Methodological Guidelines for Preparing a Master Plan for Investment in Health

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The current version of the Guidelines was prepared by Cleofe Molina and Hernán Rosenberg, who also supervised the overall process.

Introduction

Foreword

The process for investment in health in the Region of the Americas requires great effort to ensure that the preparation of a portfolio of projects is consistent with the countries' policies and priorities. This process affects both the negotiations with the national and/or external financing organizations as well as the management of the portfolios. PAHO has promoted the preparation of Master Plans for Investment in Health (PMIS from its Spanish initials) since the mid-1980s and, even more so, since the beginning of the 1990s in the context of an initiative of the Pan American Health Organization/World Health Organization (PAHO/WHO) known as the Regional Plan for Investment in the Environment and Health. Furthermore, since the mid-1990s, the need for this type of analysis was renewed as a result of sector reform processes undertaken or envisaged in many countries.

A PMIS is composed of: a) a planning instrument; b) an instrument for negotiation with the possible financing sources of the proposed projects and, c) a management tool for investments in the short, medium and long term.

The PMIS is part of a set of analytical instruments designed to strengthen national capabilities for planning, monitoring and evaluation of investments in health, as well as for mobilizing internal and external resources. These instruments are used for everything from sector analysis (where, among other things, they identify the need for investment in health) to providing management techniques for projects.

The following guidelines attempt to support this effort at improved investment in health. The guidelines take into account the priorities set in the countries for the health sector and are consistent with the technical cooperation framework established by the Governing Bodies of PAHO/WHO.

Based on some previous experiences (for example, in the state of Chihuahua, Mexico, and in Cuba) PAHO/WHO prepared and disseminated in December 1998 a draft «Methodological Guidelines for the Preparation of a Master Plan for Investments in Health.» This document was prepared in the context of the Latin America and the Caribbean Health Sector Reform Initiative (LAC HSR) co-sponsored by PAHO/WHO and the United States' Agency for International Development (USAID).

The Initiative's work plan required that the instrument be tested in two countries. The lessons learned from the tests were compiled into a final version which was subsequently disseminated to the other countries of the Region.

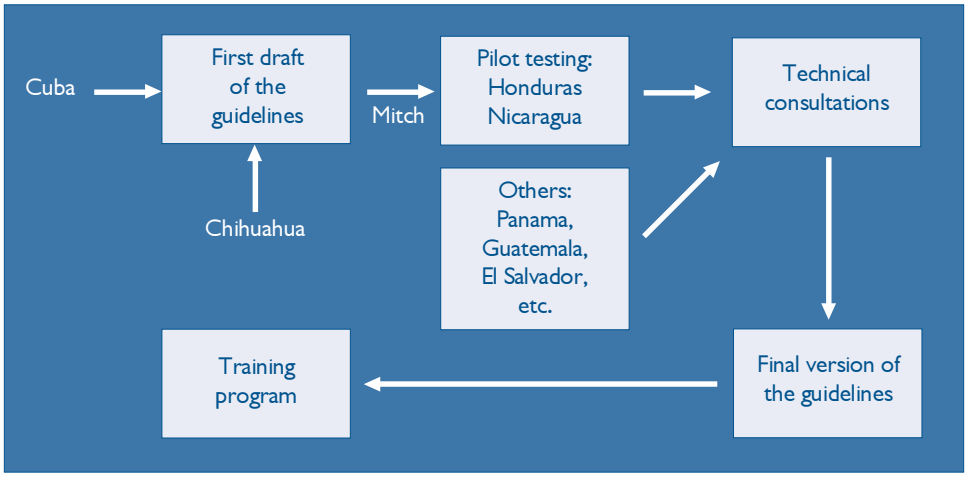
At the end of 1998, hurricane Mitch severely affected Central America. The emergency and devastation occasioned by Mitch also re-confirmed the difficulty of producing programs for investment in health, even when there is a significant offer of resources. In fact, initially, it

was not clear which projects should take priority beyond those serving to palliate the immediate effects of the tragedy, and it was even less clear in what order the projects should be considered. As a consequence, draft guidelines were used to support the preparation of a portfolio of projects that was eventually presented at a donor's meeting in Stockholm in 1999. For the purposes of the LAC HSR, the experience in Honduras and Nicaragua was regarded as the field test for the instrument. Belize, Panama, El Salvador, and Guatemala also participated in the training and utilized the instrument in the preparation of their proposals to different financing sources. Subsequently, other countries of the Region such as Paraguay and Haiti have requested the undertaking of a similar exercise.

Honduras produced a collection of 52 duly ordered and classified projects for a total of 108 million dollars, and Nicaragua 80 projects for the sum of 95 million dollars. In both countries the evaluations of the PMIS process by the participants were very favorable.

A meeting of both experts and participants at the national and regional levels was organized in November 2000 in Washington, DC, to analyze the above mentioned experiences. The outputs of that meeting were utilized to prepare the current version of the guidelines.

Figure 1. Process for preparing the guidelines



Economic context

The countries of the Americas spend a considerable quantity of resources on health. Between 1994 and 1996, spending on health increased from 6.8% to 9.9% of GDP between 1984 and 1996. Nonetheless, only recently has spending returned to the levels seen at the beginning of the 1980s. However, the average per capita expenditure is still below $100.

The distribution of expenditure within the Region is very unequal. In the industrialized countries of the Region the percentage of GDP destined to health increased from 10.5% to 14.4% between 1984 and 1996, while in the rest of Latin America and the Caribbean the change was from 4.2% to 7.2%.

The data available on the composition of expenditures for the Region is not specific enough to allow for differentiation between investment and current expenditures. Among the eight countries in which national health accounts have been prepared, in only one do «capital expenditures» exceed 7%, (and it is an anomalous case where a very high proportion of the

GDP comes from the external sector). Among the other seven countries the median is approximately 4%.

The impact of health investments on the level of health of the population is difficult to estimate in the short term. However, the impact of the cholera epidemic of 1991, a disease deemed eliminated in the Americas, showed the magnitude of the gap in sanitation and in health services investment that resulted from the macroeconomic adjustments of the 1980s. Indeed, between 1980 and 1997 the access to safe drinking water increased from 79.9% to 87.1% and access to proper sanitation from 43.2% to 70.0%. In the same period, the proportion of deaths from acute diarrhea disease in children under 5 declined from 21.6% to 8.2%. Nonetheless, at the dawn of the 21st Century[1] the population without access to health services—the excluded—in Latin America and the Caribbean is estimated to be 20%-25% of the total, or somewhat more than 100 million people.

The relationship between investment and development has been studied since the 1950s. Although investment is not the only variable that explains development, it is consistently one with the most explanatory power. If it is utilized in its broader meaning,—not only as investment in infrastructure but also in human capital—as proposed in this document, the explanatory value of investment is even greater[2].

During the nineties the macroeconomic indicators of the Region tended to improve. In 2000 the economies of LAC continued the upturn initiated in the last quarter of 1998. The regional GDP increased by 4%, compared with 2.3% in 1998 and 0.3% in 1999. The projections for 2001 indicate a growth in regional GDP of approximately 3.8%.

Although growth was only modest; the upturn in the economy caused the rethinking of economic priorities and, specifically, of the policies towards different components of public expenditure. Moreover, there was a reemergence of the notion that benefits of economic growth should be distributed to improve the living conditions of the entire population. This more even distribution of benefits distinguishes a developed economy from one that simply grows, since progress is beneficial to all layers of the population. Indeed, poverty in LAC barely declined from 41% to 39% of total households between 1990 and 1994. In 1999, the percentage of the population living in poverty had increased to 50.7%, and the absolute number of people in this situation was close to 243 million. On the other hand, unemployment remained at nearly 9% and real wages saw a small increase. The most recent inflation figures show a regional average of 8.9% for the 12 months prior to November 2000.

Furthermore, considering the definition of investment as inclusive of human capital, there was an insistence in the design of economic policies that prioritized spending for the social sectors. At the same time, the international financial institutions (IFIs), the cooperation agencies of the United Nations system—including those which have an explicit mandate to invest in the health sector—and the bilateral donors announced the availability of additional resources for this purpose. These resources were allocated not only to the traditional programs such as reproductive and maternal and child health but also offered resources to support health sector reform.

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[1]For a discussion on the subject see Rosenberg, H. and Andersson, B. «Repensar la protección social en salud en América Latina y el Caribe» (in Spanish) in Revista Panamericana de Salud Pública 8(1/2), PAHO, Washington, Julio-Agosto 2000.

[2]Pinto, M. «Hacia un nuevo concepto de inversión en el sector salud», PIAS, PAHO, Washington, 1994. IDB: Development Beyond Economics (2000 Annual Report) and World Bank: Entering the 21st Century. World Development Report 1999/2000.

Health Sector Reform and Investment

The HSR Initiative, therefore, has a semi-structured agenda, multiple stakeholders, varied financing sources and enormous investment requirements.

But even with the potential availability of resources, the health sector saw its priority diminish in LAC, even in countries that did not experience economic contractions. The countries' weak ability to justify sector requirements and the lack of a well articulated program that systematically defined the requirements and the priorities account for the sector's decreased priority.

A frequent observation is that when investments in health are made, they do not always address the investment priorities set by the participants in the sector. On some occasions no priorities have been enunciated. The sector rarely gives the impression of having a long-term strategy in which the different investments conjoined create a clear global approach for improvement of population health.

In this context, it is necessary to review the health sector's investment policy. The short term review will focus on the unavoidable need to undertake projects of physical infrastructure in order to recover the missing productive capacity. The medium and long term will deal with the challenges and opportunities arising from the processes of modernization and of HSR in the Region of the Americas.

Indeed, the design of a policy for investments and the construction of the necessary strategic partnerships for carrying it out are part of the steering role of the health authorities and it is the aim of the HSR Initiative to strengthen the authorities' capacity to carry out this function. Such an investment policy is also needed in order to guarantee the sustainability of the process of HSR. Accordingly, it is an important notion that individual projects, which are independently indispensable, should be designed taking into account broader frames of reference (such as the PMIS) that improve the allocation of the resources.

The health sector needs to be strengthened in order to achieve the maximum impact from the allocation of the funds it receives in order to adapt those allotments to the different sets of priorities.

In each country, the investment priorities are conditioned by:

a. National policies.
b. Health priorities.
c. Availabilities of national resources.
d. Decisions by the political authorities.

Externally the priorities depend on the various stakeholder plans:

a. International technical cooperation agencies.
b. International financial institutions.
c. Bilateral donors.

Traditional programs for investment training are usually found under the guardianship of institutions in the economic sector and tend to concentrate on staff from other groups in the productive or services sub-sector. The risk is that they have insufficient knowledge of sector specificities.

The above makes clear the need for health sector personnel to acquire or improve their skills in the field of investment policy. Specifically, they need to ensure the use of the general criteria for any investment process, from the pre-investment to the impact assessment of activities.

In general, the size and the composition of investments in health should be calculated on the basis of a study of demand, which depends on:

a. The epidemiological pattern.
b. The model of care.
c. The national health priorities
d. The existing investment inventory.

It is important to recall that interdisciplinary work favors more timely and efficient detection and prioritization of needs, formulation of projects, mobilization of resources, and impact assessments.

As mentioned above, the proposed concept of health investment differs from the mere physical investment. Here sector investment is considered as a whole, beyond health care providers, including institutions that provide administrative and supervision support, activities linked to information systems, institutional re-organization and human capital improvement among others. The latter may generate a more varied—and sometimes of greater impact—range of projects than occurs when organizational and institutional aspects are not included.

This is due to the fact that the impact of the investments depends to a great extent on the institutional and organizational conditions in which the sector as a whole and each establishment and program operate.

In fact, proposals for change and reform often emerge from the analysis of investment efficiency. Furthermore, within the framework of HSR processes, investments should advance the achievement of proposed objectives in terms of equity, effectiveness, quality, efficiency, sustainability, social participation and inter-sectoral participation. More specifically, investments should increase equitable access to basic health services of the population.

The preparation of PMIS is one of the technical cooperation activities that the Pan American Health Organization/World Health Organization (PAHO/WHO) propose to Member Governments in order to strengthen their national capacity and improve five of their competences:

a. Identification the investment needs of the health sector.
b. Formulation, implementation, and appraisal of investment projects in health systems and services.
c. Identification and formalization of strategic partnerships necessary for executing health investment projects of an inter-sectoral nature.
d. Mobilization of internal and external resources.
e. Support for the policies of health sector reform (HSR).

As mentioned above, in some countries the PMIS is necessary for resource mobilization; however, in many countries this capacity already exists. The problem is that many times the mobilization is achieved by personal or institutional contacts between specific local authorities, or because of the agenda of external partners interested in some specific subjects or areas[3]. That is, resources (not necessarily external) reach the sector, but do not necessarily reach the proper sub-sectors to solve the problems that have been identified as priorities in the sector. The PMIS makes it possible to identify those areas, which having been deemed important, do not receive interventions because the resources are «exhausted» in other areas. In this regard, the PMIS favors project prioritization, a difficult objective in the health sector.

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[3]As specified in Chapter VI, external partners may assist in financial (i.e. money transfers) as well as non financial terms. Unless otherwise indicated in the text, they are assumed to be capable to cooperate with any type of resources in this guide.

A common observation is that health authorities are «weak» and that countries feel forced to accept projects that they will not be useful or that are not a priority. Experience points out that only on rare occasions is there a clear and coherent presentation of the needs for investment made through a PMIS. As a result, presentations of the health authorities to the possible partners both local and external are less credible. A fair negotiation exercise is needed to achieve the best combination of the priorities of the cooperating parties and those of the health authority. The negotiation is very difficult when the priorities of the authority are neither clear nor explicit.

In short, a PMIS is an instrument that generates a planning process that makes it possible to have a structured view of the priority needs for investment in the health sector of a country, a state, or a province both in the short and medium term. It also makes explicit its relationship to other development initiatives of the health services system, such as the HSR. It is this plan's goal to surpass the fragmentation caused by isolated project planning as well as to encourage the preparation of integrated investment schemes, even beyond the health sector (using an inter-sectoral approach).

In the first chapter of this document, the conceptual framework of the PMIS is described. In the second the process and the logical staging sequence are proposed. The third chapter develops the basis for the preparation of the PMIS. The fourth chapter includes the preparation of the portfolio of investment project profiles in health; in the fifth the foundations are laid for the negotiation and mobilization of resources to finance the project portfolio. The foundations of the model of management and monitoring of the PMIS are introduced in the sixth chapter. Finally, there is a glossary of the most frequently used terms, the bibliography and the annexes. In the operational chapters (II to the VI) a box is included with guiding questions in order to make it easier for the team to ensure that the stages necessary for the preparation of the PMIS have been completed. These questions or their answers do not constitute an integral part of the PMIS but are expected to serve as a guide for the management team responsible for the PMIS.

Chapter I. Conceptual Framework of a Master Plan for Investment in Health

This chapter looks at the operational concept that underlies a Master Plan for Investment in Health, its field of application, its various uses, its content, and the objectives and scope of the methodological guidelines for its preparation.

I.1. What is a Master Plan for Investment in Health?

The Master Plan for Investment in Health is a political and technical process, which is used to steer the development of the health sector within a specific political and administrative context. That context may be either national (country level) or subnational (either at the institutional level—Ministry of Health—or at the geographical level—region, department, province, state or municipality).[4] The Master Plan takes into account the political, economic, social, and health contexts; identifies health sector problems; outlines strategies and actions to address those problems; and creates a portfolio of investment project proposals aimed at preventing, resolving, or alleviating them.

