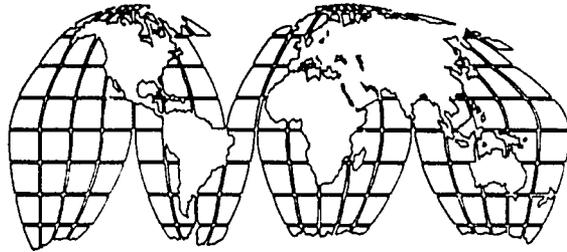


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AID's Experience in Health:

*A Review of Seven Health Project
Evaluations*

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

AID'S EXPERIENCE IN HEALTH:
A REVIEW OF SEVEN HEALTH PROJECT EVALUATIONS

PROGRAM EVALUATION REPORT NO 99

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The views and interpretations expressed in this report are those of the authors and should not be attributed to the Agency for International Development.

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1. Introduction

This report is a summary of evaluations of seven AID health projects. Since 1980, AID's Office of Policy and Program Coordination has organized the evaluation of the individual programs and the purpose of this paper is to review the major issues raised by those individual evaluations.

The projects discussed here are as follows:

- The Morocco Food Aid and Nutrition Education Program
- The Sine Saloum (Senegal) Rural Health Care Project
- The Columbia Promotora Health and Nutrition Project
- The Korea Health Demonstration Project
- The Tanzania Maternal and Child Health Aide Training Project
- The Swaziland Health Manpower Training Project
- The Onchocerciasis Control Program in the Volta River Basin of West Africa

The projects were very different from each other in size, approach, goals, and level of funding. The following section is a short description of each project. Chart 1 gives an overview of the projects discussed. Additional information is given in the Project Papers in the Appendix.

Four of the seven studies, (Morocco, Senegal, Korea, and W. Africa) have been published as Impact Evaluation Reports. The Senegal project was also the subject of a follow-up study. The material on Colombia, Tanzania, and Swaziland is taken from mimeographed reports written by evaluation team members.

There was no uniform scope of work for the evaluation and therefore, in many respects they cannot be compared. At the same time, all the reports did address certain common topics. Those common themes used as the basis for discussion are as follows:

- project sustainability
- internal organization and management
- impact on beneficiaries
- institutional development
- relationship to government policies and practices

Finally, a few generalizations and conclusions from the evaluations are presented.

Chart 1: Descript:

Country	Project	AID	Project
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2. Overview of Project Evaluated

This section comprises brief description the projects evaluated. This will give the reader background on individual projects. Because of the diversity of the programs described, the review also provides a panorama of the types of health programs AID supports.

2.1 The Morocco Food AID and Nutrition Education Project.

The Morocco project was a grant of \$450,000 to Catholic Relief Services (CRS), a private voluntary organization (PVO) to introduce nutrition education into a PL480 Title II food distribution program. CRS had already organized 250 social education centers where food was being distributed. The purpose of the grant, was to establish a nutrition institute for the training of a cadre of supervisors and teachers for the program.

Fifty additional centers were opened. CRS distributed about eight million dollars in food per year, at 45 kilograms per enrolled child. A curriculum was developed which combined practical lessons in nutrition with information on sanitation, personal hygiene, and the treatment of childhood diseases. There are 450,000 low-income mothers and high-risk children participating in the food and nutrition programs.

The grant was from April, 1975, until December, 1978. The evaluation took place in February, 1980, fourteen months after the grant ended and the evaluation team found the program to be in operation and functioning well. The evaluators found that the food, when combined with a nutrition education program, does have a significant impact on malnutrition. The main issue raised by the evaluation team is the problem of sustainability and how the Morocco government might raise money to pay for the food in the future (Gilmore, et al. 1980).

2.2 The Sine Saloum project was intended to establish a network of health posts, staffed and supported by community-level personnel, throughout the Saloum river basin in Senegal. The program was administered by the Ministry of Health (MOH). The objective was to strengthen the support infrastructure of the health posts. They intended to establish 600 community health centers which would serve 880,000 people. The grant was for \$3.3 million between August 1977 and December, 1981.

Based on information that the project was not progressing well, AID carried out a major evaluation in April, 1980, about two-thirds of the way through the project. The evaluation team found major problems with community and national financing and concluded that the project would collapse if not promptly redesigned. They also found problems with supervision and support for community health workers (CHWs) (Weber, et al 1980). The evaluation report had the desired effect and major changes were made.

A follow up evaluation, in 1983, found that the redesign had made a dramatic improvement. Health services were largely financed at the community level, community members were much more able and willing to manage their health services, and the supervision of CHWs had improved (Bloom 1984).

2.3 The Colombia Promotora Health and Nutrition Program

In Columbia, the national government had a plan for rural primary health care but lacked the resources to implement it. The program was modeled on a classic PHC model with CHWs providing first-aid and education to families within certain areas. AID gave Colombia loans totaling \$39.9 million to strengthen the rural health program.

The evaluation took place in May, 1980 and involved the collection of data to assess effectiveness and impact in one "department" (state) of the country. The evaluation team found the promotoras (CHWs) to be reasonably well trained but that they were sometimes hampered in their work by lack of supplies and poor support and supervision. Transportation problems keep supervisors from visiting and CHWs from their rounds. Low salaries contributed to low morale among delivery level staff.

Study results indicated that there was no difference in nutritional level of children between areas with a CHWs and those without. Similarly, the incidence of diarrhea and colds, and the use of contraceptives, was no different in CHW areas. Immunization rates and access to health services, however, are greater in CHW areas. The evaluators raised some serious issues concerning the financial sustainability of the programs (Hunt, et al 1983).

2.4 The Korea Health Demonstration Project.

The Korea project began in 1976 and was designed to test alternative approaches to low-cost, integrated health care in three rural areas. A semi-autonomous organization, the Korean Health Development Institute (KHDI), was formed to operate and evaluate the projects. Among the approaches tested were different community-financing schemes. Between 1976 and 1979, the project went very well, with utilization rates up and effective community financing programs operating. But the success of the programs created problems. While the use of health service in the demonstration areas went up by 86 percent, the business of private physicians in the area declined by 30 to 40 percent. Physician complaints led to charges that the health workers were in violation of Korean medical laws. As a result duties of the health workers had to be curtailed and their credibility plummeted. At the same time, the market was flooded with newly trained physicians, some of whom began to work in rural areas and charge fees comparable

with the demonstration project health centers. A mandatory health insurance program, instituted in 1980, made it possible to visit a private physician for little more than the cost of a visit to the project clinic and utilization rates dropped again.

