ISSUES IN
HEALTH SECTOR EVALUATION
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INTRODUCTION

Neither the Agency's Policy Paper on Health Assistance [1] nor the Health Sector Strategy Statement [2] explicitly require evaluation at the policy, program, or project level. The Foreign Assistance Act, however, mandates that AID not only define its objectives, but that it develop "quantitative indicators of progress" and consider "alternative means for accomplishing these objectives"; this requirement for evaluation has been underscored by a directive form the Office of Management and Budget [3].

Broad Agency policy is promulgated in an Evaluation Handbook [4], currently under revision. The Handbook discusses some of the philosophical issues of evaluation and some of the methodology, and outlines the basic AID evaluation process. Asia/NE and Africa Bureaus, however, spell out their own current policy in their own documents.

A/NE, in addition to providing detailed information on its methods for ensuring that evaluations are appropriately planned, implemented, and reviewed in its projects, also places an emphasis on the need to evaluate at the program level; to use evaluations to develop lessons learned for future programmimg; to involve the host government in the planning, implementation, review process; and to promote a dialogue on policy with the host government [5].

Africa Bureau, though not providing methodological guidance, does indicate that it is particularly interested in evaluations that develop information (lessons learned) for input to programming decisions (into which category they put impact evluations), and those that investigate similar projects or programs across countries to draw conclusions about the value of continuing AID investment in those areas. The Bureau indicated that for FY85 commodity import programs and farming systems research would be the focus of these "generic" evaluations [6].

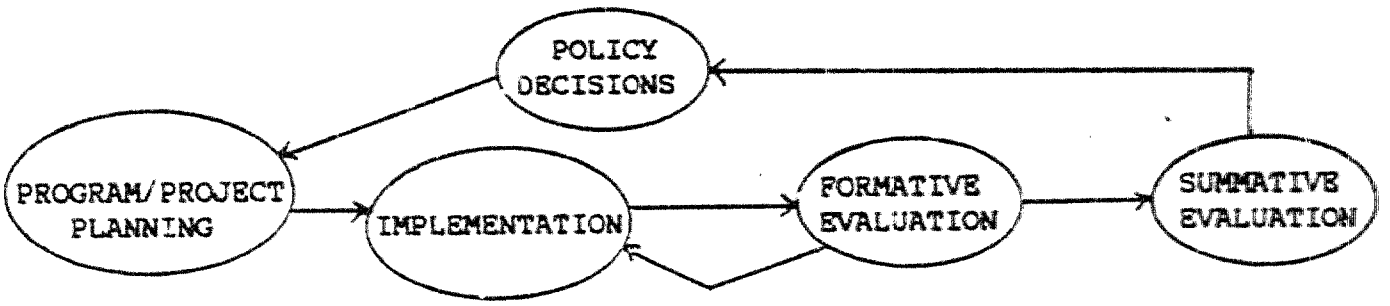
The purpose of this paper is not to add to an already considerable volume of "how to do it" documents on evaluation in general or even in the health

sector. In this paper we want to help the Agency determine what the specific focus of its impact evaluation agenda ought to be over the next year, and to suggest for consideration by the AID health and evaluation communities a methodology aimed at producing better information for policymaking and programming.

I. Purpose and Nature of Evaluation

Evaluation may be defined as the act of comparing an actual state with some standard of what is desired. Although its temporal focus is therefore basically contemporary or retrospective, its purpose is very much decision-oriented. Figure 1, which shows the role of evaluation activities in the larger context of program development, illustrates this point.

Figure 1. The Role of Evaluation in Policy and Program Development



Policy decisions precede and drive programming. Within a policy framework, programs are planned and implemented. Evaluation is performed during the implementation phase and the information produced is used to refine ongoing activities. Evaluation is performed late in the implementation phase or following it and this information is fed into ongoing or future policy determination. Thus, evaluation is an activity whose purpose is not simply a matter of "grading" performance, but rather to generate information for action.

Evaluations may be designed to serve several different purposes within this context. Each has a particular audience.

One purpose is project or program monitoring. Those responsible for operations need to know if the various activities that comprise a project or

program are proceeding on schedule, in the the right quantity, within budget, within resource limitations, and with appropriate levels of outputs--in sum, whether there is conformity with design. In an immunization program, for example, program operators need to verify that vaccines and ancillary hardware are arriving at central and peripheral points on schedule, that staff are being trained and deployed on schedule, that the cold chain is being maintained, that vaccines are being administered to targeted children, and that titers are reaching expected levels.

Program designers, on the other hand, need to know if the project or program is having the expected impact. Their needs go beyond a determination of outputs, to a knowledge of the near- and mid-term effects of those outputs on the intended beneficiaries of the program. They need to know, for example, not only that antibody titers are reaching expected levels, but also that morbidity rates are actually declining. Moreover, they need to know if the programmatic approach being taken is the most effective and/or efficient one possible: is the present village-based campaign more cost-effective than an alternative approach in which mothers would bring children to vaccination centers?

Policymakers, operating at a decisionmaking level above that of program planners, require information to make rational choices between programs and across programs within the sector. Policymakers must decide how to distribute resources between competing programs that have the same broad goals, ORT versus EPI, for example. In this case, impact evaluations must provide comparable data on cost-effectiveness for comparative analysis. Across programs, decisionmakers need information to help them decide what an appropriate division of labor is between community health workers and more highly trained workers. To do this, they need data on the effectiveness of each kind of worker in specific settings and over a given set of tasks.

An audit is yet another type of evaluation. It usually focuses on administrative aspects of a project or program and is intended to verify compliance with policy guidelines for handling funds and commodities, and with other managerial practices and legal requirements.

A taxonomy of evaluation has gained acceptance that includes definitions of

various kinds of evaluations and evaluations performed for the different purposes just named [7-11]. For purposes of this paper, the important one is that called summative evaluation.

A summative evaluation aims at producing data required to assess the degree to which a program or project achieved its stated objectives, what operational factors were key to this success or lack of it, what exogenous factors played significant roles, and whether the delivery strategies employed were necessarily the most effective and/or efficient ones that might have been employed. The express purpose of a summative evaluation is to develop information to be used in planning future programs and in policy decisions. For example, a summative evaluation may be designed to develop data to compare the relative effectiveness of several different service delivery modes aimed at increasing the effective use of ORT: one, having mothers come to the health center to receive a supply of commercial ORS each time a child develops diarrhea; two, having mothers maintain a stock of commercial ORS at home; or three, having the mother start treatment with home-prepared salts and come to the health center for ORS if the child doesn't improve. If results from enough projects are assessed, a pattern may be discovered that makes decisionmakers confident enough to prescribe a policy for future programming. Moreover, since summative evaluation concerns itself with non-operational factors as well as those directly related to implementation of activities, the environment of the service system also is considered. This provides an opportunity to discover problems deriving from the influence of other parts of the health service system, including existing policy, and even from sectors other than health. For example, it may be discovered that proximity and transportation are the key determinants of which of the three service delivery strategies will be most effective. Summative evaluation might also reveal that an existing policy aimed at recovering some of the cost of providing health service is contributing to significant under-utilization of ORT, even though it is working well overall; this kind of information would be used by policymakers in future deliberations of how to charge for health service. Most AID impact evaluations are what evaluators would label summative evaluations.

There are two approaches to evaluating impact: the goal-attainment model and the systems model. The goal-attainment model focuses entirely on measuring

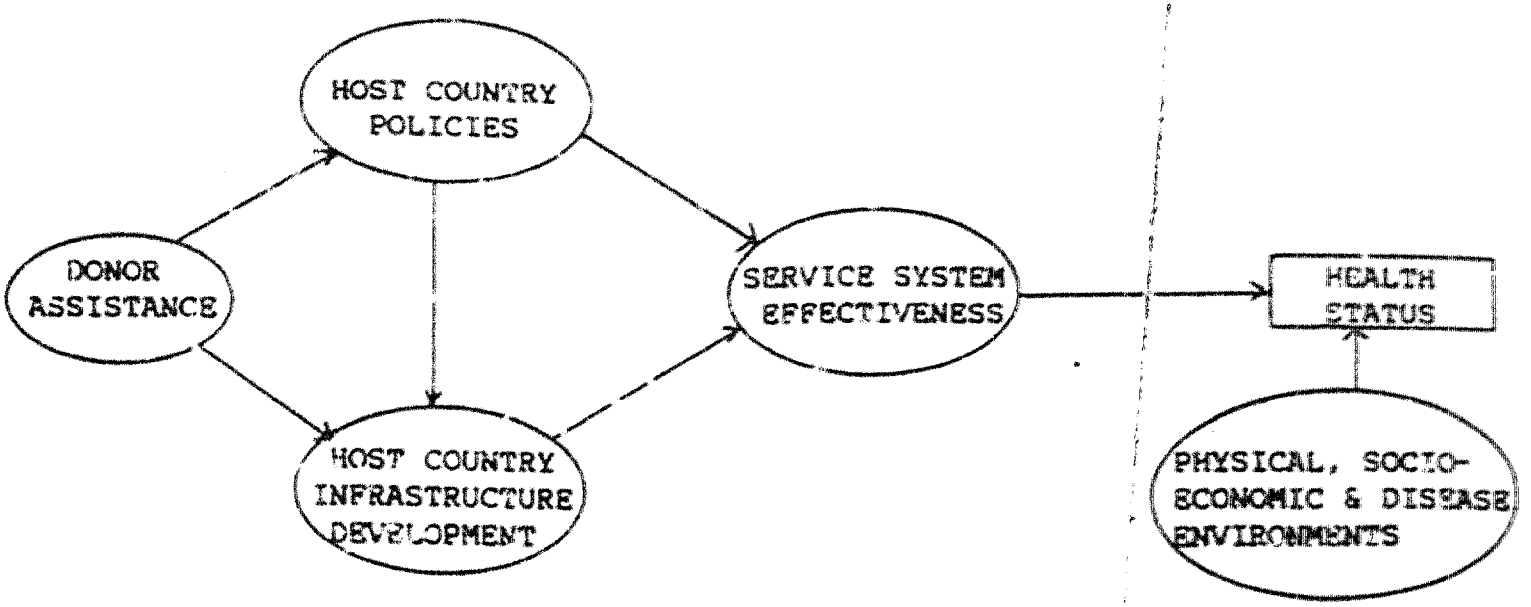
how well a project or program reached pre-determined objectives, and on doing so very precisely, often by experimental or quasi-experimental methods. The concentration on quantitative comparison of achieved levels with pre-set norms often precludes development of information that suggests why these levels were achieved; this approach therefore may not be very useful for implementing findings.

By contrast, the system model places the project in its larger context (political, social, demographic) and asks, what was achieved under the existing circumstances [12]. Moreover, since the system model is very much concerned with the organization of the system that is required to achieve the specified objectives, it also places considerable emphasis on internal linkages between system components; the effectiveness of these linkages have a strong effect on what the system accomplishes and how efficiently it does it. Finally, this approach also takes into account the possibility--really, the probability--that the system under investigation operates to satisfy multiple goals simultaneously. A primary health care system, for example, may have the simultaneous objectives of maximizing coverage while at the same time minimizing governmental outlay for health care. Goal-attainment evaluation might simply say that one objective was partially achieved, while the other was not. The systems model would look at achievement, but would also try to explain the interplay between these objectives [13]. Thus, the systems model of evaluation is a much closer approximation of the real world and is more likely to generate information that can be applied to modifying policies and planning new programs. This model will be the basis for the methodology we propose be used in the upcoming series of CDIE impact evaluations.

Impact

Before proceeding, it is important to understand the view of impact that will be taken for the balance of this paper. In the description of impact evaluation, we noted that impact could relate either to direct changes in health status measures or to factors that are thought to facilitate such changes. This is particularly relevant in the areas of policy and service system development. The model on the next page illustrates this point.

Figure 2. Flow of Effects from Donor Assistance to Improved Health Status



AID does not provide health services to host country populations directly, but rather by working with government and private entities to improve their capacities to provide service. In determining impact, the ultimate measure is what happens at the end of the system in terms of such direct definers of health status as reduced disease-specific mortality and morbidity rates, deaths averted, and disability-days saved. Although in the long run it is the intention of every assistance activity to contribute to these outcomes at the level of the service recipient, those activities that effect change early in the system also impact eventually on the service recipient. Thus, it is reasonable to include changes that positively affect host country policies or improve service delivery in a broader definition of impact. This approach, however, should not be seen as lessening the desirability of trying to obtain the more direct impact measures in each case as well. It simply recognizes that an assistance activity may be successful in its own right if it can only be shown that the immediate effect was in changing policy or improving infrastructure.

II. Evaluation Approaches and Experiences of Other Organizations

Evaluation documents from several other development groups or organizations were examined. In some cases, staff of the organizations also were interviewed.

United Nations Fund for Population Activities

The Evaluation Branch of UNFPA carries out "in-depth" evaluations (equivalent to AID's impact evaluation) at three levels: the individual project, an entire program, and comparative evaluations to analyze different projects in the same substantive area [14]. The guidelines call for an assessment of the degree to which planned inputs were used, activities carried out, and output and cost targets met. There is also an assessment of "impact", defined as positive change in immediate and longer-term objectives. UNFPA uses a form of the logical framework in designing projects, and relies heavily on this "project document matrix" to direct subsequent evaluations.

Although no comparative evaluations have yet been undertaken, when they are their focus will be on identifying different strategies for improving the effectiveness and efficiency of projects in the area of concern, and to help build up "knowledge for policy guidelines". Comparative evaluations are expected in the areas of community-based delivery systems, training of paraprofessionals, and information systems.

