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To All Members of the
DAC Expert Group on Aid Evaluation

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| January 18, 1989 | 485890 | ORU - 22 |
| Onderwerp | | Dienstonderdeel |
| Synthesis Primary Health Care | | Operations Review Unit |

Dear Colleague,

./. I have enclosed a copy of the primary health care synthesis report prepared by the Royal Tropical Institute. This synthesis report is based on 76 recent project evaluation, health sector and policy documents received from DAC Member Countries and organisations during the first half of 1988.

An earlier draft of this report was discussed at our June Meeting.
This revised version includes your comments and suggestions as well as the main conclusions emerging from the discussions at the DAC Meeting on "Strengthening Development Cooperation for Primary Health Care", which was held in Paris on 14-15th September 1988.

But, of course, the draft is open for any further changes you want to suggest.

I look forward to seeing you on February 21-22th 1989.

Sincerely,

Hedy von Metzsch

Ms. Hedy I. von Metzsch

JAN 25 REC'D

Verzoeke bij beantwoording datum, kenmerk en onderwerp te vermelden

ROYAL TROPICAL INSTITUTE

**PRIMARY HEALTH CARE:**

A synthesis of 76 recent project evaluation, health sector and policy documents of DAC member countries

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A synthesis of 76 recent project evaluation, health sector and policy documents of DAC member countries

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December 1988

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EXECUTIVE SUMMARY

In September of this year, OECD/DAC representatives met to exchange experiences and views on current policy issues which are relevant to ongoing and future assistance in Primary Health Care programmes and projects. The meeting had been designed to address issues which have been supportive or have constrained the process of PHC. Attempts were made to build consensus among DAC members regarding continued support for PHC and strategies to alleviate the identified constraints to progress.

In 1978, delegates from 134 nations attended a landmark conference at Alma-Ata to discuss the concept of Primary Health Care. A full decade later, with a broad array of experiences of both donor and host countries, it was an opportune moment to examine accomplishments and direction; in order to realign vision with strategies, structures, processes and activities.

In preparation for the meeting, DAC members were formally requested to submit their evaluation reports that had relevance to Primary Health Care 76 project evaluation, health sector and health policy documents were received and have been synthesized in this paper to provide a basis for discussions during September's meeting. The three sections of the paper are briefly reviewed in the following paragraphs.

*The context of Primary Health Care*

**The National Health System:** an understanding of the National Health System is imperative as PHC initiatives are (or are not) supported by an existing or evolving health infra-structure. In this regard, the last decade has seen two very promising trends, including decentralization from the national to provincial and district levels; and increasing attention away from the hospital toward the community.

However, despite these initial positive transitions:

- community involvement is often little more than "window dressing";
- health personnel have not yet been oriented to PHC;
- resource allocation remains centralized.

**Orientation of the donor:** the second major contextual factor influencing the success of PHC has been the Orientation of Donors. Here, it is apparent that numerous interpretations of PHC have evolved into different institutional organizations. Some donors support top down vertical programs while others have insisted on integrated structures. More recently, under the matrix approach, an argument is made for combining the efficiency of vertical programmes with the endurance of integrated programmes.

A number of donors have attempted to encourage or force integration of an already existing vertical infrastructure with other health sector activities. This approach has proven largely unsuccessful.
And, regardless of approach, donors continue to demand quick results from their contributions. Achievements are often marked in terms of coverage without clarification of what coverage means or the relationship between coverage and sustainabilty.

One constraint for which responsibility lies in the hands of donor and host countries alike is the eagerness to distribute and accept funds regardless of a host country's established policy.

**Inter-donor coordination:** another major contextual factor, under the sub-title of Inter-Donor Coordination, in the first chapter, emerges as a critical flaw in global attempts to foster PHC. Donors continue to duplicate each others efforts while simultaneously sending out conflicting messages advocating opposing approaches to host country officials.
This endangers sustainability of projects.

*The PHC project cycle*

In the second chapter of this synthesis, attention is paid to the PHC Project Cycle. In this section all related activities, beginning with project identification and ending with termination of support, are examined according to the documents which DAC member countries submitted for review.

**Planning phase:** in the planning phase, it appears that donors are increasingly including relevant socio-economic data as a point of departure. However, seldom do donors mandate in their formulation missions that counterparts and community members take a serious role in the planning process by prioritizing their felt needs. And, perhaps interrelated, is the common concern expressed in many evaluation reports: adequate time and resources are rarely allocated.

**Implementation:** during the Implementation phase, translating the rhetoric of inter-sectoral cooperation into truly complementary activity has seldom been accomplished. It is suggested that this would require planning from the onset with regular participation by the population, and authorities representing all sectors involved. This also requires an adequate resource base.

Significant efforts to involve women throughout the development process have been made. However, outside of TBA training programs in the health sector, women continue to be seen as beneficiaries rather than competent service providers.

**Monitoring and evaluation:** these two issues were examined in tandem. It was apparent that in this phase of the project cycle as well, community members are seldom seriously involved. Donors habitually dictate quantitatively measurable output indicators and unrealistic timetables from the desks of their head offices. Counterparts are rarely involved in external evaluation and methodologies are as numerous as the number of evaluation missions sent to the field.

Built-in evaluation and other multi-level feedback mechanisms are used infrequently. Monitoring continues to produce data of minimal value in day-to-day management decisions. Improvement in the above mentioned areas has potential for great rewards.

*Sustainability of PHC*

Many of the reports and policy documents submitted by DAC members indicated concern about the sustainability of general health and health related projects, but few mentioned specific aspects regarding the Sustainability of Primary Health Care. This is largely due to the relatively recent introduction of PHC but also is influenced by the complex nature of the Primary Health Care process and the difficulties associated with identifying specific factors that might influence this process.

Donor policies often stir temporary enthusiasm for a particular approach. Famine relief and population control, malaria eradication, construction of hospitals, BHS, MCH, PHC, EPI, ORS, and Child Survival Strategies have all provided "bandwagons" upon which generous contributions have been bestowed. However, it is clear that hasty transitions from one set of activity to another seriously endanger sustainability. Cutbacks in financial, technical and political support often force existing projects to collapse. At this moment, it appears that support for AIDS control related activity has the potential for such a negative consequence on donor commitments.

It is also clear from the experiences of DAC members that vertical health programmes have not often been sustained beyond donor withdrawal. Regarding financing recurrent costs of PHC, the reports indicate great expectations have been placed on community financing schemes. Such schemes at a minimum give indication that the project is valued by the community. However, it has proven unlikely that community based financial support will provide any more than a small portion of the funds necessary for a large scale programme.

And, it appears unrealistic to anticipate funding for preventive and promotional health activity from community sources.

And, although there is almost always great enthusiasm at the time of project initiation and availability of start-up funds, attention is seldom paid to who will ultimately be responsible for recurrent costs.

*The future role of DAC members*

Major recommendations are outlined and questions for further discussion are suggested.