The evaluation, carried out in July and August, 1981 found that the program had essentially folded. The KHDI was subsumed into a new institute. The Korean MOH had considered KHDI' services a threat to their own programs and had sided with physicians on many issues. The evaluators concluded that there is a high risk in setting up alternative institutions to manage health care delivery unless there has been a through analysis of incentives and of all the potential actors who may be involved in the project. The implications of various policy changes and the introduction of new health workers must be addressed in project design (Dunlop, et al. 1982)

2.5 Tanzania Maternal and Child Health Aid Training.

AID was one of several donors of the Tanzania effort to strengthen their non-hospital and rural based health care services. AID provided \$12,354,000 between June, 1973 and September, 1980. The objective was to construct 18 training centers and train a cadre of 2500 trained health workers (at three skill levels) who would staff a network of rural health centers and dispensaries.

The evaluation was carried out in 1983 and found that the program had made impressive headway in bringing health services to formerly underserved areas. Given a number of setbacks because of rising costs, inflation, and difficulties of construction and procurement, the program was an impressive lesson in what can be done with limited resources where there is firm government resolve. Main issues brought to attention by the evaluators is a lack of confidence in the financial underpinnings of the project.

Shortages of petrol and kerosene created cold-chain problems so that vaccines lost their effectiveness. There were other logistical problems of supplies, supervision, and information systems. Although CHWs were well trained in family planning and supplies were adequate, motivation (on the part of both CHWs and mothers) was low (Minkler, et al. 1983; BROWN 1986).

A further look at the economic situation in Tanzania underscores the evaluation team's concern long term financing of the project. Dunlop (1985) has argued that by uncoupling the rural and urban sectors of its economy, and by inappropriate agricultural policies, Tanzania has lost its ability to sustain its entire health sector including the maternal and child health program.

2.6 The Swaziland Health Manpower Training Project:

The objective of Swaziland project was to improve the government's health services and to expand coverage. It did this mainly by constructing and equipping an Institute of Health Sciences where Swazi nurses, health inspectors, and dental hygienists could be trained. There was considerable resistance to the Institute from within the MOH and the nursing community but they did manage to graduate a class of nurse practitioners in December, 1979. They built and equipped the Institute and trained a permanent staff of nurses in the teaching of health education. AID funding totaled \$_____ between 1977 and 1983.

The evaluation team found that the Institute still has not clarified its identity with the MOH. It could become a training branch of the MOH or an independent academic institution. Although the evaluation team found the Institute to be well managed and graduates well trained, they expressed some concern that graduates get little field experience as part of their training and that the Institute does not provide enough follow-up with graduates to determine the appropriateness of their training.

Because there have not yet been enough graduates in service in rural areas long enough, the Institute has, as yet, had little impact on health services in Swaziland. The Institute experienced a number of start up problems due to resistance from the MOH. Now, however, the Institute has earned respect because of the high quality of its graduates and its internationally trained staff (McGuire, et al. 1985).

2.7 The Onchocerciasis Control Program of the Volta Valley, West Africa.

The Onchocerciasis program, headquartered in Ouagadougou, Burkino Faso extends into nine other countries as well: Benin, Ghana, Ivory Coast, Mali, Niger, Togo and with Phase III, (1986- 1991) Guinea, Guinea Bissau, Senegal and Sierra Leone were added. This twenty-year vector control program aims to reduce the impact of onchocerciasis (river blindness) and to increase the economic potential of the area freed from the disease. The program is sponsored by four multilateral agencies: WHO, the World Bank, FAO and the UNDP but it has 22 other donors. Phases One (1974-1979) and Two (1980-1985) cost a total of \$167 million. AID contributed \$23 million and was the largest single donor during the first two phases. The final phase, which the program is just now entering, will require an additional \$135 million.

The thrust of the program has been to control the vector (blackfly) by chemical spraying. This interrupts the transmission cycle of the disease. Program results so far have been impressive. In 90 percent of the program area, the transmission of the disease has been interrupted. An estimated 27,000 cases of blindness have been prevented and some 15 million hectares of land are now open for cultivation.

In the final phase of the project, greater attention will be paid to the economic development of the former blackfly infested land and to training local government representatives to maintain the spraying programs after the main project terminates. Because the strategy of the program was to control, rather than eliminate blackfly, it could resurge. The parasite is dying out in the resident human population but people moving in from uncontrolled areas could restart the transmission cycle.

The evaluation team found the program to be well managed and the impact of the effort to be impressive and increasing. They believe a great deal is to be learned from this project of the design and management of other very large scale, multi-country, vertical programs (Kelly, et al. 1986).

3.0 Evaluation Report Findings

The findings of the evaluation teams are discussed here in terms of the sustainability of the project impact and the internal organization and management. The impact of the program on beneficiaries, institutions and policies is also reviewed. Chart gives an overview of the findings by country.

3.1 Sustainability

The sustainability of project impact is an increasingly important issue at AID and correctly so. All of the evaluation reports raise serious questions about the long-term viability of the programs evaluated.

Issues include the critical ingredient of financing, shifting political support, weak community participation, inappropriate technology, as well as a dependence on imported commodities and foreign specialists.

One project, Korea, started out so well it created problems with local physicians who were instrumental in bringing the project to a halt. That project was a demonstration project designed to use an experimental model to test alternative delivery and cost-recovery models. Because it was intentionally set up as an independent institution, the changes in government policy had a negative effect on the program. When the government instituted a new mandatory health insurance program, people could go to a private physician for about the same cost as a visit to one of the demonstration project clinics (Dunlop, et al. 1982).

The Morocco project is heavily dependent on PL480 food and there is no evidence that the government will be able to grow (or import) enough food to take over the project. "The program's reliance on food aid is an inherent problem. This

dependency inhibits its potential for expansion and possibly endangers its continuation, given any uncertainty of PL480 food deliveries. It is questionable whether Morocco can import enough food for its own consumption needs, let alone food donation programs" (Gilmore, et al. 1980:15).

In Senegal, the first evaluation found the system on the verge of financial collapse and the management system weak (Weber, et. al 1986) but as a result of the evaluation, major changes were made. Bloom (1984:24-25), in her follow-up evaluation, found that a system of user payments and increased community involvement in the financing and management of the health programs had resolved most problems. Questions remain about how the costs of supervision can be financed, how a preventive component of the now completely curative program can be introduced, and how to ensure that care is available and accessible during peak disease months.