World Bank

The objectives of World Bank evaluations are "to describe and analyze the state of the project at, or shortly after, its completion, to compare the costs and currently expected benefits with those expected" when the project was designed, and "to draw lessons from experience and to disseminate them within the country" [15]. The instrument used to guide the evaluation methodology is the Project Completion Report, which has detailed sections directing evaluators' attention to a retrospective determination of the relevance of the project to the national situation, adequacy of design, operational performance, and achievement of objectives. As might be expected, there is heavy emphasis on economic analysis. (There is also an interesting section on politico-legal aspects of evaluation that reflects the concern of an organization that is in the position of evaluating its patrons.) The Bank says it has found that these evaluations "normally take from 5 to 15 professional staff manweeks depending on the sector and project".

According to Bank staff, evaluations so far have been oriented toward

individual projects, although there has been some discussion of comparative analyses aimed at clarifying larger issues such as sustainability, institution building, and project design with more realistic objectives. The Bank only began lending in the health sector in 1980 and no health project has matured sufficiently to receive an impact evaluation. One nutrition project has been evaluated (in Brazil). The Project Completion Report for this project did discuss lessons learned for both sector programming and the Bank's own approach to working with its borrowers (they were too intrusive). Headquarters Bank staff indicated that there is a growing conviction that the Bank has concentrated too much on financing "bricks and mortar" and not enough on human resources development.

WHO/Control of Diarrheal Diseases Program

In its manual for planning and evaluating national CDD programs, CDD recommends a comprehensive program review at both the national and regional levels [16]. (No guidance could be found with respect to the frequency of these reviews.) A separate publication on guidelines utilizes a systems approach which seeks to account for the effects of interactions between different levels of the system, the flow of inputs and the chain of activities, and the impact of external factors such as national policies [17]. Because the program is expected to maintain updated information on operations, comprehensive program reviews are expected to take only two to three weeks. It is suggested, however, that data on morbidity and mortality be collected as a separate activity before the comprehensive program review begins. To help transfer information across national programs, CDD recommends that evaluation teams contain professional staff from neighboring countries.

Comparing a number of national program reviews, CDD has noted several common problems: insufficient clinical training of health workers in ORT, lack of supervision and monitoring of lower level staff, and delays in developing a strategy for promotion of home-based ORT [18].

Using a method similar to that of the CDD program, CDD participated in joint evaluations with other WHO programs (EPI, MCH, PHC) in five African countries. CDD noted that problems developed because of the need to gather large amounts of information in a short time (though presumably economies of

scale would still mean less work than four separate evaluations, to say nothing of the opportunity for joint analysis of data that normally would be collected in one program but not another).

AID/Child Survival Task Force

Although its plans are not yet final, CSTF is contemplating an evaluation strategy based on an underlying systems concept [19]. It will consist of a multi-tiered approach in which all projects will maintain real-time data on a set of standardized process indicators, i.e., inputs, activities, and outputs, and a very modest amount of effectiveness data. However, a sub-set of these projects will be provided additional resources to gather much more comprehensive data on effectiveness, and a sub-set of these will develop data on changes in disease-specific morbidity and mortality, plus other data required to pin down the causal relationship between project intervention activities and impact. Thus, it is expected that as the projects proceed, evidence can be mounted to argue that if process and outputs in the projects of the first tier are comparable to those in the second tier, and effectiveness of the projects in the second tier is comparable to those in the third tier, then it is reasonable to expect that the impact which actually was measured in third-tier projects is likely also to be occuring in the second and first.

Implementing this scheme will provide a unique opportunity to learn more about the circumstances under which it is reasonable to assume that activities at lower levels in the system hierarchy have satisfactory and cost-effective impacts on health status. For instance, at present it is assumed that educating mothers concerning growth monitoring ultimately leads to improved nutrition status. But a whole sequence of assumptions is inherent in this one leap of faith: that the educational program changes knowledge and attitudes, that this results in a greater desire for monitoring their children's growth, that the child is actually weighed regularly, that the weight is recorded properly, that low weight is properly interpreted, that corrective action <u>can</u> be taken by someone, and that the action continues long enough have effect. And there is still the question of what happens when the child is dismissed from the program.

III. Potential Issues In Evaluating the Impact of AID Health Projects

The Center for Development Information and Evaluation has asked for assistance in developing a set of key issues on which to focus its next round of evaluations of the impact of AID health projects and programs. To assist in this effort, a list of potential issues was constructed; these were organized as (1) issues that relate to Agency policy as described in the Policy Paper [1]; (2) issues related to planning and management; and (3) issues relating to evaluation methodology. In the latter two groups, issues were developed from a perusal of various published documents [20-25]. Following is the list of the issues.

Issues Related to A.I.D. Policy

1. What evidence is there that AID projects/programs correspond to host country policies and/or that they help change host country policies that are impediments to effective, efficient delivery of health services, especially to traditionally underserved elements of those countries?

2. Are AID projects/programs promoting broader access to basic health services? Are they promoting sustainability and self-sufficiency? Are epidemiologic and operations research projects clearly aimed at enhancing the relevance and cost-effectiveness of service delivery programs?

3. How well do AID projects/programs promote effective use of the private sector in delivery and support of health services?

4. How well does AID-funded biomedical and health services research promote capacity-building in local institutions?

5. Do AID and other-donor activities complement one another? If AID is deliberately leaving support for capital construction and for large-scale commodities purchases to other donors, are these being provided for as necessary to complement AID support for R & D in the other aspects of service delivery? Is the limited supply of host country resources, particularly human resources, able to satisfy the needs of multiple donors?

Issues Related to Planning, Implementing, and Managing Projects/Programs

1. Is there a marked difference in success rates of projects of different scope (i.e., national, regional, local)? Where projects are intended to serve as pilots for scaling-up, how successful has this been; can factors impeding scaling-up be pinpointed?

2. Is the AID/host country planning process adequate: are expectations of achievement and time-frames realistic; has appropriate technical assistance been provided (appropriate=skills, numbers, duration)? Is the logframe being used appropriately? What is the level of host country participation in planning and managing, especially as compared to levels proposed in project agreements? Are host country policies determined in advance and considered in the program planning phase? Is the host country capacity for health system management (human resources, information, transportation, communication) being considered realistically in the development of new programs? What should be the role of AID staff in planning, implementation, and management: directive/non-directive, direct technical advice, procurement of technical advice, monitoring for accountability to USG?

3. What is the evidence with regard to comparative value of integrated versus categorical programs (and how should "comparative value" be defined)?

4. How essential is community participation to a successful (measured as effective utilization?) PHC program?

5. Is community financing of some health services a viable proposition; which ones?

6. What do we know about the development of CHW programs leading to success in making PHC more accessible and promoting effective utilization?

7. What is the relative value of multipurpose versus single-purpose workers? Is "voluntarism" a viable expectation?

Issues Related to the Technology of Evaluation

1. Are project/program objectives being stated in quantitative terms? Can

guidelines be provided as to when process analysis is acceptable--even preferable--instead of direct measurement of outcome?

2. How does a team deal with causal attribution, especially if data on exogenous factors are sparse or non-existent? How should a team evaluate the separate effects of a program/project with multisector inputs (e.g., health education, food supplementation, and income-generation components)? How should significant positive impacts outside the health sector be accounted for? What is the effect of the time of evaluation?

3. Can guidelines be provided in the planning stage for projects to be evaluated by rapid assessment techniques (secondary data analysis, descriptive process review, debriefing of beneficiaries) versus those to be treated with evaluative research techniques (statistical research design and data collection)? Should all/most projects be placed in a comprehensive evaluation scheme similar to the graduated depth of evaluation scheme proposed for the Child Survival Program?

4. Given multiple audiences for evaluations, each with somewhat different needs (service deliverers, program managers, host country policymakers, donor agencies, perhaps even service recipients), how should priorities be determined with regard to the objectives of a particular evaluation?

5. What should be the strategy when candor in reporting conflicts with political sensitivity?

Issues Selected by the AID Staff

These issues were discussed with staff of the health offices of the bureaus for Africa, Asia/Near East, Latin America/ Caribbean, Science and Technology, and Program Policy Coordination, and the Child Survival Task Force. From these discussions, five issues emerged as being of most concern to the Agency's health professionals at this time. These were:

1. Community co-financing of health services. This issue was mentioned by every group with whom discussions were held and may be the issue of greatest interest in the Agency today. Administrator McPherson has ordered that user co-financing be implemented in AID projects, wherever feasible [20].

Underlying this issue is a growing conviction that most LDC governments will not for the foreseeable future be able to provide a full range of basic health services at no direct cost to users. This conviction is complemented by the knowledge that, in fact, people already are paying for health services in the private sector, especially the traditional component. Thus, institution of charges for some services in the modern sector would not constitute additional outlays for health care by users, but, rather, a partial redirection from traditional to modern services, which presumably have the potential for greater effectiveness.

The major questions with respect to community co-financing are: What services should be paid for, how charges should be set, how funds should be generated, and how the financial system should be managed. All of these must be considered in the light of the impact each answer will have on the appropriate utilization of services, especially by targeted segments of the population.

At present, none of these questions can be considered to be fully resolved, but some trends may be emerging. Concerning services to be paid for through community resources, there is little question that people are much more willing to pay for curative than for preventive or promotive services, especially if payment is on an individual rather than a collective community basis. There seems little doubt that people will pay for drugs. However, attempts to get communities to pay for the services of community health workers generally have not been successful although the redesigned Sine Saloum project indicates that this may not be a forlorn hope. The setting of charges for specific services has usually been based on trial-and-error experience rather than a cost analysis. The exception has been charges for drugs, where a number of attempts have been made to recover entire cost, often with some additional amount to allow for restockage in the face of rising prices. The record of community drug stores in community co-financing has been a mixture of success and failure.

Stinson [26] documents a variety of methods that communities have used to raise funds to underwrite the cost of health services. While it appears that the best approach to designing cost-sharing components for projects will have to be on a case-by-case basis--because of the great number

variables and values within each project--there has not yet been a systematic attempt to evaluate the outcome of different approaches. For example, how successful is payment in kind as opposed to cash payment? And while contributions of labor to the development of facilities appears to be a workable method, how successful has been the use of communal labor as payment to community health workers?

Of all the questions, the least is known about how community-based financial schemes should be managed. Open questions are: Under what circumstances should individual, versus collective responsibility, be favored? How much record-keeping is required? What should be the role of the community at large?

2. Effective use of the private sector. AID policy calls for more effective use of the private sector as a means for promoting efficient use of host countries' limited resources in health, and as a key element in promoting national self-reliance and self-sustaining health care delivery systems. Components of the private sector in health are:

- Physicians and midwives and other scientifically-trained providers;
- Private hospitals, clinics, and health maintenance organizations;
- Medical commodities manufacturers, shippers, and retailers;
- Insurance companies;
- Mass media; and
- Traditional practitioners of various kinds.

Private voluntary organizations (PVOs) are specifically excluded from the private-sector classification by AID because they "tend to respond to motives in addition to, or in place of, the profit motive." [27]. Nevertheless, supplementary AID policy calls for the Agency to work with and assist PVOs engaged in the provision of health services.

A major issue related to Agency assistance in making more effective use of the private sector in health is learning how to integrate the public and private sectors so as to create a system that provides comprehensive primary care to a very large proportion of the population. At present, there is a strong tendency for the scientifically trained elements of the private

sector to serve the urban population--particularly the economically better-off population--while the poorer urban group and most rural people are served by public facilities and the traditional services within the private sector. One question for evaluators is whether this variance in service necessarily translates to care that inevitably contributes poorer health status among the urban poor and rural population. A severe confounding factor is that these two groups split very sharply along economic lines (and often educational as well) and the poorer face many social problems that are believed to impact heavily on their health.

Although health maintenance organizations are a fairly recent concept for LDCs and thus may not offer many evaluation opportunities, the few that exist should be examined to see if they provide improved health care to a needy population or if they serve primarily the middle class. (We do not know of any that are designed to serve a rural population.)

Another important issue is whether expanded use of private, western-oriented providers to serve increasingly larger segments of the population actually is more efficient (cost effective) than an expanded public-sector system, especially if some user co-financing is instituted. As the thrust toward cultivating the private sector continues, there is a need to learn more about government's role in regulating costs and quality of service. In addition, based on experience to date, it seems unlikely that market forces alone will ensure equitable coverage of national populations with effective modern services. How can a Government promote reasonably equitable access?

A cornerstone of AID's policy on development of private enterprise resources and its strategy in health is the transfer of appropriate technology. One technology desperately in need of upgrading is management, including planning. We need to see if there are some lessons available with regard to how management skills can be transferred to managers of HMOs, commodity manufacturing companies, wholesalers, and retailers to help them become more efficient. This achievement would benefit not only the entrepeneur but also the public in the form of restrained costs.

Finally, our experience with incorporating traditional healers into the "modern" health care system should continue to be assessed. Traditional

healers, including traditional midwives, are the most ubiquitous of health care providers in the developing countries. By now, a number of projects have come and gone that have attempted to work with, instead of exclude, traditional healers. We need to learn how to get the maximum health effect from these providers who show no sign of disappearing and who, for some time to come, may remain the most accessible of providers for many people in rural areas. Even in the poorer districts of cities, traditional healers are widespread and are the least expensive of all service providers. We know that many of them are amenable to working with the health system, especially if they believe that doing so enhances their income potential. The task for evaluators is to cull our experience to find the factors that lead to appropriate training and monitoring of these personnel, and their continued contribution to health care.

