevertheless, be taken to ensure that private sector services and drug sales meet appropriate standards and are not unintentionally subsidized.

Private sector activities which may merit A.I.D. support include:

- social marketing of contraceptives, oral rehydration salts, vitamin A capsules and perhaps other health commodities
- employment-based health care, including direct service provision, AIDS and family planning education, and insurance schemes
- encouragement for the private provision of family planning and child survival services, especially to underserved populations
- privatization of certain MOH functions.

D. Implementing Agencies

An essential aspect of every country appraisal is to identify potential implementing agencies for A.I.D. assistance and to assess their degree of commitment to project goals and to principles of equity, efficiency, and cost recovery. Pro forma statements of interest and/or commitment are less useful for this than proven track records.

A.I.D. should generally not create institutions de novo or even new units within existing structures, but should implement projects through well-established and integrated bodies wherever possible. Experience also indicates that efforts to generate future

commitments (where current interest is mainly rhetorical) are risky and can prove counter-productive when A.I.D. project assistance ends. Project design missions should therefore concentrate on potential implementing agencies that are integrated into established structures and that have a proven commitment to A.I.D. objectives. Senior representatives of these institutions should participate in all feasible aspects of pre-project appraisal. The quality of technical and managerial systems within these institutions should figure in preliminary assessments as well, with few assumptions made about A.I.D.'s ability to develop personnel and practices where these do not currently exist. Weak institutions implement weak projects and rarely sustain them afterwards, and A.I.D.-induced institutional development is a costly and infrequently successful endeavor. Preliminary assessment of institutional and administrative strengths should reflect suggestions made in A.I.D. project design handbooks.

II. DESIGN SUSTAINABLE PROJECTS

To promote sustainability, design teams for new and extended projects should:

- consider sustainability as well as equity and other factors in selecting new project countries
- secure governmental support/commitment from the start by planning activities collaboratively
- consider potential private sector roles in service delivery and supply systems
- require identification and placement of key officials as well as early policy statements (if needed) for each major project intervention
- integrate project-related service delivery and support activities into the established governmental authority structure from central to local levels, and
- emphasize simple, low cost, interventions, with appropriate technology and maximum feasible use of existing resources and processes.

It is important for potential project implementors to participate in project design and negotiation. The more they are "on-board" the more likely they will be a constituency to support project continuation. If a broad constituency sees the project as the result of a mutually respectful process of give-and-take and not A.I.D.-imposed, then they are more likely to want to implement and continue A.I.D.-supported activities. In addition, the participation of implementors in the project design makes it more likely that obstacles to implementation will be considered and that a more effective project will emerge -- effective projects are also more sustainable.

Every project design should incorporate sustainability targets and actions, to be reviewed (and possibly revised) annually. Detailed workplans will identify actions required to achieve sustainability, the individuals and agencies responsible, and indicators by which achievement will be measured. Targets are particularly appropriate for:

- building local capacity in all aspects of program implementation
- gradually transferring financial and managerial

- responsibility to national authorities
- decentralizing training and management functions
- encouraging appropriate private sector initiatives
- piloting alternative financing schemes
- broadening governmental financial sources.

A. Analyze Project Costs

Financial sustainability (defined here to exclude further donor funding of local currency costs) depends on the affordability of project costs, the efficiency of general and financial management, and the willingness and ability of governments, users and other groups to assume responsibility. A.I.D., though only one part of a complex health care financing picture, will design and implement financially sustainable projects while, nevertheless, promoting equitable access to Child Survival interventions.

To promote financial sustainability, every new and continuing project will have a financing plan, which will be reviewed and updated annually. This plan will:

- analyze direct project-related costs
- distinguish recurrent (including capital replacement) from development costs
- distinguish local currency from foreign exchange costs
- identify current and future sources of finance for each cost
- provide for specific actions to achieve funding targets
- specify assumptions about macro health sector financing and analyze their appropriateness, and
- specify steps to be taken to ensure adequate supportive funding by other donors.

Designs will identify all resources needed to sustain project benefits during the project lifetime and for an initial period of three years after termination. Resources to be provided by the government, by other donors, or through community contributions will be included. Specific financing sources, both current and future, will be identified, amounts to be provided quantified, and the degree of certainty of funding indicated.