**Recommendations**

A strong plea is registered to institutionalize donor coordination at the country field office level as well as directly between donor ministries or agencies of development cooperation.

Regarding the project cycle of Primary Health Care, it becomes clear that donors must create more flexible project designs and in so doing, must allocate adequate time and resources for:

- systematic collection and sharing of relevant baseline data including prioritization of felt needs;
- involvement of a host country's MoH, Ministry of Planning and other relevant Ministries, and local policy makers;
- stepping beyond the "window dressing" approach to community involvement and seeking serious and consistent inputs from those who will ultimately benefit from new initiatives;
- formulating honest estimates of long-term recurrent cost requirements and a clear identification of and acceptance by those who have agreed to finance them;
- retraining of existing staff in order to provide an adequate orientation to the needs of the PHC process. Also, any strategy that has been designed must involve community members (especially women) in implementation, to the largest extent possible. Thus, recruitment and selection of staff must give priority to those who know their community, as well as those who know about health;

- developing methods for self-evaluation and participatory evaluation. Also, monitoring and evaluation must focus not only on the traditional output indicators, but with respect for the principles of PHC, particular attention must be given to process indicators.

Furthermore, it is recommended that an evaluation compendium be designed with inputs from all donors in order to insure consistency and maximum benefit from all future DAC member PHC evaluations.

Regarding the issue of the sustainability of PHC, very little is known. Therefore, it is recommended that comparative studies be initiated with the intention of examining the benefits, constraints and longevity of various strategies after donor withdrawal.
Operational research in appropriate methods for cost-recovery which do not endanger equity, and undermine national and international drug policies is necessary.

## INTRODUCTION

During the 1950's, the major emphasis of donors on health in developing countries was the financing of hospital-based, curative services in urban settings. Great strides forward have been taken over the last three decades and much of the credit is due to those policy-makers of developing and industrialized nations who have insisted on broadening the scope of health care systems to include the introduction of decentralized infra-structures called Basic Health Services (BHS), and increasing attention to public health measures.

In the 1970's, however, it became evident that accessibility of services was still limited, that socio-cultural factors were often neglected in health care activities and that the utilization of services remained disappointingly low. The services were still oriented towards medical-technical needs rather than towards felt-needs of the population and, as such were not accepted by the people. This often resulted in continued poor health status.

It was believed that more success could be achieved if special attention were paid to the following principles:

- deprived areas and people at risk should get particular attention. In this way, equal access to services for vulnerable groups could be developed. This re-distribution of resources strives for a higher level of equity of access and service delivery;
- the services should take the felt-needs and expectations of the population more actively and thoroughly into consideration throughout the project cycle. It was expected that participation of the community would result in more effective management of health services and simultaneously improve the processes that lead to self-reliance and self-determination;
- increased emphasis should be put on the prevention of prevalent morbidity as opposed to curative care;
- appropriate technology, adapted to the socio-economic and cultural conditions of the people, should be used;

- health measures should be seen as only one part of total care, recognizing the underlying causes of ill health (such as inadequate education, housing, water, and nutrition). This recognized that an inter-sectoral approach would be necessary to combat health problems.

This approach is called Primary Health Care. It is not a substitute for Basic Health Services or hospital care. It is a strategy to extend health services to more peripheral levels and to improve the health of the population as a whole. Hospitals and Basic Health Services remain indispensable parts of the health system. The PHC concept and strategy was discussed in the Alma Ata conference in 1978 and accepted by the majority of the WHO member states. In this regard we quote the familiar definition of Primary Health Care and use it as a reference point for this synthesis report:

> "Primary Health Care is essential health care, based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination. Primary Health Care forms an integral part of both the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact between individuals, the family and the community, and the national health system, bringing health care as close as possible to where the people live and work, and thus it constitutes the first element of a continuing health care process".

This definition implies that PHC must be integrated within the existing National Health System. Furthermore, it is based on the recognition that lack of education, the status of women, environmental hazards and a gross mal-distribution of resources are among the most important causes of ill health.

Consequently, improved health can only be brought about through a developmental process in which people are enabled to take action which will improve both their lives and their lifestyle.

From the following analysis of a sample of DAC members' experience during the early years of PHC initiatives, it appears that a great transition has begun. Where direct support to hospital projects is continuing, there has been an added component of community health or Primary Health Care.
In new projects, attention is often given to at least some of the principles of PHC.

It can also be observed that a significant gap remains between the philosophy of PHC as conceived at Alma Ata and the field realities of design, implementation, evaluation and sustainability of projects. In this paper, will be discussed those issues which have appeared the most significant.

The format for discussing each issue supports has the following goals:

- to raise questions for further consideration;
- to propose recommendations based on the analysis of DAC members' experience in providing support to PHC initiatives;
- to build consensus about future directions.

The issues that were analysed (see methodology, appendix 2), are those that were most frequently recorded in the discussion sections or recommendations of the 76 documents under review. A short list of these issues was presented to DAC members in February, 1988 in Paris and accepted as a foundation for this synthesis paper.
The synthesis paper served as a background paper for the September 1988 DAC meeting on PHC, the conclusions of which, in turn, were included.

Another background paper to the same meeting which was based on interviews held with donor's health sectors was also used as far as its contents were relevant to the issues raised in the previously received reports.

Sustainability is becoming a major issue in development aid (DAC/EV(88)1). In this paper, the concept of sustainability is addressed as it relates to PHC in relation with issues discussed in each of the following chapters.

As a basis for discussing the characteristics of sustainability in development, the following definition presented in the DAC 1988 report on sustainability of development projects will be used:

> A development programme is sustainable when it is able to deliver an appropriate level of benefits for an extended period of time after major financial, managerial, and technical assistance from an external donor is terminated (DAC/EV(88)1).

The **objective** of sustainability, as defined in the DAC paper, provides a suitable starting point in the discussion on sustainability of PHC projects: *"The objective of sustainability should be self-reliance, not self-sufficiency" (DAC/EV (88)1).*

The definition of Primary Health Care states that Primary Health Care should be developed in the spirit of **self-reliance** and **self-determination.** The DAC paper argues that a sustainable project is one in which the host country has become reliant on its own efforts and abilities to determine pace and direction. Seen in this way, self-reliance is quite different from complete self-sufficiency. Self-sufficiency, in the view of DAC, would place unnecessary demands on local resources to meet development needs (Cf. DAC/EV(88)1).

The central issue in the discussion on sustainability is therefore how the above definition and objective can be translated more specifically to PHC projects.

Since PHC, by definition, is a long term process, the relative scarcity of specific sustainability reports on Primary Health Care projects may not be surprising. Assessment of the sustainability of these types of projects may still be premature. However, a number of studies gave indications on sustainability issues in primary health care projects. (NL-6; CH-6; USA-3,9). This way it was possible to include in every chapter a section on sustainability as it relates to the issue the chapter deals with.