3. Relative effectiveness of integrated and categorical service approaches. The Agency's 1980 Health Sector Policy Paper [28] took an unequivocal stand in support of integrated programming, while recognizing that it had some disadvantages: The tendency of multipurpose workers to be overwhelmed by the demand for acute care was specified. Despite this general stand, the Policy Paper stipulated that under some sociopolitical circumstances categorical programming would be supported. Four years later, the Health Sector Strategy paper, reflecting a changing climate of opinion in the Agency, stressed concentration of assistance efforts on "proven, cost-effective technologies delivered in primary health care programs." Immunization, ORT, family planning, and nutrition monitoring were cited. "Cost-effective technologies to control major communicable diseases, particularly malaria," would also be focal points of the AID strategy. As noted earlier in this paper, recent Agency programming in health has shown a marked increase in support of ORT and immunization. Possibly also reflecting a certain disenchantment within WHO--ostensibly a strong advocate of integrated PHC--that organization now is promoting a separate categorical effort in diarrhea control.

Several arguments are proferred in support of an integrated approach. One is an assumption that it should produce some economies of scale, especially in administration and logistics, that is, that supervisors can deal with multiple purposes in a single encounter and that supplies required for

several interventions can be physically moved together to health care facilities. A second assumption underlying the integration of skills in community based workers is that demonstration of skill in one area (e.g., acute care) of particular interest to service recipients is likely to enhance the credibility of their service in another area that patients may be less interested in (growth monitoring, for example). Third, it seems reasonable to assume that optimized use of resources for multiple interventions is concomitant with coordinated planning and that coordination is maximized when a single person or organization is responsible. In sum, an integrated system would be expected to deliver health services more effectively and more efficiently.

Gillespie, in an article aimed mainly at the question of integrated versus categorical family planning programs, lays out many of the general arguments against integrated service programs [29]. First, for the short run at least, integrated, full-scale PHC programs have proven to be more difficult to organize and administer than highly targeted categorical programs. Gillespie even speculates that "there is every reason to assume that the integrative process results in a potentiating effect, with the combined difficulties...being greater than their sum." A number of evaluation reports commented on problems demonstrated by ministries in trying to absorb the additional administrative burden of an integrated PHC system. Second, integrated programs tend to load service deliverers with a multiplicity of tasks, with the result that workers seem either not to learn some skills or to become very selective in what they do; either way, important services may be neglected. Third, developing an effective integrated program takes more time than organizing and implementing a categorical program; thus, in the near term, at least, categorical programs may demonstrate more health impact than integrated programs. Finally, Gillespie poses the proposition that the complexity of integrated programs renders them more vulnerable to the breakdown of such vital components as, for example, logistics systems that have to deal with a wide range of commodities with different ordering, storage, and transportation requirements.

At this time, there is very little evidence from project evaluations to help decisionmakers decide if they should opt for the potentially more rapid impact of a few carefully selected interventions (using the Walsh and Warren

criteria of cost effectiveness and feasibility [30]) or the slower comprehensive integrated approach that might in the long run prove more effective and more enduring in terms of improving health and promoting overall development. The task for evaluators, then, is not necessarily to determine whether an integrated approach is better or worse than a categorical approach, but, rather, what information LDC planners need to optimize the use of their resources in the short run while planning for a more permanent PHC approach in the long run.

A careful look shows the arguments for and against integrated programs to be basically administrative and managerial. Therefore, evaluations should be aimed at developing, insofar as completed and ongoing projects address these problems, information that clarifies questions about how much can realistically be expected from CHWs doing multiple interventions, how to motivate CHWs to implement a planned program of tasks, how to select and train CHWs, how to train and motivate supervisors, whether integration of service with unintegrated administrative lines is feasible, whether unintegrated service delivery but integrated administration is feasible, and how to estinate the overall administrative burden demanded by an integrated PHC system. Finally, we need to look for clues about how private-sector providers and institutions can be integrated into a system including both the public and private sectors.

4. Policy Dialogue. One the the Agency's four priority areas is the maintenance of meaningful dialogue with host country officials about specific policies that impede the effectiveness, efficiency, and long-term viability of health programs. This stress on long-term development of economic and social policies is a shift in US development assistance strategy from much of the 1970s though a renewal of strongly felt and articulated interest in AID for the first 10 or so years of its existence.

Two general approaches to policy dialogue have been identified from AIDs previous experience: The "Latin America Strategy," characterized by tough and formal conditioning and performance evaluation and the "Near East - South Asia Strategy," exemplified by informal conditioning, with emphasis on continuing dialogue [31]. In both cases, we know that effective policy dialogue depends on a good understanding of the country situation, a clear

policy message, mutual respect for the process, early introduction of policy concerns in the negotiation process, and cultural sensitivity.

Rarely has the process of policy dialogue been documented or evaluated. How it is carried out usually depends on the particular desires of the host country and AID personnel. Because AID has substantial experience with the process, it would be useful to identify what aspects of it are effective and which have been less so. One of the first questions to address in this regard is whether policy dialogue is more effective when using an "ex post" or "ex ante" approach to conditionality, i.e., is it better to require the implementation of a policy before receipt of health assistance or is it equally valuable or more valuable to link aid to future policy?

In health, what policy requirements need to be in place in order to assure a successful program, for example,--a national health policy for PHC, rural staff dedicated to PHC, a PHC budget in the rural areas of percent? What kind of conditions precedent are most common in health programming? How specific (measurable) and how strictly enforced have the conditions precedent been?

From the evaluations reviewed, a number of projects have been delayed because of unmet conditions precedent. Were these conditions realistically established? In the cases where they were not met and the project was funded anyway, how did their status affect the success of the project?

The Health Policy paper identified several negative health policies that are priorities for dialogue: Commitment to free services, willingness to expand beyond management and financial capability, inefficient urban/rural resource allocation, neglect of private enterprise, inappropriate import tariffs, discouragement of indigenous practitioners, and no incentives for rural services [1]. Have any of these been affected by the AID project? Can we identify factors in the political and economic environment that facilitate or impede the policy dialogue process such as diplomatic relations, domestic politics, unforeseen economic developments, other multilateral presence? Has their potential impact been taken into account relative to the dialogue process?

Many ministries experience constant turnover in key personnel. Can policy dialogue, a process requiring the interaction of both collaborating organizations, be effective when LDC (and AID?) decision makers change regularly?

Effective policy dialogue is an important Agency priority, and information collected on the process used for policy dialogue will benefit other AID development efforts as well as the health sector.

5. Sustainability. The basic objective of AID's health programs is to help developing countries become self-sufficient in providing essential preventive and curative health services. In a review of five impact evaluations, Stinson found that virtually every evaluation raised questions about long-term viability relating not just to financing, an obvious component, but also to shifting political support, weak community participation, inappropriate technology, and dependence on imported commodities and foreign specialists [22].

Financial viability has two components which must be carefully evaluated before and during implementation: Affordability and desirability. Though affordable technologies and delivery systems have been the priority, once in place, the support systems and commodities often absorb significantly more resources than planned. A realistic costing of individual technologies and complete programs is needed. Once developed, the program must meet a perceived need of the host government; otherwise, resources will not be appropriated when the program competes with other programs for limited budgetary allocations-- no matter how cost effective. How well is financial viability evaluated prior to program implementation? Have private-sector programs and resources been included in the financial feasibility study?

Institution building is a long-term process of developing manpower and infrastructure that often conflicts with another common project objective: provision of direct service delivery. Pressure from host governements and AID to demonstrate results as rapidly as possible often shifts priority from institution building to service delivery where outputs and outcomes are more direct. How supportive are MOHs to institution building, especially where

there may be strong incentives for expanded health service delivery? Have projects that have incorporated both institution building and service delivery been able to carry these out better than projects with only one of those objectives?

Institution building is most often approached through training and/or the technical assistance provided by contractors. Training issues are abundant (e.g., attrition of personnel after training, unqualified candidates, inapproporiate content and context, and undirected application of acquired knowledge and skills). Issues relating to the transfer of skills from technical assistance teams are also numerous (e.g., lack of formal mechanisms to facilitate transfer of skills and management capabilities during implementation, physically separate contractor offices, introduction of culturally inappropriate systems, a focus on project management instead of facilitating or teaching others to perform management tasks). A review of projects where technical skills and capabilities have been successfully transferred, to identify programmatic components that have contributed to such transfer will be useful.

The Agency's health professionals recognize that some of the technical aspects of the evaluation field itself are still themselves under development, particularly the issue of causal attribution (i.e., separating program/project effects from other factors that also cause observable changes in variables that measure progress toward objectives). Nevertheless, they do not feel that CDIE's efforts should at this time be devoted to methodological development at the expense of this opportunity to resolve some of the issues just named.

Interestingly, one does not see here as an issue the one question that probably springs first to mind when considering either the totality of AID's efforts in the health sector or any one program or project, to wit, does/has it made a difference in the health of the people it is supposed to affect? The probable reason for this is the awareness of health development professionals that, except for a few kinds of programs--the most obvious is immunizations--the linkage between programs and their outcomes is exceedingly difficult to demonstrate directly. Health and disease are determined by many interacting factors [14, 21-25] and isolating the effect of interventions that change only one or two at a time in terms of changes in morbidity and

mortality simply is, given the present state of the art, not possible with a high degree of confidence. Rather than simply say that since the effects of many interventions (human resource development, information systems, logistics, different approaches to financing) can not be measured with certainty it is therefore not worthwhile to pursue them, planners proceed on the assumption that some improvements in the system are so logical that they must in the aggregate make a difference and therefore are worth the effort. It is in fact the role of evaluation to help build evidence for and against these assumptions so that planners and policymakers may discard those that appear unsupportable and concentrate resources on those that appear to hold up.

IV. Analysis of Selected Recent AID Evaluations

To see how recent evaluations have addressed the same issues that were discussed with the Agency health staff, 34 evaluation reports on health projects (nutrition, and family planning projects were not included) were obtained from the archives of the regional bureaus. Of these, ten were final reports, the balance midterm. An attempt was made to locate as many reports as possible for each bureau going back to approximately 1980.

Each evaluation report was read and the most salient points within each issue placed in a matrix in order to see what, if any, lessons could be learned from evaluatons already done when these were placed into a comparative framework. Annex A shows the results of this analysis.

After the evaluations were placed in the analytic framework, the results were studied to see if trends or generalizations could be discerned. A series of comments and lessons learned are shown on pp. 23 and 24 for each issue.

Nearly every evaluation addressed the issue of how host government policies affected the results of the project, mainly to say that while governments had generally positive policies on paper the reality usually did not match the rhetoric. Nineteen evaluations dealt with, or commented on, the issue of cost-sharing. Only a few projects were able to demonstrate that some costs will be borne by direct beneficiaries. Sixteen evaluations referred to private sector activities; these were most common in pharmaceuticals

manufacturing, drug retailing, and family planning re-supply, all of which were noted as services for which recipients seemed most willing to pay. The issue of sustainability was addressed in every case, the main comment being that where access was expanded recurrent costs posed an enormous problem for the long-term outlook. Nineteen evaluations commented on the issue of integrated and categorical programming. Most countries had policies favoring integrated programs in the long run but were either finding its implementation very difficult.

Of the 34 evaluations examined, 12 attempted to document change in one or more direct measures of health status, usually change in morbidity and/or mortality. Of these 12, only one (Egypt/CDD) claimed to be able to do so. The others all determined that such documentation was not possible because data that had been planned to be obtained were not, often because the information system had broken down, or that those data that had been obtained were too unreliable to be useful.

A word of caution: it must be remembered that an analysis such as this is very impressionistic. We feel that a deliberate attempt to assess multiple evaluations systematically against the same issues is bound to produce more reliable conclusions than reading a series of evaluations at widely separated points in time and without a framework of specific issues to look for. Nevertheless, the approach is a weak vehicle when each evaluation is essentially a stand-alone exercise designed in isolation from other evaluations that happen to address the same issue. Much better would be a detailed protocol that refined each issue into a set of much more specific sub-issues. Every evaluation that covered a particular issue then would produce detailed information of much greater comparability. Just such an approach to comparative analysis is proposed later in this paper.

V. Proposed Framework for Carrying Out Issue-Oriented Impact Evaluations

It is important to emphasize that there is no single methodology for carrying out impact evaluations. As White [38] has so aptly stated, "each field evaluation is a uniquely crafted activity". Each one must be tailored to fit its own circumstances with regard to available time, staff, and money; type

and quality of data available; and level of precision or degree of certainty required to suit the purpose of the exercise [39]. Nevertheless, it is possible to employ a general approach to evaluating that is likely to enhance the comparability of a group of evaluations and facilitate drawing conclusions for policymaking and programming purposes.

A. The Systems Approach

The approach we will propose here is based on the systems model described earlier. Before doing so, we define some essential systems terms. They are presented in a sequence intended to convey a hierarchy of conditions (states of being with respect to variables under consideration) and events (activities that modify current conditions and lead to new ones) within the system. Although all analysts in the field of systems agree that a hierarchical format best conveys the feeling for the flow of events and subsequent conditions in the system, there is not total agreement on the hierarchical arrangement of the terms employed. What is presented below is one common set [40]. Regardless of the confusion which sometimes arises as a result of this non-standardization, the important concept is the hierarchical sequence.

Goals: The broadest, most non-specific, and most subjective of intended achievements of a system. Goals are often propounded as unquantified statements, such as "improving the health status of under-fives", and tend to be longer-range expectations. To be evaluable, "improved health status" would have to be defined, perhaps as "lower mortality due to diseases a, b, and c, and higher average nutrition levels on the Gomez scale".

Objectives: The set of quantified targeted ends which, if achieved, would sum up to achievement of the goal. Reducing the incidence of disease A by X%, disease B by Y%, and disease C by Z% and reducing the prevalence of Gomez 2 and 3 malnutrition by X% would constitute objectives within the goal of "improving health status".