Two major groups of factors need to be considered when formulating a Master Plan. The first group includes external factors that occur outside the sector yet affect its performance. The second group includes the internal factors affecting the sector's operation.

The main external factors are the macroeconomic context, public policies, the national (or subnational) planning cycle, the evolution and composition of public investment, and the characteristics of the various participants in the investment processes. Especially important are the national system of public investment and the relationship between the health sector and funding sources, whether national or international.

Particularly salient among internal factors are the relevant elements of the political, economic, and social contexts; the national health priorities; the demographic and epidemiological factors; the degree to which the health authorities have fulfilled the essential public health functions; the organization of health services, funding and sector expenditure, and the supply and demand for services. Also important are delivery of services, inter-institutional relations; and the degree of efficacy, efficiency and effectiveness in the coordination of components of the welfare system.

Although it is not always the case, preparing the Master Plan may be regarded as one of the logical outcomes of health sector analysis and should therefore be formulated after that process

[4]This document refers to «health authorities» in a general sense, but the term should be understood to include all authorities at the central, federal or subnational level, whichever applies.

has been completed. Thus, most of the themes and contents of the Master Plan will have been previously clarified, and it will suffice to summarize them and to make them operational. Note, however, that the recommendations of the health sector analysis may or not be investment-oriented. For example, it may be that a review of the maternal and childcare model does not yield an investment-oriented recommendation in the context of this document. Thus, although the health sector analysis is not indispensable, preparation of the Master Plan becomes much easier if such an analysis has been completed, especially if it clearly differentiates its investment-related recommendations.

However, the Master Plan can be submitted even if a health sector analysis has not been completed. Instead, the relevant data can be gathered and confirmation sought from a group of experts, so that a rapid health sector analysis can be drafted.

1.2. Purpose of the Master Plan

The Master Plan is a useful tool for decision makers and opinion shapers. It is a process that strengthens the health authority's steering capacity where necessary, and meets the various disparate needs of the implementing agency and of other sector participants.

The Master Plan is a planning tool. It offers a framework for coordinating investment projects in all their phases, using the sector's strategic orientations and policies [including those of Health Reform (HR) programs].

Ideally, the Master Plan will be implemented within the context of a national investment system, acceptance criteria, centralized project records, a comprehensive project database, and criteria for evaluating follow-up, outcomes and impact indicators. The Master Plan should thus be consistent with national development projects, with health sector policies, and with related health sector reforms. Its project proposals should be consistent with the methodologies established for formulating social investments in the relevant political and administrative area, and should prioritize project proposals in accordance with previously established and clearly defined criteria.

The Master Plan is also a negotiating tool. It gives the health authority a better platform for negotiating with potential resource providers, be it the national economic authority, cooperation agencies, donors and/or international financial institutions. Its usefulness stems from its coherence and from the fact that it is consistent with national and sector policies. Furthermore, the fact that other sectors help to prepare the Plan ensures that they will already be familiar with it before the negotiation process begins. If the Master Plan is to function properly as a negotiating tool, the preparatory process should take into account the general criteria applicable in the process of allocating resources. Furthermore, it must strengthen the negotiating capacities of the health authorities and of the institutions involved in its preparation. In this context, the commitment of national, sector, and non-sector actors is vital, as is the participation of international cooperation agencies.

The Master Plan is a management tool. Health authorities will have a tool for planning projects and monitoring their status over the short, medium and long term. It is thus possible to set up a project database that is modular and flexible and can be adapted to each stage of the country's planning process and/or current HR process. To function properly as a management tool, the Master Plan should incorporate criteria for accepting project proposals into the portfolio. One of those criteria should be the consideration of the real operational capacity of the applicants and the financial sustainability of the proposed investments. The Plan should include a draft investment schedule, as well as criteria for evaluating the outcome and impact of each project. It should also include procedures for periodic review of the portfolio throughout the life of the Master Plan.

The Master Plan is useful to monitor and evaluate health investment projects. It gives health authorities a tool for formulating, monitoring, and evaluating sector investment processes[5]. It can also be used to validate its relationship with the national investment system, if such a system exists. In order to fulfill this role, the Master Plan should be built using a participatory approach. It should involve the country's major institutions and build consensus around the various processes, outcomes and impact indicators, with a view to monitoring and evaluating its progress.

The Master Plan is used to strengthen health authorities' institutional capacities. For the sector authority to perform its steering function effectively, it must win legitimacy, both within sector institutions and on an intersectoral basis. The health sector must therefore answer the needs of the population, and its investment projects must have a solid foundation. Preparation of the Master Plan is helpful, in this respect, because it involves political and technical leaders from within the health sector, as well as inter-institutional and intersectoral authorities, as well as participants from civil society. Pilot cases demonstrate that, for participants and health authorities, this was among its most important impacts.

The Master Plan aids institutional, inter-institutional, and intersectoral communication. The Master Plan facilitates communications among the various actors involved in the preparation process, regardless of the level at which the Master Plan is prepared (whether on a limited, intra-institutional level or within a broad, intersectoral level). Whatever the context, it has an important impact, both in facilitating communications about, and in promoting the acquisition of, knowledge among the various teams involved. To fulfill this objective, the preparation of the Master Plan must meet two essential requirements. First, it must set out current national and sector policies, and describe the current debate and consensus about the health sector and its main problems. Second, it should involve all those interested in categorizing and prioritizing health sector problems, identifying possible strategies and actions, and preparing the portfolio of investment-Project Proposals.

I.3. Contents of the Master Plan

The Master Plan document should include the executive summary of the health sector analysis (if such an analysis has been carried out) or equivalent document, a matrix of health sector problems, intervention strategies, and a portfolio of investment project proposals, duly prioritized.

Executive summary of the health sector analysis. The executive summary should contain the most important information about the sector. It must address the political, economic, socio-demographic, and epidemiological contexts, showing how they are organized and how they function. It must identify the various actors, their areas of activity, and their policies. It must describe the nature of sector infrastructure, and the human and technological resources available. It should describe the financial context, showing current sector expenditures and expenditure trends. It must include an outline of the effective supply and demand for services. It must describe the national system for disaster prevention and relief, and detail any international cooperation provided to the sector.

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[5]Projects per se need to be evaluatated at relevant stages. This subject will be revisited in Chapter VII, and developed in depth in the fothcoming Investment Projects Manual, a separate document of this initiative.

Matrix of health sector problems. The matrix is generally drafted at the end of the health sector analysis. It is designed to identify the principal health sector problems and diagnose their causes. Once those problems have been set out in a logical and coherent manner, causes, influences and other determining factors can be established. The matrix should be prepared collectively so that it can be used to guide decision makers at all levels.

Intervention strategies and project ideas. Once the health sector's main problems have been identified, strategies for solving them can be recommended, and actions and/or implementation methods proposed. The strategies and actions to be developed should be presented logically and coherently, with strategies matched to problems and actions to strategies.

The outcome will be a chain of interrelated factors, based on a specific strategy, which in turn includes a series of actions that are designed to achieve a specific purpose and respond to a previously identified problem or set of problems. A strategy may be used to address more than one problem and an action may be based on more than one strategy. Strategies become interventions via projects, which originate as an idea that is then fashioned, through successive revisions, into information documents showing the broad outlines of the project and its costs. These are then refined into a series of further documents, culminating in a project proposal. Once a funding source has been identified, a project is prepared, incorporating any suggestions made by the various parties. This becomes the legal agreement between the parties. Obviously, each new version of the project will involve financial and human costs, and it is very important to establish how much is to be invested in the project proposal, even before ascertaining whether resources for its implementation are available. For the purposes of the Master Plan, it is enough to reach the project proposal stage, as outlined below.

Portfolio of investment project proposals. This is an organized, prioritized and validated set of investment projects, formulated as project proposals, describing a group of actions that are consistent with the matrix of priority problems and with the strategies recommended for their solution. Their nature is such that they tend to require additional resources to achieve their objectives, although this is not an indispensable precondition. In the past, there has been a tendency to identify the project proposal portfolio with the Master Plan. In fact, the portfolio is just one element of the Master Plan, which is a document produced through a participatory process, such as the one described above. The portfolio is only one component of that process.

The relevant technical teams, together with the necessary national and international advisory services, must design each project proposal. The projects should be consistent with the national investment system (if such a system exists) and with the project proposal formats used by other sectors (mainly other social sectors and planning and/or finance sectors), as well as with agreed upon strategies and actions for identified health sector problems.

1.4. Objectives and Scope of Methological Guidelines

The methodological guidelines for preparing the Master Plan should meet the following objectives:

Facilitating preparation of the Master Plan. The use of procedures and formats that are standardized and comparable can help national technical staff, especially at the central level (ministries of health), to produce a more effective Master Plan. Implementation of the Master Plan at the national or subnational levels (province, region or state within a country) also provides a more coherent vision of the national strategy for the sector.

Improving health authorities' negotiating capacities. The Master Plan clarifies sectoral investment needs, arranging them into a prioritized portfolio. Hopefully, it will thereby

strengthen the country's capacity to identify potential sources of resources, whether national or international, and to negotiate with them. The Master Plan provides a more comprehensive overview of the sector, while identifying and highlighting development trends. As a result, the sector becomes more attractive to national funding sources, and interaction with international sources is made easier.

If the Master Plan is implemented on the basis of sector priorities, it is more likely that these priorities will be taken into consideration during the final allocation of resources. If not, or if there is no agreement within the sector, priorities may come from other sectors or partners. If the Master Plan is implemented in a participatory manner, the aspirations of internal groups of resource users can be integrated more effectively, and the relative importance of each project proposal can be better understood.

Strengthening institutional capacities. It is hoped that the guidelines will help strengthen national and/or subnational capacities for identifying, formulating, implementing, and monitoring as well as prioritizing their needs.

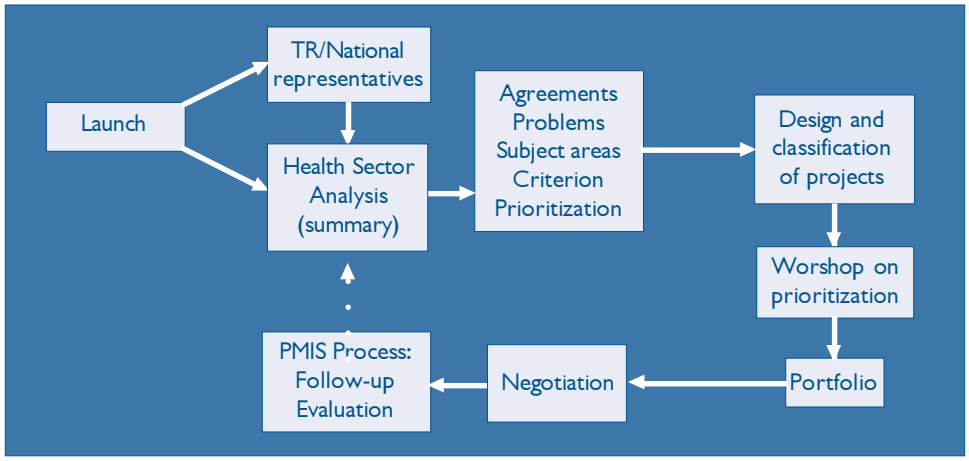
Chapter II. Preparing a Master Plan

This chapter describes the main stages involved in the preparation of the Master Plan. It follows a logical sequence, on the basis of the information available. Some stages may be implemented simultaneously, or even in a different order, or may be grouped in different ways, but it is recommended that no stage be omitted. The model below may be used in following this process.

II.1. Health Sector Analysis

The health sector analysis should include the most relevant, systematized information about the sector. It is the starting point for describing the main problems and identifying intervention strategies. It may derive from a formal process, such as the one described in the methodological guidelines for the implementation of the health sector analysis. It may also be the result of a rapid health sector analysis, produced through systematic review of official documents, and revised through interviews with relevant actors or some other tool, such as a SWAP.[6] In this regard the Master Plan is part of a continuum of tools and processes, as illustrated in the figure below.

Figure 2. El proceso PMIS



[6] A method of sectoral analysis that seeks to achieve explicit consensus between cooperation agencies (including international agencies) and the country concerned, regarding complementarity between international technical cooperation and the directionality that the country desires for the county concerned.

II.2. Launching the Master Plan for Investment in Health

The explicit affirmation of the political will to prepare the Master Plan is a prerequisite for ensuring its viability, particularly in light of the need for collaboration between a large number of actors. Consequently, the idea of preparing the Master Plan needs to be a part of public debate, involving the health sector, institutional health service providers, and other participants. It would certainly be a good idea to «**launch**» the Master Plan preparation process at a formal ceremony, attended by the country's highest authorities. This would provide an opportunity to set out existing policies and distribute basic documents as widely as possible.

II.3. Executive Summary of Health Sector Analysis

The executive summary of the health sector analysis (or equivalent document) should include the political, economic, social, demographic and epidemiological contexts and summarize the analysis' main conclusions. It must therefore:

- identify the demand for benefits and the delivery of services;
- identify the main actors;
- describe human resources, infrastructure, equipment, drugs, and other technologies;
- provide the relevant information concerning health insurance funding and delivery of health services;
- describe the country's degree of vulnerability to disasters, as well as preparations for disaster prevention and relief;
- analyze the international cooperation provided to the sector;
- propose the areas of investment that will be required for the sector to resolve its problems.

Note that the objective of health sector analysis is to identify health sector problems and diagnose their causes.

II.4. Preparing the Terms of Reference

The Terms of Reference (TR) define the purpose of the work, its scope, the composition of the working team, the functions of its partners, the budget, and the timetable for preparing the Master Plan.

The TR require an accurate assessment of the country's situation, of the real capacity of the health authority to manage the sector, and of the specific objectives to be attained. In particular, they should identify, accurately and in a timely manner, those national counterparts who will be involved in the political and technical process.

In some countries the TR have included a review of the aforementioned aspects related to the health sector analysis or its equivalent. In other countries, both processes have been implemented simultaneously, although not entirely separately.

II.5. Health Sector Problems and Intervention Strategies

Once the health sector analysis has set out the health sector problems in a logical and coherent manner, the chain of causal factors and potential intervention strategies may be established. By conducting a systematic analysis of health programs, it is possible to identify

both deficiencies in coverage and duplication of efforts. Furthermore, a systematic analysis can identify any inefficacy, inefficiency, and ineffectiveness deriving from the allocation and utilization of resources. Intervention strategies can also be subsequently developed into investment projects.

The Nicaraguan experience is instructive in this regard. When Hurricane Mitch struck the country, at the end of 1998, the first step taken was to calculate the immediate emergency needs. Then, a short-term emergency project was drawn up, and submitted at the beginning of the third quarter 1999. At the same time, discussion of the terms of reference had begun, and an institutional working team was formed, to prepare a medium-term Ministry of Health Investment Plan (PIMINSA). This was based on a rapid assessment of the health sector, and was submitted at the end of 1999. Finally, preparations began for an analysis of the health sector on an intersectoral basis. That process was completed at the end of the first quarter 2000.

II.6. Portfolio of Project Proposals for Investment in Health

This is an organized, prioritized and verified set of investment projects, formulated as project proposals.