B. Strengthen Financial Analyses

Systems will be established for planning and monitoring project-related expenditures by both the government and private sources. Relevant data will be included in routine management information systems. Appropriate national and regional staff will be taught to effectively manage financial resources.

Project agreements will require gradually increasing governmental and/or private assumption of local currency recurrent costs. Project staff will meet this requirement by:

- increasing and/or reallocating government expenditures for Child Survival activities
- encouraging existing insurance schemes to cover preventive Child Survival interventions as well as the creation of new insurance schemes

- examining the equity implications and cost recovery potential of possible user charges
- where appropriate, promoting policy changes to permit or require user payments
- conducting studies to set commodity prices and/or user fees and to develop policies for the indigent
- experimenting with specific fee-for-service or community financing schemes
- encouraging local retention of clinic fees and use of them for health services, and
- collaborating with other projects and donors to reduce broader health sector financing constraints.

It is critical that both donors and national officials have an accurate assessment of the new operating costs occasioned by a proposed project, and the expected means to finance them. This knowledge will help planners to identify the amount of resources required to operate the project and to plan for ways to find them.

A.I.D. can help ministries of health to strengthen their capacity for financial analyses through the following steps: (1) offering tools for financial analysis of a project or of the health sector as a whole. For the latter, two models developed by the World Bank may be of use -- one by Barnum, Shepard, and Kleinau (still in testing) and the other, now published, by Manuel Zymelman. Simple Lotus spreadsheets designed by the user may also be helpful. In addition, technical assistance and training are needed to build the necessary skills.

C. Design Cost Sharing Elements

A.I.D. designers should seek modest cost recovery in every project. A reasonable goal for most child survival and family planning projects may be for users to cover 50% of operating costs other than salaries. Depending on local conditions, service providers may charge for pharmaceutical supplies, contraceptives, oral rehydration salts, prenatal and delivery care, and immunizations. Communities may generate cash and other resources for these services and for environmental activities, health education, and such support activities as supervision and training. Employers may be convinced to pay for all aspects of both preventive and curative care. The potential for such cost recovery efforts is rarely fully exploited and should be analyzed during project design.

Plans for longterm sustainability must not rest excessively on direct user charges, however, particularly in rural areas and for goods and services for which demand is only weakly established. In many cases, greater resources may have to be expended to generate and manage beneficiary contributions than might actually be generated. Cost sharing should be particularly promoted as a means to improve efficiency (e.g., by "pulling" drugs into rural areas, to encourage completion of an immunization series, or to reduce non-essential utilization), or as a way to pay for local quality improvements.

Direct cost recovery, defined as user or third party payment for health care, takes many forms, including:

out-of-pocket user payments to health care providers and drug sellers

- community-organized financing for drug supplies, worker salaries, facility construction, and other local costs
- "health cards," employment-based insurance and other forms of prepayment, and direct employer service provision
- ad hoc fund raising through private contributions, special appeals, and so forth.

A.I.D. mission and REDSO staff play significant roles in creating demand for cost recovery and in following through on project designs, but unless experienced they should seek expert assistance for the technical details of method selection, price setting, and revenue collection and management methods. The discussion that follows suggests directions and options but should not be construed as a manual.

1. Levy Direct User Charges for Most Curative Care and Drugs; Subsidize Prevention

Personal curative care, such as the care of a broken arm, most closely resembles a private sector service and, thus, most easily lends itself to bearing a charge. On the other hand, such general preventive services as the draining of a swamp to eradicate malaria more closely approximates a pure public type of service and can only be financed through general taxation. In between these two extremes, there lies a whole range of health care services that government health facilities provide. One general rule of thumb that church mission facilities that have been highly successful in cost recovery use is to price those services that are in the greatest individual demand at the highest possible level for those who can afford to pay.

Thus, drugs are always in great demand, and people are willing to pay at-cost prices for them, when they are available. Parents think, on the other hand, that preventive care for children can always be put off for another day, making it unwise to charge fees for such services. Charges for hospital care can be more readily collected and can bear higher prices than can many forms of outpatient care.