Sub-objectives: One or more quantified lower-level objectives within an objective which, if achieved, would lead to, or facilitate achieving the higher objective. Immunizing X% of children with a full set of shots would lead to reduction in the incidence of the targeted diseases. Some analysts prefer the term outcome to sub-objectives.

Inputs: Resources required by a system in order for it to achieve its objectives. In an immunization project, the children, the vaccines, and the staff are required inputs (along with a multitude of other resources).

Process: The set of activities that are required to convert inputs to outputs. Training would convert inexperienced staff into vaccinators, education would convert unaware mothers into mothers who desire their children to be vaccinated.

Output: The tangible result of process interacting with inputs. Trained staff and aware mothers would be the output of the training and education processes.

The causally progressive nature of this scheme should be apparent: Process converts inputs to outputs, outputs lead to achieved objectives, and objectives achieved constitute goal-attainment. The systems approach to evaluation is based on the conviction that, if lessons are to be learned from measuring the success or failure of a project or program in achieving its objectives, it is vital to study and understand both this logical flow and the interaction between the components of the system and the outside environment. The logical framework employs this systems approach for planning and that makes it also a very useful tool for evaluating along a systems line. Particularly useful are those variants of the logframe that require consideration of assumptions about linkages between adjacent levels in the system.

A system is defined as a collection of components organized so as to achieve a particular goal. The individual components of large systems often are smaller systems, sometimes designated subsystems. Subsystems may consist of even lower level systems (sub-subsystems?). Subsystems may be virtually independent of one another in the context of the parent system, or may be linked in a causally progressive way. For example, in a primary health care system, the subsystem for improving water and sanitation and the subsystem for moving commodities may perform their own tasks pretty much independently of one another, but the output of the logistics subsystem is a vital input to successful service delivery of the health centers.

B. Selection and Analysis of Projects or Programs to be evaluated

Although individual projects or programs will be studied in this series of evaluations, the main thrust of the series will be a comparative analysis in which all projects dealing with the same issue will be evaluated against a standardized set of criteria. For example, if the issue is cost sharing/community financing, then specific data to be obtained would be such items as [26,41,42]:

a. Means of payment (fee for service, drug sale, prepayment, community fundraising, etc.)
b. Relative prices of financed services
c. Proportion of service covered from national/regional sources vs. local vs private
d. Financial management scheme
e. Role of credit
f. Level of community participation and control
g. Type and degree of technical guidance provided at local level
h. Record-keeping and scheme for monitoring cash flow
i. Achievement of project/program objectives (coverage, service-specific utilization, sustainability, user satisfaction, savings in public sector, re-deployment of savings, total cost for health services)

A list such as this should be developed for each issue to be studied. Many projects or programs will not have information for every variable, but some items, e.g., community participation and control, can be developed in the few weeks available to an evaluation team in the field by means of discussions with local managers and ostensible beneficiaries. In many cases, teams will be confronted, as they always seem to be, with a paucity of hard data, particularly those that measure achievement of objectives. It is important for the sponsors of these impact evaluations not to expect rigorous statistical analysis, but rather a mixture of real data, insightful observation, and informed speculation on the relationships between inputs and outputs and between outputs and the achievement of objectives.

The general methodology consists of a systematic examination of project <u>inputs</u>, <u>outputs</u>, the <u>process</u> that converts inputs to outputs, <u>outcomes</u>,

objectives, and exogenous factors. Into the latter category will go such items as the specific policy issues under investigation in this series of evaluations. For each of these categories, there will be an initial study of documents to determine what had been planned or expected or anticipated at the time the project was designed. The logframe will be a particularly useful source of this information and also be a starting point for specific indicators of achievement. Information then will be collected on actual attainment in each category, the gap between what was expected and what actually happened determined, and, to the degree possible, information or informed judgment developed to try to account for the discrepancy.

A system model should be produced, showing the logical flow of inputs, process, and outputs that was expected and where (if at all) the chain of causal linkages was interrupted. The impact of exogenous factors, such as changes in economic conditions, government policies, or non-project health inputs, should be noted and discussed, showing where and how they impinged on the system. Particular attention should be paid to the process, that is, the specific tasks and activities that were proposed to convert inputs to outputs.

The preceding part of the evaluation, treating with the evaluation of a specific project, is largely designed (except for the methodological approach) for that project. However, the evaluation within the project of issues relating to AID policy and programming will follow a framework designed for use in all cases. This is the key to analyzing these issues across cases and maximizing the certainty of conclusions drawn.

This aspect of the methodology will start with systematic collection of data on the same set of factors relevant to a given issue over four to six projects in various settings (urban/rural, moderate/low income, etc.). This will be followed by a qualitative cross-site analysis aimed at drawing out cause-effect relationships that are not site-dependent, as well as those that seem to be greatly affected by their context. While qualitative analysis is not as conclusive as quantitative analysis can be, this systematic, multi-case approach is a vast improvement over the each-case-on-its-own approach. Decisionmakers can be reasonably confident applying information developed this way to new policies and programs. Moreover, unless the day is reached when every AID project actually incorporates a good quantitatively-based evaluation

component, qualitative data will remain much more abundant than quantitative, and probably in many cases more reliable.

Miles and Huberman [43] describe a range of techniques based on matrix analysis and causal network modeling for carrying out cross-site analysis. Some are fairly simple to apply (the matrices of Section III are examples), others are considerably more complex. All, however, bring new power to maximize the informational return from comparative analysis of multiple evaluations.

An important question in the selection of projects to be evaluated is whether the process should focus on programs or on issues. A program focus would select a group of projects or programs that all include as an important component a particular intervention, e.g., ORT or EPI or infrastructural development They might or might not also deal in depth with such issues as involvement of the private sector or cost-sharing, but the objective of the series of evaluations would be to find those factors that determine the success of the intervention. Issue-focused selection would first locate the set of projects and programs that all deal with a specific issue and select from them; all would not necessarily contain the same intervention.

Since current Agency policy stresses both issues and interventions, it may be that some from both groups should be selected. This will require the Agency to intermix issues and interventions in its order of priorities, for example, highest priority, immunization; next highest, cost sharing; next highest, ORT, etc. (This is not our suggestion of an order.) Given the number of projects that either have concluded in recent years or soon will, it may well be possible to in fact create sets that cover interventions and issues simultaneously. Thus, a decision might be taken to focus on child survival strategies (ORT, immunization, growth monitoring, etc.) and on important policy issues such as cost sharing and sustainability. In the future, the Child Survival projects are likely to be particularly rich subjects for impact studies because of the elaborate monitoring/evaluation components slated for them.

(A standard criterion in selecting projects for evaluation, of course, is cooperation from the USAID and from the host government. Access to data and to personnel who are or had been involved in the project is also a factor.)

C. Recommended Impact Evaluation Protocol

Following is a recommended protocol for applying the systems approach to evaluation in the context of the comparative analysis described above. The output of the protocol is both a summative evaluation of the individual project and the production of data and information required for the comparative analysis. A number of manuals are available that discuss issues such as causal attribution, appropriate metrics, threats to validity, and data analysis [3,4,11,24,38,44] that are generic to all evaluations. These issues will not be repeated here. Also, the protocol does not provide moment-by-moment details of the evaluation, only certain key points.

1. Assuming that the purpose of the collective set of individual evaluations has been established, that is, that the issues and/or programs to be evaluated have been determined by the Agency's policymakers, a team is convened to select specific projects to study. The team should comprise health professionals who collectively are familiar with the full range of the Agency's portfolio in the health sector.

2. An Issue Coordination Team is convened to specify what questions should be gathered specifically for the comparative analysis. These will come from the list created for each issue (such as that shown in Section B). The Coordination Team will specify tentative comparative analyses to be done. This step is expected to require considerable communication with the field to verify that most of the people who should be interviewed and that records needed for specific quantitative data are available. It may be necessary to shift projects if much of the necessary information can not be obtained and/or to modify the proposed comparative analyses. The Coordination Team also will determine what the appropriate mix skills on the Evaluation ought to be.

3. An Evaluation Team is formed. If several projects are to be evaluated simultaneously, it may be necessary to constitute more than one Evaluation Team. The Coordination Team meets with the Evaluation Team(s) to assure that the nature of the comparative analysis task is clear. Each team is given the responsibility for familiarizing itself with the project it is evaluating using project design and management documents and intermediate evaluation results. The Team is responsible for designing its own specific protocol.

The protocol will take into account the need to meet the requirements for the comparative analysis as determined by the Issue Coordination team, as well as those of an impact (summative) evaluation of the specific project being studied. The protocol will include a plan for comparing actual inputs, outputs, and activities with what had been planned and will carefully lay out project objectives and determine how the degree of success in achieving these objectives can be measured. The flow of chained causal links that underlayed the project planning will be specified and measures for determining whether the actual implementation of the project matched the plan will be devised.

4. The Team Leader makes a preliminary site-visit to establish links with the USAID and with host country agencies and individuals who will cooperate or participate in the evaluation. He/she determines where, how much, and what kind of data are available, and may start the collection process in motion. In addition, he/she produces a preliminary model of the system under consideration, taking into account components and their linkages and what role each plays in moving the system toward successful achievement of objectives. He/she may also make some preliminary judgments about exogenous factors that should be considered by the team, for example, economic, cultural, and political.

5. Upon the return of the Team Leader, the Team finalizes the type of information it plans to gather and prepares its instruments for gathering data (interview guidelines, secondary data, perhaps some primary data).

6. In-country, although the team follows the protocol it has devised, some leeway must be allowed for the evaluators to pursue avenues that were unforeseen, but that contribute greatly to the larger objectives of the whole effort. For example, one component of a project was aimed at shifting part of the cost of providing drugs to the users by means of community drug stores. These were capitalized initially by the Ministry of Health with the understanding that the people would maintain them. In the course of the evaluation, it was found that the drug stores were very lightly patronized. On the other hand, in some places drug stores that were originally capitalized by the people were self-sustaining. Although a study of these "non-project" stores was not part of the protocol, the evaluator should be allowed to spend some time trying to find out what accounted for this difference.

7. Following the in-country portion of the evaluation, the Evaluation Team(s) meet with the Issue Coordination Team to discuss and hand over the data gathered for the comparative analysis. While the former pursues its analysis of the impact evaluation for the project, the latter performs the comparative analysis of the larger issue.

8. For both parties, reporting and dissemination is the last step.

ANNEX A

NEAR EAST	Scope	AID/Host Country Planning Process	Integrated v. Categorical	Com Finance/ Cost Recovery	Community Participation	CHW: Role, Compensation	Contractual Obligations	Comments on E Methodolog
EGYPT Control of Diarrhoeal Diseases (263-0137) Midterm eval, May 1984	Pilot project with national scale-up; through media campaigns, IE&C efforts already national level	Remarkable success in achieving Phase I outputs; must address staffing, fin mgt, disbursement procedures, and eval of cost-effectiveness before scale-up Project is semi-autonomous, has facilitated implementation of activities, recruitment Regular surveillance, established base-line positive Some problems with fin mgt, USAID approval and procurement mechanisms		Many cost-effectiveness studies undertaken; MOH already supports major operating costs of project	Home-made ORS training at community level	Problem of salary scales and incentive payments complicate implementation		Collective eval by GOE/USAID/UNICEF/WHO: used methodology as described in WHO Manu for Planning and Evaluation of Nation Diarrhoeal Disease Control Programs
MOROCCO Population/Family Planning Support Project (608-0155)	Regional with plans for national expansion	Delays in planning and facility development, need for more streamlined data collection and analysis, clearer IE&C component Project production good, exemplary working relationships between MOH/USAID	Firm committment to integrated health services, all services collectively delivered and firmly entrenched w/in existing infrastructure	Used to focus of self-financing capabilities of FP activities, already some fee for service experimenting		Multipurpose workers provide health/FP interventions; supported by MOH and fully integrated into system		
YEMEN ARAB REPUBLIC Tihama Primary Health Care (279-0065) Midterm Eval, April 1985	Regional	Confusion about immun. policy regarding target groups impeded progress; disagreements between MOH and AID regarding MOH contributions impeded progress; about 50% project outputs unrealistic given project inputs or poor definition of "output"; lack of communication; long term TA insufficient for required tasks with respect to availability of Yemeni counterparts	Mixed integrated/vertical programs	Project explores drug funds and other mechanisms (local development agencies) to lower PHC costs in the villages	Community support through use of local development agencies	PHCWs, LHAs, TBAs have been trained and integrated into part of civil service. LHA trng may be suspended due to uncertain support and function; innovative approach to TBA trng in form of womens health meetings	Current contractor providing satisfactory assistance, having met 50% of project objectives at midterm, the balance being unrealistic	

LATIN AMERICA	Scope	AID/Host Country Planning Process	Integrated v. Categorical	Com Finance/ Cost Recovery	Community Participation	CHW: Role, Compensation	Contractual Obligations	Comments on E Methodolog
Peru Integrated Health and Family Planning Projects (527-0219, 527-0230) Midterm Eval, May 1985	National, 14 out of 17 regions.	- Slow start - Flow of funds single most important prob, esp between regions and central office. - Great variations in services with similar inputs, implies systematic monitoring could enhance productivity. - Unnecessarily detailed controls at central MOH, focuses on cumbersome admin procedures rather than delivery of services. - Targets unrealistic - Plan, norms, procedures usu developed at central level, in region considered inappropriate. Decentralization imp means of improving management. - Personnel concentrated in urban areas, rapid turnover of regional personnel. - Valuable TA from contractor - Management info system OK but info not used.	Making imp progress in development of integrated hea'th and family planning system.	Testing approaches to generate money to pay. CHW's such as revolving funds, charging for services. Most PVO's depend on outside fin support, charge fees but cannot survive on these.	Communities aware of CHW's but don't know what they do.	CHW's core staff in rural areas lacking PHC services. Yet only task agreed upon is "difusion" and question whether its worth the investment. 3000 trained, no specific data available on their performance. Volunteers, rapid turnover.	After slow start, progressing well. Should revise targets.	Team leader returned for second visit for further observations. Draft report then sent to MOH and their comments incorporated in final.
RDO/C Caribbean Epid Surveillance and Training (538-0027) PES, Feb 1985	Regional	Well managed, well defined selection criteria for participants. Good support systems in place.					Can't compare obvious in^'cators to measure succ. as because changing disease patterns and more accurate reporting. Has met quan targets.	