The Colombia CHW program is progressing although it seems to have tried to do too much too soon. Original cost estimates were too low and it is doubtful that the program can expand or be replicated without more outside assistance (Hunt, et al. 1983). In Tanzania, the poor economic planning for agricultural production combined with a division between urban and rural sectors of the economy suggests the entire health system is at risk. Although the government is struggling to improve its agricultural pricing policy, whether or not it can gain its equilibrium remains to be seen (Dunlop 1985:56).

In Swaziland, the evaluation team found that the Swaziland Institute of Health Sciences is turning out well trained nurses and that the Institute seems to be a permanent part of the Swazi health training system. The evaluation team did not address the problem of the financing of the health system but it seems likely that the new trainees will create additional demands on an already inadequate health care system.

Since graduates of the institute are highly trained in clinical skills, their salary requirements will be high and they may be reluctant to work in rural areas and "there are some serious questions concerning whether Swaziland can afford the large number of registered nurses currently being produced and whether that level of personnel is most effective in extending the preventive and promotive services in the rural areas" (McGuire, et al. 1985:17).

The multi-country, multi-donor Onchocerciasis program in West Africa raises an interesting question about the definition of sustainability. The control of blackfly will be a continuing problem as new people move into controlled areas from places where blackfly is still common. The twenty-year project has demonstrated dramatic benefits already and it is expected that health condition will improve even more as the agricultural potential of the blackfly free zones is developed. The project has depended on imported technology (aircraft, chemicals) and an international management staff. Because of its success, it has attracted 22 donors, including most European governments, the multilateral donors, and OPEC. It seems likely that the project will be able to maintain its outside funding over the foreseeable future (Kelly, et al. 1986: D-4).

There is virtually no likelihood that the eleven target countries could finance such a major project on their own. The plan calls for a "devolution" of the project, training of local staff to carry out the project and the introduction of more appropriate technology. How effective this ploy will be remains to be seen. If a program is able to maintain itself post-AID through broad based funding from other sources, is it considered sustainable?

In summary, every evaluation team raised questions about the long term viability of the project results, particularly with regard to financing and policies affecting finance.

3.2 Internal Organization and Management

The PHC projects report problems with internal organization and management, particularly in relation to the development of mid-level management and the logistics of supply. The Senegal project experienced serious problems in this regard, many of which were overcome by increasing the role of the community in management. The project still has problems with supervision and cost-recovery for supervisor's salaries (Weber, et al 1980; Bloom 1984).

Similarly, in Tanzania and Colombia, evaluators found serious weaknesses in the supervision system. Problems included a lack of trained people to fill the slots, transportation problems, and inadequate support for CHWs. Transportation and logistic problems also contributed to breaks in the cold-chain so that vaccines were ineffective. The Tanzania team reports:

Like the areas of transport, kerosene, and printed health records, there seem to be major problems in the procurement and distribution of equipment and medicines, especially the former. Specific problems were noted with regard to the kerosene refrigerators, many of which are growing old and rusty, or have broken legs which makes them difficult to level properly. Many instances of expired or absent vaccines (especially BCG) have also been noted, but this seems to be related more to the lack of kerosene and transport than to inadequate medical supplies per se (Minkler 1983:75).

In Colombia, interviews indicated that vaccines have been rendered ineffective by breaks in the cold chain due to improper storage. The administration of ineffective vaccines can seriously damage the credibility of a vaccination program (Hunt, et al. 1983:29).

In both Colombia and Tanzania, CHWs are government employees. In Senegal, by contrast, CHWs and health centers belong to the community and staff are not government employees. Because there was weak community involvement in the earlier phases of the Senegal project, many of the health centers had closed. Cost-recovery mechanisms were ineffective and stocks of drugs and supplies were depleted with no funds for resupply (Weber 1980:8).

The follow-up evaluation found that community financing for the program came from user fees, cash or in-kind contributions to construction and maintenance of the health centers, and a "contribution" from each household to pay the CHW's salary. The contribution was in cash or voluntary labor in the CHWs' fields. Communities not only financed the local delivery system, they also received training in their responsibilities in managing the system. Health committees choose the CHWs, monitor the functioning of the center, and hold periodic meetings with the community (Bloom 1984:14). Senegal still had not resolved the problem of supervision and support. Supervisors from the MOH do not visit as often as they should and one result has been poor record keeping. When records are incomplete, supervision is more difficult.

Programs with more specific objectives have fewer problems with management. The Korea Health Demonstration Project was very efficiently organized and managed. That they failed to foresee the reaction by physicians, and later, the effect of the national health insurance program, was more a problem of planning than management. It is for that reason that the evaluators suggest that future projects of this type begin with a better assessment of the circumstances which may affect it.

An incentives and contextual analysis of all the potential actors who may be involved in designing, implementing, and sustaining the project intervention -- in this case, rural primary health care -- must be conducted before completing

the project's design. Without such an analysis, the implications of various envisioned policy changes and the introduction of new health workers will not be addressed in the initial phases of the project design (Dunlop 1982:33).

The Morocco evaluation team was impressed with the consistently good operational procedures by which food was transported to the nutrition centers, the growth records kept by the nutrition workers, and the outreach for children who failed to attend or failed to grow. Mothers were expected to pay a small amount for the food but the key to the system seems to be highly motivated nutrition workers and a good supervision system by CRS staff (Gilmore et al. 1980:12). The efficiency of the system may be due to CRS' relative affluence and its ability to hire skilled staff and pay them well. In addition to AID's contribution, and CRS funds, the government of Morocco contributes \$4.7 million per year to the project.

The Swaziland Institute for Health Sciences suffered initial start up problems, partly because there were not many people in Swaziland who were trained to manage an institution of that size and objectives. There was resistance from nurses and criticism of the morals of the students. There were also problems with transportation to field sites for training. Initially, senior staff were sent for training in the U.S. and now that they have returned, the institute is better managed and its reputation is growing. That it "was a Swazi organization, run by the government, and staffed by Swazis with advanced training" was an important point of pride and a determinant in its success (McGuire, et al. 16-17).

The management structure of the Onchocerciasis Control Program is complex. A committee made up of major donors makes policy. WHO is the executing agency. The World Bank manages the project's funds, the UNDP and FAO have "advisory functions" and another committee of sponsors coordinates. There is also an Expert Advisory Committee of 12 experts appointed by WHO who

review the scientific and technical operations. Each country then has its own committee which acts as liaison to the project. In spite of this rather complex management structure, the project was noted for its efficiency. Headquarters has considerable autonomy but uses WHO systems of internal management (Kelly et al. 1986:3-4).