In setting user fees, policy makers have several objectives: (1) to raise revenue; (2) to reduce unnecessary use of services; (3) to strengthen management by providing appropriate incentives; and (4) to improve the quality of services. These objectives are best achieved through structuring user fees in the following ways:

First, policy makers should assure that a substantial part of the revenues obtained through user fees are retained at the facilities that provide the services. In mission facilities throughout West Africa, this practice applied. In government facilities in Zaire, where decision making is decentralized to the zone level, hospitals did retain their own revenues. Revenues of health centers remained within the health zone (a small area with 100,000 population), but sometimes was shared with other health centers in the zone. These factors contributed to the ability of mission health facilities to recover 60% or more of their costs from users. A health sector reform in Kenya proposed a formal sharing system for revenues in government facilities, with at least half the revenues to be retained by facilities.

Second, user fees should be graduated to be lowest for services which have the highest priority for public health, and highest for those services for which private demand is relatively high. In general, this policy means that child survival services should not be burdened with high user fees. In many countries, vaccinations are offered free of charge

to the user. In Zaire, where additional revenues are needed, vaccination cards are sold for \$0.25 to \$0.50. The card provides a ticket for the full series of vaccinations. The fee offers some revenue for covering the costs of administering the vaccine (even though the vaccine itself is generally donated) and apparently is not so high to be a serious deterrent. While the country's level of vaccination coverage (50% of children under 1 fully vaccinated) is not as high as in some other African countries, logistical problems, rather than fees, are the primary constraint. Fees for curative inpatient services, on the other hand, approach their full cost (e.g., about \$20 for a typical admission in a rural Zaire hospital).

Third, staff should be offered a share of user fees as a motivation. In Cameroon, patients pay a consultation fee of about \$0.50 to be seen by a physician in an outpatient department. The physician is given part of this fee. Practices like these can be institutionalized to encourage staff to be more productive and more responsive to patients.

Last, mechanisms should be set up to assure that health facilities can make purchases locally with revenues that they retain. In this way, drugs can be purchased to circumvent shortages and delays that sometimes arise with national facilities.

2. Give Only Cautious Support to Community-Managed Financing

Communities do and should have significant roles in Child Survival management and financing, but the effort required to achieve it is inevitably substantial. A.I.D. should respect efforts to mobilize communities, particularly through the Bamako Initiative, but should devote significant resources to community financing only after realistic pilot projects have demonstrated that replication is feasible.

3. Promote District Financing

District governments in many countries have been made responsible for many local costs, but most lack understanding of health priorities or ability to manage revenue effectively. A.I.D. project designs may provide for measures to sensitize district leaders to health needs modest technical assistance for financial management

4. Encourage Social Financing, Including Insurance and Other Prepayment Schemes

Health insurance is generally not a reform specific to child survival services, though it may aid those services. It is most appropriate when the following conditions hold:

First, there must be an adequate quality of services. If services are already being heavily used, then the population probably feels that quality is adequate. Many mission hospitals or referral government hospitals can be useful sites for beginning insurance.

Second, there must be adequate administrative capacity to operate existing health services. Insurance adds to administrative complexity; the required capacity in both trained people and systems must be present.

Third, a financial guarantor must be present when insurance is initiated to reinsure its first year. Subscribers to a new insurance system must be assured that an institution in which they have confidence will guarantee that the insured services will be provided as promised.

Fourth, sensitization and marketing are needed to assure that the public understands and will be inclined to enroll in a proposed insurance system.

The design of an insurance system requires care. Well designated systems can and do increase access to care and the financial viability of the sponsor. Less thoughtful plans attract few members if they are too expensive for the services offered; or they become insolvent, if they attract only the sickest persons. Poorly designed obligatory schemes, such as some social security systems, simply become another tax from which the population receives little benefit.

Decentralization of management authority to hospitals, health centers, and district offices (the offices that oversee health centers) can strengthen management. As mentioned previously, health facilities or these district offices should have the authority to retain the revenues they collect from users, be able to spend the money on operations, and to distribute a portion to staff as a bonus. An accounting mechanism is needed to report these transactions.

III. IMPLEMENT SUSTAINABLE PROJECTS

Project implementation will be guided by generally accepted primary health care principles and will be coordinated to the maximum feasible extent with existing WHO, government and donor policies and procedures. Activities will be implemented in ways that enhance sustainability as well as effectiveness. Specific attention will be given to:

- sustaining technical effectiveness
- creating and sustaining national leadership and commitment
- enhancing, and sustaining management capacity
- promoting financial sustainability, and
- institutionalizing behavioral change and demand for health services.