LATIN AMERICA	Scope	AID/Host Country Planning Process	Integrated v. Categorical	Com Finance/ Cost Recovery	Community Participation	CHW: Role, Compensation	Contractual Obligations	Comments on E Methodolog
Peru Integrated Health and Family Planning Projects (527-0219, 527-0230) Midterm Eval, May 1985	National, 14 out of 17 regions.	- Slow start - Flow of funds single most important prob, esp between regions and central office. - Great variations in services with similar inputs, implies systematic monitoring could enhance productivity. - Unnecessarily detailed controls at central MOH, focuses on cumbersome admin procedures rather than delivery of services. - Targets unrealistic - Plan, norms, procedures usu developed at central level, in region considered inappropriate. Decentralization imp means of improving management. - Personnel concentrated in urban areas, rapid turnover of regional personnel. - Valuable TA from contractor - Management info system OK but info not used.	Making imp progress in development of integrated health and family planning system.	Testing approaches to generate money to pay. CHW's such as revolving funds, charging for services. Most PVO's depend on outside fin support, charge fees but cannot survive on these.	Communities aware of CHW's but don't know what they do.	CHW's core staff in rural areas lacking PHC services. Yet only task agreed upon is "diffusion" and question whether its worth the investment. 3000 trained, no specific data available on their performance. Volunteers, rapid turnover.	After slow start, progressing well. Should revise targets.	Team leader returned for second visit for further observations. Draft report then sent to MOH and their comments incorporated in final.
RDO/C Caribbean Epid Surveillance and Training (538-0027) PRS, Feb 1985	Regional	Well managed, well defined selection criteria for participants. Good support systems in place.					Can't compare obvious indicators to measure success because changing disease patterns and more accurate reporting. Has met quan targets.	

LATIN AMERICA	Scope	AID/Host Country Planning Process	Integrated v. Categorical	Com Finance/ Cost Recovery	Community Participation	CHW: Role, Compensation	Contractual Obligations	Comments on Eval Methodology
EL SALVADOR Urban Health and Rural Nutrition Project (519-0253) Midterm Eval, May 1983		- Weak project design, done quickly - Rural program unsuccessful less because of politics than 1) inadequate management procedures and support for field activities within MOH 2) lack of flexibility and insufficient resources given to Regional Health Offices to plan/execute programs. - Regional personnel had little input into planning process. - Eval plan never carried out. - No MIS.	Sectoral, nonintegrated approach little impact on complex socio-econ problems.		Organization and response of communities around urban envir sanitation activities impressive. CHW's able to organize and unit community residents for various self-help projects, community relations improved. CHW's gained trust where other com workers suspect (they have no political affiliation). Given political limitations to community organizing in rural areas, com part unrealizable in some areas.	Careful not to affiliate CHW's with political motives, have developed trust. Effective in urban sanitation program. Receive monthly cash bonus in addition to food incentive.	Achievements not met project targets.	Eval plan never carried out.
GUATEMALA Community Based Health and Nutrition (520-0251) PES, Aug 1983		- Long delay in start-up (24 mos): slow Guatemala Congress approval, TA contract, failure to meet conds precedent. - Implementation slow due to 1) inability of central grant-funded staff to plan/manage complex project 2) personnel changes 3) key staff not qualified for resp. - Budget cut because of IMF pressure. - Underestimated need for experienced central staff to manage.	Lack MOH personnel capable of coordinating, integrating, managing activities.		Good participation even when materials not provided. Communities responded well to participation when they see tangible reward for labor (e.g. water system).	60% of targeted TBA's trained, 40% of promotors. Volunteer.	Far behind targeted outputs. Input/output coordination probs result of probs with central admin unit and its relationship with field activities. Absence of supervision and info system, progress toward MOPS cant be measured.	Consultants left drafts to be produced by mission. Unacceptable.
HAITI Rural Health Delivery System (521-0091) Interim Eval, March 1983	National but too ambitious, MOH could not support this scope.	- Presupposed admin capabilities and capacity for expansion and support that didn't exist. - Should develop strategy for self-sufficiency. - Objectives/time frame unrealistic. - Conds precendent should be renegotiated (unmet, unreal). - Conflict in interpretation of contractor role: DSPP thinks too directive, AID thinks not directive enough. - Recommends separate manpower unit at DSPP. - Good TA provided.	Intergration was cond precedent- unmet and no pressure to comply (all vertical programs were to be integr into DSPP while decentralizing decision making). Nutrition program was substantially integr but had prob: difficulty in executing programs because of budget delays in ministry. Normative functions should be integr such as manpower planning.	Initiated revolving drug fund. Not self-sufficient yet but expect success. Need to investigate user fees.	To date, focus of project at ministry level (policy development) not community level.	Trained 550, but don't have support system to maintain. Prove training program. Multipurpose, salaried. Question of effectiveness and sustainability.	Set quantitative goals, but unrealistic, need to revise them.	
HONDURAS Health Sector I (522-0153) Midterm Eval, Feb 1984	National	- Difficult for MOH to absorb new positions (critical to success of project). - AID/govt should expect to redesign implementation plan after start-up, inevitable. - Delays in start-up due to unmet conds precedent, TA contract. - High quality TA. - Prob with decentralization: regions don't have authority to make decisions. - Unclear role of project coordinating unit. - Some activities consolidated.	Diarrhea Control program good example of integr sanitation/nutri program.	After dialogue with GOH, changed law prohibiting fee for service. In reprogramming considering com part component, means of generating funds to compensate CHW's. Establishing short term work group to study com financing options.	Community part to be stimulated by VHW's. Early stages of project focus above community level. Been as essential to PHC system.	Little change in services provided by VHW as result of project. MOH proposed guidelines recommending VHW's paid directly by communities, then more responsive to com needs.	Pace acceptable, esp given external constraints.	Follow-up memo with actions taken as result. Mission should be more directive with team, weed out secondary info that is not necessary for team to read.

LATIN AMERICA	Scope	AID/Host Country Planning Process	Integrated v. Categorical	Com Finance/ Cost Recovery	Community Participation	CHW: Role, Compensation	Contractual Obligations	Comments on Eval Methodology
DOMINICAN REPUBLIC Health Sector I (517-0107) Final, Feb 1982	National success	Admin reform: key people must be involved in planning process, needed more "low-key" approach from contractors Urban program dropped because it duplicated services and lack of interest of CHW's. Assumed GODR would support nutrition proram despite its indifference in the past. Contractor did not provide adequate TA in statistics, transport, maintenance.	Health Secretariat made some admin changes improving its management ability as demonstrated in the integration of the rural health serv ces and nutrition programs.		Each village has committee who selects promotor.	5400 trained, multipurpose.	Some dissatisfaction with the contractor, tho using log framework indicators, system improved.	Cant attribute cause/effect, tho IPR dropped, assume project health interventions positively influenced health status.
DOMINICAN REPUBLIC Health Sector I, II (517-0120) Midterm Eval (PES), May 1983	National	90% community coverage, but not getting most for money because of weak management support systems, logistic probs, weak MIS, minimal cont ed. Dropped urban section because existing programs duplicate, CHW's turnover.	AID encouraged integration of this program with SESPAT (Health Secretariat), mixed results. Question of establishing new authority- previous lines severed. Also now the program must compete with other programs in larger institution for limited resources. Success depends on degree perceived to meet larger institutional needs. Can larger insti actually absorb?		Good community involvement and support while CHW doing activities community perceives as important, such as immunizations, basic curative.	Focal point of program. CHW's receive salary regardless of effort (prob of low productivity). Cant take salary away now, part of system. Currently trained in immun, FP, nutri, san, stats: effective in immun, curative. Should be careful how expand duties.	Promotor coverage of 80%, but could be more effective.	Hard data not avail, any statistical analysis of large sample fraught with error, eval based on impressions.
ECUADOR OPG Rural Community Health (518-0002) Final Eval, Nov 1982	Regional	- First 2 1/2 yrs focus on planning, develop training materials and curricula, gaining govt/com acceptance. - Now govt trains all CHW's, can use parts of program but program itself will not cont. - Use of expatriot staff: difficult to replicate, locals would not get same benefits (schools for children, social support).	Once began integrating with MOH in 1980, had to move much slower in implementation.	Govt supporting some CHW's. As took on more responsibilities, CHW's earning community money from multiple sources.	Communities has to ask for CHW, some rejected once trained tho some CHW's have left. Easier working thro existing community organizations than creating new ones. Unplanned: enhanced ability of communities to access govt for additional assistance (learned how to get help).	130 CHW's trained, 90 functioning. Multiple purpose, promotive and preventive. All male, men seem to get along better with community leaders. Began as volunteers, after govt integr, CHW's given stipend, others then would not work as volunteers, tho one region has maintained volunteer status. CHW's means to reach communities and involve them in services. Salaried, multipurpose.	Meeting terms of plan, but original plan very flexible, adaptable. Project didn't document fully its activities, changes, special adaptations so can be communicated to outsiders. Neglect of systematic collection of info on health conds in service area precludes impact eval.	Qualitative assessment, not able to determine extent project coverage satisfies needs or compare performance of project with other health activities. Difficult to attribute any change to project because of dynamic forces.
ECUADOR Integrated Rural Health Delivery System (518-0015) Midterm Eval, March 1986	Originally targeted 14 other IRD areas for expansion. Probably unable to scale up and maintain same intensity of resources, too expensive.	- Delays because limited Ecuadorian counterparts. - Regional MD's impede implementation because not "educated" about usefulness of PHC. - Project objectives overambitious. - MOH financial monitoring undeveloped, unable to trace expenditures. - Nebulous definition of decentralization. - To date, more time has been spent on higher levels (MOH) instead of community level. - Successful ORT component could be used as model for other components.	Intergration is key strategy, to work needs more coordination and cooperation of others in MOH and other promotor agencies. Very long slow process requiring strong effo t.		Com part critical aspect of goal realization. Rural MD's were to stimulate community activities thro outreach, very weak. More concern at higher levels, less focus on participation, except in ORT component which successfully involved community.		Many delays, out of control of contractor, did well under difficult circumstances.	After consultation, experts separated, 4 eval reports produced instead of one.

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PAKISTAN National Oral Rehy.tation Program 19847	National	Planning constraints involved lack of full-time manager for ORT component; poor information delivery to the general public; emphasis on media for health educators despite their having no IEC orientation; lack of involvement of trad healers in ORT program; inefficient epidemiologic surveillance system	Gov't initiated health care programs now integrated, although current ORT efforts vertical			CHWs mandated by project although remain untried; problem due to program being built from top down		
PAKISTAN Basic Health Services (391-0415) Final Eval, 1981	Serving 4 provinces	Project fell somewhat short of quant. obj of project for first 3 yrs; pp written by MOH w/assistance from AID and contractor; problems with long term TA and keeping them in the country;health centers planned and built but none in operation;base-line not done although mandated; training of supportive workers,OH on costs,IEC all mandated not done; generally overoptimistic project objectives						Few accomplishments of project lent themselves to quantificaiton; problem on having 2 teams assessing different aspects of project at same time
THAILAND Lampang Health Development (931-0971) Final Eval, 1981	Provincial with phased expansion plan to cover at least 2/3 of rural population decentralization necessary if scale-up is to be effective	Problems with project resulted from cumbersome administrative arrangements with contractors and gov't; no institutional affiliations with MOH; difficulty in est. clear eval obj between donors, causing delays;many delays in data processing because of institutional problems; quasi-experimental design inappropriate with extensive project implemented w/in existing gov't infrastructure	Nat'l health policy stresses committement to integrated servcvices. Mobile unit promotes integrated services in rural areas	Implementation costs of project substantial; without external funding, financial sustainability not likely, although most costs were non-recurring;MOH assumed most operating costs	Broad based CP especially as st[illegible]ited by CHWs and volunteers; nat'l policy stresses importance of CP in successful PHC program	Trng of many different cadres of health workers; all contribute to increase access to services and increase utilization; 4 types of single purpose CHWs		Very definitive emphasis on monitoring and eval of project; absorbed many resources