The role and status of women, also proposed as a critical issue, is discussed in each of the first three sections, where it is relevant. Women are traditionally health providers of the family, and, because of their specific needs, they - and their children, are the main consumers of health services as well. In Primary Health Care it is therefore important to analyse in which way projects contribute to an improvement, not only of the health of women, but also of their status in society, and to their socio-economic status - which will, in turn, contribute to their health and that of their children. The accessibility of the project for women, and the decision making power women have in the project, are very important in this process.

Outline of the paper

In the first section, attention is given to the Context of Primary Health Care. This includes:

- the host country's National Health Sytem Orientation towards PHC;
- donor's orientation towards PHC;
- inter-donor coordination.
- the PHC context in relation to sustainability

The second chapter focuses on issues that have arisen in DAC members' experiences in the various phases of the Project Cycle.

This will include a detailed synthesis of constraints and recommendations in regard to:

- planning;
- monitoring and evaluation;
- implementation of Primary Health Care projects.
- the Project Cycle in relation to sustainability

The final chapter, "The role of DAC member countries", provides a synthesis of major conclusions as they apply to each of the above-mentioned issues, on the basis of the report. The emphasis of this section is on points for further discussion, specific needs in regard to operational research, and recommendations for the future role of Donors in their most essential position as supporters of Primary Health Care. The conclusions and recommendations of the 1988 Paris meeting of DAC on Primary Health Care, have been included in this chapter.

# 1. THE CONTEXT OF PHC

The well-being of a Primary Health Care system is based upon a web of interdependent variables. Individual, socio-economic, cultural, demographic, environmental, political, and micro-economic variables influence the context within which PHC will or will not flourish. Furthermore, these contextual factors of National Health Systems are heavily influenced on the global level by structural adjustment policies and a climate created by other macro-economic and political dynamics. Africa's total debt is more than 50% of gross national product (WHO, 1987). Servicing debts amounts to 27% of Africa's export earnings. Costs of servicing debts are increasing. Reduction in demand for raw materials, rising cost of oil imports together with pressure from lending banks for debt repayment leads to austerity measures most acutely felt at the level of new initiatives such as PHC. Thus, the effective planning, implementing and the ultimate impact of a Primary Health Care system is dependant upon a thorough understanding of each of the above-mentioned variables as they influence:

- the National Health system;
- the donors' health sector;
- inter-donor cooperation.

The description in this chapter of the context of Primary Health Care will focus on these three institutional components, their orientation towards PHC, their policies and their role in sustaining PHC projects.

## 1.1 The orientation of the national health system towards PHC

A National Health system is: a complex of health facilities, policy-making and executing bodies, consisting of the health services pyramid (from community health post to university hospital) and the Ministry of Health and its representation at lower levels. It may include a private sector, an insurance system and a traditional medical system.

Ministries of Health are primarily responsible for the country's health system, including personnel development, construction of health facilities, health policies and planning. For the latter function, there is often a separate planning unit.

A country's commitment to Primary Health Care is reflected in its official policy, its unofficial policy, and its budgets. Up to date information on progress towards "Health For All" is given in the WHO 1987 country reviews carried out in all member countries. According to these reviews, 144 out of 166 member countries have endorsed the Health-For-All policy which is based on building the capacity of National Health Systems to support PHC. However, the way PHC is perceived varies: *"many countries still view it as a method of extending basic health services, especially in rural areas; others perceive it as a way to mobilize the community as an equal partner in the development process" (WHO, 1987).*

Whatever their policies, however, they are often constrained by political considerations and lack of resources. The reason why few developing countries have elaborated a feasible implementation of their health policy is analysed in several of the received reports (USA-1,6,9,10; NL-2,3; D-1,2,3) as being due to:

- deteriorating national economies;
- poor planning and management capacity at all levels;
- political pressure for curative, urban-based health services at the expense of rural health care.

In addition, USA-1 mentions that: *"(...) primary health care is often seen as a separate system (some countries even have separate ministries to deal with primary or rural health care, governments frequently duplicating costly administrative functions rather than taking advantage of complementaries with curative systems. (...)*

*PHC is not properly understood by senior and mid-level health officials responsible for planning and implementing PHC. They think of Primary Health Care as merely an extension of the health system to improve coverage in the rural areas".*

A Swiss health sector report on Tanzania further elaborates on the problem of poor planning and management capacities at national level and an overall lack of resources.

In general, obstacles to development of PHC in developing countries are:(DAC (88)3)

1. Inappropriate and ill-defined operational procedures and management systems at the intermediate (District of Regional) level adversely affecting the coverage and effectiveness of PHC
2. Serious shortages of financial resources required for the implementation of PHC affecting the long-term sustainability of government-funded initiatives
3. Limited national capacity for policy implementation, programme planning, financial management, implementation, operational research and evaluation.

With diverse interpretations of PHC, the coverage of the worlds' population is difficult to express.
A few developing countries are reporting 80-100% coverage while others find it difficult to measure coverage at all.
The figures that are available from the WHO Global Review report that of 112 countries reporting on access, 75 have local health care within one hour's walk or travel for 80% of their population.
These figures must obviously be interpreted with caution as they are without a consistent denominator.
The information on National Health Systems found in the reports is not very elaborate. This does not mean donors lack interest in this information.

Rather, descriptions of systems usually appears more extensively in project-formulation documents, and most reports which were received were mid-term evaluations. What was found in the reports will is analysed for the National Health System's adherence to the principles of Primary Health Care.
Some information from the WHO evaluation of health for all (1987) and of DAC (88)3 is added.

Equity implies for National Health Systems:

- re-allocation of resources from better-off urban areas to rural areas and urban slums, from curative to preventive care, and with emphasis on those groups of the population who are most at risk.

Apart from the MoH, there is usually a private sector, and in some countries, a social security system. The role of the private sector should not be under-estimated. In some countries, spending on health in the private sector is higher than that in the MoH. The private sector, though, has *"inherent inequities, because it serves predominantly those who can pay rather than those in greatest need" (FRG-2).*

In most Latin American countries, social security, or insurance systems, exist for employees of government and private business. These insurance systems also have **"inherent inequities"**, as they provide, against a % of the person's salary, free medical care to people who have a stable income, whereas the jobless and the subsistance farmers usually have to pay fees (unless declared "indigent") for poorer quality service. In the reports under review on Latin American countries, 60-85% of the population depends on the MoH services, whereas the percentage of the health budget going to the MoH is often only 40%. In one Latin American country, the per capita budget for Social Security was reported to be 3.5 times as high as the one for the MoH (IADB).