In some cases, minor technical compromises may be required so as to reduce costs or demands on scarce personnel, and to increase consistency with existing systems and policies. Shortcuts, salary supplements, and other deviations from standard practice will be discouraged if not sustainable.

A. Sustain technical effectiveness:

The effectiveness of technical interventions in reducing childhood morbidity and mortality is both a prerequisite for and an essential outcome of this sustainability strategy. Effectiveness results from appropriate selection and implementation of disease reduction strategies, from rapid identification and creative solution of problems, and from development and retention of skilled professional and non-professional personpower. It also requires ongoing access to international expertise and professional bodies. Early demonstration of technical effectiveness is essential to convince both implementors and users that activities are worth sustaining. Support strategies for health and management information, supervision, training, and operational research play critical roles in sustaining technical effectiveness.

B. Create and sustain national leadership and commitment:

National leadership and commitment is essential to ensure that A.I.D. activities are continued with energy and creativity as direct assistance diminishes. This commitment is best expressed through:

- appointment of technically competent and responsible program coordinators
- official policies supporting Child Survival goals and activities
- necessary legal and regulatory changes
- adequate staff and vehicle allocations
- active encouragement for health education, management information systems, operational research and other key Child Survival support strategies
- replication of project interventions in non-project areas, and
- gradual assumption of recurrent costs by government and private sources.

Experience suggests that governments are more likely to commit themselves to activities that are fully integrated into existing programs and structures and not seen as a separate donor project. Activities developed through mutual agreement and joint planning may be better sustained than those that are perceived to be imposed. The demonstrable effectiveness of Child Survival interventions, as discussed above, may be critical in generating political and financial support. Professional consensus enhances commitment and is promoted by WHO policy statements, donor policy coordination, and consistent technical direction.

To promote leadership and commitment, project staff will develop and adopt national policies for each technical intervention and appoint program coordinators. Local organizations will be assisted to take over planning and implementation functions as rapidly as they are able to handle them. Local technical personnel will be used whenever appropriate, even in some cases where they may be formally less qualified than external sources. Where possible, national program coordinators will manage internal evaluation tasks.

C. Enhance and sustain management capacity:

Weak management capacity, rather than lack of funds, may be the most critical barrier to the sustainability of immunization programs and certain other Child Survival interventions. Inadequate personnel incentives and motivation gravely affect current performance and future sustainability. Even when leadership commitment is strong, programs are unlikely to survive without effective and efficient systems for health and management information, planning, budgeting, accounting, supervision and personnel.

Organizations in which both authority and resources are decentralized to field levels respond more readily to changing local circumstances. Private sector organizations may also be more responsive to changing field conditions and user preferences than are

public ones. Locally directed and managed operational research contributes significantly to management capacity and responsiveness to change.

Project officials will develop competent, flexible and self-renewing management structures and processes by:

- preparing annual and multiyear implementation plans for major technical interventions and support strategies
- training appropriate national and regional personnel in supervision, financing, health education, logistics, planning and other support functions
- implementing management information systems
- building institutional capacity for problem identification and solution
- decentralizing decision-making authority and capacity
- encouraging other efforts to strengthen planning capacity, personnel systems, and other critical management activities.

D. Promote Financial Sustainability

1. Emphasize Financial Management as well as Appropriate Pricing

West Africa features many ineffective cost recovery policies, due to inappropriate pricing, poorly implemented exemption procedures, and lack of staff incentives for revenue collection and management. Large price hikes can be avoided, and significant new services supported, if management principles are more effectively applied.

Use Prices to Motivate Appropriate Use: In the typical West African country, the central hospital or hospitals are usually working at more than 100 percent capacity, while regional and district hospitals work at levels below capacity. Health centers and posts usually operate well below capacity. Part of the reason for this anomaly is that lower-level facilities usually lack pharmaceuticals and skilled personnel. However, another reason that central facilities are overused is that there are no price signals in the system, so that care is costless to the patient wherever the patient goes. If a system of prices were to be established so that prices would become progressively higher as the patient moves upward within the health-care system (except upon having been referred from a lower-level facility), the patient would clearly have a stronger financial incentive to use lower-level facilities first, and then be referred upward. The system of prices would even out demand at all levels. Of course, this pricing policy must also be accompanied by MOH measures to make sure that lower-level facilities have more drugs and skilled personnel.