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BANGLADESH International Center for Diarrhaeal Disease Research Bangladesh (931-1012) Midterm Eval, Dec 1982	Int'l research center;need to assist other countries in developing nat'l programs more geographic specific.	Project thought to be balanced and appropriate, although distinct lack of immunologist and epidemiologist on research staff						
BURMA Primary Health Care I (482-0002) Midterm Eval, April 1982	Pilot support for nat'l health delivery system in 147 rural townships; plans to extend to 55% of all townships	Computerization of management and health info systems premature and inappropriate; poor existing health info system; Quantitative project goals mostly successfully met as stated in p.p. Close AID collaboration with GOB in developing project design; both knew of constraints of rapid expansion of services at risk of quality; Problem with heavy p.p. focus on commodity procurements and pharmaceuticals				Single purpose CHWs: Aux midwives, TBAs, multi-purpose CHWs; initial focus of quick coverage thus compromising on adequate training of CHWs; more curative focus than preventive; CHWs were mostly volunteers, reinforcing Burma's religous and cultural orientation		Lack of impact data or institutionalization of internal monitoring system to facilitate impact evaluation at MOP
INDIA Integrated Rural Health and Population (386-0468) Midterm Eval, Nov 1983	Debut in 14 rural districts in 5 states with goal of national implementation.	Slow startup of project due to problems with T.A; original timeframe unrealistic; serious delay in completion of base-line and needs assessments: to have been completed before any other activites began; absence of adequate technical staff at state and diartict levels; project goals TOO quantitative; need for more qualitative orientation; problems experienced with financial disbursements for construction costs		Concerns about costs of implementing national model health plan. Recommend: comprehensive cost analysis, recurrent cost analysis, sensitivity analysis and alternative financing schemes	Noted lack of emphasis on CP; suggestions for its use in the diffusion of Health and family welfare measures in the rural population	Shortages of TBAs; problems getting training programs established		No post-survey in project design to assess impact and compare to base-line (pre-test)
INDONESIA Comprehensive Health Development Program - Province Specific (CHIPPS) (497-0325) Midterm Eval, June 1984	Focus on 3 provinces	Project developed with GOI to help determine progress in introducing and implementing decentralized epidemiologic and problem-solving approach to health planning; mechanics of financial disbursement often unclear, resulting in low expenditure of project funds - budget constraints and procedures differed between vertical and integrated programs; lack of process indicators to measure performance; problems identifying long term consultants	Most health sector programs vertical (1 province has 20 programs and 17 CDC interventions) making health status difficult to measure; project focus one integration of PHC interventions		Major emphasis on CP in one province; development of coordinator position to manage all CP activities; caution against CP as an end in itself	Single and multi-purpose CHWs being compared for effectiveness in distributing oralyte and teaching mothers ORS; other incentive programs for CHWs being tested		Lack of process indicators by which to measure performance

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SENEGAL	Regional	- Initial plan did not provide for adequate preparation of village health committees. As result, did not understand scope of local management & financial responsibility & couldn't communicate it to villagers. - Apparently did not consider effect of GOS policy to provide free care at health posts on willingness to pay at health huts. - Underestimated problem of generally hands-off management by USAID, exacerbated by no regional field location. - 1983 evaluation concludes that weak original design was improved enough by re-design to offer prospect of some success.		Initially, huts decapitalizing because drug charges unrelated to cost. Utilization records very poor so no way to tell if patients being charged for visits. Financial records did not correspond to cash on hand. By 1983, financial record-keeping greatly improved, drugs being charged for at full cost. VHWs being paid for by user fees. People resistant to paying for supervision, so still paid by MOH. People will not yet pay for prev/promotive services so these aspects of PHC greatly neglected. May also be possibility that services under-utilized during cash-poor season.	Initial failure to train Village Health Committees led to their failure to educate the community in their responsibilities and concomitant opportunity to control the system to a degree. After Committees trained, were able to inculcate sense of ownership of health hut and people more willing to pay for some services that they valued (curative). Found that women participate less and may underutilize; organized Mothers Committees to get more participation.	No comment about quality of training or care. Supervision initially very poor. Improved after redesign but still weak. Had to go to motor scooters for transportation because horses not maintained. First selection criteria included literacy, but resulted in training younger educated people who were more upwardly mobile; turnover rate reached 30%. Now look for older, more established trainees.	Redesign seems effective in most areas. Big exceptions are how develop adequate supervision system and how finance preventive and promotive activities.	1980 evaluation concentrated on process because was obviously deficient. 1983 evaluation looked at same questions to see where project was headed. No attempt yet to determine impact in terms of changes in health status indicators. First evaluation complained that no baseline data existed so there would be no way to evaluate health impact directly. Subsequently, baseline data collected on morbidity and mortality, nutrition, and family planning KAP.

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NIGER Rural Health Improvement (683-0208) Midterm, August 1981	National	- rural health system is well developed, approp to country's general situation and provides good coverage. - unrealistic objectives/time frame. - managerial probs in terms of lines of authority and reporting.				Volunteer health teams.	Problem fielding long term TA. On target.	Eval team confined to formal proceedings, couldn't do anything without ministerial approvl. Used WHO eval methodology.
SOMALIA Rural Health Delivery (649-0102) Midterm, Feb 1984	Currently in 2 regions, should not expand to other 2 regions	- PP proposed expansion and inapprop buildings. - substantial delays in commodities and building materials further delayed training efforts. - expenditures for commodities for exceeded budgeted amount. - procurement planning neglected. no logistics management training. - after 4 of 5 years, only 50% of budget spent. - transport probs (drivers and vehicles).			Villagers actively waiting to participate and receive PHC services.	Some incompatibility of CHW's with posts and training	Overall dissatisfaction with contractor and their inability to provide any managerial, logistical of tech support.	
SUDAN Rural Health Support Project (650-0011) (650-0019) Midterm Eval, April 1985	National (separate contractors for north and south) Pol difficulties in south prevented implementation. All 3 south projects closed.	- inadequate design. preparatory field work not undertaken. - implementation plan does not address likely constraints (ex. govt unable to finance regular operations in project locations, brain drain, security probs in south, drought). - 2 yr delay in start-up frustrated MOH and AID, lost interest. - no overall strategy linking activities. - need to establish management systems that reflect local capability and resources before starting substantial activities. - no manpower devel plan needed to project future costs. - unworkable division of prev and curative services at regional level.		Various attempts made at cost recovery with limited success. These include govt insurance, patient visit fees, com pharmacies. Citizens led to believe entitled to "free" care, reluctant to pay to volunteer labor and materials for construction.	Com part essential to project, to date, not implemented. Plan orientation for community leaders. Recommend bottom-up planning (collaboration with interest demonstrated by community in willingness to contribute to activity.	Multipurpose, paid by local government	Not achieving objectives.	Tried to use log framework, but found errors and quite vague.

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TANZANIA Morogo District Health Project (621-0130) Final Eval, Sept 1981	Pilot	- govt not involved in early planning causing difficulties in transition will need interim funding. - info systems failed at local level - project strategy too ambitious - need good logical framework, indicators and data needs clearly spelled out.	Developed new program outside of MOH without good integration strategy at outset. Should have involved MOH in decision-making from beginning.	Village shares in supervision/financing resp.-esp where good quality services. Project did not start paying VHW's villages consequently filled this gap.	Use village leaders to bring services to communities. They provide admin supervision	Volunteer-but not feasible to have unpaid VHW's in long run. Currently more competent receiving reg salaries from local vill govt.	Progress toward objectives good. Target pop able to discuss health practices. Need better infor system.	
TOGO Rural Water Supply (693-0210) Midterm Eval, April 1983	Regional (areas where other donors concentrated activities)	- severe admin deficiency in managing project, many probs arise from inconsistent implementation of existing procedures. - communication probs between donors (ex some villages had geological probs so were replaced by others. PCV's unaware of change, mobilized original village causing some disappointment later. - financial accounting needs improvement, probs stem from centralized system - diff in obtaining funds for transportation, inequities in per diem. - objectives for health ed component should be restated to focus on outputs rather than inputs - AID tech advisors spend too much time in Lome		After an initial grace period, villages should pay all maintenance, operation, depreciation costs. Currently they contribute to construction costs.	Village health committees organized in all affected villages. Working with promotors have conducted activities such as village clean-up, disease prevention, fund-raising for pump maintenance.	100 promotors trained. PCV's full-time counterparts to social promotors in village or promotor's supervisors. Top project management (Lome) regard USAID's policy of not paying "indemnities" as a disincentive. Major difficulties in promotor's work is management related.	On schedule, doing well.	No econ eval was adopted because of scarce data. Due to lack of documentation, not able to eval effectiveness of some activities.
ZAIRE PSV/CCCD (690-0421) Midterm Eval, April 1985	National	- in design of project, emphasized need for GOZ to incrementally assume project-generated costs, to avoid over-expansion. But actually decreasing GOZ contributions over 3 yrs - these only go for salaries. Consequently, unreal targets. - PSV basically categorical, relies on budget allocation from central govt, rapport important. - with budget cuts, need to revise objectives targets. - working parallel to SANRU, facilitate implementation. - basically good program, major concern is financial support from GOZ	National strategy has been to develop specialized services for country (TB, malaria, leprosy, EPI) and integrate at the regional level. EPI has regional offices but not resp for direct services. Relies on regional MD's, over whom they have no control. Long term objective is integration at national level.	ORS: Sold by PSV covered total costs in 1984. Very sale price as function of cost. Chloroquine: less demand as many sources sell it cheaper than PSV. Vaccin: mothers willing to pay something, but not much. Not enough to cover costs.	CHW's to organize community.	CHW's receive special training from CCCD/PSV at regional level (MD coordinates) CHW's responsible for all PHC services tho training is categorical. Compensation varies.	Plan to extend (no cost) for one year to attain objectives.	Too early for impact eval, but should be done in 2 yrs.

NEAR EAST	Host Country Policies	Access/Sustainability	Private Sector	Biomedical/Health Services Research	Donor Coordinatio
EGYPT Control of Diarrhoeal Diseases (263-0137) Midterm eval, May 1984	MOH advocates use of ORT; integrated into PHC/MCH policy; distribution of WHO ORS packets by MOH; nat'l program evolved from research done on CBD of ORS; Nat'l steering committee provides strong leadership to project	Training of over 500 MDs, 400 nurses, 29 pharmacists etc; ORS production facility in place producing 8.2 million packets in 1983; Standard rehydration center supply kits and marketing plan in place; By 1987 all project activities will be fully integrated into health system	Very successful media campaign within both private and public sectors	Research on clinical patterns of diarrhea, etiology, and operation/sociocultural aspects of ORT	Organizational structure at nat'l and governate levels successfully coordinating program with other agencies
MOROCCO Population/Family Planning Support Project (608-0155) Final eval, December 1983	Lack of overt population policy, doesn't hinder project objectives; cultural constraints; support of Pop/FP efforts in 5 year plan, including quantitative objectives; substantial budgetary commitment to project	Contraceptive prevalence increased nationally from 12% in 1978 to 27% 1983; CBD increased from 41% to 53%; Service delivery through existing health structure assures sustainability and availability of products Exploring possibility of mobile and fixed service delivery to reach uncovered population	Emphasis on improved FP services thro private sector activities; commercial retail sales emphasized; media blitz very effective through private sector; some delivery of contraceptives through factory representatives		Linkages between MOH, other ministries and private organizations important to promote FP activities
YEMEN ARAB REPUBLIC Tihama Primary Health Care (279-0065) Midterm Eval, April 1985	Original contractor cancelled due to unsatisfactory performance in fulfilling MOH policy. PHC policy developed over course of project.	Not clear whether existing efforts and accomplishments can be replicated from the PHCP to all of Yemen although possibilities exist that MOH can sustain technical aspects of project. Project goal is for MOH to absorb 75% of recurrent program costs by EOP.			Successful linkages made with World Bank health manpower development efforts: Health Manpower Institute.

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BOTSWANA Child Health/Family Planning Project (663-0078) Final Eval, Sept. 1978	National	- No clear definition of how project would be integrated into existing training programs - should have had counterparts - breakdown in field/central communication - admin, tech, logistic commodity support weak - contractor failed to develop insti commitment and degree of involvement required for support and management of overseas project of this scope. - one year gap in training, did not take new grads into account when projected trainees. - recommend mid-term eval to review implementation of project objectives.	Developed spec training program without specific strategy on how it would be integrated. System resistant to change.				Training targets not met. No refresher course developed. Retraining not integrated into basic training.	Recommended mid-term eval to review progress.
KENYA Kitui PHC (615-0185) Final Eval, Nov 1982	Regional, unserved by other services	- very reliable mobile teams key to success, trusted - weak info system, no baseline surveys need monitoring system - need to involve MOH (shared resp) in services as plan to integrate, yet continue supervisory role.	Began as extension of hospital program. Plan to integrate yet aware govt can't provide same services as cost-effectively. Need to develop strategy	Eval recommends exploring possible fee for service	Lack of com involvement, problem. Currently, com requests clinic, offer building, nominate people for training. (plan training for com members) Com ready to be more involved. Active development committees willing to cooperate.	Eval recommends CHW system developed in next phase.	Lack of sufficient data change in health status, (midterm study helpful but not enough) Provided consist, high quality services com very satisfied with.	let midterm, no reliable baseline. 2nd midterm proposed small study to measure change. Recommends incorporating eval strategy into project from beginning.
LESOTHO Rural Health Development (632-0058) Midterm Eval, April 1982	National	- created MOH Health Planning and State Unit that designed decentralized health services delivery system - design of PHC system sound - need strategy for planning process that links planning to programming and budgeting. - long term success depends on good MOH management, adequate financing, vigorous follow-up in field. - critical to formally establish nurse status and pay scale, analyze incentives needed to keep nurses in field. - worked closely with MOH from beginning. Govt will cont program but maybe not as early as expected.		MOH uses fee for service system. PVO's charge twice as much, know can't raise fees to cover cost of nurses because communities won't pay more.		Nurse Clinicians to train VHW's. Focus to date on developing health infrastructure not VHWs. VHW will not receive govt compensation but will get free medical care.	Most of the MOP objectives should be achieved.	