The WHO report on the Region of the Americas states:

*"In most of the countries, however, many poor people continue to have difficulty in gaining access to health services because of economic, cultural and institutional factors. Efforts are being made to strengthen the health services, especially peripheral units of the service network to respond to the needs of marginal population groups living in urban and rural areas."*

In Francophone countries, government employees with stable sources of income are often exempted from payment, whereas, at least at health centre- and hospital level, fee- for service has been introduced. (WB-2)

In Korea, about 50% of health services are private, the remaining 50% the responsibility of the MoH. An insurance system has been introduced for the latter (FRG-6,7).
In most African countries efforts are on their way to increase the coverage of health services to the rural areas. In many West African countries, training of Village Health Teams, consisting of VHWs, TBAs, and Health Committees for rural areas became national policy long time ago (FRA-1,2, CH-4,5, NL-4,5, USA-2).

At the 1988 WHO conference on PHC at Riga it was noted that:

*"Most countries have made considerable gains in increasing the equity and effectiveness of health services."*

Community Participation implies:

- decentralization. If health activities are to respond to local needs, planning, implementation and evaluation of activities should be the responsibility of lower (eg. district) levels, and not of the ministry of health which can only set guidelines. These lower levels, however, should be provided with the resources to do so;
- re-allocation, re-orientation and training of personnel in the health sector for PHC.

Decentralization has taken place in a number of countries (IADB-2, USA-6, S-1, S-6). In many countries, however, the MoH is still highly centralized.

Decentralization of responsibilities is not always accompanied by decentralized control of the budget (IADB-2), in fact, many countries fear too much financial autonomy (WB-2).

For all countries which had information on health systems, the health pyramid has a national hospital on top, and at the bottom the dispensary or village health post. Quite a number of countries have included community health workers at village level, selected by their communities. These can be volunteers, or paid by the MoH. Their level and duration of training depends on the socio-economic situation of the country. In West-African countries, the village health teams are usually illiterates, who receive four weeks of training (CH-4,5, NL-4, USA-2). In Latin American countries these community selected workers may receive one full year of training, and must have completed primary education (IADB-4).

A problem which is repeatedly mentioned concerning various countries' health systems is the **orientation of health professionals.** Training of doctors, nurses and midwives is not at all directed towards the needs of community-oriented work in health centres (FRA-1,2, FRG-2). There is consequently still an urban bias in availability of professionals. Quite a number of countries are trying to improve this by requiring one or more years of compulsary service. The more fundamental question of the adaptation of the training of professionals to their future role is raised in two French reports on Mali and Senegal. Other reasons given for the limited performance of professionals in regard to PHC are the poor working and living conditions, and inadequate salaries and incentives (FRG-2).

A Swedish health sector report suggests better housing and children's day care centres especially for female health workers (S-3).

Another - related - problem is the weakness of the intermediate level of the health system and its many administrative and logistic difficulties (DAC (88)3).
WHO mentions as problems in mobilizing communities:
(WHO, 1987, Vol.1)

- excessive centralization in the control of resources and decision making
- lack of a clear policy
- low educational level, traditional customs and beliefs
- long history of dependence on government
- community participation in urban areas is more difficult than in rural.

In the Eastern Mediterranean Region, few mechanisms for community participation have been developed, except for financial requests from communities.

In the Western Pacific, the community is seen either as needing to cooperate, and provide information, or as a catalyst of opinions. Several strategies have been developed to improve community participation.

In South East Asian countries community participation is well established, and there are government recognized bodies at every level. NGOs often play a leading role.

Latin America has a long history of community participation. A lack of coordination between different institutions, and a lack of regard for genuine participation and political inability of governments to respond are noted.

Intersectoral Approach implies:

- collaboration for the achievement of a common goal by the co-ordination of actives among all relevant sectors.

Intersectoral activities in PHC are described in a small number of countries, where other sectors, like the Ministry of local government, social welfare, agriculture, and university departments contribute to, or participate in, PHC (FRG-2, D-6). A lack of active efforts is, however, noticed.

In South East Asia most countries have intersectoral committees.
In Latin America, WHO/PAHO have played an important role in promoting intersectoral cooperation by organizing a conference in Mexico city on the subject, and by developing a training curicullum for Schools of Public Health on intersectoral action.

In the Western Pacific, in only 11 out of 18 countries the health plan is an integral part of overall development plans. 13 countries have some mechanism for interministerial consultation.

Most Eastern Mediteranean countries have ministries or secretariats of planning, and health planning is part of the overall development plan.

Appropriate Technology implies:

- that methods, procedures, techniques and equipment used in the health system should be acceptable and relevant to the local conditions, and in line with available resources. This requires a shift in focus away from sophisticated hospital care.

A transition from hospital care to community based care, together with the training of health workers in public health measure and simple-home remedies can be noted (FRA-1,2, WHO, 1987).

Focus on prevention

The reports give no information on this principle in relation to National Health Systems, except the following quoted from the WHO Global Review:

- 62 of 149 countries providing information in the WHO Global Review reported that 80% or more of their population have safe drinking water;
- regarding coverage of underfives by vaccination against the six target diseases, of 117 countries responding:
  . 51 had 80% or more coverage for DPT,
  . 32 had 80% or more coverage for measles vaccination,
  . 54 had 80% or more coverage for polio vaccination,
  . 33 had 80% or more coverage for BCG vaccination.

## 1.2 Donors' orientation towards PHC

Donors' orientation towards PHC is expressed in the extent of donors' policies, resource allocation, and projects which follow the guiding principles of PHC.

The concepts and goals laid out by Alma-Ata and "Health for All" have been interpreted and put into operation by donors in a variety of approaches. A continuum has emerged along which the familiar terms of **selective** and **comprehensive** approaches form end-points. In the **selective** approach, interventions that concentrate on controlling or preventing disease are selected by managers and policy-makers.

In the **comprehensive** approach priorities are given to felt-needs, and the involvement of community members in the planning, implementation and monitoring of their own programme is central.

It appears that in translating the PHC policy into the reality of projects, the large donors *"sought to define specific interventions to put PHC into practice. The result was not only the articulation of a concept of "selective Primary Health Care", but also the promotion of specific interventions and strategies which it was claimed could radically alter the pattern of poor health,*

*particularly among people living in less developed countries. Those who pursued this course adhered to PHC, but acted upon their own interpretation of the concept" (Rifkin and Walt, 1986, page 563).*

From a number of countries, sector evalutions or policiy papers were received. More information on donor's policies was collected for DAC paper (88)3, which was the result of interviews with representatives of the health sectors on its policy and experience. It was, however, not always possible to apply all the PHC principles to what could be read from donor's orientation.
More could be said about donor's practices, as many project evaluations were received. This will be analysed in the next chapter on the Project Cycle.

### 1.2.1 Donors' Health Sectors

Health policies in donor countries are subject to various political and economic forces. Aid is part of a country's foreign policy, and aid agencies are subject to the control of whatever governmental body is in charge of external policy. In addition, a great number and variety of special interest groups aim to influence the government's role in aid.

The World Bank and the United Nations' system are, of course, important factors in any government's foreign policy, and its stance towards these international bodies will help determine the amount of aid money that will flow to them rather than bilaterally to individual developing countries. It will also to some extent shape the kinds of health projects an agency becomes involved with, through agreements to share in the cost of large projects.