Adjust Prices for Inflation: Once a price structure that strengthens the referral system is in place, it is highly important that the prices be adjusted periodically in order to reflect increases in the general price level and for labor and supplies, particularly for increases in the cost of drugs. One of the basic components of a cost recovery policy is to make an effort at establishing a revolving fund for drugs. If drug prices do not reflect some of the increase in the cost of drugs, to that extent will the revolving fund not be sustainable. Likewise, if price increases in the health sector do not reflect some of the general inflation within the national economy, they will diminish the ability to collect increased

revenue to be spent upon the poor and will cease to be effective over time in motivating appropriate use of the referral system.

Enforce Exemption Policies Fairly: Recent studies have shown that much of the cost recovery practiced in West Africa unfairly exempts many persons who could reasonably be expected to pay for some of their own health care. Such persons include civil servants, military personnel, and children and students from upper and middle-income families. In one or two countries, as many as 60 to 70 percent of those in hospitals as patients are exempted from payment. Not only do such exemption policies severely dilute the revenue-generation potential of cost recovery, but they also lead to the perception among the general public that selective enforcement of the pricing policy is taking place and that evasion of the pricing policy is more acceptable socially.

Decentralize to Motivate Staff: One of the major goals of cost recovery is to mobilize additional financial resources that can be spent upon the poor at lower level facilities. Experts in health finance agree that hospitals offer the greatest potential source of cost recovery revenue. However, in order to motivate hospital personnel to collect, and patients to pay, it is important that part of the revenue collected remain at the collecting facility. In that way, hospital personnel will have the motivation and the funds to spend at their professional discretion for the improvement of the quality of care. Because hospital personnel are in closer touch with the needs and desires of the people who use the hospitals, one would expect that the expenditure decisions would foster a greater willingness to pay on the part of the clientele and would be more cost-effective.

Good Administration: Recent cost recovery experiences in West Africa show that considerable leakage can occur if revenue collectors are not trained and a system of accountability established. Therefore, it is important to implement protocols for hospital revenue collection and the use of receipt books, and to assure the financial literacy of persons charged with revenue collection. Receipt books should be audited periodically against financial ledgers, and the flow of funds from hospitals to Ministry of Health to lower level facilities thoroughly documented. Exemption policies should be implemented at the site of fee collection.

2. Ensure Full Public Support for User Charges

Relations with the public are mainly the government's responsibility yet may be affected by A.I.D. recommendations. Misunderstanding or opposition to user charges threaten project financing but can be avoided by listening to user opinions, conducting public education, and monitoring the effects of new fees.

Perhaps most important is to ensure that users receive value for money.

Improve Quality of Care: People willingly pay for quality care but avoid even free services when they expect inadequate treatment. In primary health care, quality is equated with drug availability plus trust in worker competence. These in turn require effective logistics systems and regular contact with outside health specialists through supervision and training. Cost recovery necessitates improved systems - but it also generates the resources to pay for them.

To ensure improved service, A.I.D. staff should insist that a significant portion of new revenue be directly and visibly applied to local health services. They should also devise methods for monitoring quality of care using standard indicators. A portion of new

revenue may also be used for performance-based worker incentives, as in Benin (see country profile).

Monitor Both Negative and Positive Effects of Cost Recovery: A.I.D. should ensure that governments have adequate technical and financial resources to monitor the effects of new fees. Technical assistance in operations research and/or evaluation should be offered as needed.

Effects to observe may be both positive and negative. On the negative side, fees may reduce necessary utilization: accessibility for the poor, use of preventive services, and completion of therapeutic regimens. On the positive side, new revenues may permit quality improvements, increased utilization of certain services, and geographic expansion.

3. Ensure that New Funds Are Used to Promote Equity and Efficiency

Effective financial management requires hard heads and relatively tight operating principles - but it also requires local responsibility and sensitivity to the needs of the poor and those unwilling to pay for preventive care. The balance between revenue management and public control may be critical to viability.

A.I.D.'s objective in supporting cost recovery is to promote equity and efficiency, not to maximize monetary income, and policy dialogue, technical assistance, and operations research may be needed to ensure that these benefits occur.