As with every investment operation, one difficult decision to be made concerns the level of resources to be used to develop projects. Very detailed development can drain resources if funding is not obtained for the project. On the other hand, if the ideas presented are not specific enough, projects will be less attractive to potential partners. It is therefore important to understand that the project proposal is more advanced than a simple information document, since it must include costs, times and impact indicators. It is less advanced, however, than the project document finally agreed upon with project partners. The draft is presented in a summarized form called the «project document», which is described below.

The leading political and technical institutional officials concerned, together with the relevant national and international advisory services, should prepare the project proposal. It should be consistent with the health sector problems identified, the strategies and actions agreed upon, the national investment system, and the project proposal formats used. If necessary, modifications may be recommended and agreed upon.

This phase requires extensive discussion and agreement about the minimum quality of project proposals, their appraisal and, especially, the evaluation criteria to be used. The portfolio must also formalize the relationship with the national investment system, so that it can be included in the national database of projects. The database may be organized by sector, by factor of production, by cost, or by level of state organization. The portfolio of the Master Plan for Investment in Health will of course serve as the sector's health project database.

II.7. Negotiation Process

The Negotiation Process is is a set of activities that rely on technical and financial cooperation for carrying out the portfolio of project proposals for investment in health. The negotiation stage begins once preparation of the portfolio is complete.

It is essential to understand the content as well as the political, technical and financial constraints of the negotiation process. Also, it is advisable to define the intra-institutional, inter-institutional and inter-sectoral financial component, as well as the international cooperation component. This phase requires working teams trained in negotiation techniques, with

experience and knowledge of other restrictions typically encountered in certain countries, eligibility requirements and funding sources.

II.8. Implementation, Follow-Up, and Evaluation

This stage is critical in terms of achieving the objectives of the Master Plan. It is absolutely essential to agree on process, outcome, and impact indicators, within the context of the evaluations that are performed before, during and after preparation of the Master Plan. It is also crucial to agree on processes for evaluating the projects themselves. Process indicators are important in terms of correcting errors in the preparation of projects, and impact indicators are important in terms of ensuring their efficacy, efficiency, and effectiveness. For the Master Plan, it can be more important to evaluate the level of investment resources mobilized, the progress made in achieving the objectives identified by the health sector analysis, and the efficiency of the organization responsible for implementing the Master Plan, with respect to management and other related issues.

II.9. Keeping the Health Sector Analysis Up-To-Date

Thorough evaluation of the Master Plan is a very important aspect of reorienting the investment process while keeping the health sector analysis up-to-date. Analysis of the demand for projects can be a useful guide when drafting future projects to determine which subjects generate interest and which ones do not.

The Master Plan is not set in stone. As projects leave the portfolio, either because they have moved on to the implementation stage or because they are no longer important, new projects may be added. Once the duration of the Master Plan has lapsed (usually 4-5 years) it is recommended that the process be restarted, or at least conduct a review of the priorities and orientations of the health sector analysis, to verify their continued validity. Of course, preparation of a new health sector analysis should at least lead to a readjustment of the Master Plan.

Checklist of Questions - Chapter II

1) Was there agreement on the stages needed to develop investment projects?
2) Was agreement reached on the contents of the health sector analysis (or rapid health sector analysis) which would serve as the basis for the Master Plan?
3) Was the context of the current health policy explicitly considered during preparation of the Master Plan?
4) Did the process include the principal actors generally involved in health sector analysis (or its equivalent)?
5) Was there consensus on the format and contents of the executive summary of the health sector analysis (or its equivalent)?
6) Was there an analysis of health programs already under way?
7) Was an accord achieved on the conceptual framework for the portfolio of investment project proposals, on who would prepare them, and on the requirements to be fulfilled?
8) Do there exist a health sector investment system and/or a national investment system? How are they interrelated?

9) Were the restrictions on the negotiation process clarified?
10) Does the negotiating team meet the chosen requirements regarding education and experience?
11) Was there concurrence as to the types of indicators to be used in implementing, following up and evaluating projects?
12) Were the terms of reference for evaluating the Master Plan agreed upon?

Chapter III. Basis for Preparing a Master Plan Portfolio of Projects

This chapter takes a more detailed look at the five basic components required for constructing a portfolio of draft investment project proposals.

III.1. Health Sector Analysis

The health sector analysis is a study (or group of studies) of the current situation of the health sector, and of its constituent elements and their interrelationships, taking into account their historical, political, economic and cultural contexts.[7]

For operational purposes, the «health sector» is defined as the set of values, standards, institutions, facilities, programs, actors and activities that contribute to the promotion of the health of individuals or groups, to the prevention and control of disease, and to the provision of rehabilitation, research and training in those areas. Unless the specific situation in the country dictates otherwise, environmental health is not included as a subject.

General objectives of health sector analysis. The health sector analysis describes the overall health situation and analyzes trends; identifies health sector problems and diagnoses causes; suggests studies that can help to further develop the analysis; helps with policy design, proposes strategies for solution, and suggests implementation methods. Health sector analysis makes it possible to define and classify health sector problems. The executive summary of the health sector analysis contains relevant and up-to-date information about the health sector. Note, once again, that some recommendations of the health sector analysis do concern investments. However the health sector analysis can, and generally does, recommend interventions that are not investments, as in the case of the review of the primary care model.

Is the health sector analysis necessary for preparing a Master Plan? A Master Plan can be prepared on the basis of the health sector analysis. In such cases, the executive summary will probably provide the information needed to prepare the first part of the Master Plan reference framework. In other cases, since there is no systematic health sector analysis, the working team should produce a rapid report, which may consist of collected data, subsequently confirmed by interviews with key experts in the sector.

Note that, at the request of technical and financial international cooperation agencies (PAHO, UNDP, IDB and World Bank), most LAC countries have produced a number of reports on the health sector. However, even if they include relevant information, they may not be coordinated or consistent with each other. In some cases these reports have been published

[7]The methodological guidelines for the health sector analysis are to be found in another publication in this series, which details the stages and processes involved in this instrument.

by requesting agencies. Most may be found in the respective ministries of health and/or secretariats of the presidency and government departments in charge of development planning. They may also be consulted as the source for each country's contribution to the Health in the Americas report published by PAHO every four years, or the Profile of Health Systems and Services for each country published on the Website of the Health Sector Reform Initiative (http://www.americas.health-sector-reform.org).

As part of its terms of reference, the working team compiles and analyzes information from the summary of the health sector analysis (or equivalent document) and then prepares its own document. All Master Plans require the executive summary of the health sector analysis (or equivalent document), which should include the following:

- Sector political, economic, and social context;
- Evolution of demographic and epidemiological patterns;
- Demand for health systems and services;
- Overall description of health sector and identification of principal institutional and non-institutional public and private actors, and their policies and spheres of activity;
- Essential public health functions;
- Human resources, infrastructure, equipment, drugs, and other technologies;
- Funding, insurance, and sectoral expenditure;
- Delivery of services, by level of care;
- Vulnerability to, and preparation for disaster prevention and relief;
- International cooperation provided to the sector.

III.2. Terms of Reference

The Terms of Reference (TR) define the purpose of the work, its scope, the composition of the working team, the functions of the partners, the budget, and the timetable for preparing the Master Plan.

The TR require an accurate assessment of the country's situation, of the real capacity of the health authority to manage the sector, and of the specific objectives to be attained. The following points need to be considered in order to define the terms of reference:

The political framework. The political framework in which the Master Plan is to be implemented must be explicitly set out, in order to clarify health sector policy guidelines, how they fit in with social policies, and the objectives set by the Ministry of Health itself. Moreover, it is intended that the main political, technical and social actors should be thoroughly familiar with the political framework and use it to draft projects and programs. The TR should therefore consider the time needed to set out and reach consensus on the existing national policy.

Relations with international cooperation agencies. This point is of particular importance in countries that depend mainly on external funding. In some countries, health care programs are influenced by external participants who place particular emphasis on their objectives, which do not always address the priorities of the country concerned. Experience has shown that when there is a Master Plan, it is almost always possible to reconcile the positions of the various parties. If this is not the case, however, the following may result:

- Duplication among projects funded by donors and international Financial Institutions (IFIs);

- Technical and political differences among the various technical cooperation agencies;
- Countries will incur undesired recurring expenditures.

This situation is easy to foresee, difficult to prevent, and hard to resolve.

Capacity for sector management. This is a very sensitive subject. Each country should evaluate the capacity of its health sector to interact with other sectors or even to manage the health sector itself.

Thus, the TR should state the time needed to strengthen the institutional component, either prior to the formulation of the Master Plan, or as a simultaneous measure. An alternative would be to limit the scope of the Master Plan, initially, to the more institutional components. This was the approach taken in Nicaragua, through PIMINSA (which was implemented at a sub-national level) and in Honduras, where the project was initially restricted to the central part of the Ministry of Health. In both cases it was thought that, since institutional strengthening would be a long-term process, the institutional investments, at least, should be defined.

Minimum essential information. Countries do generally have some information on which to base the Master Plan, but since such information is not usually part of the country's national information system, it does not tend to be gathered on a regular and timely basis.

Nonetheless, most countries do possess methodological guidelines for preparing the health sector analysis, Master Plans, National Health Accounts (NHA), national documents on sectoral social, economic, health and reform policies, national census and household surveys, as well as national health surveys and epidemiological surveillance surveys.

New approach to investment in health. The new approach recognizes that in the short and medium term, infrastructure projects and other projects related to health sector reform and modernization are inevitable.

They should include:

- Health programs focused on populations and sometimes on the environment;
- Factors of production in health services (such as human resources, infrastructure, equipment, drugs), and ideas about how they should be organized;
- Regulation, funding, delivery and evaluation functions;
- The intersectoral approach (education, environment and labor regulation);
- Social participation and control.

Investment coordination. The TR should take into account the fact that projects already under way or at the funding negotiation stage should be continued, given the amount of time needed to formulate and negotiate a project and the degree of commitment required. A situation in which there are multiple funding sources (technical cooperation agencies, IFIs, national donors and other sources) and a number of investment projects under way and at different stages requires very strong national counterparts. It is especially important to strengthen both the national health authority, to ensure that it can perform its steering function, and the national planning authority, so that it can coordinate investments. This requirement is discussed in detail below. Furthermore, the TR should consider the relationship between the Master Plan and the national investment system. That relationship should include standardization of instruments, forms, procedures, and criteria for evaluating processes, outcomes, and impact. At the same time, efforts must be made to establish a dialogue aimed at ensuring that the project portfolio is incorporated into the national portfolio.

Timeframe for Master Plan. The timeframe will depend on the Master Plan's degree of urgency, the steering capacity of the national authority, the relative importance of the institutional

and intersectoral component, and the quality of the national investment system. The TR should state whether the Master Plan is to be implemented over the medium term (four-to-five years) or the long term (up to 10 years). Without going into exhaustive detail, the TR should at least give precise answers to the following questions:

Checklist of Questions - Chapter III.2

Who?	Who commissioned the project?
	Who will prepare the project?
	Who will benefit from the project?
Contents?	Summary of sector or equivalent analysis;
	Matrix of strategies and priority problems;
	Portfolio of project proposals.
Why?	To formulate, follow up, and evaluate investment in health;
	To increase the flow of internal and external resources to the sector;
	To develop the capacity to formulate and implement health policies and/or sector reform policies.
Where?	Country;
	Department / State / Province / Region;
	Institution.
When?	Beginning;
	Phases;
	Duration (How many phases? Total time?).
How?	Methodology
How much?	Budget for preparing Master Plan;
	Funding sources and their relative contributions.
With whom?	Institutional, inter-institutional, and intersectoral component;
	International technical cooperation agencies;
	International financial institutions;
	Bilateral donors and partners;
	Civil society;
	NGOs, etc.

The terms of reference should also establish who will act as official country counterpart, and define the applicable functions and responsibilities.

III.3. Working Teams

There are in fact two separate working teams. One team is responsible for implementing the process, and will be referred to hereafter as the **working team**. The second team is in charge of monitoring, supporting, and supervising the process, and may be formed according to one of two models: the **national intersectoral group**, which acts on a broader, intersectoral level, or the **investment committee**, which acts on a more institutional level. Regardless of the model chosen, the second group is in charge of political and technical matters.

The working team. The working team is a multidisciplinary team, comprising technical officials at the central level. It should fulfill the following functions:

- facilitate and coordinate the work of technical counterparts;
- provide training, and implement internal training whenever necessary;
- analyze and review proposals regarding «health sector problems», regarding the «national database of proposals for projects on investment in health», and regarding «proposals for projects on investment in health»;
- lead the prioritization process;
- prepare the final report;
- establish—and perhaps constitute—the machinery for monitoring the Master Plan, once the first version of the portfolio of projects has been finalized.

Depending on needs and the available resources, the Master Plan may be implemented by experts of the country concerned, either with or without external support. The second model may be advisable for Master Plans with a national scope, or when one of the results sought is to strengthen the country's capacity, both in the specific area of investment in health and in the more general field of strengthening the health authority's steering capacity.

It is recommended that the working team comprise the following:

- A national **technical coordinator,** which will act as lead agency. It should be strategically located to help decision-making and have political backing;
- An interdisciplinary group, including representatives from the administrative and political levels and institutions involved;
- If necessary, one or more external advisers (national and/or international consultants).

It is advisable that the national technical coordinator and the coordinator of external advisers help prepare and define the TR.

The team should work jointly at all stages of the process. In some cases, it will be advisable to provide training for the national group, to improve its understanding and management of the guidelines for preparing the Master Plan, as well as understanding of basic investment concepts, the criteria for prioritization, and management of the project cycle and database of proposals. This will help with the preparation of the proposals and reduce the time needed to prepare the portfolio.

In any case, an institutional group of 20 to 30 technicians from the Ministry of Health (and the other institutions involved) must be identified and brought together. The group should then be trained in methodological guidelines for preparation of the Master Plan. Training should also be given to a critical mass of institutional human resources representatives, who will provide support.

As part of the process of organizing the team, a meeting will be held with representatives for the institutions involved, in order to:

- Identify those who will act as institutional counterparts and representatives at the various levels and as focal points for institutions and regions;
- Form working groups by subject area and by organization level;
- Resolve logistical issues (financial support, secretariat, computer systems, transportation, etc.).
- Determine whether counterparts and institutional teams need to be strengthened to prepare project proposals, and take any necessary action.

In addition, the working team should analyze and approve the TR, including objectives, timetable, and desired outcomes, so that all team partners understand the nature and scope of the work. The team should also verify whether there is enough up-to-date material to draft the Master Plan and agree on the methodology for preparing the portfolio of project proposals.

The work will be carried out according to the timetable agreed to by the national coordinator and other team partners.

Supervisory teams. Depending on the scope given to the work, an investment committee or an intersectoral national group should be formed.

Investment committee. The investment committee should be composed of the senior management of the Ministry of Health, and will act as the lead political and technical agency for the institutional aspects of Master Plan preparation. Its formal tasks are to approve the methodology, formalize the constitution of working groups, agree on a work timetable, monitor progress and make adjustments as necessary, until political approval is given to the final document.

Intersectoral national group. This group should comprise representatives from the Ministry of Health, operational units of the health system, regional (or state) governments, if any, and municipalities; representatives of other ministries (Finance, Labor, Education, Environment, etc.); and representatives from relevant social security agencies, universities, the private sector, civil society, etc. It should be formally convened to validate the methodology, to formalize the constitution of the working groups, to agree on a timetable of work, and to monitor the progress until the presentation of the final document. It may also convene an executive committee to monitor its own work. Several workshops should also be held with a view to evaluating the progress of the study.