Another consideration is the interest of the business community in aid policies. Tied aid can be profitable. It is an opportunity to expand contacts and to gain contracts. In the health sector, tied aid is not so frequent.

Most donors reported that tied aid did not apply to their health sector (NL,Sweden, Denmark, Switzerland, Germany), that local funds are available (ODA, JICA), that tied aid is only justified in circumstances where it does not represent an important constraint to the efficacy of the programme (Italy), that goods can be procured from neighbouring countries (JICA), or that only a certain % of aid is tied, and exceptions are made for the poorest countries and humanitarian assistance (CIDA,Can-3). Most donors agree that tied aid raises the costs of the intervention, that it is "counter-productive and exploitative to the partner (GtZ)", "represents a limit to adequate maintenance services, and reduces the use of local resources"(JICA). Only AIDAB reports that "pressures for the provision of tied aid .... could constrain an Australian response to an integrated PHC project." AIDAB is investigating the possibility of a wider range of options to meet local costs. It is felt that, as health objectives geared towards needs, they cannot meet the commercial opportunaties present for other sectors. (AUS-5)

The following information on donor's health policies as regards to an orientation towards PHC was received:

An **Australian** sector evaluation concludes that much aid goes to the "primary level" (but not necessarily community based PHC), or tertiary level. There is a tendency to shift in the direction of the primary level, geared at women and children and including: health interventions for women, family planning, child survival programs and women's income generating programs. This programme (WATCH) has strong intersectoral components: income generation, education and nutrition.

A **Canadian** health sector evaluation concludes that success was greater when effective community health care delivery systems were created for which, however, existing infrastructure and management capability is essential.Canada stresses its commitment to fight global poverty (equity).

DANIDA explicitely supports the WHO health-for-all strategy. It aims to"help health systems to build on active participation of the community. There would be a focus on appropriate technolgy. Equity would be emphasised and priority would be given to the development of low-level health care infrastructure, education and training of community health workers, improved planning and administrative capacity (especially for drug management), antenatal and -natal care, child care, strengthened family planning, communicable disease prevention, prevention of handicap, improvements in drinkingwater and sanitation supplies nutritional interventions and dental care" (DAC(88)3). (the latter showing an intersectoral approach).

The **EEC** health sector report recommends that health services should be complemented by measures to meet the essential needs of the people in education, water, sanitation, and nutrition. (intersectoral approach) It also recommends more community participation in the health sector, in planning and execution. It recommends further a shift from curative, hospital-based projects to community-based ones, but with a guarantee of support and supervision by the higher levels.

**Finland's** health sector policy mentions PHC, but its activities are mainly geared towards health centres and training.

**Germany**, in 1984, carried out an evaluation of its existing PHC projects, 16 projects in 15 countries. It recommends donors should concentrate more on PHC activities, and more attention should be paid to community participation and -financing, and communication with the other sectors. With UNDP and WHO, Germany carried out an evaluation of health resource development in PHC in six developing countries in order to better meet the needs in this field. Both reports show a large interest by the German health sector in aid for PHC.

(**Italy**'s) policy is "to support the implementation of primary health care and to favour a preventive rather than a curative approach to health. Integration takes places according to local needs and situations. The newest policy stresses the development of national systems for improving population health (improvement of services at community level, and, where needed, at secondary and tertiary level, including the support of national policy goals for health development where they exist." (DAC(88)3)

JICA (**Japan**) aims at "improvement of social welfare in developing countries suffering from epidemic and endemic diseases through three types of technical co-operation: namely, technical training in Japan, dispatch of Japanese experts and provision of equiment and materials"(DAC(88)3)

**The Netherlands**' health sector evaluations of hospital-based care (1987) and first line care (1988) (NL 1,2) both support a PHC-oriented policy: the evaluated hospital projects were shown to have high recurrent costs, using funds which could have been better spent on peripheral care, and activities planned outside the hospitals did not take place. The percentage of aid spent on hospitals by the Dutch has gradually gone down (not, however, in favour of more spending on peripheral care).
The report on first line care, (33 projects since 1975) gives an evaluation of 4 comprehensive PHC projects, 12 PHC projects in which Dutch aid supported certain elements, and remaining projects with emphasis on basic health services, essential drugs, vaccination campaigns, training or construction. It shows more effectiveness in improving accessibility of health services. Although in most projects there was a focus on prevention, in the long run most emphasis was on curative care. Participation of the population was interpreted differently in the different projects, but found essential in most. Intersectoral activities scored very low in most projects.

**SIDA** recently carried out health sector evalutions in Kenya and Tanzania, where they have mainly given aid to health centres.

There is indication of a re-orientation of this aid towards more support of the community level (S-1,2).
In Vietnam, Sida is supporting both hospital care and community- based PHC (S-3).
In Zambia (S6), SIDA supports at national level health planning, trainig of community health workers, health information systems, rural health centres, and a national nutrition surveillance programme.
**(Switzerland)** emphasis the importance of "assistance being used to support equitable provision of health care"- (DAC(88)3)
A brief overview of the **United States** Government policy changes on health aid shows how they are reflected in the health policies of other large donors (USA-1,9). The earliest **US** Government health projects overseas were "categorical" programmes, with very specific objectives, often in malaria eradication or other types of vector control. In the 1960's and 1970's, USAID developed broader-based projects. It focused its projects on the extension of Basic Health Services, and the training of Community Health Workers in the delivery of a wide range of health services. These projects were usually integrated in the national health system.
By 1978, when the Primary Health Care policy was declared *"AID had planned or funded low cost health delivery projects in 24 countries, using non-physicians to make initial contacts. More than a dozen of these projects would now be judged as primary health care projects" (USA-9).* In that same year the majority of the WHO member countries signed the Alma-Ata Declaration, triggering off changes in health policy and concept, followed by a focus on "Health For All by the Year 2000".

In 1982, USAID had 52 Primary Health Care projects evaluated, the majority of them having been initiated after 1976.

The report made some important recommendations for the continuation of the Primary Health Care Policy, and stated: *"It is still impossible to assess the implications of these programmes. The time frame has been far too short. However, evidence of progress made, provides a convincing rationale to sustain PHC efforts as an alternative to historical approaches of health care delivery" (USA-10).*

In the mid 1980's the Child Survival strategy began to gain prominence in USAID and UNICEF's health policies. These agencies began to talk about "focused health activities aimed at saving the lives of children in the developing world". Expanded programmes of immunization and oral rehydration therapy came to be considered the twin engines of the Child Survival Strategy (USA-7).