3.3 Impact on Beneficiaries

Every evaluation team discussed the impact of the project on the health status of beneficiaries. In addition to interviews with project staff, most teams interviewed beneficiaries on their views of the health services. One team analyzed existing data and another collected new data to attempt to measure nutritional change in children.

In Tanzania, the evaluation team was unable to assess impact on beneficiaries for lack of adequate records. The most immediate beneficiaries of the training centers were the 2,509 CHWs who had been trained. One unanticipated, but major, impact has been that the well-trained CHWs often migrate to the urban areas where they find work in clinical settings. As skilled nurses, they are more apt to marry men with urban-based jobs. The result is that many do not stay in the rural posts they were trained to serve (Minkler 1983:94-95).

Brown (1986:4), in an independent study of the health impact of the Tanzania project found that both MCH clinic staff and mothers were able to demonstrate a commendable understanding of such issues as pre natal care, immunizations, and growth monitoring. While there was, as yet, no evidence of impact on health, the potential for a position effect is clearly demonstrated.

One of the most consistent benefits from most PHC projects is the affect training has on the CHWs themselves. Most CHWs are women with limited educational backgrounds. Most come from

rural areas where the employment opportunities for women are limited. Training as CHWs instills women with confidence, prestige in the community, a profession, and a much broader network of contacts in the community. It changes her life in many ways. Of course, many such women move on to other jobs or leave for work in urban areas but the impact on the CHWs should not be underestimated.

The Colombia evaluation team carried out original research which included interviews with a random sample of beneficiaries and CHWs in project and control areas. The interviews covered knowledge and practice in the areas of immunization, contraception, and nutrition. The team found that the CHWs are well trained and that many of their education programs have been successful in imparting information to mothers .

The Colombia team found nutritional status of children, health condition (within the last eight days of the interview), and contraceptive use to be no different in project than in control areas. Immunizations were slightly higher in project areas but were still substantially below target levels. The samples used in the study were small and may account for a lack of differentiation between the target and control groups. However, the team concluded that much of the health education effort is not being carried over into practice (Hunt, et al. 1983:24-33).

In Senegal, in the original evaluation, records were inadequate for an assessment of health impact. Even with the serious startup problems the evaluators found, over 200 health centers had been opened in rural areas and they had provided minor curative services to thousands of people (Weber 1980:5). In the follow-up, no attempt was made to assess the impact on health but since the system was found to be functioning at a much higher rate of efficiency, it may be presumed that health impact is greater. The other benefit was the increased community involvement in the management of the local clinics and CHW (Bloom 1984:13-16).

The Morocco project was the only project to demonstrate improved nutritional status of children. Using data routinely collected by CRS staff, and conducting their own interviews with 25 mothers, the evaluators compared children in the nutritional programs less than three months with those in the program for more than one year. The evaluators found that participation in the food program resulted in a 69 percent reduction in moderate and severe malnutrition (Gilmore 1980:5).

More importantly, the team demonstrated conclusively that nutrition education is an important component of food distribution programs. Comparing data from CRS' early programs (before 1975) where children were given food but mothers received no education (fed), with those after 1975 where children were fed and mothers were given nutrition education (fed and ed), the study found "staggering differences."

"In 1975, 34 percent of the 'fed' children were moderately and severely malnourished. In 1978, after the addition of nutrition education, only 16 percent of the 'fed and ed' children were in this category. Severe malnutrition was virtually eliminated. All the while, the program maintained the nutritional status of these who were relatively better off to begin with" (Gilmore 1980:5-6).

The Swazi team could not measure changes in health status and felt that even if they had, it would have been difficult to attributed any changes to the nurses training program. They raise the question of whether the program, in and of itself, can have a health impact.

In summary, no impact is evident to date and we doubt the training program per se will have a positive impact on health indicators. Absent changes in utilization of paramedical staff, perceptions of quality, and the curative/preventive emphasis, it is unlikely that SIHS can have such positive impacts (McGuire et al. 1985:33).

The Korea Health Demonstration Project made considerable progress in improving access to health care services and increasing the use of the new health care services in rural areas. They also carried out research on alternative financing mechanisms, improved the training of three levels of CHWs, and greatly increased the participation of the community in the project (Dunlop et al. 1982:8).

All categories of people interviewed, government officials, providers, and villagers in both the control and demonstration areas believed health status had improved since 1976. However, they attributed this increase primarily to rising incomes, better nutrition, and better education. The importance of improved health care delivery was infrequently mentioned. The most important health status effects achieved through this project were obtained via the health education efforts of the Community Health Aides working with village volunteer workers (Dunlop et al. 1982:33).

The Onchocerciasis program in West Africa has demonstrated impressive results so far.

In 90 percent of the program area, the transmission of onchocerciasis has been interrupted. This has already had a measurable impact on human health by decreasing the incidence of blindness, disability, and debility. An estimated 27,000 cases of blindness have been prevented in Burkino Faso alone over the past decade. The economic consequences of effective control are potentially large and could extend for generations. It is estimated that the control program has helped open up some 15 million hectares of tillable land in the former onchocerciasis-endemic areas (Kelley, et al. 1986:viii).

The dark side of this progress is that the resettlement of people has created problems for women.

Women do not fully benefit from the effects of the program and may be in some ways even less well off in the zone than elsewhere in the area. They have less access to land for their own garden plots in resettlement areas than previously and they have less access than men to OCP and other training programs (Kelly, 1986:23).

Since women are expected to raise enough food for their children and, where access to land is limited, they are unable to do so, this negative impact of the program on women has nutritional implications for children. Most agricultural programs for developing the newly opened lands are aimed at men although women do at least half of all agricultural work.

This review of impact information shows that sometimes you cannot win for losing. The three programs which most successfully demonstrated health impact, all have serious sustainability questions. The Korea program folded because of unanticipated policy changes, the Onchocerciasis program is heavily dependent on multilateral donor support and is having a strong negative impact on women and children while the Morocco nutrition program is so dependent on PL480 food that there is little likelihood that the government will ever take it over.

In those programs where sustainability is less in question, such as Senegal or Columbia, while service use has gone up and accessibility of services is greater, there has been no demonstrated health impact. The studies may also show that where there is money for a sophisticated monitoring system, there is more apt to be demonstratable impact. Where programs struggle to make ends meet, monitoring and the analysis of data are often of given very low priority.