III.4. Health Sector Problems

In order for the Master Plan to function efficiently, health sector problems need to be classified. There are many ways to group health sector problems. In practice, it is simpler to list all health sector problems identified in the health sector analysis and then implement a grouping system of some kind, if this has not already been done. For this exercise, information from secondary sources should be sufficient. The main difficulty arises when there is no health sector analysis or similar document.

It is suggested that the following classification system serve as a starting point, although each country should find the form that best suits its own situation. It is suggested that the problems proposed be discussed, analyzed, and either selected and grouped, or eliminated. Participants should also feel free to incorporate other problems not appearing on the list.

III.5. Focusing of Investments

It is essential to analyze the nature of investments and describe their composition and trends, in order to facilitate preparation of the portfolio of proposals for investment projects and help integrate the portfolio with projects that are either being negotiated or already at the implementation stage.

Composition of investments. It is important to know the focus of investments, the size of recurring expenditures to be incurred by the country concerned, and the efficacy, efficiency and effectiveness of their results and impact. It is also important to know the funding sources.

Evolution of investments. It is necessary to identify the various actors participating in the investment process and their areas of interest. In addition, it is necessary to be familiar with the existing priority areas and especially their impact on the population's level of health.

If a Master Plan has been previously formulated and implemented, it is very important to become familiar with that project's evaluation when preparing the new Master Plan. If there is no previous Master Plan, it is necessary to be aware of other national investment projects. If there is such a project, it is important to know the results and the impact of its implementation, with respect to whether its projects were implemented and, especially, its impact on health and on the development of the national investment system.

What remains to be done? Although not always easy to perform, a search for discrepancies between the health sector problems identified and the investment projects implemented, including those under way and those in negotiation, will highlight what gaps remain between health needs and provision.

Identification of priority investment areas. The identification of priority areas will guide the composition of the portfolio of investment project proposals. This is the starting point of a negotiation process that will consider project evaluations, availability of resources, the main areas of interests for funding partners and the management capacity to implement projects.

The consideration of these factors is the first step in setting priorities for health investment in the country.

Checklist Questions - Chapter III

1) Was a precise definition adopted for the health sector and its analysis?
2) Is there sufficient available information to prepare the health sector analysis?
3) Is there an adequate national information system? Are other sources of information available?
4) Were the issues that should be considered in the health sector analysis identified?
5) Do the TR address current policies and institutional capacities?
6) Were the requirements that are critical to defining the TR taken into consideration?
7) Was the importance of international cooperation for the TR considered?
8) Is there institutional capacity for intersectoral cooperation?
9) Were the TR utilized as a new approach for making investments in health?
10) Did the TR take into account projects under way and those being negotiated?
11) Was the relationship between sectoral and national or subnational (if they exist) investment systems evaluated?

12) Was the timeframe for the Master Plan defined?
13) Were the basic mechanisms for organizing working teams analyzed?
14) Were the «working teams», their functions, participants, and objectives determined (if such teams are to be used)?
15) Were the intersectoral national committee, its functions, participants and objectives, defined (if such a committee is to be set up)?
16) Was the Investment Committee, its functions, participants, and objectives determined (if such a committee is to be set up)?
17) Were the composition and historical evolution of investments analyzed?
18) Was a Master Plan previously formulated and implemented?
19) Is it possible to identify and quantify discrepancies?
20) What factors make it possible to identify priority investment areas?

Chapter IV. Preparing the Master Plan Portfolio of Project Proposals

This chapter describes the basic definitions of the terminology for the portfolio of proposals, the stages of preparing the portfolio and the process for prioritizing projects.

IV.1. Basic Definitions

The preparation of the portfolio of project proposals needs a common language to be used by the different actors who participate in the process with a view to guaranteeing the internal coherence of the Master Plan.

The definitions presented below do not comprise an exhaustive or absolute list. They are formulated as the result of successive exercises of consensus between various actors in very different scenarios, and they are included here as a reference. What is relevant is that such definitions (or others that are considered adequate) are explicitly identified as soon as possible and are kept throughout all the process of preparation of the Master Plan.

The definitions that are presented were prepared for this document and do not include all the possible interpretations that could be given to the terms.

The basic definitions include:

Priority problems. Priority problems are situations that are known, undesired, and resolvable, and which impair the well being of individuals or of the community. In the health sector, such problems tend to be related to aspects of human biology, lifestyles, the environment, and health services. Problems in health services are usually manifested through failure to meet the needs of users, failure of institutions to fulfill their missions, failure in the management of resources or poor management of the resources, or as a result of situations that depart from an established ideal. It is important to define the problem, so that it will be clear whether the proposed solution indeed resolves it. The problem of «improving the health of the elderly», for example, can be a real need, but more information needs to be provided, so that its improvement can be confirmed in operational terms. Such elements—so-called indicators—should at least be observable and, if possible, measurable.

Recommended strategies. Recommended strategies are medium-term guidelines for addressing priority problems. They are normally designed to take advantage of the strengths of the health system and minimize the potential problems deriving from its weaknesses. They are used to provide guidance for the various actors concerned and for resource allocation, to ensure that a sustainable impact on the health situation is made and that the health of the population is improved. Recommended strategies may be implemented through a number of different yet complementary actions. In the same way, a particular action may be used to develop more than one strategy.

Suggested actions. Suggested actions are a set of programmed activities that are part of an intervention strategy. They have expected results, involving attainment of one or more short and/or medium term objectives. Suggested actions may affect programs, health services, the health system as a whole, and the intersectoral approach.

Such actions may also concern the use of human resources, infrastructure, drugs and technologies, and financial resources. Many related actions might not require investment, even though they do generate expenditure (e.g. grant approval, publishing and disseminating standards), and may even incur minimal expenditure (e.g. taking or postponing a decision).

Project cycle. The project cycle has three stages. The first is the design stage, which involves preparation of the documentation describing the action suggested to solve the identified problem. The second is the implementation or execution stage, during which the planned activities are carried out. The third is the evaluation stage, which verifies whether or not the actions resolved the problem concerned.

The design stage begins with identification of ideas for high-priority projects that warrant funding. One of the most important aspects of this stage is the need to gain a sound understanding of the problem to be resolved and then consider ways to resolve it.

The project proposal is prepared on the basis of the best solution or solutions. Selection of that solution requires a preliminary analysis of the technical and economic viability of the various options. The evaluation criteria include cost-benefit and cost-effectiveness criteria, whose application will depend on the national investment system's stage of development or the country's state of knowledge with respect to these criteria. Note that there is always the option of not going ahead with the project at all: the problem would not be addressed, but no expenditure would be incurred. This is sometimes referred to as the «zero option». If the evaluation indicates that it would not be advisable to go ahead with any project variant, it is eliminated from the portfolio of investment project proposals. If the evaluation indicates that it is advisable to go ahead, then preparation of the project document continues, and the design phase is completed.

An initial goal of the proposal is to facilitate negotiations among its author or authors and the author or authors of the other proposals, which are included in a process of intra-institutional, inter-institutional, or inter-sectoral prioritization. Although this will depend on the degree of development of the national investment system, it will help determine opportunities for mobilizing resources.

This preparation process is also accompanied by an intensification of economic and technical analyses aimed at ensuring the viability of the project and specifying the various other related variables that affect it. Technical analysis identifies the most viable alternatives to carrying out and operating the project, in order to maximize the probability of achieving the objectives. Economic analysis seeks to determine the minimum cost alternative, as well as ensuring the financial sustainability of the project, once it is in the implementation phase. This is also known as the pre-investment stage.

Once included in the Master Plan, projects approved under the criteria for appraisal (that is, for the evaluations carried out prior to project implementation) or already having received indications of support from a partner and supplier of resources, move on to a stage of more detailed analysis. Its components are defined, and additional data are incorporated into the proposal, thereby creating a project document. The main task at this stage is to define the scale of the project. This is achieved by establishing a relationship between intended goals (specific objectives) and the quantity, type, volume, and cost of the project's components. This stage is often postponed until a source of resources has been confirmed, since the transition from proposal to document requires disbursements. Moreover, such sources normally add their input to the final document.

During this phase, aspects related to project implementation are also defined: detailed budget, disbursement schedule, timetable for implementation, institutional arrangements, allocation of responsibilities, arrangements for monitoring and information, and the implementation and operational phases. The goal is to make the entire process more efficient.

Once the project has been approved and the necessary resources obtained, the execution phase begins. This phase lasts until implementation of the scheduled activities is complete. Once the execution phase is over, the project's operational phase—that is, the economic life of the investment—begins.

In other words, projects may be evaluated on four separate occasions:

- During the design, or «appraisal» phase;
- During the execution phase, through «monitoring», or the use of surveillance indicators that evaluate physical and financial progress;
- At the end of the execution phase, through «evaluation»;
- Once the execution phase is complete, through «impact evaluation».

This phase is described in the manual on project preparation, which is also included in this series of publications.

The Project

A project is an articulated set of activities geared toward an objective or group thereof, to be accomplished over a specific period, and for which resources are available. An investment project is contained within a project. The investment project differs from other projects—research projects, for example—in the sense that its fundamental objective is to change the status of programs and/or services, using proven knowledge and technology.

Investment projects can involve physical assets (infrastructure and equipment), human capital, and institution building. Investments may also be subdivided, for methodological purposes, into new investments (aimed at the creation of services, programs or skills that do not yet exist) or replacement investment (designed to replace obsolete services, programs or skills).

Portfolio of Project Proposals

The Portfolio of Project Proposals is an organized, prioritized and validated set of project proposals. Its main objectives are to mobilize internal and external resources, and facilitate negotiations between those who formulate project proposals and potential suppliers of resources.

Ultimately, the portfolio may lead to the creation of a project database, which is a database of project proposals and/or investment projects having explicit eligibility criteria. It should be submitted for periodic review, in response to changes in priorities and available resources.

Criteria for Grouping

The present state of health care systems is such that it is not easy to prioritize too broad a range of project proposals. It is therefore advisable to combine proposals into smaller groups, to make them comparable. The subject area is the name given to the criterion for grouping project proposals. Subject areas are usually derived from the priority problems and recommended strategies identified in the health sector analysis.

Although the grouping criteria should conform to the actual conditions in the country (specific political and administrative context), certain general options may be considered, such as grouping by similar areas of activity, levels of care, factors of production, etc.

Grouping by level of care. Projects may be organized into primary level, secondary level, tertiary level, or system leadership or management level. An example of the application of this approach is shown below:

Example of subject areas organized by level of care (Panama)

I. Environmental Health Program:
   - Water and sanitation (includes human, solid and hospital waste);
   - Control of environmental risks and toxic and/or hazardous substances;
   - Vector control.

II. Primary health services program:
   - Promotion and prevention (education, immunization, traditional medicine, etc.);
   - Social participation (organization, volunteers and promoters, etc.);
   - Patient care.

III. Specialized health services program:
   - Promotion of regulatory capacity;
   - New investment;
   - Replacement investment;

IV. Institutional program:
   - Development of managerial capacity;
   - Information system development;
   - Health research;
   - Inter and intra institutional coordination;
   - Support for decentralization processes.

Grouping by basic function. Another option is to organize projects by level of leadership or management, funding area, insurance area, delivery area, and evaluation area. In this case, it is possible to subdivide some areas into specific secondary areas. For example, the area of delivery would be subdivided into programs and services. An example of grouping by basic function is given below:

Example of subject areas organized by function (Cuba)

I. Primary care and family medicine:
   - Emergency subsystem
   - Development of health services at local level
     - Outpatient services;
     - Household income;
     - Social and community participation;
     - Dental care;
     - Human resources training.

II. Specialized care program:
   - Revitalization of the surgical clinical hospitals
   - Revitalization of specialized hospitals
     - Revitalization of surgical activity;
     - Human resources training.

- State-of-the-art technology.

III. Drugs:
- Basic and essential drugs
- Revitalization of laboratories, drugs, medical equipment, instruments, and fixed assets.
- Development of drugs services and medical insurance at the local level
- Development of pharmacies and dispensaries
- Advances in natural and traditional medicine
  - Development of drug-epidemiology and epidemiological surveillance;
  - Training of human resources and managerial development.

IV. Health promotion:
- Disease-prevention program;
- Immunization program;
- Program of chronic non-communicable diseases;
- Program on communicable diseases;
- Program for TB eradication;
- Maternal and infant care program;
- Program for the elderly;
- Eye-care program;
- Municipality and community health;
- Mass communication.

V. Management of the national health system:
- Health surveillance;
- Health information system;
- Information system and managerial development;
- Health regulation;
- Health economics.

Another possible approach would be to group projects according to the criterion of **productive factors**. Projects might be organized by infrastructure, equipment, human resources, and health technologies (including drugs). If necessary, it may also be possible to combine various grouping methods.

In some circumstances, subject areas may function as **selection criteria**. For example, a certain proposal may be included in the portfolio only if it is consistent with at least one of the subject areas previously identified as being a priority.

IV.2. Stages of Preparing the Portfolio of Project Proposals

Preparing the Technical Database of Project Proposals

Specific database elements are listed in detail below. Each country may use them to determine what other criteria to include, in what order, and whether they need to develop a simplified

database for monitoring and evaluation. The general or simplified database should include instructions to help clarify the nature of its various components.

Without considering special national circumstances, information will fall into one of four broad areas:

Defining the problem. This area includes the title, the argument, and the context. It should present a brief description of the main problem or problems to be addressed by the proposed project, including causes and effects. It will address both the sector or subsector level (macro level) and the level of the project itself (micro level). The project argument should address priority problems and recommended strategies, ensuring that the project goal is consistent with them.

Proposed solution. This should include the objectives, the general description of the project, the expected benefits, and the indicators for each of the aforementioned levels. An explanation should be given as to why the proposed solution represents the most appropriate response to the problems described. The explanation should clearly outline the general objectives (or goals) and the specific objectives (or purposes). It should describe, in general terms, how the project will be implemented - that is, the expected results and the various, activities and in what order they will be implemented. It should also describe how those activities will help achieve the specific objectives, what benefits will be derived from those objectives, and how they will be measured.

One tool that can be helpful in this regard is the project-based approach (also known as the logical framework approach), which offers other partners a proven, systematic, and communicable methodology for project design. Among other things, this approach can help define indicators designed to measure the execution of project components (monitoring indicators) and the degree to which expected results have been achieved (outcome and income indicators).

Logistical considerations. Logistical aspects include the steering and executive agencies and the period of execution. The operational, institutional and administrative aspects of the project's implementation should be briefly described. The steering and executive agencies should be established, the project duration should be included, and other similar programs or projects in the area should be noted.

Financial considerations. This section should include the total amount of the investment, show how that total is to be broken down among different types of costs, and between national and international sources of funding, as well as providing an estimate of the recurring costs to be generated by the project during its economic life.

One of the critical aspects of the drafting of the project proposal is the definition of the costs. Health professionals, administrators, and economists must work together, first setting out the basic concepts and cost categories that will apply in each case and which will determine the unit costs and prices to be included in each category.

Preliminary calculation of the project cost may be organized by activity or by component. In either case, the inputs necessary for executing the project should be determined. Those inputs generally include human resources, equipment, and materials and supplies, among others. Account should be taken of their volume, duration, and cost, and mention should be made of those inputs that can be supplied through internal resources (the country or the political and administrative area in question) and those which will require external resources.