In this instance it may be worthwhile to present the opinion of one evaluator who, wondering what is going on behind the USAID scene, briefly summarizes the changes in health policy of USAID:

- *"the policy evolution from health for its own sake in the pre-AID years, to health as an economic development during the 1960's, to health to save children's lives in the 1980's,*
- *the movement from categorical to integrated programmes and then back to categorical, vertical, and centrally-funded programmes,*
- *the shift from large programmes to small programmes in the mid 1960's and 1970's and back to large programmes in the 1980's" (USA-1).*

### 1.2.2 The Role of NGOs in PHC

Not many reports were received concerning the role of NGOs in PHC, so therefore their role in this report is possibly under-estimated. Only the Netherlands, USA, and Australia sent reports on their support to NGOs, while one of the project evaluations sent by Switzerland was of a Swiss NGO

project (CH-6).
NGOs have their historical roots in relief and (often church- related) curative services. More recently, some NGOs have moved to the front line in terms of adapting the principles of PHC in a variety of innovative health systems. Some NGOs are well integrated within the National Health System while others rigidly remain independent (USA-3). "Some church-related NGOs are in the frontline of community based projects with a strong commitment for the poor and the oppressed. As they nearly always question the existing patterns of resource distribution and power, they often come into conflict with the government" (CMC-1)
The diversity of approaches utilized by NGOs have lead to equally diverse programme results.
CMC has during the last 20 years promoted the organization of ecumenical coordinating agencies in many countries. Their objective is to form a forum for exchange of ideas and coordination of activities. Areas of growing cooperation are training of personnel and purchase of equipment and pharmaceuticals. The coordinating agencies start common purchase or production organizations for pharmaceuticals and supplies.
(CMC-1)

One of the major hesitations about donor support for NGOs is the question of replicability. Concern lies in the fact that the basis for NGO success (i.e. freedom from government bureaucracy, salaries that attract top quality personnel and overall flexibility) is the exact reason why NGO model programmes cannot be duplicated within the government health system (AUS-4).

However, there is also the more positive perspective that NGOs provide a critical and catalytic role in national systems where the basic concepts of PHC have not yet been developed.
NGOs are responsible for implementing most of CIDA's PHC projects and receive more than half of CIDA's disbursements for health assistance.

USAID has a policy of increasing private sector approaches to providing healthcare where appropriate. These include the use of PVOs, both indigenous and international, that are involved in health delivery programmes in LDCs. In the Netherlands' experience, small-scale voluntary agencies can be instrumental in getting PHC off the ground. Australian NGOs have been a major channel for Australiaan Health assistance. In Japan the significance of NGOs' aid activities and the need for their utilisation have been increasingly recognised among the government and the people. Italy has fostered coordination between NGOs and involved them in the definition of Italian aid policies in the health sector. The UK-ODA regards voluntary organisations as innovative and cost effective. They have "proved their worth in many countries where tahey are providing a substantial part of all health services".(DAC(88)3)

### 1.2.3 The Institutional Organization of Health Aid

In the delivery of health aid, different types of institutional organization can be distinguished:

- **vertical organizations**, which are relatively autonomous, separate hierarchies outside the normal administrative structure of the MoH, and in some cases only nominally under the authority of the minister. Vertical organizations are focused on a limited set of goals and objectives and often have their own separate budgetary authority (USA-6);

- **integrated organizations** work through the Ministry's administration, using the established authority structure, through the regional, area and local officials. Integrated projects have the central objective of building general institutional capabilities, of upgrading several aspects of administrative structure, so that the institution is capable of achieving multiple goals and of maintaining flexibility (USA-6).

In practice, there are often combinations where vertical and horizontal programmes work together.

In PHC, one of the most important criteria is active community participation. Integration and horizontal, multi-disciplinary co-ordination is important, but many PHC programmes have vertical elements.

USAID has recently introduced a third alternative: *"the matrix organization, which combines elements of vertical and integrated organizations. A matrix organization combines the potential to effectively address specific problem areas -one of the advantages of vertical programmes- with the endurability of institutionally integrated programmes.*

*This organizational structure has 18 sub-components, and each is given the kind of priority that is often associated with vertical programmes. Since many divisions within the MoH receive some focused attention, there is less likelihood that any one programme will be perceived as privileged, as happened with the family planning programme. In addition, the matrix is dominated by a large management and planning component that integrates the other components within the ministry structure" (USA-6).*

Institutional organization of MoHs of developing countries often also follow a vertical structure, with departments of MCH, FP, TB and leprosy control (or control of endemic diseases), etc. In some countries co-ordination between different divisions is strong, and all relevant sections co-ordinate in PHC activities. On the other hand, MoHs exist, where PHC is yet another vertical structure (USA-1).

A number of reports provide examples where different institutional organizations give rise to problems. Sometimes a vertical disease control tries to integrate into PHC, but the latter has not yet developed enough (Fin-1,3). Other reports mention the problems arising when vertical programmes operate too independently (S-4,5), or when they try to integrate into the health services in a later stage (CH-7, ADB-1). If no integration takes place, duplication and high costs are the result, and programmes with most resources predominate. Resistance of MoH or local health staff can hamper the integration of initially vertical programmes (ADB-1, D-2). furthermore, USAID reports: *"in developing countries where ministries of health may be underfunded, poorly organized, highly politicised or held in low esteem, vertical programmes are easier to manage than integrated programmes and their effectiveness is easier to assess. However, if too many vertical programmes are established, efforts are duplicated and resources wasted. The majority of efforts to merge the horizontal and vertical programmes have not been successful" (USA-8).*

A complicated situation is described from Yemen (FRG-8) where PHC falls under the MoH, but health (sub-)centres under the provincial health office. Development of EPI is independent of both. In Korea the MoH is reported to have integrated what were originally vertical MCH/FP and chronic disease programmes into hospitals and health centres.

A number of reports (CH-7, S-6,7, USA-5) mention the detrimental effect of uncoordinated vertical programmes and mobile clinics on the implementation of an integrated health strategy. The MoH does not usually have the resources to integrate these services into their PHC network, so that health-centre level staff are completely absorbed by vertical programmes. Community-based workers lose esteem with the introduction of mobile teams and other vertical action into their communities while they themselves are not involved.

### 1.2.4 Inter-donor Co-ordination

The reports give various interpretations of the co-ordination of aid efforts. It can mean **collaboration** in the same project (USA-10); it may mean the **division of labour or geographical region** in a host country (CH-7), it can mean the **exchange of information** (NL-4), **supporting the same health policy** in a country (USA-10), or **sequencing of support** (USA-6). All definitions have in common, that one purpose of donor co-ordination is to prevent duplication of efforts and wastage of resources.

Little mention is made of ways to institutionalize inter-donor co-ordination.

Some projects affecting health belong administratively in other sectors, so that the co-ordinating body should be outside the MoH, although it is the main site of health activities. Sometimes project planning is co-ordinated by national planning agencies, but often co-ordination between the planning agency and the MoH is deficient. WHO has Programme co-ordinators who work in close contact with the MoH.

UNDP sometimes plays the role of bringing the UN funding sources relevant to PHC together into the planning process of activities in an early stage, so as to avoid duplication and maximize the effectiveness of programme delivery (FRG-2).