3.4 Impact on Institutions

Because of its importance to program sustainability, institutional development is a high priority with AID. Two of the projects reviewed established new institutions, Korea and Swaziland. One, the Onchocerciasis program, created a very large and complex new bureaucracy to manage a multi-country vector control program. The three PHC programs tried to build a rural health delivery system, and the nutrition program in Morocco created a system of self-financing centers.

The Korea and Swaziland projects have some similarities in that a new institution was created to strengthen the health care system. The results, however, were quite different. These two cases at least offer us a lesson about the resistance that comes from within the health profession when new categories of professionals are created or when training is changed.

The Korea Health Development Institute (KHDI) was an autonomous organization. Its objective was to use an experimental model to test some alternative approaches to health care delivery in rural areas, evaluate them, and derive a simple, effective system which would be replicable throughout the country. The fact that it was not attached to the MOH is part of the reason it may have failed. As an independent unit, management was not included in MOH policy deliberations which, ultimately, contributed to the failure of the project. "When the Ministry of Health viewed the fledgling system as potentially competitive, it supported the political efforts of physicians to circumscribe the paraprofessional's scope of medical practice" (Dunlop 1982:vii).

The Swaziland Institute of Health Sciences (SIHS) experienced some of the same resistance from the health profession but as a part of the MOH, it received very strong support from senior MOH officials. That support may have helped it weather a number of problems in its first years. Before SIHS, all nurses

training was carried out by a Nazarene Church where training was very curative, hospital oriented. Trainees had to adhere to a strong moral code which forbade drinking alcohol, or smoking, and pregnancy resulted to dismissal from the program.

SIHS was very different from the earlier training program. Training emphasized preventive care, rural and community problems, and practical assessment skills. Men and women attended classes together and were even housed in adjacent dormitories. Nurses trained in the Nazarene program were critical of SIHS graduates for not having enough hospital based experience and rumors abounded about the "loose" women at SIHS.

There were other start up problems including curriculum issues, collaboration with other institutions, and problems with transportation to training sites. "The Institute had strong support in the upper levels of the Ministry of Health which helped it weather the storms of criticism, much of which came from within the Ministry itself" (McGuire 1985:17).

The CRS nutrition program in Morocco has created a more dispersed institution in the form of a network of 300 nutrition centers. The total recurrent cost per beneficiary is \$34.47 per year.

Each mother pays about \$6.48 a year which goes for maintenance of her center and a salary for the teacher. Costs for training, supervision, and management are paid by CRS and the Government of Morocco. "This translates into approximately \$74 worth of food annually for each Moroccan family participating in the program, an income supplement ranging from 4 to 24 percent of the \$50 to \$260 per capita incomes of these poorest families" (Gilmore et al. 1980:7).

The Morocco evaluation team praised the "well organized and high quality" system which operates the centers. They attributed the success of the project to a delicate balance of strong central management and standardization of procedures with local variation and 'bottom up' communication..." (Gilmore et al. 1980:15). The program, however, is highly dependent on PL480 food and the continuing management services of CRS. There has apparently been no effort to "spin off" program management to a local organization.

In the PHC programs in Tanzania and Colombia, the evaluation teams found CHWs in place but with serious problems of supervision and support for CHWs and with the logistics of transportation and supplies. Both management and supply systems, particularly in Tanzania, are on shaky financial ground. Without adequate institution building at all levels, the mid-level is often the weakest part of the system (Hunt et al. 1983; Minkler et al. 1983 and Dunlop 1985).

Problems of mid-level and community management were also found in the original Senegal evaluation. That team found that the program actually discouraged community involvement (Weber et al. 1980). The follow-up found great improvement in the area of institution building. Community committees roles were strengthened, committee members were trained in management, and the health centers were operating much more smoothly than in the original evaluation. Some problems of supervision and supply persisted, however (Bloom 1984).

The Onchocerciasis Control Program is an institution created for the twenty-year project. It was not intended to be a permanent body. The program is just now moving into phase III during which the "devolution" of the project begins to take place. Training of national teams for epidemiologic evaluation, training, and "recycling" of technicians, sensitizing the population, and national administrative structures for onchocerciasis surveillance is under way by a

seven -country working group. How effectively the individual countries will do their part in controlling the blackfly population, given their lack of resources, will have to be monitored over the next ten years (Kelly, et al. 1986:B-10).

3.5 Impact on Government Policies

Of the seven projects reviewed, most were created to support government policies of stronger rural or primary health care programs rather than to change those policies. Consequently, the project can be said to have strengthened some policies but not have changed them.

In Senegal, the initial evaluation of the project prompted a major re-design of the project. The MOH took much greater interest in the project, including the appointment of a project director. A new Governor was appointed in Sine Saloum and expansion of the project was delayed until problems could be addressed. The methods used in other projects were studied by specialists, and AID/Senegal as well as AID/Washington monitored the program more closely (Weber, et al. 1980:15).

The negative evaluation, therefore, had a very positive impact on AID and the Senegalese government. Whether it can be said to have affected policy in any sustained way cannot be certain.

In Tanzania and Colombia, AID was assisting in carrying out existing policies aimed at expanding health services in rural areas. The projects may have contributed to a government

Chart 2: Findings Emphasized

Internal Organiza-

Ir

Illegal width.

Printout terminated by system.

awareness of the importance of mid-level management for CHW supervision and for the logistics of supervision, transportation, and supply systems.

In Tanzania, experience with attrition of CHWs in rural areas resulted in a tightening of admission criteria along with stronger enforcement of rural posting requirement (Minkler et al. 1985:95). To what extent this was a result of involvement is unclear.

After the AID funded program began in 1971, the Tanzanian government made a strong commitment to primary health care including the extensive use of paramedical workers, decentralization, and preventive rather than curative services. The number of health facilities increased from 1580 in 1970 to 3100 in 1980. There was a 250% increase in health aides for rural areas (Brown 1986:13).

In Morocco, the CRS project has clearly demonstrated that a food distribution program, when combined with an effective education program can dramatically reduce the incidence of malnutrition and the Ministry of Social Affairs has established a system of nutrition education services. There have been attempts to improve the nutrition education program and cooperate with the immunization program. "Morocco is a case in point of the potential rewards and possible risks in building up an organizational infrastructure around PL 480 commodities" (Gilmore, et al. 1980:15).