Once inputs and costs have been defined, they can be presented in summarized form, according to various methods. The most familiar are:

- *By expected result and activities*. This is the method preferred by bilateral partners. For example, if the objective is the institutional strengthening of three clinics, the budget is prepared in such a way that investment in each clinic can be identified;
- *By component*. This method is preferred by the civil services. In this case, the above example would be presented by indicating the cost of equipment, of staff under different types of contracts and of training, etc. Distinction would not be made by clinic.
- *By category*. IFIs use this approach. With this type of classification, it is important to know the ratio of national products to imported products, since loans by IFIs differ for each product type.

The total budget of the project cost is the same: all that changes is the presentation. There should also be a budget that shows inputs organized by some of these criteria, and broken down by source (national counterpart and external funds). Depending on the circumstance, it will be necessary to present the annual budget and the total budget for the project duration.

An analysis should also be conducted of the **recurring costs** required to maintain the expected benefits, once the investment process has been finalized and the project's operational phase has begun. The cost the country will have to assume in order to guarantee continued project benefits during the economic life of the investment should be set out in economic and institutional terms. The analysis should take into account the potential for procuring the resources to cover these costs once support has been exhausted, and indicate procedures to ensure the continued provision of those resources (e.g. once the clinic has been built, job creation or transfer, changes in local budgets, etc.).

Even in the preparation phase of the project proposal it is essential to provide an estimate of the project's recurring costs, since the sustainability of the project and, consequently, its credibility with many of the donors, will depend to a large extent on those costs.

The methodology for formulating the database of project proposals should be as consistent as possible with the methods used to draft investment projects in other social sectors. In view of the fact that these methods tend to be defined by the ministries of planning, finance, or other equivalent agencies, it is advisable to include technicians from those ministries in the team that designs the database.

Another possibility is to use an existing database model and to adapt it to the special features of the health sector. It is also possible to consider the project formulation methods most commonly used by technical cooperation agencies and adapt them to accommodate specific national characteristics.

Model Database for Project Proposals

1. Title of project	Expresses the purpose of the project. It should be clear and precise.
2. Area	Brief description of the geographical or functional space in which the project is to be developed. It should include geographic, demographic and socioeconomic information where relevant.
3. Rationale	Explains the importance of the problem for which the solution is being sought (economic, social, political, technical or other reason) and demonstrates, in technical terms, why the project offers the best solution to the problem.
4. General objective (purpose)	Expresses the project's purpose or goal. Related to general, sector, local, provincial, or national policies. It is not always measurable.
5. Specific objectives (purpose)	Concrete expected results designed to achieve general objectives. It should be measurable through quantitative and/or qualitative indicators.
6. General description	Describes in broad terms how the project will be developed, what activities will be undertaken, and in what order they will be carried out. Outlines ways to achieve the objectives and specifies the areas of action for the intervention.
7. Expected benefits	States clearly the general benefits expected and describes the beneficiary population.
8. Indicators:	Indicators measure the degree to which project objectives are achieved. There are three types of indicator:
a) Monitoring	a) Measures the physical and financial progress toward attainment of the objectives.
b) Result	b) Measures the implementation of the project per se.
c) Impact	c) Measures the final effects of the project in health and/or social and economic terms.
9. Lead agency	Agency that oversees the project at the institutional level.
10. Executing agency	Unit or units responsible for project execution.
11. Execution period	Estimated time between the beginning and end of project implementation. Includes start and end dates, when these are known.
12. Total cost	Total cost of the project. Specifies currency, exchange rate, amounts of national counterpart funding and amount requested from the funding agency. Amounts are specified by component.
Pre investment	Cost of completing the project and going from project proposal to project (e.g. additional studies for project design).
Investment	Includes investment per se and the costs that are required for project administration and implementation.
Implementation	Includes the costs of training human resources to participate in the project's operational phase.
Operating	The recurring expenditure of the project - that is, annual expenditure to be incurred once the project or one of its components is completed.
13. Follow-up projects	Identify and describe the relationship with other programs in this subject area, implemented by the Government, NGOs, or other organizations or programs of a similar nature.
14. Current project status	Specifies what stage of the project cycle the project is at: identification, proposal or project stage (in order to create database of proposals).
15. Comments	

Identifying Project Ideas

The most dynamic stage of the preparation of the Master Plan commences with the identification of the project ideas. At this stage, an effort should be made to identify the sector's investment needs and formulate them as project proposals in accordance with the agreed format for the technical database.

This task requires communication with numerous health professionals and other actors who either work in, or are related to the sector's various functional and geographical levels, so that they can present their ideas to the working team. With the technical input of the working team, they can then enter the available information into the technical databases.

A fundamental purpose of this phase is to eliminate ideas that are shown to be inconsistent with investment priorities and/or previously selected subject areas. Another purpose is to help professionals from the sector and other sectors, as well as other actors (e.g. users' associations, NGOs, local representatives, etc.) to formulate their ideas in understandable terms and, ultimately, as project proposals.

Project identification may be described as the beginning of the process by which national investment projects and sectoral strategies lead to specific investments.

The initial identification and the preliminary selection of project ideas constitute a critical stage in the process of preparing the portfolio of projects, since the greater the efforts made to identify priority and viable projects, the more representative and complete the portfolio will be.

Project ideas derive from a multiplicity of sources; the sources are as numerous as the participants in the sector. Ideas may occur at any time, as a consequence of efforts by administration (e.g. during realization of the health sector analysis, a health project or a sectoral strategy), or the work of insurers, administrators and managers, health professionals or the community.

In practice, project ideas frequently occur through the identification of:

- Unmet demands or needs and the discussion about possible measures to meet them;
- Problems or limitations in essential installations, services and material or human resources and other types of institutional obstacles;
- Material or human resources that are either not used or underused and opportunities to divert them to more productive purposes;
- The need to complement other investments;

Project ideas may also derive from:

- Initiatives by organized communities at the local level, reacting to a situation, or wanting to take advantage of perceived opportunities;
- The reaction of a government to political or social pressures, whether or not deriving from economic, social, or regional inequalities;
- The monitoring of national objectives;
- The occurrence of natural or man-made disasters (droughts, epidemics, famine or earthquakes);
- The desire to create a permanent institutional capacity to carry out development activities.

Finally, project ideas may originate not only within the country, but also from beyond its borders, as a result of:

- Investment projects with cooperation organizations or international NGOs;
- Programmed activities by bilateral or multilateral aid agencies and their existing projects in the country;
- The influence of investment strategies adopted by other developing countries, as well as opportunities created under international agreements;
- Prevailing professional opinion or public consensus within the international community in fields such as population, nutrition, and poverty relief;
- The definition of global problems being considered by the international community, but not yet considered by the country in question.

As with every creative process, identifying project ideas is rarely an ordered or consecutive process. Instead, it is a repetitive process, which involves retracing steps, reformulating ideas, playing with various options, weighing costs and benefits, and analyzing technical, economic, funding, social and institutional questions with varying degrees of detail.

Regardless of the source of the project idea, special attention should be paid to the analysis of possible alternatives when defining project objectives and activities. This will ensure that the proposed solution is the most appropriate.

Reviewing project ideas by current projects and subject areas

In order to be able to select project ideas in a transparent manner, it is advisable to produce a clear matrix of criteria. Some possible criteria are:

- Problems and concerns of those involved;
- Resources and mandates of those involved;
- Probability of achieving the objectives;
- Political feasibility;
- Cost-benefit ratio;
- Cost-effectiveness ratio;
- Effect on cash flow;
- Environmental criteria;
- Gender criteria;
- Social risks;
- Project timeline;
- Sustainability;
- Existing projects that may cancel each other out;
- Existing projects that complement each other.

As part of the efforts to determine whether projects should be included in the portfolio, questions such as the following might be formulated:

- Does the project conform to the country's development objectives and priorities?
- Is the sector policy framework compatible with the attainment of the project's objectives?
- Is the project technically sound, and does it represent the best of the available technical options?
- Is the project feasible from an administrative standpoint?

- Is the project justified economically, and is it viable from a financial standpoint?
- Is the project compatible with the customs and aspirations of the beneficiaries?

Once those projects that might become part of the portfolio have been identified, the next step is to add the available information to the technical database of project proposals. This part of the process should be carried out at the local level, with the support of the working team.

Preparing project proposals categorized by subject area and organizational level

Preparation of project proposals categorized by subject area is also a decentralized process that should enjoy the technical support of the working team, which in turn should itself pursue two fundamental objectives:

- To assemble, review, and categorize the project proposals to be included in the Master Plan Portfolio of Project Proposals;
- To strengthen national, subnational or local capacities for the formulation of project proposals and project documents (workshops, meetings, and distribution of materials).

The result will be a broad range of project proposals that are representative of the many and varied investment needs of the system's diverse functional and geographical areas.

Adapting subject areas and grouping project proposals

«Subject area» is the category used to classify the project proposals within the portfolio. The working team should agree on the grouping criteria to be used. They should then consider whether they are consistent with the priority problems identified and make any necessary adjustments.

The list of subject areas included in the present guidelines should be considered tentative, since any subject not included here, yet deemed relevant, may be included. Conversely, if certain subjects in the list are not thought relevant, the team should state why and eliminate them. Experience has shown that sometimes certain subject areas attract just one or two projects, making it pointless to prioritize them. It is suggested that these subjects be regrouped into more inclusive categories. Of course, this will be possible only when the project proposals being recommended for the portfolio have been submitted.

The most complex part of this stage is conveying the project idea precisely and coherently in the database. The transition from the «idea» to the «data file» requires that project objectives be refined and that the functional and geographical areas, as well as criteria and process, result and impact criteria and indicators, be clearly explained to senior operational staff. As the objectives are being refined and the options and possibilities for attaining them reduced to a more manageable number, the project can be written up in greater detail.

This process tends to be longer than expected and tends to require the participation of professionals from several different areas, under the direction of the individual selected or appointed to lead the work. It will not be concluded until participants are in a position to respond clearly to all points included in the project proposal database.

As the projects proceed and are classified according to previously defined subject areas, it would be wise to build up an index for every subject area, giving project name, along with some identifying characteristics (e.g. title, sphere of activity, total cost and cost of external funding). Such indexes make it easier to manage the portfolio and subsequently to negotiate with future resource providers.

Reviewing compliance with requirements

The partners of the working team will be responsible for reviewing the project proposals, for discussing them with their proponents, for rejecting the inconsistent or poorly formulated proposals, and for positioning admissible projects within the portfolio according to the subject matter. Ideally, the portfolio should not contain an excessive number of project proposals.

For practical purposes, and to reduce the number of proposals, it is recommendable to establish a minimum budget (e.g. $10,000). When there are several similar projects with small budgets, they should be grouped together. For example, four projects for the construction of health centers, of $5,000 each, might be grouped together as one project of $20,000. It should not be forgotten that transaction costs for processing projects are almost identical, regardless of the project's size.

To be admitted into the portfolio, projects should:

- Meet a priority need, as identified in the matrix strategies and problems;
- Be technically sound;
- Demonstrate that the proposed solution is appropriate;
- Be correctly formulated.

Checklist of Questions - Chapter IV.2

1. Was an agreement reached about the number of stages for the project preparation?
2. Were minimum size limitations defined for projects, as well as a rule for the grouping of smaller projects?
3. Were the components of the project proposal database agreed upon?
4. Is there a national investment system with a database that is accessible to various entities?
5. Which elements are included in the component entitled «identification of the problem?»
6. Which elements are part of the «proposed solution?»
7. Is the solution proposed the most appropriate to respond to the problems described?
8. Is the project feasible from an administrative standpoint?
9. Are the benefits identified? How will they be measured?
10. Which elements are contained in the projects' «financial aspects?»
11. Are the costs definable and which elements were taken into account in determining those costs?
12. How will the costs and the equivalent budget be outlined?
13. Were recurring costs analyzed?
14. Were the requisite non-financial resources (those that can be used without incurring payments) identified?
15. Is the project economically justifiable? Is it financially viable?
16. Which basic goals of the idea formulation were followed?
17. Where did the project ideas come from? (e.g. institution, community, external sources?)
18. Were criteria for the selection of project ideas identified?

19. Were projects adapted to the country's development objectives and priorities?
20. Are the project's objectives compatible with the sector policy framework?
21. Is the project technically sound? Does it represent the best of the available technical options?
22. Is the project compatible with the customs and aspirations of the beneficiaries?
23. Are the grouping criteria consistent with the priority problems?
24. Were the criteria for selection and exclusion agreed upon?

IV.3. Prioritizing the Portfolio of Project Proposals

Once the project proposals have been assembled, and classified by subject area, the next step is prioritization. This is necessary not only because resources are limited but also to give them a logical sequence in terms of time and problem solving, especially those with a higher priority.

Appropriate prioritization involves defining who will perform the prioritization, what methodology will be used, and when is the right time to carry out the initiative.

Criteria for Priorization

Below is a list of the criteria commonly used for project prioritization. It should be emphasized that these are not the only criteria possible, and that in each case they should be explicitly defined and agreed upon before the prioritization process itself begins.

- **Size**. Includes problem prevalence, incidence, trends, and the characteristics of the affected population;
- **Importance**. Includes the severity of the problem, the level of dissatisfaction of the population and the negative impact on the health and social situation in the country;
- **Cost benefit or cost effectiveness**. Includes the need to achieve the greatest benefit, either in money or in impact on health per unit cost. It is not always possible to obtain these figures;
- **Feasibility**. Two types of feasibility are taken into consideration:
  - Technical feasibility (also referred to as «vulnerability»). Determining whether the problem has a technical solution;
  - Economic feasibility. Determining whether there are the resources to carry out the actions included in the project, or whether it is possible to obtain those resources.
- **Sustainability.** At least three aspects will be considered:
  - Financial sustainability. This refers to the capacity to fund the costs of the activity, once the project funding is completed;
  - Social sustainability. This is the capacity to generate social support for the activities of the project, in the context in which it is carried out;
  - Political sustainability. The ability to mitigate the risks from the political, economic, social and technological context encountered during the life of the project.
- **External factors.** Takes into account the potential beneficial or detrimental effects of the project on other relevant aspects of the health and/or social situation of the population.

- **Areas already covered.** It may be the case that the existing supply of resources already sufficiently covers a particular subject area, so that priority may be given to others that, for good reasons, are not being considered.

Even with clear or essentially automatic criteria (whether cost-benefit can be done, for example) it should be noted that a great deal of resistance exists to the process of prioritization in the health sector. This is partly due to the natural, although not always correct, tendency to suppose that any health intervention must be good. The other explanation concerns the existence of delineated specialties within the health sector. For example, staff working with the control of communicable diseases prefers not to deal with issues surrounding chronic diseases, based on the understanding that those working on chronic diseases will reciprocate. The consequences for the sector of a lack of prioritization have already been pointed out. In light of the experience gained through pilot projects, below is a simple process for classifying project proposals by putting them into one of three categories:

- **Category A**. Project proposals with the highest priority and impact on the sector;
- **Category B.** Project proposals with a medium priority because of their level of contribution to development of the sector;
- **Category C**. Project proposals with a lower priority although they are still important for obtaining certain achievements in the sector.

Methodology

The prioritization process normally includes two phases: a technical phase and a political phase.