Many international, bilateral and NGO programmes are reported to operate according to the organization's own programme cycles, funding procedures, etc. An example of Tanzania is a relevant case. CH-7 points to the fact that, although donors are following Tanzania's official health policy, lack of co-ordination at the Ministry of Health and lack of co-ordination among donors, cause a chaotic health care system. The Tanzanian Ministry of Health, although subscribing to the PHC strategy, does not have the resources or planning capacity to integrate development projects into routine health activities as regards staff, equipment and maintenance (CH-7).Lack of planning and management at national level hampered the design of a well-integrated national health care system. The sector report states that, as a result of these deficiencies *"Donors are given a very free hand in implementing their projects and programmes" (CH-7).*

USAID acknowledges the need for a concerted co-ordination effort if the child survival initiative is to achieve its desired impact.
UNICEF has played a central role in the international Task Force for Child Survival, an important forum for many different constituencies concerned with international child health.

The Scandinavian donors work very closely together in an informal forum which provides an opportunity for exchange of experiences, a consolidated appreciation of what their assistance aims to achieve, and an opportunity to examine how it can most constructively be delivered. In the health sector, informal discussions are held annually.

The UN Resident Co-ordinator in a country is reported to be designated as the official to assist the government in co-ordination (FRG-2). However, in most developing countries, inter-donor co-ordination remains weak.

DAC(88)3 mentions as possible mechanisms for improving co-operation and/or co-ordination between donors:

1. Improving the co-ordinating capacity of the recipient country.
   DANIDA suggests a strong co-ordination secretariat should exist within each recipient country's national health ministry at a position where information about different donors' activities is readily available.

2. Increasing the number and calibre of donor agency field staff so that they have more capacity to co-ordinate their actions.
   FINNIDA and CIDA have undertaken administrative and policy reforms aimed at decentralising and increasing field level representation.
   The experience of NGOs in the co-ordinatioan field is appreciated as valuable by some donors.

3. Identifying one agency or organization that has country level representation to act as the lead agency.
   Lead agencies mentioned by different donors are WorldBank, UNDP, UNICEF, WHO.

4. Strengthening co-ordination between health sector officials at donor agency head office level.

## 1.3 The context of PHC in relation to sustainability

Factors such as macro-economic, macro-political, socio-cultural and environmental factors were found to be influential factors in all studies on sustainability. However, the weight for these factors could not be assessed for the individual projects. USA-6 suggests that in order to properly assess these factors, more comparative research on sustainability needs to be done.

The reports received for this paper showed a range of interpretations in defining sustainability, seemingly dependent on the context. Studies often cited one or more of the following characteristics as the basis for determining whether or not an activity is sustainable:

- **covers recurrent costs, or becomes self-financing;**
- **maintains a continuing stream of benefits;**
- **puts in place organizations or institutions that will continue to provide benefits.**

### 1.3.1. Principles of PHC in relation to sustainability

- None of the reports gave information on equity in relation to sustainability.

- Community participation. The form that community participation takes in the various projects follows a continuum from mere utilization of health services to active involvement in the planning, implementation and evaluation of projects. Community participation in many instances was found to be difficult to realize (USA-1,6,7,8,9,10; NL-2,4), and, especially in those countries where the political climate was not favourable to the concept (USA-6,10), to sustain.

- Nothing was found in the reports on **involvement of women** in relation to sustainability. As women are traditional health providers for themselves and their families, it would be worth while investigating this relationship.

- Focus on prevention. Some reports state explicitly that programmes focussed on prevention are more difficult to sustain than curative programmes (USA-1; NL-4).

- Appropriate technology. Case studies are presented in the reports where the use of appropriate technology may have contributed to sustainability (USA-1,7,8,10) and where the use of inappropriate technology may have inhibited sustainability (IADB-2,3,,5; ADF-1; NL-4).

- Intersectoral approach. Only one report (CH-7) made mention of the factor of intersectoral approach in relation to sustainability and presented a study of the Joint WHO UNICEF Nutrition Support Programme in Iringa, which consists of a total of nine intersectoral projects including food security and preparation, child care and development, improvement of existing health facilities and environmental health hazard control.

### 1.3.2. Donor and Host Country Policy in Relation to Sustainability

It seems that health projects are more likely to be sustainable if they are in line with the host country's health policy. This statement is corroborated by the findings in the USAID sustainability studies on health projects on Guatemala and Honduras (USA-10; USA-6).

Since health policies are subject to change, a question arises as to whether projects are sustained, having been conceived under a previous health policy.

How have **changes in health policies of donors** affected the sustainability of health programmes?

During the past two decades there have been numerous changes in health policies. The design of projects seems highly subject to trends in policies. This is well illustrated by the evaluators of USA-8, who, after having highlighted the **success** and **sustainability** of this **integrated** programme, conclude their analysis by remarking: *"One cannot help but notice how critical the timing was. Only five years before the project began, or even now (less than two years after completion), AID would probably not have designed a project like this. At the time this project was designed, there was a major shift in the health policy toward comprehensive rural Primary Health Care. Perhaps because of the difficulties AID has had with so many other PHC programmes, the Agency now believes it can be more effective if it supports a limited number of focussed interventions. An example of such interventions is the recent priority given to child survival strategies. (...) If AID were planning a project for Lesotho now, facing the same set of circumstances that existed in 1976, the programme would most likely centre on these two (immunization campaigns and ORS campaigns) activities and not a comprehensive PHC system" (USA-8).*

It is regrettable that a new approach has already been introduced without having given PHC projects an adequate chance to develop and grow over time. It seems large donors assumed that PHC projects would follow the traditional project process and could be sustained after three years' project period.

**Donor's health policy changes** do affect sustainability. This is shown in a synthesis report on the sustainability of health projects in Guatemala: *"The 1960's, when AID, PAHO and UNICEF pursued a strategy of malaria eradication, clearly demonstrated one danger of the "bandwagon" effect. With all donors providing funds for the same type of project, the government of Guatemala had to absorb a significant financial burden when all three donors pulled out in the 1970's (...). A second case of the international "bandwagon" effect is the current period of Child Survival Projects. Again, many donors are pursuing similar strategies and assuming major responsibilities for funding those activities. The total funding level for the next five years is exceeding the absorbtive capacity of the government. Should all donors shift their support to other activities, as they did with malaria, it is unlikely that the government of Guatemala could absorb the funding of project activities. With the possibility that AIDS will provide a future bandwagon, it is not far-fetched to consider the possibility that donors might shift emphasis again and leave Child Survival with considerably lower funding levels" (USA-10).*

Other reports also scrutinize the effects of changing health aid policies of donors on host country health systems. They are said to weaken the planning and management capacity of the national host governments (USA-1; CH-7); and cut financial and technical support abruptly when policy changes, leaving projects to collapse (USA-7).

What role does the **host country health policy** play in the sustainability of health programmes?