Policy decisions with the MOH in Swaziland tend to be ad hoc, based on informal relationships, and dependent on personal negotiating skills of upper level bureaucrats and technocrats. There is a parallel government in the traditional power structure which operates independently and with its own sources of revenue. The MOH has enacted several health policies to increase the fees at government health centers and to decentralize planning and administration. Many of the policy

shifts, however, have not been matched with budget shifts. "The impact of the Health Manpower Training Project on these policy changes is difficult to assess, but at best it was indirect" (McGuire et al. 1980: 41-46).

The Korea project was a case of policy having impact on the project rather than vice versa. There is a lesson for other projects:

Without continuous monitoring of the economic effects of potential policy changes which might affect the emergent system and provide the means for such analysis to be seriously reviewed by policy-makers, such projects as the one developed and implemented by KHDI will be short lived after donor support has been removed (Dunlop et al. 1982:33).

The onchocerciasis program is currently making an effort to create national onchocerciasis programs which will carry on the work OCP has started. As yet, it cannot be said to have an impact on policy. The evaluation report suggests stronger emphasis on the economic and social development of resettlement areas (Kelly et al. 1986:23). The extent to which national and local governments will address these issues in their policies, or more importantly, in their budgets, is yet to be determined.

In summary, the Tanzania project may have had the greatest impact on policy of the projects reviewed. In Colombia, the program gave support to an existing PHC program. In Morocco, Swaziland and Senegal, lessons were learned which may have been adapted by the local government. The Onchocerciasis program is now working to affect local policies and the results are not yet in. The Korea project, however, demonstrates the importance of policy considerations in program planning.

4. Evaluation Issues Related to AID's Priority Emphases

In this section, the results of the evaluation will be discussed in terms of AID's Priority Emphases as set out in the Blueprint for Development: The Strategic plan for the Agency for International Development. This major policy statement for the agency sees the goal of development as a world free of extreme poverty, hunger, illiteracy, and illness. AID's approach to that goal stresses four strategies:

- policy reform
- institutional development
- use of the private sector
- technology research, development, and transfer

The seven projects reviewed here began in the mid- to late 1970's and ended when the four strategies were informal but not formal AID policy. In that respect, it is unfair to assess their effectiveness in terms of current thinking. On the other hand, the four priority emphases do provide a useful way of discussing the lessons we have learned from the projects.

The accompanying Chart Three, gives details about the projects while the narrative focuses on generalizations.

4.1 Policy Dialogue

The projects reviewed have resulted in little change in local government policies. The projects were undertaken, for the most part, to strengthen existing policies aimed at broadening health care coverage and increasing the emphasis on primary health care.

The evaluations do confirm the importance of government policies, not just in health but in other sectors as well. In Tanzania, macro-economic and agricultural policies seem to

threaten the entire health care system. In Korea, a new mandatory health insurance program had a profoundly negative impact on the demonstration project.

A policy of decentralization, it has been shown, requires strong government support as well as effective local leadership. Community leaders require training, as they received in the second phase of the Senegal project, to effectively manage a PHC program. While community involvement is essential to a functioning, decentralized program, great attention must be paid to a strong mid-level management and supervision level. Without support, supervision, routine training, and assured supplies, the effectiveness of CHWs is dramatically curtailed. Colombia, Tanzania, and Senegal all experience weaknesses in supervision and the availability of supplies.

Policy is hollow without a financial commitment to supporting the policy. Colombia and Tanzania have impressive goals but few resources to carry them out. In Senegal, a strong system of community financing has minimized some of the financial strain but there are still problems of financing the supervisory level.

And finally, planners should not underestimate the power existing health care providers have on policy. In Korea, physicians' objectives to the CHWs contributed to the downfall of the project. In Swaziland, nurses objected to new methods of training and new types of CHWs. This resistance to change was an important component of the start-up of the new nurses training facility.

4.2 Institutional Development

These projects reviewed have contributed to the development of effective and efficient institutions has been both directly and indirectly. Training for community nurses in Swaziland and CHWs in Tanzania will provide more and better-trained health care personnel.

Training can be counterproductive, however. CHWs who are too highly trained are often upwardly mobile, and there may be a high attrition rate as young women gain self-esteem and seek out other jobs.

In Tanzania, CHWs made attractive wives for men with urban based occupations and many left the rural areas for town. In Swaziland, there is grave question of whether the already overloaded health system can pay appropriate salaries to the nurses the institute will produce. In Colombia, also, salaries for health workers are already undependable. Adding needed additional CHWs will definitely over-burden the system.

Two projects, Morocco and Senegal, were successful in strengthening local participation in projects. In Morocco, community members finance their own nutrition center and pay the salary of the instructor. In Senegal, a variety of community schemes pays the salary of the CHWs and community members effectively manage the local delivery system.

The evaluations confirm the importance of institutional development for long-term project viability. The first Senegal evaluation chided AID and the government for actually harming community organizations and regional health authorities. The second evaluation was much more optimistic largely because these institutions had been developed.

The Korea project, in its early years, demonstrated the importance of research on local conditions and on increasing the planning capacity at both local and national levels. Unhappily, the same project demonstrated the vulnerability of institutions set up outside existing government structures.

Both the Swaziland and the Tanzanian evaluations question the policies which strengthen isolated institutions without adequately addressing weaknesses in the overall health system.

4.3 The Private Sector

The evaluation reports make it clear the project planners too often either ignore the private sector or assume its cooperation, sometimes with disastrous effects.

The success of the Senegal project rested heavily on community financing, yet planners and managers failed to provide for its development. Initially, the community was not involved in decision making. Only after major revisions in program management were local citizens trained to manage the program and effective cost-recovery schemes worked out. The follow-up evaluation demonstrated the importance of service pricing, community management skills, and response to demand. The project also shows clearly that there can be financing for curative services. Private financing of preventive care and supervision is not possible, however.

In none of the PHC projects were traditional healers, pharmacists, or private physicians incorporated into the delivery system. In Korea, the failure to consider the financial impact of the project on private physicians was a major shortcoming of the program. In Swaziland, nurses were critical of new types of nurses and of the training methods. The nursing profession was not included in planning for the project nor was the impact it would have on them calculated.

Community financing of some health care services is possible. In Senegal, the community builds and maintains health centers and pays and supervises CHWs. In Colombia, some communities have created revolving drug funds and in Morocco, community members pay for nutrition education (although they receive in return a substantial food supplement).