- **Technical phase**. Three major groupings of participants should be considered:
  - Planners and managers;
  - Professionals directly involved in the topic; and
  - Users and their representatives.

These three groups should be sufficiently well represented during the prioritization process so that they can ensure balance in the viewpoints presented and mitigate against any biases of evaluation. There are a number of methodologies that may be used.

The first methodology involves circulating information among a group of people comprising senior technicians from sector and intersectoral institutions and skilled representatives from the community of users. This group assigns priority to the project proposals using a questionnaire with a numerical scale and a set of instructions. Group members do not meet each other and often do not know each other. A central team assumes the task of proposal distribution and, subsequently, evaluation of results. The usual objections raised to this method are that it is a monotonous procedure, wastes time, and leaves room for error and loss of documents. It is also expensive and cumbersome, due to the volume of information circulated.

Another methodology is to bring together a group of about twenty or thirty people, possesing the same characteristics noted above. Facilitators, who instruct the group about the criteria for prioritization and give them summaries of project proposals prepared to facilitate the exercise, run the group. Facilitators then present the summaries of project databases, for each subject area, one by one. The duration of the presentation is the same for each project and at the end of every presentation; participants give the project a score (for example, on a scale from 0 to 10).

After each session, the facilitators add the scores and classify projects from each subject area into three categories (A, B and C), according to the frequency distribution of the scores obtained.

If the number of projects included in category A is considered excessive—which is highly probable given the sectoral characteristics mentioned above—the rules can be changed so that at least 20 per cent of projects must fall into each category.

A third method is to utilize the idea of three project groups (A, B and C). The following tables are useful for organizing the process. The process is organized as above, except that, instead of assigning a score, each participant classifies the projects as A, B, or C and enters the data in the first column of the personal prioritization list (shown below). The facilitator of the meeting also enters the data in the group prioritization list, noting that this is the first round. If consensus is reached about the classification, the process finishes there, but participants who classified the project as A, B or C are asked to justify their decision. Then there is a second round, and the process may then be repeated, up to a fourth round. Although this is rarely the case, it can occur. If so, a simple majority is used. It is a very good idea if participants are made aware of the consequences of not reaching consensus, as this offers the best incentive for achieving it!

Personal priorization list (at least 20% for A, 20% for B and 20% for C)

Subject Area:

Project	Round 1	2	3	4	Final
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Group prioritization grid

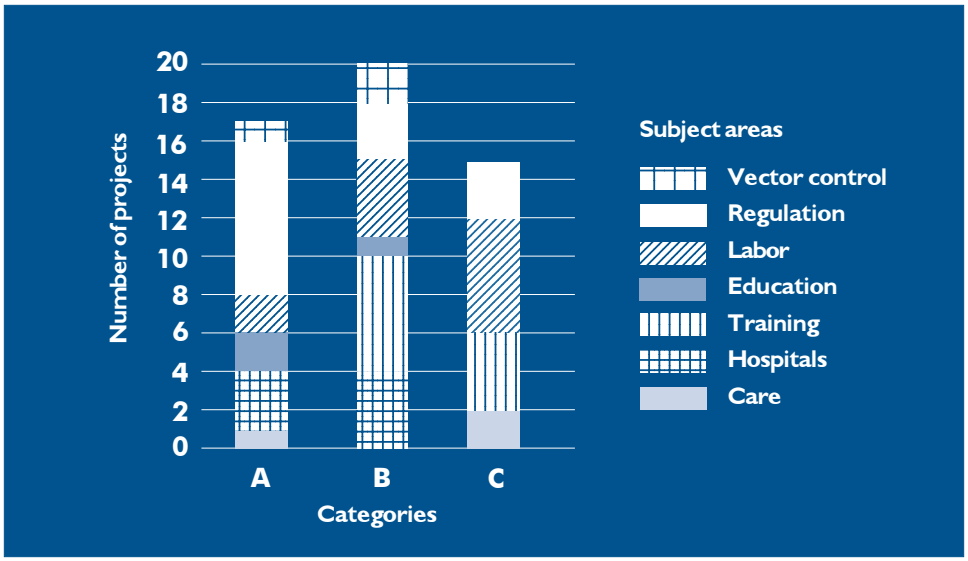
Subject area:

Negotiation round: 1 2 3 4 Final

Project	Participant 1	2	3	4	5	6	7
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							

Cost-benefit and cost-effectiveness criteria can be part of the discussion during this phase. Applying those criteria requires mature national investment systems which have been in place for several years. Applying cost-benefit and cost-effectiveness criteria is possible in some countries, but in others, system development is such that only less complex systems may need to be used. The next graph shows the result of the prioritization exercise carried out under the land validation exercise in the Hondura Master Plan.

Projects distribution prioritized by category, according to technical area



Whatever the method used, it is important to achieve the broadest possible consensus on the classification to avoid any future negative fallout. At the very least, group consensus should be achieved on the highest projects (category A) and the lowest (category C).

- **Political phase**. Once the technical phase has been concluded, the portfolio of prioritized projects is presented to the authorities responsible for the exercise (supervisory team), which will then validate the projects using the appropriate criteria. Experience has shown that if the previous year was handled correctly, the variations that need to be introduced in the political phase are minimal and affect a relatively small percentage of the portfolio of projects.

Portfolio of prioritized project proposals

The outcome of the above procedure is a series of project proposals, prioritized by subject area, which will be used to create the portfolio of health project proposals. This usually also includes an introduction and analysis of the portfolio, considered from various perspectives—for example, classification of projects by geographical area, population covered, value, etc.—which can be useful for the subsequent mobilization of resources.

Once the portfolio has been created, however, it is sometimes necessary to repeat the prioritization process, for national development purposes. For example, if the Ministry of Planning is preparing a round table of cooperating parties at the national level, a request may be made for an overall sectoral list, not a list by subject area. Another possibility is that the Government may find itself with a cash surplus, which it decides to use on investment projects in all sectors. The Government will then go on to identify sector projects of the highest priority for the country—that is, those projects that need to be carried out first, in relation to the availability of funds, and regardless of their field. Procedures such as these use the results of the Master Plan but are not an integral part of it.

It is possible that the Ministry of Planning will repeat the exercise again (perhaps outside the sector) in order to prepare a national portfolio of projects from a certain sector. Obviously those sectors that have prepared their portfolio more effectively, and thus appear more credible, will have a better chance of heading the national portfolio.

Checklist Questions - Chapter IV.3

1. Was a decision reached as to who would prioritize the methodology that would be applied, and when it would be applied?
2. Was agreement reached on operational definitions of size, importance, cost-benefit, cost-effectiveness, feasibility, sustainability, external factors and areas to be covered?
3. Was a decision reached as to the group of national participants in the technical phase?
4. Was the risk of a biased evaluation taken into account when forming the working groups?
5. If the decision was taken to circulate the information to selected groups, were the cost associated with time requirements and the potential for error or document loss taken into account?
6. If it was decided to use the judgment of group of experts, was the potential for bias on the part of group participants taken into consideration as well as the risk of their forming alliances and the tendency to prioritize everything equally?

7. Was it possible to incorporate cost-benefit and cost-effectiveness criteria?
8. Was it possible to achieve consensus on classification within high and low priority groups?
9. Was an ad hoc discussion group considered for the political phase?
10. Were the project proposals prioritized by subject areas?
11. Was the project proposal portfolio analyzed according to geographical distribution, covered population, or other criteria?
12. Was it possible to break down the portfolio into smaller projects, to gain access to funding available outside the usual sources?

Chapter V. Resources for the Portfolio of Project Proposals

Once the Master Plan portfolio has been prepared, it must be submitted to potential resource providers. The ensuing negotiation process should include both national and international providers. Within both categories, the distinction is made between public and private providers. Among national public suppliers, a further distinction is made between providers from the health sector and inter-sectoral providers attached to the ministries of finance, economy, planning, and political affairs. More will be said below about international and private providers.

It is sometimes possible to obtain resources for preparation of the Master Plan, and such resources should not be confused with those needed for its execution. It is generally thought that preparation of a Master Plan should not take up more than 1% of the total estimated investment. Mobilization of resources for the preparation of the Master Plan should of course be formulated as an independent project, prior to its execution.

Although it is sometimes possible to procure enough resources to fund the execution of the Master Plan in full, it is more generally the case that individual funding sources cover specific projects, which are prepared in the context of the plan and are of interest to partners or resource providers.

V.1. Type of Resources

A useful way to classify the resources needed to carry out projects is the following:

Source/nature	Financial	Non-financial
Local		
External	XXX	

Mobilization of resources is usually associated with financial and external resources (marked as xxx in the table). However, that association, which is conditioned by years of managing investments as financial transfers, tends to waste resources and tends to obscure the possibility of collaborating in non-financial terms (mainly human resources), both with local and external partners. Further, this association obscures the existence of local financial resources. In one Master Plan, implemented during the preparation of this study, 40% of the projects were implemented with existing local resources, with which the sector was not familiar. This avoided the considerably more complex procedure of approaching external providers for resources.

Cooperation in health

Cooperation in health seeks complementarity between governmental and nongovernmental bodies, and between external and local subsectors. Still in places where there is not an active nongovernmental sector or where it is not in a position to contribute resources, there is always the possibility of mobilizing non-financial resources. For example, a university might offer the participation of students, who can use the opportunity to carry out research for their theses.

Local resources

There is a tendency to be unaware of the existence of local resources, both financial and non-financial, and an underlying idea that projects should come complete with «outside» funding.

Experience has shown that good project proposals help mobilize existing financial resources from the government, even if outside the health sector.

Non-financial resources

Notable among financial resources are established technical capacities (professional staff, studies, analysis, etc.), infrastructure, logistics, and systems for supplies, equipment, drugs, political influence, and efforts to provide spaces for dialogue.

These resources are often implicitly included in the design, without being explicitly mentioned. This tends to give the impression that there is a lack of interest on the part of the communities affected. For example, logistical support from the counterpart is often assumed but not explicitly valued.

For many foreign partners it can be easier to collaborate through non-financial resources. Those resources can take the form of professional human resources and contributions in kind, ranging from equipment to medicines. Contributions in kind tend not to be as great as contributions in money to acquire the same inputs.

It is therefore essential that project proposals calculate their non-financial resources and costs well, so that the best possible mixture of funding sources can be used.

When there is a possibility of procuring partial resources, some projects can be broken up into stages, provided that these are self-sustainable stages, and that measurable indicators of process, result, and impact can be applied to them. Thus, the stages may be regarded as independent projects.

On the other hand, if partial funding is procured, very good judgment must be used concerning the project's real viability. Indeed, projects sometimes fail precisely because they did not procure all their funding from the beginning, or because their stages of execution were not properly thought out, resulting in non-productive partial investments.

V.2. National Resource Providers

Public providers

This section looks at the acquisition of resources in the public sector's political and administrative areas.

In view of the fact that the financial aspects of the public sector are committed in annual budgets, it is important to understand how the budget is approved, to ensure that requests for

funds can be negotiated early enough. In general, such requests need to be made about a year before the approval of the budget itself, and there is generally an interval of about a year before approved funds can be used. The more centralized the budget (e.g. national budgets versus subnational budgets), the longer this period will probably be.

In some countries coordination of the investment budgets is handled in the ministries of planning, the treasury, or the ministry of the economy. This means that mechanisms for accessing this process need to be established. Other countries with more decentralized governments and investment processes should include subnational decision-making levels in their search for funding. Note also that many projects, such as public works or education funds, may be financed with funds from outside the health sector. As a result, interdisciplinary and inter-institutional contacts should be kept in mind.

As the negotiation is transferred to a more local level (subnational or municipal) processes can be faster. In such cases, the regulatory framework of the investment process and the steering framework of the Master Plan are needed to ensure that similar criteria are applied and users in different areas are afforded the same levels of protection. To ensure that these two processes are not regarded as interference by the central government, local levels should participate actively in the debate surrounding their creation.

National public providers may also be used to obtain non-financial resources, such as human resources support, logistical support, equipment, installations, etc.

Nongovernmental nonprofit providers

The nonprofit sector includes funding institutions (usually associated with for-profit companies, e.g. Venezuela's Polar Foundation), service institutions (rotary clubs, lions clubs and philanthropic organizations of various churches), lobbying or advocacy institutions serving specific causes, such as diabetes or cancer, and grassroots institutions (e.g. mothers' centers). Resources that can be mobilized are usually non-financial, except for institutions associated with for-profit companies.

The flexibility of these institutions can be quite variable. Some have programming cycles that are as complex as governmental programs, while others respond to requests almost immediately. The important thing is to understand that most have their agendas and specific concerns, and these should be researched in order to build upon existing relationships or open new ones. For example, there may be a foundation that works with adolescents, but is not concerned with «health» per se. If the presentation is adapted to address adolescents from the standpoint of their health, a very different response may be obtained.

Grass roots and advocacy organizations rarely provide financial resources. However, they can play a very important role in mobilizing voluntary human resources or political support, which can be critical to the implementation of some projects.

Private, for-profit providers

For-profit private organizations can generate resources through donations that bring tax breaks and use of surplus resources (where legislation allows). They can also take over various types of administrations on a delegated or franchise basis. This is particularly interesting because it frees public resources to be used for other programs and/or projects. On other occasions, these institutions can contribute specific resources to an event.

V.3. International Resource Providers

Public providers

There are two types of public entities that provide resources: bilateral and multilateral institutions.

- Bilateral entities

Bilateral institutions usually represent the technical and financial cooperation of industrialized countries. The complete list, together with contact names, may be found in PAHO's «International Cooperation in Health: Profiles of Donors», in its various printed and electronic publications, and also in the publications and Web page of the OECD.[8] Many bilateral institutions have their own national offices, which can provide specific details about their programs.

For investment projects, some countries, such as the USA and Canada, also have programs on capital goods exports («trade and development»), as well as a series of credit programs for their investments. These programs are normally run by specialists in trade (not in development) at the respective embassies. Recently, several South American countries (e.g. Brazil, Chile) have also set up cooperation agencies, which are usually effective at providing non-financial resources—especially when there is the chance of a subsequent purchase of capital resources and the chance of achieving effective international technical cooperation.

Bilateral agencies meet the needs of their countries—needs that range from the commercial to the political and often involve certain defined areas and countries of interest. They usually have bilateral arrangements with some central entity (normally the ministries of planning or cooperation), and function according to annual budgetary cycles, although some prepare longer-term programs. This procedure has the advantage of ensuring resources if there is participation in the initial negotiation, but it lacks flexibility. It is essential to be aware of the relevant policies, interests, and schedules, so that requests can be made in a timely manner.

The European Union (EU) is a multinational entity that plays an increasingly important role in international technical cooperation. The integration process involving many European countries has led not only to greater coordination of cooperation policies among Member States, but also to actions coordinated through their EU contributions. For practical purposes, the EU functions more as if it were a bilateral entity.

- Multilateral entities

Multilateral entities are intergovernmental agencies, which include many countries.

The United Nations system specializes in technical cooperation, not in funding. Thus, it is more likely to support realization of the Master Plan than provide investment. It has agencies specialized in direct health (World Health Organization, WHO), or involved indirectly in health (International Labour Organization, ILO), or in occupational health, as well as funds for specific purposes, such as the United Nations Development Program (UNDP), the United Nations Children's Fund (UNICEF), etc. Various publications, available from national United Nations information centers, describe these agencies in detail.