LATIN AMERICA	Host Country Policies	Access/Sustainability	Private Sector	Biomedical/Health Services Research	Donor Coordinatio
Peru Integrated Health and Family Planning Projects (527-0219, 527-0230) Midterm Eval, May 1985	1979 GOP adopted national plan for PHC, specific objectives set in 1980. GOP strategy: 1) reorganize MOH 2) improve supervision, eval, info , and logistics systems 3) improve physical infrastructure 4) strengthen intersectorial and donor coordination. Peru has had positive govt pop polict since 1976, no serious religious opposition. MOH budget from govt declined every year for last 3 years, contradicting supposed support.	Services have increased substantially, coverage not adequate but improving. Steadily developing infrastructure, systems and trained personnel. Unlikely govt able to cont program as is without external support for some time.	143 private health and family planning agencies working in Peru (some supported by projects). MOH slow to approve worthy family planning programs from them, doesn't monitor them after approved. IPSS (Soc Security) also provides services and supported by AID since 1980. Many private sector opportunities for collaboration that should be pursued. Efficiency of PVO's programs benefit from management unit similar to Ass Demografica de Costa Rica. AID should consider separate project to develop non-govt channels of contraceptive distribution complementary to MOH efforts.		One of GOP's priorities is improving donor coordination. Donor's include World Bank, PAHO, UNICEF, IDB, German Agency for Tech Coop, several other govts. Many donors arrived with preconceived notion of how PHC should be delivered, GOP unab to plan coherent strategy. Presently more than 60 externally funded projects underway. Monitoring Committe created to coordinate.
RDO/C Caribbean Epid Surveillance and Training (538-0027) PES, Feb 1985	At 9th conference of Ministers Responsible for Health, expressed cont support for centre, Multilateral Agreement thro 1987. PAHO to manage thro 1990. Effect functioning depends on its being part of an international health agency that can look beyond national interests.	Trained 3,400 health personnel. 50% of countries' surveillance units improved outbreak recog capability, 84% labs improved services: training provided had positive impact on performance of health personnel in the region. Region has sustained unit (10 yrs with AID support for 6 yrs). It performs important function, of interest to countries.	Unplanned: training program influenced food safety of private sector, regional institutions.		

LATIN AMERICA	Host Country Policies	Access/Sustainability	Private Sector	Biomedical/Health Services Research	Donor Coordinati
EL SALVADOR Urban Health and Rural Nutrition Project (519-0253) Midterm Eval, May 1983	Project design weak because developed very quickly in response to govt demonstration (change of govt 1979). Implementation affected by unresolved pol situation. Rural component weak - sites selected politically, discouraged community organizing. Current rural policies only partially satisfy needs. At MOH, constant key personnel turnover.	55.3% coverage of urban slum areas reached during first 2 yrs. Rural component no: progressing as expected because of pol decision-making, lack of tech and admin support, irreg commodities. Question rural sustainability if communities unable to actively organize and participate.			
GUATEMALA Community Based Health and Nutrition (520-0251) PES, Aug 1983	Health policies unclear. Two changes in govt during project period. MOH budget decreased 26% as result of IMF pressure to limit deficit. Conds precedent not met causing delayed start.	Questionable how sustainable project is because so complex. Developed for twice the funding, activities decreased with reduction in budget, but remained very complex.			
HAITI Rural Health Delivery System (521-0091) Midterm Eval, March 1983	Assumed (cond precedent) health policy and goals existed. Instead, contractor invested first year in developing these and setting targets. Shift from urban to rural (esp personnel) didn't happen. Budget still favors central MOH. Need to "encourage" change as currently budget used for central operating costs, not rural development.	550 CHW's trained but not effectively deployed. Should stop training until services better planned. Can't afford current system. DSPP (Haitian MOH) forced to rely on donors for operating costs for intermediate term (10 yrs). Need to develop strategy for self-sufficiency that may include user fees, better use of manpower, better accounting, subcontracting rural dispensaries to PVO's.	Met with PVO's to discuss roles, established umbrella organization (AOPS) to coordinate. One option: turn rural services over to existing private groups (they would adopt DSPP goals). Some PVO's hesitant to get too closely involved with DSPP. Also physical problem as project did not consider geog location of private dispensaries when built new govt ones, some duplication.		Haitian PVO's coordinate thro umbrella organization (AOPS). AID considering fin support for AOPS.
HONDURAS Health Sector I (522-0153) Midterm Eval, Feb 1984	Project integrated into MOH. Policy dialogue recommended and being carried out on local programming, adminreform, alternative fin/drug sales, fam planning. Constant turnover in key personnel.	Access improved (EPI coverage 60-80%, target 70%). With recent econ crisis and IDB hospital commitment, difficult for MOH to cover recurrent cost. Have not hired staff as promised. As recommended in eval, fin mechanisms improved - using ESF funds to expand revolving drug fund. Will consider recurrent cost prob in Health Sector II project. Conducted pre-feasibility study of local drug production options, would save on imported drugs. Must be involved in institutition building, long term commitment.		OR activities incorporated into project. 2 part-time contractor OR advisors. MOH created Science and Technology Unit to coordinate and conduct OR, demonstrates substantial and explicit support for new activity.	GOH committed to completing IDB hospital construction project which is absorbing alot of the the scarce resources in the health budget.

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PAKISTAN National Oral Rehydration Program 19847	MOHSW devised strategy to link health care in villages to gov't hosp system. MOHSW implemented Diarrheal Disease Control prog in 1982. Orientation and training of physicians not oriented toward ORT. MOHSW interested in policy change toward this.	Access to services exist but utilization is low in govt facilities.	5 private pharmaceutical companies provided ORS, at approx 25-30 million 1 liter packs in 1980. Need for local marketing firm to develop marketing strategy for delivery of ORS.	Interest of doing CM on mass media techniques and surveillance and reporting systems, as well as biomedical aspects of diarrhea by local research institute .	Extensive donor coordination between UN agencies, PVO's a bilaterial organizations.
PAKISTAN Basic Health Services (391-0075) Final Eval, 1981	Concept of CHW's and 3 tiered health system, supported by GOP although implementation has not yet occured Change in gov't to military from civilan hindered successful start-up. Anti-American activity made project implementation difficult. Evolution of health policy with emphasis on rural health over course of project.	Schools and health centers built. CHW's trained, although not in originally specified numbers, yet not deployed. Recurrent costs supported only with AID input, although MOH capable of technical support.			Coordination with WHO, providing a management office and public health officer, bu with such delay that contract had to supplement with its ow staff.
THAILAND Lampang Health Development (931-0971) Final Eval, 1981	Rural health policy and health care delivery system exists, although underutilized by target rural population. Emphasis of gov't spending and overall manpower development curative rather than promotive and preventive Overall budgetary focus on health more than doubled over life of project. Nat'l PHCP launched by MOH., along with other high priority health programs. Integrated delivery of health services stressed;special budget for implementation of PHC	Direct influence on Thailands rural PHC expansion project, (in 20 provinces) Great improvement in availability of services, substantial improvement in accessability of services, moderate improvement in utilization of services. Many more health workers, more village health posts linked with gov't health centers for sustainability. Sustainability and replicability successfully field tested in another district.	Private sector providers encouraged to participate in PHCP system, i.e. sales of pharmaceuticals, trad. healers, private health care providers.	Institutionalization of network to coordinate activities, especially vendor health services research, training, and continuing ed.	AID, APHA, U of Hawaii, GOT collaboration. Problematic institutional relationships to too many institutional liasions, unclear guidelines for collaboration and financ arrangements. Coordination between local universities determined to be critical. Board established t collaborate efforts

LATIN AMERICA	Host Country Policies	Access/Sustainability	Private Sector	Biomedical/Health Services Research	Donor Coordinati
DOMINICAN REPUBLIC Health Sector I (517-0107) Final, Feb 1982	No National Development Plan so difficult to determine strength of commitment to health. Pre-1978 preoccupied with infrastructure and pub health and fam planning had little support. Current admin is supportive of PHC. Attempted admin reform so objective, very difficult as ministry wasn't fully involved in planning and decision-making process. Tried to create Nutrition Institute, didn't succeed because idea was not sold to highest ranking officials.	Increased coverage, esp. Immunizations, to rural and hard to reach populations (estimated 60% coverage). Expanded beyond original scope because of success of promotor system. Expansion financed by OUDR.		Research component in nutrition program. Completed food/behavior study and nutri assessments of children. Others planned but not adequate OUDR funding.	Nutrition component: lack of coordination among agencies and institutions dealing with nutrition in PR hindered timely implementation of nutrition interventions.
DOMINICAN REPUBLIC Health Sector I, II (517-0120) Midterm Eval (PRE), May 1983	Program regarded by govt as important as urban program (neg consequence: pol appointees). Govt provides salary supports for CHW, demonstrating commitment.	Increased pop coverage (attained proposed target), tho full service coverage of child immunizations only. Low productivity of CHW's, could be providing more services with same infrastructure. Expensive system because not very efficient (largest expense is salary support provided by govt.) At maintenance phase, but weak supervision, cont ed, MIS.			
ECUADOR OPG Rural Community Health (518-0002) Final Eval, Nov 1982	Project influenced govt PHC policy. Cooperation between project/govt enabled govt to extend its own program to train more CHW's and expand coverage.	Trained CHW's in rural areas to expand coverage using evangelical groups. Hard to judge impact because of multiple dynamic forces, but project contributed to increased coverage. Questionable whether MOH could cont same support system for personnel.	Used evangelical groups on a limited basis as intermediaries to reach communities. Proved: 1) easier 2) more supportive response from community 3) more community participation.		Project staff have coordinated health activities with MOH and Peace Corps.
ECUADOR Integrated Rural Health Delivery System (518-0015) Midterm Eval, March 1984	MOH has long term commitment to decentral./integration. Past efforts have made some progress but slowly. Key MOH personnel turnover (5 ministers during project period) caused instability in policy. Budget allocations still favor central system. Problem in defining decentralization.	Extended services into 3 of 17 Integrated Rural Development (IRD) areas providing health services to isolated and hard to reach populations. When scale up for other IRD's will be very expensive. Little actual cost data available as full complement of workers not in place nor are all the systems necessary to maintain the services (e.g. MIS, supervision).	Over 10 major public/private health agencies providing essential services. National Health Council (NHC) created to coordinate these efforts though not actively doing this yet. Project working principally with MOH.	National Health Council resp for recommending research agenda, not active presently. Minister is chair and cont turnover caused instability. OR studies by AID contracting agencies should focus on project capabilities.	

ASIA	Host Country Policies	Access/Sustainability	Private Sector	Biomedical/Health Services Research	Donor Coordinatio
INDONESIA Health Training, Research and Development Project (497-0273) Midterm Eval, March 1983	Focus on control of infectious diseases, construction of health centers, production of health manpower, increased effectiveness, health services research, information processing. GOI focus on health planning activities (5 yr plan) caused delays in project implementation, as critical project staff were required to participate for extended periods of time.	Extension of PHC services, especially MCH, to underserved village areas. Sustainability to be fostered by improving the central and provincial planning capabilities.		Health research and development sub-projects incorporated and designed to improve MOH capacity to identify problems of health care delivery and mgt at central and provincial levels. 1/3 of project focused on institutional development.	Recommended coordination of project activities with JHU/ISPH activities; development of steering committee to coordinate all health sector activities with both int'l donors and ministerial efforts.
KOREA Health Demonstration Project (489-0-092) Final, July 1982	Conditions precedent: development of Korean Health Demonstration Institute for management and implementation of project, outside the rim of the existing ministerial structure. Active gov't policy to expand health services to urban and rural poor. Numerous policy changes over course of project greatly affected project outputs negatively (i.e. compulsory health ins, increased taxes, change in MOH personnel structure). Continous shift in policies. Shift in jurisdiction of CHW's, thus limiting their ability to perform given tasks.	Access to services increased dramatically after 1st yr of implementation; less physician services were required. Accessability defined as: mean travel time for primary care, (which declined from 62 mins in 1976 to 25 in 1979); change in mean expenditure per curative visit; mean # of visits per person (increased 86% over life of project.)	Curtailed demand of private physicians, who effectively protested, thus effecting a change in policy toward CHWs and weakening their role.	KHDI able to do some basic health services research, although outcome never affected program planning.	Creation of National Health Council to coordinate interes of MOH and other private organizations providing healt services.
NEPAL Integrated Rural Health/ Family Planning Services (367-0135) Midterm Eval, Oct 1982		Goal of absorption of up to 50% of cost of CHW support by MOH at MOP.	Negotiations with local pharmaceutical company to mfg drugs on a timely basis, although company doesn't have ability to supply quantity necessary. UNICEF supporting additional machines for industry.		Peace Corps collaboration with rural development aspects of project.
NEPAL Population/Family Planning (367-0096) Integrated Health Services (367-0126) Final Evals, 1980	Nat'l policy to control pop growth, provide minimal basic health serv to all through integrated delivery system Shortages of qualified personnel in health system Policies address high priority problems: provision of min services to max # of people. Use of 5 year health plans	Health/FP services generally provide inadequate coverage, although covering 62 of 75 districts. Need for improved quality of coverage to complement actual accessability			

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BANGLADESH International Center for Diarrheael Disease Research, Bangladesh (931-1012) Midterm Eval, Dec 1982		Need for more hands-on training for host-country nationals and development of training facilities for Bangladeshi and others to foster sustainability.		Project focus on undertaking and promoting study, doing research, and disseminating knowledge on diarrheael diseases. Have made significant research advances; research noted to be of excellent quality.	Multidonor effort; AID provi 27% of total budget.
BURMA Primary Health Care I (482-0002) Midterm Eval, April 1982	PHC initiative w/in MOH reflected in Peoples Health Plan. Severe budget constraints w/in MOH Significant importance placed on voluntary health staff working in the rural community	Underlying project obj. to provide access to services USAP before considering content or quality of those services. Heavy reliance on imported drugs, limiting prospects of sustainability with regard to foreign exchange shortages. Indigenous production and support of Burmese pharmaceutical industry encouraged.. PHCI designed to build training capability for subsequent expansion of PHC network	Interest in involving Burmese pharmaceutical industry to aid minimizing foreign exchange expenditures on drugs which could be mfg locally.		Joint AID/WHO/UNICEF projec with AID providing mostly commodity support, WHO providing mostly T.A., and UNICEF complamenting both.
INDIA Integrated Rural Health and Population (386-0468) Midterm Eval, Nov 1983	Particular concerns with high fertility and high infant and child mortality, as reflected in policy emphasis on PHC	Improving access to health care services in rural areas of India is primary objective. Sustainability should be fostered by manpower development Central, regional, and local training institutions should be used to build capability to facilitate full scale-up of project.			
INDONESIA Comprehensive Health Development Program - Province Specific (CHIPPS) (497-0325) Midterm Eval, June 1984	Traditional focus in health sector very centralized, with vertical programs. New shift in policy emphasizes decentralization and integration. GOI health policy considered comprehensive and exemplary amongst other developing countries.	Project focus on education and involvement of officials in order to internalize problem-solving approach, leading to sustainability.		GOI interested in improving capacity of provincial health staff to identify and solve special needs without external assistance. Emphasis on health services research and improving levels of teaching and reserach at nat'l school of public health.	