4.4

The only project reviewed which placed great emphasis on hard technology is the onchocerciasis program in West Africa which is a very high technology project with various air-craft, technical monitoring devices, and pesticides. The project will "devolve" over the next ten years to more appropriate technology which can be sustained by local governments. Although there will be ten years to develop suitable technology and train staff, the evaluation team raises some questions about the sustainability of the effort when it is turned over to local governments.

The Senegal project experienced difficulties with supervision because supervisors were expected to visit health centers in specially designed horse-driven buggies. Although the technology was "appropriate" in that horses were available and required no imported replacement parts, the planners failed to consider that program supervisors often own their own automobiles and considered it a loss of dignity to travel in buggies. When they were later given small motorcycles, willingness interest in visiting health centers increased.

The Korea project had an important research component which yielded substantial information on alternative approaches to health care delivery. The Morocco project was commended for its effective monitoring and record keeping system. The Onchocerciasis program has a substantial research and evaluation component. While a strong evaluation component does not guarantee project success (Korea), it does contribute to the impression evaluators have of it. The two most positively reviewed projects, Morocco and the Onchocerciasis program, also have the strongest monitoring systems.

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Appendix B

CHART FOUR Evaluation Findings Related
to AID's Priority Emphases

ISSUES AND FINDINGS REGARDING PROJECT DESIGN AND MANAGEMENT

I. Overall Organization	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
A. What health development tasks should be performed by (a) govt. (b) communities (c) the private sector.	Communities can take on significant health activities, but only if govt. supports them.	Communities can take on significant health activities, but only if govt. supports them.	Govt. restrictions may hamper community initiatives.	Assessment found costly overlaps between various govt. & private activities.	Private sector cannot fill gaps in existing govt. programs.		
B. What are the values & limitations of pilot projects?	Testing in a small area appears to have been very valuable.	Assessment criticized absence of pilot project.		Project involved pilot studies but changes in govt. policy largely invalidated results.			A number of "Lessons Learned" for future projects of this scale
C. Should AID take an active or largely "hands off" approach to project implementation?	Contractor & govt. management appears to have been adequate.	Assessment attacked "hands off" approach.	Issue not discussed.	Project elements mainly threatened by policy changes, not by implementation difficulties. AID's role in policy development not discussed.		AID/MCH relationship apparently good.	Not discussed.

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CHART FOUR Evaluation Findings Related
to AID's Priority Emphases

ISSUES AND FINDINGS REGARDING PROJECT DESIGN AND MANAGEMENT

I. Overall Organization	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
D. Is the Policy Paper's emphasis on medical technologies appropriate? Or should AID stress planning, management & organizational development technologies instead?	The latter were clearly more important for this project.	The latter were clearly more important for this project.	Medical technologies not relevant.	Control over medical technologies became a major issue.		"American" system of nurses training works well. Gives prestige to Institute.	Technology of vector control was central to project.
E. Should AID give greater emphasis to urban health systems, especially in Latin America?							
F. What should be AID's role in the strengthening of local pharmaceutical production, & modification of import controls and national formularies?		USAID clearly needed to take greater interest in this question.					

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CHART THREE Evaluation Findings Related
to AID's Priority Emphases
ISSUES AND FINDINGS REGARDING PROJECT DESIGN AND MANAGEMENT

Overall anization	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
ave AID projects an appropriate nce between munity level act- ties & the develop- t of essential ort systems.	Yes	Activities were part- icularly weak at the community level, though supervision & & other support systems were also weak.	Community activites suffered from in- adequate super- visory & log- istical support.		Project mainly concerned training.	G. More community health experience and feedback is needed.	No community involve- ment.
's establishment ffective curative ices a prerequisite preventive health ivities?	Project apparently functioned well with- out curative services.	Preventive health workers appeared ineffective & were dropped from the redesigned project.	Promotoras offered both minor curative & preventive services.	Little apparent public interest in preventive activities.			
hat research & uation activities ld AID support?		Improved routine monitoring.		A major research effort which, however, had limited benefits.	Report recommends 4 specific studies but also notes absence of routing manage- ment data.		Tech problems of equip- ment, more on socio- economic change. Resulting from vector control.

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CHART THREE Evaluation Findings Related
to AID's Priority Emphases
ISSUES AND FINDINGS REGARDING PROJECT DESIGN AND MANAGEMENT

II. Community-Level Activities	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
A. How essential is community participation for achieving improvements in health status?	Community resource & organizational inputs contributed greatly to project effectiveness.	Project depended on community cost-sharing.	Broad women's participation appears to have been helpful.				May be critical to long term sustainability.
B. Are health workers & systems more effective when service components are limited, say, to ORT, immunizations & family planning?		Original scope of work clearly too broad.					This single intervention was effective - cannot compare with PHC projects.
C. Are minimally trained community health workers a viable means of strengthening local health activities?	Yes	Problems with selection, leading to high turn over.	Yes, if paid.	Questionable.	Possibly, if support systems are in place.		

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Chart 4: conti.

CHART THREE Evaluation Findings Related
to AID's Priority Emphases
ISSUES AND FINDINGS REGARDING PROJECT DESIGN AND MANAGEMENT

III. Costs	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
A. Are actual costs similar to those projected.		No	No, actual costs were about double.				Yes
B. Are selective health interventions less costly than a comprehensive PHC approach, as the Policy Paper asserts.							Hard to assess social & Economic benefits.
C. What costs & efforts are required to develop community participation?		Project inputs were clearly inadequate.					
D. What financial, career, or other incentives are needed to motivate effective CHW performance?		Incentives were clearly inadequate.	Govt. salary, though small, considered key to worker effectiveness.	Assessment showed that issue was important but not adequately addressed.			

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Appendix B

CHART THREE Evaluation Findings Related
to AID's Priority Phases

ISSUES AND FINDINGS REGARDING PROJECT DESIGN AND MANAGEMENT

IV. Financing	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
A. Will govts. assume recurrent costs as planned?	Govt. unable to pay for food imports, a major project element.	No	Probably not at the higher cost level projected by the assessment team.	Issue not clearly addressed.	Very doubtful.	Whole health care system has economic problems.	Will not know until phase III is over.
B. Under what conditions will communities contribute significantly to project costs?	When they receive an immediate tangible return (food).	When they receive an immediate tangible return (drug).	When they want to supplement govt. services.	When they receive quality health services not obtainable more cheaply elsewhere.			
C. How should community health workers be financed?		Community financing as originally designed - not adequate.	Govt. salary reportedly increased workers effectiveness.	A major unresolved issue.		MOH salaried; fee for service cost recovery.	