An essential use of new revenue is the subsidization of health care for those truly unable to contribute. In some countries, these include whole geographic regions, while almost everywhere there is a significant minority unable to do so. Even in relatively wealthy societies, women may lack access to their husband's income (or even their own!) and may be unable to pay for themselves or their children. Every financing scheme needs a carefully devised (and costed) exemptions policy to ensure two things: full legitimate access by those lacking the means to pay, but also adequate resources to ensure financial sustainability.

Policy dialogue should begin early to ensure that a significant portion of new revenue derived from curative care (especially in hospitals) should be allocated to geographic service expansion and preventive care.

E. Institutionalize behavior change and demand

The effectiveness of immunization, diarrheal disease control, and malaria activities depends on caretakers' willingness and ability to take appropriate action in the home and to bring children to services when they are required. Public support for immunizations has sustained accelerated efforts through civil wars and economic collapse. Strong user demand for ORS and chloroquine sustains private sector supply systems and in some cases generates additional income for health workers. Research suggests that behavioral change is more likely to be sustained once 35% of the population adopts new practices.

Project staff will enhance the sustainability of behavioral change and household demand by:

- ensuring that senior staff understand the importance of health education and demand creation
- developing health education units with adequate funding within Ministry of Health
- encouraging program staff to contract with qualified private sector media design and production groups
- developing capacity at both the central and regional levels for (1) formative research, (2) use of mass media, (3) training of health workers in health education techniques, (4) community organization and development, and (5) material development
- providing technical and, if necessary, financial support, to ensure that key messages are maintained after project termination, and
- integrating health education into each technical intervention.

Demand will be further augmented by better adapting clinic schedules and operations to women's daily and seasonal activity patterns and responsibilities. New knowledge and practices will be sustained through the repetition of messages and the availability of recommended services.

IV. MONITOR AND EVALUATE PROGRESS

Progress toward sustainability will be routinely assessed through:

- periodic discussions with the government
- annual reports to REDSO/WCA
- internal evaluations by national program coordinators and A.I.D. staff, and
- external evaluations.

A. Evaluations of technical effectiveness, in addition to looking at standard performance indicators, will assess the program's ability to maintain and expand achievement levels after A.I.D. assistance ends. Qualitative indicators include ability to identify and respond to changing technical requirements, access to new ideas through professional bodies, literature and further technical assistance, and the quality and job stability of key staff. The degree to which donors and others have adopted consistent technical approaches will also be examined.

B. The degree of national leadership and commitment will be a major evaluation concern during the early project years when projects are not yet fully established. Particular attention will be given to the integration of A.I.D. personnel, activities, and information systems with those of other programs. Evaluators will also assess the adequacy of staff allocations and any legal or policy impediments to sustainability.

C. Evaluations of management systems and capacity will look particularly at qualitative aspects of decentralization and at the Ministry of Health's ability to identify and resolve problems as seen in information systems and operational research.

D. Financial evaluations will analyze project costs and the degree to which they have been and will be assumed by the government, the public, or other donors. The adequacy of costing systems and financial management procedures will be assessed, looking specifically at:

- the frequency of financial reporting and analysis
- the capacity of program personnel to understand and analyze financial information
- the characteristics of budgetary and expenditure control, and
- the degree of integration of A.I.D. activities into government budgets.

A.I.D. may also assist in health sector financial analyses conducted by other groups.

E. The sustainability of behavioral change will be assessed by examining a program's health education capacity, both built-in to the program's structure and accessible in the private sector. The ability of health educators to manage formative research, use mass media, train health workers in educational techniques, organize community action, and manage the development of materials will be considered along with the leadership's level of commitment to continue these activities and to reinforce key messages after project termination.

V. ADAPT PROJECTS TO INCREASE SUSTAINABILITY

A.I.D. has learned through experience that some projects will not satisfy all of the sustainability requirements discussed above, though most have generally moved in the appropriate direction. Officials will consider a range of options when the project as a whole, or individual activities within it, are not proceeding as planned. Options include:

- extending A.I.D. assistance for brief periods when there is a clear plan for overcoming obstacles
- reducing A.I.D.'s scope of work
- assisting MOH officials to find other donor funding to supplement or replace A.I.D. support
- placing the project on temporary probation with clear conditions precedent for further funding
- terminating A.I.D. assistance.