The specialized agencies of the United Nations have both their own funds from member quotas and extra budgetary funds (which are voluntary and are provided for certain projects

[8]Organization of Economic Cooperation and Development, an economic organization comprising most industrialized countries and concerned with coordinating and standardizing countries' international cooperation practices.

or for specific initiatives). Their programming is generally annual, although some institutions have a two or three-year programming cycle. The system is represented in almost every country and the representative of the UNDP usually carries out the coordination function.

In the case of many initiatives, investment in health is not the central component, but it may be an implicit component. For example, childhood interventions by (UNICEF) benefit maternal and infant health.

Agencies of the UN system usually coordinate with the government through an international cooperation office, generally attached to the Ministry of Planning. Programming is carried out in accordance with some project or national priority. It is thus essential that investments and/or associated studies be included in such projects, in order to be assured of obtaining resources. It should be noted that the health component of projects under discussion are often not readily apparent to planning offices.

The specialized agencies tend to have direct relations with their respective ministries (e.g. PAHO/WHO with the Ministry of Health). Although this relationship is very important, focusing on it exclusively closes the access to an enormous quantity of alternative resources.

Inter-American Regional System. The task of the Inter-American Regional System is essentially to provide support of a political nature (Organization of American States, OAS) in the form of major human resources programs, mainly fellowships (OAS), support through research and engineering studies (Economic Commission for Latin America, ECLAC) and technical cooperation in certain areas, mainly health, through PAHO. The latter has a dual role, as the system's specialized health agency and as WHO's Regional Office for the Americas.

International Financial Institutions (IFIs) usually provide support in the form of loans. Although they specialize in capital contributions, there has been a recent trend to use this support also to finance structural adjustments when major reforms are being funded, but not necessarily with a physical infrastructure component.

As far as the Master Plan is concerned, there are two types of IFIs: global and regional. Global IFIs comprise the World Bank Group and its subsidiaries. They notably include the International Finance Corporation (IFC), for the private sector, and the International Development Association (IDA), which operates only in relatively less developed countries. Other subsidiaries are of lesser interest for the health sector. The main regional subsidiaries are the Inter-American Development Bank (IDB), the Caribbean Bank of Development (CDB), the North American Development Bank (NADB), the Central American Bank for Economic Integration (CABEI), and the Andean Development Corporation (ADC). The last three provide subregional coverage: NADB covers the countries of the North American Free Trade Agreement (NAFTA), CABEI covers Central America, and ADC the Andean region.

Some of these banks do have representative offices in the larger countries, but they tend to function in a centralized manner. The vast majority of IFIs activities are loan-related, although they do also make provisions for technical cooperation, which, in some cases, does not need to be reimbursed.

Because these investments are loans, internal negotiations usually involve several actors outside the health sector, since countries' debt servicing is handled by the Ministry of Finance. The loans may come with a number of requirements (conditions) regarding fiscal or other government policies. The loans are not administered by the health sector. The Ministry of Health does not generally take part in negotiations between the other agencies mentioned and IFIs.

The size of these operations tends to be greater than those involving other agencies. The loan amount is usually no less than 10 million dollars. Bilateral projects or UN system projects rarely exceed two million dollars, and the average amount is around 600,000 dollars.

IFIs programming are not comparable to those of other institutions. A policy dialogue, of an «indicative» nature, is established with the country in which the project is ultimately based. If there has been no participation of the Master Plan team in the national preparation for the policy dialogue, it will be difficult to incorporate it after the basic agreements have been reached. Negotiations and conditions are established on the basis of each separate project.

Nonprofit non-governmental institutions

Within these institutions there are two major groups: funding groups and lobbying groups. The first group includes a number of foundations that are interested in the social sector, such as the Gates Foundation, the Ford Foundation and the Rockefeller Foundation. Lobbying and advocacy institutions pursue specific causes, such as diabetes or cancer (e.g. the International Diabetes Foundation). Grassroots institutions, almost by definition, are only local, although there are some associations with offices in several countries that can help with organization or advocacy (Consumers International is one example). The resources that can be mobilized through NGOs specialized in lobbying or, sometimes, services are usually non-financial. In some countries, offices and subsidiaries have been created to assume management of specific projects and programs. It is possible in these cases to apply the concept of delegated or franchised administration.

Like their local counterparts, international NGOs have a very variable flexibility. Most have specific agendas and interests, and it is important to know them, in order to build upon existing relationships or open new ones. This is the case with international institutions concerned with specific population groups. An effort should be made to adapt the «health» focus to these interests, with the understanding that the resulting intervention will improve that group's state of health. The programming cycles vary, although in the larger foundations they tend to be comparable to those of multilateral agencies. There are various lists of foundations that work with the health sector in the Region of the Americas.

Private institutions

Private institutions include a large number of foundations created under the guise and funding of international private enterprises and which can assume various responsibilities. In some cases, the funding is aimed at governmental and non-governmental agencies, sometimes with the provision of its products, such as pharmaceuticals, transportation equipment, etc.

V.4. Criteria for Policy and Strategies

Here are the main themes generally addressed by parties negotiating the funding of a project.

Sustainability refers to that which happens within institutions and in the sector, from the standpoint of results and impact, once the intervention is completed. For example, if the investment is tied to the construction of a physician's primary care surgery unit, it is presumed that its personnel, resources, and ongoing maintenance will be the responsibility of the community, whether local or national. Negotiations will be much simpler if these arrangements are set out explicitly in the documentation.

Impact refers to the search for the visible effects of projects on the target population. This means that, in addition to outlining the activities involved, the project should indicate how its

effects will be shown and who will benefit from them. It is not that the processes of achieving the said impact are not important. On the contrary, it is assumed that they undergo a serious technical analysis. However, once the intervention is completed, the processes should be examined in terms of impact. If this is not done, then it is assumed that the resources were wasted.

Decentralized interventions. Although most of the aforementioned agencies (with the exception of some NGOs) tend to interact with the central government, there is a marked tendency to intervene at subnational decentralized levels, or directly with other organizations of civil society.

This tendency increases the system's flexibility, since agencies and decentralized and/or grassroots institutions now have the opportunity to access resources directly. However, this trend can also complicate the negotiations in two ways: first, there is the risk that direct intervention by agencies will not take into account specific national policies on some subjects. Second, it is also possible that the national machinery for the allocation and use of resources will not be respected.

Thus, although efforts are made to decentralize interventions, many outmoded practices continue to be implemented, including the need for contact at the central level—especially since most agencies also try to intervene in policies and major decisions.

Donor fatigue is another important negotiating factor. Donors can become tired of continuing to support efforts that do not look likely to solve the problems presented. In this regard, two of the most important issues are sustainability and impact, as mentioned above.

Agency decentralization. Most of the aforementioned entities tend to decentralize their own operations. Agencies of the UN system and regional agencies (PAHO, IDB) have always had national offices. In recent years, however, both bilateral agencies (with the exception of Canada's, which is taking the opposite line) and the World Bank are opening local offices that are given an increasing degree of discretionary capacity.

The co-funding strategy is a powerful tool. Potential partners prefer to have the feeling that both investment costs and risks are shared. In particular, they are concerned about establishing the level of interest of the community targeted by the project, which tends to be measured by counterpart contributions, whether financial or non-financial. This makes it clear how important it is to define the roles and contributions of the various partners effectively.

Essential coordination. It should be assumed that each agency has different policies and procedures, which also vary over time. This makes two approaches necessary: first, existing conditions should be examined and projects adapted to them; second, the Master Plan should be validated. Since the Master Plan is the organizing factor, this will avoid duplication of efforts and reduce gaps in coverage. This strategy will optimize the use of resources and improve the social efficiency of programs.

V.5. Types of Funding

Loans are sums of money that are advanced to the country (borrower) for specific purposes and are repaid to the lender according to the terms negotiated. Loan amounts are rarely less than one million dollars, and can be much greater (up to one billion dollars).

Loan terms may include:

- **Grace period**. Period during which the borrower does not need to begin paying off the loan.

- **Maturity**. Period during which the borrower must pay back the loan amount, plus interest. Dictated by the nature of the project and the amounts involved.
- **Interest**. Payment for the cost of the money and the risk factors associated with the borrower. Some less developed countries have access to more favorable terms, such as longer maturities, extended grace periods and lower interest rates.

Non-refundable loans are usually granted by IFIs. They are associated with the preparation of loans, and are rarely for amounts exceeding one million dollars. Maturities are limited and can be quite significant when the capital investments are not very large. Some IFIs regard them as technical cooperation.

Export credits are loans for commercial operations involving capital investment. They are usually applicable only to products or services of the country granting the credit. They may be for any amount and their maturity depends on the project. They include programs such as the aforementioned «trade and development» programs, which advance pre-investment funds on the basis of a potential future investment.

Technical cooperation refers to regular programs run by technical cooperation agencies of the systems referred to above, including bilateral agencies. They usually accompany programs negotiated with the country at the national level, although increasingly there is the possibility of acting at the decentralized level. With some bilateral exceptions, the amount rarely exceeds one million dollars and the maturity does not generally exceed two or three years.

Donations. Apart from donations of non-financial resources (which account for most donations), this tool does not tend to be very important in volume terms (although it is important in terms of its impact). They generally involve nongovernmental entities. For donations of equipment and medical supplies it is recommended that there be agencies responsible for safeguarding quality. In the specific case of medical equipment, attention must be paid to obsolescence and costs, regarding both operational matters and the technical service required to maintain them.

V.6. Institutional Arrangements

The arrangements for mobilizing resources are many and varied, and it is impossible to be familiar with all their possible combinations and their various advantages and disadvantages. Usually, the individuals or agencies sponsoring projects focus on their technical contents and on the problems of the community where the projects will be executed.

Administrative contents and legal procedures tend to be handled by specialized units. Sector units are found in the Ministry of Health and national units of the Ministries of Planning, Cooperation, or Foreign Affairs. Most of the international agencies listed above have national representation.

A contact program for the mobilization of resources might include the following steps:

Contacts with potential local providers. No central entity can ever be more in touch with what is happening locally than local agencies. In general, it is advisable to work with other potential providers involved in the field, as well as the local nongovernmental sector, and not just the traditional health sector providers. It is a particularly good idea to focus on potential resource providers, whether financial (local foundations) or non-financial (e.g. universities).

Contact with potential national providers. Once local providers have all been approached, the next step is to contact national units for the mobilization of health sector resources, and then the national units of the national investment system. It is the highest policy level of government that will make the ultimate decision.

Contact with national cooperation authorities. Once national funding sources have been exhausted, the next step is to contact international cooperation authorities attached to the Ministry of Cooperation, when it exists, or to the Ministries of Planning, Finance, or Foreign Affairs.

International contact. The next step is to establish contacts with the United Nations system. At this point, contacts begin with cooperation agencies, IFIs, and accredited embassies (wherever agencies do not have specific representation).

Reviewing the information. Once the list of potential providers has been established, the next step is to review the existing documentation and Web pages, etc., to target the analysis, adapt the portfolio to the formats of each potential provider and ensure that the project is not rejected, either for lack of information or because it is not consistent with national objectives and/or the objectives of the provider in question. In addition, a systematic review of the formal literature and Internet databases on the topic should be performed.

Rounding off the project. At this stage, contact should be established and agreement reached with national authorities for the relevant authorizations, in the event that national financial resources are to be used.

V.7. Process for Negotiating Master Plan Resources

Acquisition of resources for the Master Plan requires a series of negotiations, beginning at the most local level and finishing at various levels of the State, depending on the degree of decentralization, the level of sophistication of the national investment system and the availability of resources.

In some countries the process may end at the subnational level, while in others, the decision on investment and the allocation of resources will be handled at the national level (with or without a well developed national investment system). A further group of countries, which are more dependent on foreign capital, will go rapidly from the national to the international level.

Negotiations with resource providers go hand-in-hand with negotiations for determining priorities and/or allocating resources conducted with other government sectors. The Ministry of Planning—or technical secretariats of the Presidency—is the main authority responsible for the national coordination of investments and funding sources. The ministry also deals with competitive bids from all sectors and aims to find consistent solutions among national projects and programs and sector health plans and programs.

Marketing

Experience has shown that if initiatives under the Master Plan are to be successful, the Plan should be marketed as a national initiative. That is why intersectoral preparation is important and why it is also important to specify the sociopolitical and health policy framework in which the Plan is to be developed.

The objective is to define the institutional political framework for the Master Plan. This should include at least the following four phases:

- Establish the program management, including the teams in charge of pre-investment studies, and execution, evaluation and monitoring;
- Explicitly describe the matrix of health problems and their intervention strategies;
- Prepare and disseminate a summarized document describing the Master Plan;
- Create the promotion and dissemination plan, which should include political lobbying.

Forming the Negotiating Team

The process of selecting team members should include consideration of their specific technical training and administrative integrity, and their negotiation skills.

Of particular importance is knowledge of the counterparts (their regulations, structure, constraints, and history), previous negotiation experience, team attitude, and the ability of selected members to establish known negotiating terms.

The negotiation team requires a training program in negotiating techniques.[9] The program should develop and analyze the following points:

- Constitution of the team;
- Negotiation styles, their advantages and disadvantages;
- Criteria for selecting the appropriate tools;
- Simulating negotiations;
- Criteria for identifying good negotiators;
- Forming the negotiation team.

The capacity to negotiate is a professional specialization. Just as there are professionals who know a subject well but are not the best managers, knowing the content of the Master Plan inside out does not by definition make one a good negotiator. One of the advantages of the workshop is that it helps identify good negotiators, who will become members of the negotiation teams.

The workshops also make it possible to simulate situations that may arise during the actual negotiations. Experience has shown that participants in workshops on negotiation believe them to be worthwhile because they help them obtain better results.

Presentation

The presentation is an opportunity to show the underlying rationale for the Master Plan, for national policies on social and economic development and for national health policies and their health policy context. It presents the portfolio of investment project proposals, duly prioritized and categorized by subject area.

The Master Plan may be presented to:

- National State authorities;
- Cooperation agencies, IFIs and donors;
- Communications media;
- Organizations of civil society;
- Public groupings, designed to raise public awareness;
- Specific presentations of selected projects to certain sources.

When it is known which entities are interested in the subject, systematic contact may be established with all of them, and the Master Plan presented to them. Sometimes these contacts may be complemented by visits to the headquarters of the various ministries, inter-ministerial committees, cooperation agencies, IFIs and bilateral agencies. This process may involve anything from programming agreements between national and subnational institutions to missions

[9] PAHO has a negotiating program linked to the Master Plan preparation process.

aimed at establishing cooperation agreements between countries, between a country and agencies, or between a country and IFIs.

It is important that before a meeting begins, potential participants have already reviewed the program and identified the relevant topics. If possible, they should arrive at the meeting with concrete offers of cooperation, to be negotiated and signed during the meeting.

Round tables

One alternative to the foregoing, which requires more organization but less time to execute, is the round table. In this scenario, all or some of the potential funding partners meet with the interested party in a single time and place. This was the approach adopted for Cuba's Master Plan. An advantage of this process is when some agreements are signed, other potential partners and funding providers may see that there is interest and sign on as well. Of course, the opposite effect is also possible: the alienation of one potential partner may discourage other donors. However, a combination of effective organization and prior research should ensure that this does not happen.

The round table should meet the following objectives:

- Present the Master Plan;
- Establish the reason for participating;
- Optimize the use of available resources;
- Coordinate projects and ensure consistency among them;
- Sign funding agreements.