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Chart 2:

CHART THREE Evaluation Findings Related
to AID's Priority Emphases

Issues and Findings Regarding Project Impact

I. On Host Country Policies	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
<p>A. What has been AID's impact on the govt. policies? (See A.I.D. blueprint for Development)?</p> <ul style="list-style-type: none"> - commitment to free services - willingness to expand beyond management & financial capacity - inefficient urban/rural resource allocation. - neglect of private sector. - inappropriate import tariffs. - discouragement of indigenous practitioners. - no incentives for rural services. 	<p>Project demonstrated value of beneficiary payments & the feasibility of rural activities. govt. has since assumed financing responsibilities & expanded project coverage.</p> <p>Project demonstrated need for overall govt. leadership and support even for decentralized efforts.</p>	<p>The impact assessment itself appears to have had considerable positive impact on govt. policies, esp. eagerness to expand beyond capacities.</p> <p>Decentralization requires effective local leadership; AID must be actively involved.</p> <p>Nat'l officials must understand & support decentralization must start at high levels.</p>	<p>Supports existing Policy</p> <p>All levels in medical system should agree on functions of CHWS before training begins. Govt must encourage community contributions.</p>	<p>These do not appear to have been the major policy issues in Korea.</p> <p>But, project demonstrated that changes in govt. policy can quickly change project impact & sustainability.</p>	<p>No Impact. But, macro-economic policies greatly affect PHC sustainability.</p>	<p>Little if any. Health policies not supported by economic policy.</p>	<p>None Govts. have many problems. Cannot have a policy on every disease.</p>
<p>B. Have AID inputs & activities caused the govt. to allocate additional resources to PHC?</p>	<p>govt. has increased funding for nutrition education, possibly as a result of the project.</p>	<p>Project probably increased govt. attention to PHC, even if not spending.</p>	<p>No evidence.</p>	<p>Reportedly a major project achievement, but not mentioned in the impact assessment.</p>	<p>NO</p>	<p>NO</p>	<p>NO</p>

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CHART THREE Evaluation Findings Related
to AID's Priority Emphases

Issues and Findings Regarding Project Impact

I. On Host Country Policies	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
C. Have recent AID policy shifts toward selective PHC influenced govt. planning?							
II. On Private Enterprise							
A. Have AID activities strengthened or weakened private and traditional practitioners?	No plans for their involvement.	No plans for their involvement.	No plans for their involvement.	Project initially harmed project sector. Private practitioners eventually secured policy changes which reduced likelihood of project success.	No PVO involvement.	Nurses complained about completion from new CHWs.	NO NO
B. Has AID support for private voluntary organizations affected govt. policies or served as a model for related activities?	CRS Program has been adopted by govt.	No PVO involvement.	No PVO involvement.	No PVO involvement.	No PVO involvement.	One U.S. based PVO is helping with training.	NO

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CHART THREE Evaluation Findings Related
to AID's Priority Emphases

Issues and Findings Regarding Project Impact

I. On Institutional Development	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
Have AID activities strengthened national capacity to plan & manage health programs?	Perhaps indirectly.	There is some suggestion that the original program actually weakened "national capacity."	Perhaps indirectly. Need more trained support personnel.	Project augmented PHC research capacity, but future of the research group (KHDI) was unclear at the time of assessment.	No-training institutions may not be worth developing if the rest of the health system is not in place.	Provides more trained but trainees are not posted to rural areas. Overtrained CHWs may end up in urban hospitals.	Not yet-final phase will concentrate on this. Training local staff may not be enough. More economic planning is needed.
Do AID procedures appear to be more effective in this regard than those of other donors?	No evidence.	Other donors possibly more effective.	No evidence.	No evidence.	No evidence.	No evidence.	No evidence.
Have AID activities promoted the growth of community groups, men's organizations, and other groups with health interests?	Yes-local residents properly supported and encouraged by the govt. can manage educational centers.	Activities appear to have discouraged community groups. Follow up demonstrated value of community involvement.	Yes	No-planning must account account of existing providers and their ability to influence govt. policy.	No	No	No
Have AID activities strengthened local government development capacity?	Yes	Issue not addressed.	Yes	Yes	Yes, with qualifications.	Yes	Yes

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CHART THREE Evaluation Findings Related
to AID's Priority Emphases

Issues and Findings Regarding Project Impact

IV. On Technology Dev., Adaptation & Transfer	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
A. What have been the costs & benefits of AID's investment in medical technologies?							High tech approach to spraying has been effective but not sustainable.
B. Have planning, management, & organizational development technologies transferred from the U.S. been appropriately adapted to LDC's?	Effectiveness of food supplements was significantly increased with the addition of a low cost educational component.	No				Nurse training follows American model.	

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CHART THREE Evaluation Findings Related
to AID's Priority Emphases

Issues and Findings Regarding Project Impact

V. On Beneficiaries	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
A. Have AID health activities significantly affected the health status of population served?	Yes	Evidence of change in utilization patterns only.	Project improved access to health services; no significant change found in nutritional status.	Project increased access to health services, but other development activities probably had greater impact.	Increase in national utilization of MCH services probably due to project.	No	Yes, dramatic decline blindness.
B. Have selective interventions, such as ORT and immunizations, had greater impact than comprehensive PHC programs?	A selective (supplemental feeding) program with demonstrable impact.	No evidence.	Services provided were reasonably comprehensive.	No evidence	No evidence.		This intervention is effective.
C. What impact have non-health activities had on health?				Beneficiaries reported considerable benefits from general rural development, esp. road construction.			None

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CHART THREE Evaluation Findings Related
to AID's Priority Emphases
Issues and Findings Regarding Project Impact

VI. On Beneficiaries	Morocco	Senegal	Columbia	Korea	Tanzania	Swaziland	W. Africa
D. Have AID health activities benefitted women, through increased employment or other status changes?	Program strengthened women's organizations & mobility outside the home.	No evidence.	Employment, esp. for a salary, increased women's status.			D. Has increased status of nursing profession.	Negative effect re-settled woman lost landrights, have additional domestic chores. Ag. work done by women but prog. aimed at men.
E. Have AID activities increased the quality of PHC services countries?	Yes	Yes, at least as perceived by users.	Yes	Probably	Probably	E. Probably will when trainees are in place.	May when it is turned over to countries.

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