None of these is considered a desirable outcome, but choices may have to be made when sustainability of current activities appears unlikely.

A. Extend A.I.D. assistance: Development of local systems and institutional capacity may take longer than anticipated, due to unforeseen events or inadequate planning. Additional funding may be extended for one or two years to those activities which are clearly moving in the right direction but at a slower pace than intended.

Although formally, A.I.D. can offer no more than a five-year assistance for a project, longer involvements are sometimes needed. Designers should expect the need for follow-on projects in many countries. A follow-on project should be seen as a sign of success that a worthwhile activity is underway, not a failure of instantaneous

sustainability. Some of the most successful development efforts have a horizon longer than five years. The CCCD project, one of A.I.D.'s most successful efforts in Africa, is well into its second five-year cycle. Even its first cycle was a follow-on to regional programs in EPI, and previously in smallpox control. Specifically, designers should consider a follow-on activity which will continue to maintain and strengthen the infrastructure and procedures set up by one project, while adding new activities.

B. Reduce Scope of Work: Most projects represent a mixture of strong and weak components, some likely to survive even without A.I.D. assistance, others clearly unsustainable regardless of the level of effort. Between these two extremes are activities which may not be sustained on their own but are likely to survive if given adequate A.I.D. support. Staff may choose to concentrate resources on these marginal activities and reduce or eliminate support for ones that will clearly survive without further help or will lapse even if extensive help is given. Such cuts, if they become necessary, will reflect sustainability criteria and will generally not extend to critical financing and management activities. Expansion of project activities to new geographic areas may also be delayed until the sustainability of existing activities has been ensured.

C. Arrange other donor funding, if unavoidable: Designers should consider A.I.D. support of efforts jointly with other donors. EPI and AIDs control programs illustrate this principle well, in which A.I.D.'s activities complement those of UNICEF, the Rotary International, the Italian, Danish, or Swedish Governments, etc. This constellation of international support provides a safety net when some further international assistance is needed and A.I.D.'s funding is at an end.

D. Probation: Some governments lack firm commitment to A.I.D. goals and activities and are slow to overcome specific policy and managerial obstacles. Probation makes further A.I.D. support contingent on strengthened commitment, as shown by accomplishment of required policy and/or management decisions or by increased provision of local resources.

Probation plans, when necessary, will be developed collaboratively with implementing organizations and will specify the steps that must be taken to obtain A.I.D. funding beyond an identified cutoff date.

E. Termination: Projects which will clearly not be sustained may be terminated early at the discretion of A.I.D. officials.

APPENDIX A

GENERIC TERMS OF REFERENCE FOR HEALTH FINANCE CONSULTANTS

1. The first phase of your mission is to collect as much current and historical data as possible on the financing of the health sector in the country to which you are being sent. This data will be for government facilities, for NGOs such as church-mission facilities, and for the for-profit health-care sector; it should also show foreign aid. The data should be for both capital and recurrent costs.

2. The next phase of the mission is to ascertain in as much detail as possible the sources and uses of funds by level in the public health-care system for the most recent year or years. The effort here is to understand the percentage of public monies being spent on curative care and on preventive care and/or on primary, secondary and tertiary care. It is also desirable to know what percentage of these government funds are being spent in rural areas and in urban areas.

3. Once these general data on health financing have been gathered and descriptively analyzed, it would be desirable to have as much information as possible on (a) the different forms of risk sharing (health, insurance) that exist in the country, and on (b) the cost-recovery activities that are taking place. If possible, the cost recovery data should show representative fee schedules and amounts of budgets collected by means of cost recovery for both the public and private sectors.

4. In order to fulfill items (1) through (3) in these terms of reference, it will be necessary to:

(a) Meet with those officials in the Ministry of Health and other Ministries, such as the Ministry of Finance, who are interested in the various aspects of health care finance and in cost recovery for drugs and inpatient and outpatient services;

(b) Meet with officials in the Ministry of Health and in other Ministries who have direct responsibility for planning, directing, and operating components of the public health-care system where cost recovery has been tried, is being tried, or will be tried; and

(c) Meet with officials in the private health care sector, including officials of Mission hospitals and clinics, and obtain a clearer idea of, and possibly data on, what is occurring in the private sector as regards to cost recovery.