Checklist of Questions - Chapter V

1. Is there an up to date database of national and international, financial and non-financial providers, whether governmental or nongovernmental?
2. Are there national health sector and intersectoral resource providers?
3. What resources were used to formulate the Master Plan?
4. Were local and external non-financial (e.g. human) resources considered?
5. Were local financial resources taken into consideration?
6. Was additional public or private funding sought?
7. Were established local technical capabilitiesused?
8. Were local expertise and resources explicitly included?
9. Were the funding of the project by stages and the feasibility of this arrangement evaluated?
10. While preparing the portfolio of project proposals, was the national budget cycle considered?
11. Was horizontal cooperation considered as an additional source of non-financial resources?
12. Are the types and scope of technical cooperation available within the United Nations system and the Inter-American System known?
13. Are the machinery, the participants, and the methods for accessing the technical cooperation of the United Nations system known?
14. Are the types and scope of technical cooperation available from IFIs known?

15. Is there a list available of nongovernmental organizations providing technical cooperation, whether financial or non-financial and lobbying services? Are their objectives known?
16. Is there a list available of the private foundations and corporations involved in technical cooperation, whether financial or non-financial, or lobbying? Are their objectives known?
17. Did the preparation of the marketing plan for the portfolio of projects consider the policy and strategic criteria of potential partners? Those criteria may include sustainability, impact, decentralized interventions, donor fatigue, decentralization of agencies and co-funding and coordination.
18. Were the various types of funding, such as loans, non-refundable loans, export credits, technical cooperation and donations, taken into consideration?
19. Were loan terms (grace periods, maturities and interest rates) evaluated?
20. Were sequential contacts made with potential local and national providers, national cooperation authorities, and international partners?
21. Did subnational, national and international agencies participate in the Master Plan?
22. Was the Master Plan marketed as a national project?
23. Were the members of the negotiation team selected for their technical training, administrative probity, and negotiation capacities?
24. Where necessary, was a training program in negotiation provided?
25. Was there a presentation of the foundations of the Master Plan, national development policies, national health policies, the health context, and the portfolio of project proposals?
26. Was the Master Plan submitted to authorities, agencies, IFIs, donors, the media, civil society, and other sources as well as included in government activities for the public, in order to raise public awareness?
27. Were round tables held with potential partners?

Chapter VI. Master Plan Follow-Up and Administration

The success of the Master Plan process depends to a large extent on the arrangements established for its implementation, monitoring and administration. Monitoring the Master Plan will guarantee control over its implementation and will also give the authorities and the project managers a mechanism for evaluating and updating projects in the portfolio.

This chapter defines what is understood by monitoring and evaluation, as well as the basic elements for managing and monitoring the Master Plan. Individual projects within the Plan have their own monitoring mechanisms.

VI.1. Master Plan Follow-Up

As indicated throughout these guidelines, the Master Plan is a short, medium or long-term tool for planning, negotiation, and management. It serves as an organizing framework for investment projects, and makes it possible to monitor and evaluate sectoral policies, strategies, and projects. Furthermore, it should clearly not be seen as a package or a rigid set of projects, but as a modular, flexible product, which can be adapted to every stage of the sectoral planning process.

Reasons for monitoring and evaluating the Master Plan

In order to guarantee that the Master Plan becomes a planning tool that is consistent with sectoral strategic orientations and health policies, and ensure progress in relations with cooperating partners, there should be a constant monitoring process.

The Master Plan should be updated to reflect project progress, changes in sectoral and national policies, and changes in the situation of the sector and the country. Otherwise, there is a risk of making an incorrect diagnosis of which projects are not compatible with the priority problems or the strategies for sustainable development of the health sector, after they have been prepared. Note that the Master Plan has a specific duration (usually 4-5 years). As such, it should be subjected to an **impact (or ex-post) evaluation,** once the period is over. The impact evaluation should include a review, not only of the portfolio of projects, but also of the matrix of priority problems and strategies, the subject areas and the prioritization criteria. Conversely, the monitoring process is for making adjustments during the Master Plan's period of validity.

Information Required by Planners and Managers

The process of monitoring and evaluating the Master Plan and its projects can be very useful to managers and planners. The following are examples of information that is obtain through monitoring:

Identification and selection of projects and programs: ensures that approaches are consistent with national development objectives, have a good chance of success, and use the most cost-effective strategies for achieving their objectives.

Project replacement, elimination, and termination: ensure that the portfolio maintains its relevance through a constant process of revision which adds, removes, or replaces projects according to whether they satisfy the various funding offers or whether demand changes. This activity includes management of partially approved projects (for example, approval may be given to one out of two areas of a project), which can still be presented to other potential partners, for the non-funded portion.

Project effectiveness and efficiency: determine whether projects are being implemented efficiently and whether they are meeting the needs of the supposed beneficiaries, as well as helping to detect and correct potential problems as early as possible.

Social effectiveness and efficiency: measure whether the projects and programs under way achieve their economic and social ends, as well as helping to achieve sectoral and national development objectives.

Impact on development: measure the impact of projects on the achievement of broader development objectives, such as environmental protection and the participation of women and of minority social groups in activities of an economic, social, and political nature.

Effective progress of projects: it is important at the national level that the evaluation process include both financial and physical monitoring of the implementation of the group of projects and evaluation of their sustainability, the quality of socioeconomic development projects, and the distribution of benefits among socioeconomic groups or geographical areas. It is also important to note how far projects have achieved their desired impact. This can also be applied at the subnational level (provincial, departmental, state or local).

Fulfillment of agreements with partners supplying resources: in general, partners supplying resources tend to group projects, even though these projects are being managed by different entities. Thus, the failure to produce reports on the date specified for a certain project tends to be noted as «country XXX does not fulfill» rather than as a flaw in the specific project. Therefore, management of the Master Plan must ensure that the exchange of information (although not necessarily its content, which is the responsibility of the project's management team itself) for all projects takes place in a timely and correct manner. This is also the case for other activities of a «macro» nature, such as collective funds transfers and negotiations on general conditions.

Maintaining information about cooperating partners: this activity is sometimes carried out by the national investment system, but in any event, Master Plan administrators must remain fully apprized of information relating to the cooperating partners, whether actual or potential. This includes basic data (contact names, addresses) as well as the policy for cooperation, areas of interest and other characteristics facilitating the mobilization of resources.

It should be recalled that every project presented should have its own monitoring process, which should be part of the project design and should be finalized as part of the negotiation process. For the purposes of this discussion, our focus is the monitoring of the Master Plan itself. At the project level, it is enough to be familiar with its most salient points.

At the Master Plan level, this process not only provides information about what is happening, it also helps steer and monitor the commitments agreed upon and establishes an institutional memory of the interests of various partners and co-workers. This includes both the subjects and projects that concern them and those that do not. This database can subsequently be used as a starting point for future plans or investments.

Contents of the program for monitoring of projects of the Master Plan

At the very least, the program for monitoring projects should include the following information:

- General
  - Project title;
  - Beneficiary population;
  - Geographical area affected;
  - Duration;
  - Follow-up and evaluation indicators;
  - Preparatory team responsible for the design;
  - Team (unit, person) responsible for execution.
- Project status
  - In preparation;
  - In negotiation (with whom, results of negotiations, timeline);
  - Under way;
  - Completed;
  - Eliminated (give reasons, e.g. too few interested parties, change in priorities, etc.).
- In negotiation
  - Program for presentation to interested partners and partners who are not interested a priori;
  - Negotiations (dates);
  - Signed agreement (date);
  - Observations on the project made by different partners.
- Implementation
  - Request for resources (quantity/date of request);
  - Exchange (date);
  - Receipt of resources (quantity/date);
  - Evaluation indicators (impact);
  - Follow-up indicators, showing material/financial status;
  - Reviews (dates);
  - Reports sent (committed and effective date).

Effective progress of the Master Plan

Monitoring of the Master Plan generally complements, but does not replace, monitoring of each project itself. In the general overview of the Master Plan it is necessary to describe its most relevant criteria:

- Progress in executing the portfolio;
- Incorporation of new projects;
- Modification of budgetary scenarios;

- Change in health priorities;
- Revision of political priorities;
- Adjustments of other projects in negotiation and under way;
- Adaptation of subject areas;
- Unexpected events (catastrophes, wars, etc.);
- Adjustments to accommodate the requirements of potential partners.

System for monitoring partners. This system requires a database (which can be a subdivision of the one used by the national technical cooperation or investment authority), which is used to register the main contacts of the different partners, their policies, framework agreements (nonspecific to projects), and references to project agreements. Notes and other relevant information (for example, embassy contacts) should also be included here.

VI.2. Evaluation

Although it will not be discussed in detail here, as already mentioned, the Master Plan should be submitted to an evaluation process when it is completed. This process should answer the following questions:

- Did the Master Plan meet its specific objectives?
- Was any other, unanticipated impact achieved? (e.g. improvement in health authority planning system)
- Should the experience be repeated for the next period?
- If so, should the structure, the institutional arrangements, and the internal and external partners remain the same? What should be replaced? What should be added?

The technical team

Just as it is necessary to clearly set out the technical and political characteristics of the working team that will prepare the Master Plan, it is also necessary to have a multidisciplinary working team that is well trained and has the skills necessary to measure outcomes. The results of the multidisciplinary working team's evaluation will be communicated to the sectoral authority, which will decide whether to abandon, redirect, or continue each project in particular or the Master Plan in general.

Similarly, a decision should be made as to whether the country requires a political and technical steering entity to which the technical team would report, and which would be charged with recommending to the national sector authority the steps that should be taken.

VI.3. Master Plan Management Team

As with any process, the Master Plan needs a team to carry out its activities, once the process of preparing the portfolio is completed. Of course, using staff who helped prepare the portfolio offers the advantage that all participants are already known. However, their skills may not be the ones required for the aforementioned activity, so the team's capacities should be analyzed before automatically including the same team in this phase.

The decision as to whether the team will be independent or assigned to some unit of the institution that requested the Master Plan is a local matter. The size of the team will depend on

the size and scope of the Master Plan. In the sector, for example, it is possible to conceive of a larger team than the one at the level of the Ministry of Health or at a municipality. In any event, the team should at least be able to perform the following functions:

- Coordination and liaison with other authorities and investment projects;
- Monitoring and maintenance of the project portfolio database and its various functions of resources transfer, reports, etc. Sometimes personnel who have specialized knowledge of partners or of the subject carry this out.
- Monitoring and maintenance of the database of cooperating parties. This function can vary in importance, depending on the degree of articulation with the national investment or cooperation system. At one extreme, there may be specialists among the various partners. At the other, it can be enough to establish a link with whoever is responsible for the subject within the country.
- Facilitation of project design. In some countries, the process of designing projects has been difficult, so the Master Plan team has had to be available to facilitate design processes. It is again possible to perform this function with ad hoc external personnel, training centers or other systems, but there should be a coordinator of activities;
- The tasks of evaluating the Master Plan, or overseeing projects or dealing with problems are generally carried out by outside personnel, but for the Master Plan, coordination of those tasks should be performed by team members.

Naturally, the team should be accompanied by support personnel, and have the necessary access to computer systems and computer support. The minimum personnel required for a small undertaking, such as a municipality, would consist of a coordinator (possibly part-time), a professional staff member, and a support staff member.

Checklist Questions - Chapter VI

1. Is the Master Plan consistent with national policies and, more specifically, national health policies?
2. Were the Master Plan's duration and its evaluation criteria agreed upon?
3. Was the Master Plan's impact on development evaluated?
4. Is the goal of the evaluation of the Master Plan to monitor effective financial and material progress of projects?
5. Has an evaluation been carried out to determine whether agreements with partners supplying resources have been fulfilled?
6. Do partners stay informed about the progress and about any difficulties in executing the projects?
7. Is a list of active and potential cooperating partners maintained?
8. Does each project have its own follow-up plan? Is the plan maintained?
9. Are projects classified according to their current status?
10. Are projects currently being negotiated analyzed?
11. Is the progress of existing projects evaluated?
12. Are the criteria for effective progress of the Master Plan defined and proven?
13. Was a database organized to record the principal partner's information? (policies, objectives, existing framework agreements, contacts and specificities?)
14. Did the Master Plan achieve its specific objectives?
15. Was there any other unexpected impact?

16. Should the experience be repeated for the next period?
17. Is there a skilled technical team to follow up and evaluate the Master Plan?
18. Is there a political and technical team to redirect the Master Plan?

Glossary

Activities: Substantive actions to be carried out under the project in order to achieve the desired results.

Appraisal: Analysis of a project during its preparation and negotiation (before implementation begins).

Effectiveness: The degree to which a project achieves the desired results, thereby achieving its purpose and helping to achieve its goal.

Efficacy: Measure of the degree to which the desired results are achieved. Indicates the extent to which the activities carried out succeed in resolving the problems identified. The results and indicators must be clearly stated from the outset, so that actual performance may be measured against projected performance.

Efficiency: Relationship between results and resources utilized. Represents the degree to which activities under a project are appropriately carried out, administered and organized, at the lowest possible cost, to yield the desired products and/or components.

Evaluation: Independent, systematic examination of a project, designed to determine its importance, efficiency, and effectiveness; its performance and impact (expected and unexpected); as well as the sustainability and relevance of its objectives.

Evaluation (Impact): «Evaluation» and «impact evaluation» exercises are performed after implementation of the project, and include assessment of its effects and its potential sustainability. These evaluations focus on the areas of efficacy, efficiency, effectiveness, and purposes. Funding agencies usually require them.

Expected results: Services and/or products that are controlled by the project's management, and that are provided to the target population to produce the expected impact.

Impact: To what extent the problem addressed by the project has been resolved. The changes produced through implementation of the project may be positive or negative, direct or indirect, intentional or unintentional. They usually depend both on the project and on other factors beyond the control of its management.

Indicators: Indicators give a clearer sense of whether objectives have been attained. They should include quantity, quality, and time (QQT). The essential characteristics of an indicator are: validity, reliability, sensitivity, and specificity.

Inputs: Material resources needed to implement the project.

LAC: Latin America and the Caribbean.

Monitoring (follow-up): Continuous assessment of the implementation of a project, focusing on agreed timetables and the use of inputs, infrastructure, and services. Follow-up provides ongoing feedback on the implementation process for managers and participants. It also identifies

successes or problems, both current and potential, early enough to incorporate the necessary adjustments to the operation of the project.

Objective, general: The general objective emphasizes the long term. By definition, one project alone cannot achieve the objective, which will require the implementation of similar, follow-up projects or other efforts, and may depend on external factors, such as government policies or other cooperation projects. Projects should aim to have a sole general objective.

Objective, specific: This is the desired objective of the project itself. It should also help achieve that objective. It describes the expected situation once the project has been fully implemented. The definition of results, activities, and resources is derived from the specific objective or objectives.

Reliability: Extent to which repeated actions produce the same results.

Resources: These are the raw materials of the project, and include human resources, infrastructure, equipment, supplies, and funding. Resources are determined through analysis of the activities to be carried out as part of the project.

Sensitivity: The degree of sensitivity indicates how far an indicator will reflect changes.

Specificity: Measures only those changes related to the situation or phenomenon in question.

Validity: Shows to what extent an indicator measures that which it aims to measure.

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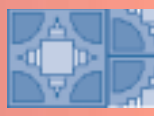

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