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SENEGAL Rural Health Services (685-0210) 2nd midterm (special)	After 1980 eval, GOS changed policy to allow decentalization of drug distribution. Agreed let village health committees retain collected fees. Elevated importance of project by assigning person to be responsible for project in MOH. MOH & USAID agree decentralization shoud move more slowly, have greater central MOH involvement for while.	Prospects much better but still big question if anything other than curative service can/will be sustained by community. Villagers maintaining physical facility (health huts). USAID had beed paying supplemental fee for each supervisory visit, but now has stopped because neither villagers nor MOH will be able to sustain.	Mentioned that trad healers in area providing service, but no discussion of incorporating into PHC project.		Using record forms for illiterate health workers from nearby Dutch project.

AFRICA	Host Country Policies	Access/Sustainability	Private Sector	Biomedical/Health Services Research	Donor Coordinati
RWIA ng District Health Project -013R) l Eval, Sept 1981	Project parallels govt priority of rural development, self-suff. Pilot project begun on cond that govt would cont at end.	VHW's trained for 95% of villages (up from 25%). High drop-out rate after trained (56%) need to evaluate factors in good VHW performance (supervision, logistics, selection). GOT will have to reduce inputs to afford, use bikes instead of cars for ex, transport costs very difficult. MOH to assume but not brought into project early enough, poor transition planning, threatens programs.	Contractor local PVO brings dedication, discipline, rapport with pop, practical eye on costs	Need to study supervision	GOT not ready to assume project. Will have to identif interim donor
l Water Supply (693-0210) rm Eval, April 1983	GOT stated in Nat Development Plan that safe water for pop highest priority.	Wells functioning provide water to 47,000 Togolese, others drilled but incomplete. Health ed component maximizing community coverage.			Pump installation resp of French Fonds d'Aide et de Cooperation and hydro-geol tech consultants funded by Fords European de Developpement (FED). GOT provides manpower for ed component, Peace Corps provided 10 PCV's, USAID supplements ed funds. Problems occurred in coordination of tech (French) and education (USAID). Togolese nat coordinator appointed.
g CCCD (690-0421) erm Eval, April 1985	CCCD project builds on existing PHV project. Confusing govt policies, multiple depts dealing with PHC components. Also many donors trying to influence govt policy. 1983 devaluation caused severe budget cuts across programs, need to reorganize. Thro policy dialogue, AID should emphasize advantages of integrating all offices contributing to PHC, this need not affect autonomous budgets such as PHV's.	Used former smallpox campaign network to quickly reach targeted regions. Estimate 40% of targeted zones covered by CCCD/PHV services. GOS expected to cover all costs after 4 years. Amended: cover recurrent cost, still questionable. Have developed reliable infrastructure.		OR component has 2 goals: 1) solutions to PHV probs with interventions 2) training of Zairian scientists in conducting studies. 4 studies and 24 surveys have been initiated	Tech coordination by CDC via 2 consultants. Peace Corps provides volunteers. FONBRES (Belgium donor) also provides PHV assistance. Confusion over CDC, AID procedures, use of funds. Presently considering reorganization of PHC offices to better coordinate USAID, FONBRES, French.

AFRICA	Host Country Policies	Access/Sustainability	Private Sector	Biomedical/Health Services Research	Donor Coordinatio
NIGER Rural Health Improvement (683-0208) Midterm, August 1981	MOH committed to improving 1) rural health care 2) its capacity to plan and manage. Major emphasis on further development of facilities to make approp curative and preventive care and health ed programs widely available. 9% of nat budget dedicated to health. 4% increase over previous year.	Overall project goals led to better access to health services, implementation radically hindered by contractor, AID, MOH. Eval teams feels project recurrent costs can be sustained by MOH if cost reducing activities proposed adopted and decentralization implemented. Thorough recurrent cost analysis completed. If can find long term donor support for drugs, annual recurrent cost much lower. (Recommend AID give recurrent cost support from end of project until 1992. No TA, just money).	PHAL (Private Health Ass of Lesotho) represents interests of PVO's in Lesotho. Receives support from donors, patient fees and changes. Sign amount health services provided by PHAL instl agree w/ govt on basic PHC features. Interested in collaborating with LRHD. Considering grant program for PVO's delivering services in rural areas. PVO's can reduce supervisory and admin burden of MOH. Should share management systems PVO's have developed with MOH.		
SOMALIA Rural Health Delivery (649-0102) Midterm, Feb 1984	Concept of National Training Centers institutionalized within MOH. No clear direction on PHC policies. Very centralized system, eval team urges decentralization. Few national resources invested in health.	Increased coverage (almost 50%) of rural pop by village health teams on target. Increased from 1500 to 4000 villages participating. Project emphasis on training and re-training, including village level to increase self-sufficiency. System is well-organized, far reaching and seems affordable.	Private sector should be involved in manufacture of pharmaceuticals.		
SUDAN Rural Health Support Project (650-0011) (650-0019) Midterm Eval, April 1985	When project originally designed, favored by MOH, though neither specific govt policy nor depts of family planning of MCH at nat level.	No comment in eval on change in accessibility. Given worsening econ conds, MOH can't finance already low level of PHC much less expand services in manner project planned (resource environment). RHSP examined recurrent cost prob and made recommendations to encourage sustainibility. Less attention on role of counterparts and transfer of skills above level of health worker. Institutionalization hampered by lack of policies, plans, and no MCH/FP Dept.	Com pharmacies not serving rural areas. Located in urban areas in direct competition with private pharmacies. GOS should consider ways to reduce regulatory burden on private pharmacies which, in turn, would reduce drug prices for rural pop		

AFRICA	Host Country Policies	Access/Sustainability	Private Sector	Biomedical/Health Services Research	Donor Coordinati
BOTSWANA Child Health/Family Planning Project (663-0078) Final Eval, Sept. 1978	MOH committed to shifting from curative to preventive emphases. To accomplish, supported training and retraining of personnel to carry out PHC duties. Priority programs for MOH: 1) dispatched staff to attend training 2) budgetary support to support students in training 3) appointed qualified counterpart to Senior Public Health RN 4) Senior officials took time to lecture students.	Established Health Ed Unit now capable (though weak) to carry out activities. Institutionalized. Did not integrate curriculum into RN training; even recent grads sent to special program. System resistant to change.			
KENYA Kitui PHC (615-0185) Final Eval, Nov 1982	Inspired by 1972 MOH directive - reallocate funds toward rural services and integrate preventive and promotive aspects with curative	Excell immun coverage, nutri surveillance, prenatal counseling. Mobile PHC team designed for each remote pop, 4 teams reaching 16 sites each. Good but should increase cost-effectiveness by maximizing community coverage. Services less expensive than govt services, but these conditions not easily replicable by govt institutions. Recommend secunde MOH employees to work under guidance of Catholic diocese. Next phase will integrate into MOH's proposed Integrated Rural Health Project (partially funded by AID)	Project organized by Catholic diocese missionaries. Able to provide mobile services efficiently and effectively.		
LESOTHO Rural Health Development (632-0058) Midterm Eval, April 1982	GOL policies strongly support PHC, including redistribution of health resources from urban to rural areas. Budgetary allocations contradict this. Inconsistencies between policy and budget reflect lack of consensus in GOL, causing confusion and hesitancy among donors in health sector. MOH does not appear to have considered cost implications and organization effort needed in carrying out programs. MOH willing to face up to inevitable probs - refreshing.	MOH first ministry to begin implementing decentralization policy thro LRHD. Created new cadre of workers (Nurse Clinicians) to supplement expatriate MD's in rural areas as constant turnover of MD's is destabilizing and expensive. Institutionalization of Nurse Clinicians status in law and in civil service not resolved pending legislation. Attempting to incorporate Nurse Clinician training into University curricula. Need to address personal and psychological factors that relate to retaining these trained staff in remote rural areas.			

	Host Country Policies	Access/Sustainability	Private Sector	Biomedical/Health Services Research	Donor Coordination
OMMENTS AND ESSONS LEARNED	- Many govts have supportive policy, but budget allocations do not follow. Money stays in urban areas, central programs. - Where no policy exists or rapid turnover in key personnel, difficult to get commitment. - Often conditions precedent not met, causes delays in start-up, yet some projects also funded before resolve. Logic for CP's if unrealistic or fund before met? - Decentralization important topic of policy development. Problem in definition.	- Many projects increase access, though not to acceptable level or not efficiently because of underutilization or low productivity. - Most projects do not project costs accurately. After projects funded, realize govt can't afford the scope of the intensity of resources to sustain. - Few projects have useful transition plans to assist govts assume responsibility for services. - Sustainability often question of long-term planning yet projects use short-term time frame. Admit in evaluations that institutional development takes time, even when well planned there are always unpredictable events that preclude implementation of planned activities. Can AID deal with long-term planning? - Problem of sustainability for services dependent on commodities that must be purchased with foreign exchange (drugs in particular).	- Private sector activity most common in pharmaceuticals and family planning. - Many PVO's involved in health/FP are barely self-sufficient, rely on outside assistance. - Some PVO's have coordinated with MOH to pick up some service delivery responsibilities or govt, they are more efficient. - Some PVO's do not want to collaborate with MOH because MOH so poorly managed. - Religious organizations are important resources, often have good community rapport. - PVO's able to provide same services as govt often more cost-effectively. - Little discussion of traditional healers. - Need to at least communicate with private MD's and pharmacies, they could undermine efforts.	- Almost no biomedical research explicitly described in evaluations. - Applied research and operations research used to study management problems in more organized, well managed MOH's/projects. - Little research in Africa (function of poor info systems?), alot of research activities in Asia. - Regional center important resources.	- Very little donor coordination occurring in Africa, Latin America. More multiple donor activity in Latin America than Africa according to evaluations. - Many instances where donors conflict with each others programs, and don't necessarily support MOH efforts. - When there is some coordination, common to have steering committees at National level to deal with donors.

	Scope	Planning Process	Integrated vs. Categorical	Cost Recovery	Community Participation	CHW: Role, Compensation	Contractual Obligations	Comments on Eva Methodology
COMMENTS AND LESSONS LEARNED	- In some national programs and regional programs targeted for scaling up, when really doing it right the program consumes core resources than projected.	- Overall weak management system in detrimental to even the best designed projects-- all management aspects mentioned. - Need to incorporate decision-makers inplanning process from beginning. - Many unrealistic objectives and time frames that need to be revised. Possibly should expect to always revise implementation plan after first year. - Centralized system causes delays, often unnecessary procedures. - Unmet conditions precedent and contractual delays impede timely implementation. - Often contractor needs to spend initial period developing policy, gaining govt/community acceptance instead of planned implementation activities. - Barely sufficient qualified MOH staff - Disbursement of funds and financial monitoring problems always.	- If central MOH not managed well, problems adding more responsibilities to it (integration) Question of absorbative capacity. - A categorical program will probably have to change its pace (slow down) as integrated into MOH. Also MOH usually less efficient in providing same service. - Should incorporate appropriate decision makers in planning process from beginning or intergration may be sabotaged. - Long slow process. - Some normative systems better integrated, others better left categorical. - Need personnel capable of managing/coordinating integrated programs. - Number of ORT programs that are categorical.	- Some preliminary efforts, but few close to self-sufficiency. - Revolving funds seem likely to provide revenue. - Many PVO's aren't self-sufficient, they rely on outside funding and user fees to survive. - Revenue generated most often for CHW salary, drugs (including ORS), curative services. Difficult to charge for immunizations. - People often not willing to pay for preventive/promotive services.	- Com participation recognized as essential to success of PHC system in most projects, also lack of com participation in projects recognized as problem in most projects. - More effective to work through existing groups than creating new ones. - Many projects have started by focusing at policy level and have not started real community level component yet, though they programmed it in initially. - Good involvement from community when they get something tangible in return such as water, curative services.	- In most govt programs, CHW's expect compensation. - Programs propose to increase coverage using CHW's to reach communities. - Biggest issue: compensation.	- Difficult to generalize, but most do not meet obligations. If enough external factors involved and still some progress, considered satisfactory. If contractor aware of constraints from beginning and fails to incorporate them into implementation plan, contractor blamed.	- Biggest issue: lack of data to document progress. - High cost of good data. - Causal attibution difficult. - Weak objectives set at outset, no good standards of performance.

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