Donors often criticize governments who, despite the enormous shortages of resources, remain committed to providing free health care for all citizens (USA-1,7,8; ADF-1). WB-2 describes efforts of 4 West-African countries (Mali, Senegal, Ivory Coast and Ghana to achieve cost-recovery in the health sector. Senegal and Ghana have introduced fee-for-service at all levels, whereals Mali and Ivory Coast stress health centre- and hospital level. Ghana's cost recovery ratio was nevertheless only 12% in 1987. The report observes that generally people are willing to pay if quality of service is good (as mission hospitals in the countries concerned have shown). It also stresses the importance of equity when applying cost-recovery, one of the definitions of equity being "equal financial and physical access for equal need", and notes that in some countries people who need it less are exempted from payment.

Poor working conditions for personnel in the health sector, lack of management capabilities of those in charge are also mentioned as a threat to sustainability. Especially at district level, this shortage is prevalent. In Zambia, the MoH tries to improve mid-level management with Dutch and Swedish aid in a Management Development Programme with the aim of strengthening management teams at all levels, in a series of workshops and seminars. (S-6)

### 1.3.3. Inter-Donor Co-ordination in Relation to Sustainability

Can donors, through co-ordination of their aid, provide a collective capacity for the sustainability of projects? Several positive examples of donor co-ordination were found in the reports. The Lesotho Donor Health Co-ordination Group is chaired by the WHO resident representative. It is reported that the Group meets regularly and has been successful in facilitating exchange of information and in avoiding duplication of efforts (USA-8).

In Honduras, despite the lack of formal mechanisms, donor co-ordination has sometimes occurred spontaneously. An example is provided by a rural health project in which AID provided the training, PAHO emphasized planning, and UNICEF provided equipment for the health posts and health centres that were built with IADB funding (USA-6). It was stated that this type of co-ordination affected the project's sustainability (USA-6).

A Primary Health Care project in Senegal was only formulated after extensive discussions with (and use of documents of) other donors working in health in the area. This extensive preparation was later rewarded when the financing of the project was taken over by another donor (NL-4) and finally led to adoption of a national cost-recovery scheme on the basis of both experiences (WB-2).

An ex-post evaluation of a rural health project in Guatemala ascribed the continuation of the project to the support of WHO, UNICEF and other donors for Primary Health Care (USA-10).

On the other hand, lack of coordination has a detrimental effect on sustainability:

Apparently, the major donors in Tanzania have opted for large-scale projects such as the Extended Programme on Immunization (DANIDA, UNICEF) and the construction of Rural Health Centres (SIDA). One problem with this type of programme is that the Tanzanian Government cannot provide for the personnel and recurrent costs of these type of programmes. The author of one evaluation (CH-7) continues to say that: *"the problem is a recurrent one since donors do not like to become involved in the long-term financing of facilities and programmes. Lack of continuity means that donor-financed projects often yield disappointing results. Moreover, the proliferation of unco-ordinated vertical programmes makes the integration of an integrated health strategy increasingly problematic" (CH-7).*

### 1.3.4 Institutional Organization in Relation to Sustainability

Several reports mention the difficulties of sustaining vertical programmes and document the problems of trying to integrate a programme after it has run for some time as a vertical programme (CH-7, USA-1,3,6,7; EEC-1). Examples are given of collapsing malaria control and Maternal and Child Health/Family Planning programmes after donor-funding ended (USA-6,10).

Although information on the sustainability of **integrated** Primary Health Care Projects has been scarce, some indications on their sustainability can be presented here. **More chances for sustainability are given to integrated health projects.** This is indicated by data in USA-3,6,8,9,10; NL-2,4,6; CH-6. In addition, USA-3 states that: *"The projects evaluated which seem to have the best chance of continuing without foreign assistance are those which were designed to strengthen and expand existing health activities".*

Other reports also quote increased chances for sustainability when programmes are based on existing structures (USA-7,8,9; NL-2,4,6; CH-6).

No information on the potential of sustainability of the **Child Survival Approach** which represents the matrix model was received. This may also be explained by the relative newness of this approach. However, USAID is taking care that sustainability factors are in-built in its monitoring and evaluation model (USA-13).

### 1.3.5 Financing recurrent costs of PHC

Whether financial support for a PHC programme has an origin within the international donor community or has been provided as in-kind contributions in a tiny sub-Saharan village, there will always be resource constraints. These constraints are most acutely felt in the period of a project cycle during the planned transition from external to local support. What has been observed at an alarming rate over the past decade, is the frequency of project failure precisely at the moment when a Ministry or local council is confronted with the unanticipated burden of such a programme's recurrent costs.

An initial reaction to this growing awareness was to design more "cost-beneficial" programmes by selecting interventions that resulted in the largest short-term impact. One of the underlying assumptions to this approach was that a recipient country could more likely muster the resources necessary to finance recurrent cost burdens if the impact of such investment were more obvious.
Upon recognition that the problems associated with financing recurrent costs remain (almost regardless of magnitude, structure or impact of a programme), more recent attention has been committed to community financing and other cost-recovery schemes. *"First generation PHC programmes funded completely by national government health budgets have found that higher than anticipated operating costs per beneficiary, plus over-ambitious attempts to expand coverage, have severely strained those governments' total health budgets. Many agree that the goal of health service availability for all is an impossible objective in most countries unless local financing schemes can be established to partially support PHC programme costs" (USA-5).*

Such community-based financing rests on the assumption that the consumer, as an individual or collective, is willing to pay for some part, or all, of the cost of health interventions.

Under the umbrella of "cost recovery systems" have risen schemes such as revolving drug funds, prepayment insurance, in-kind contributions, fees for service, income generation activity, individual and community volunteer labour, fund raising, and local taxes (EEC-1, NL-7,8, USA-1,9).
However, the results of such schemes thus far have been mixed: *"Prior to 1980, the Sine Saloum rural health care project suffered from several fundamental weaknesses that jeopardized its viability (...)"*. Following an evaluation and recommendations, *"Project management and health worker supervision were strengthened. Training of village health committees was intensified to keep simple financial accounts and handle drug reorders. The system of fees was overhauled. The government reversed its policy and began charging fees for health services at all levels. As a result of these efforts, by the time of the last CDIE evaluation in 1984, the Sine Saloum project had managed to achieve a high degree of financial self-sufficiency through community participation and contributions holding promise as a model for future replication" (USA-5).*
On the other hand, because financing relied heavily on the sales of drugs, the fact that the project became "drug-driven" was seen as a negataive point. It also was not possible to finance costs of supervision with the sales of drugs.

The APHA report states: *"A number of projects have been successful in getting communities to finance drugs, but of the 28 projects that use community financing to compensate community health workers, none has a satisfactory method for obtaining local support" (USA-9).*

And, from a broader context of 5 health interventions in Guatemala: *"Since cost recovery was such a small portion of recurrent costs for projects and since projects with cost recovery were not any more likely to be sustained than projects without; cost recovery - as implemented in these cases - did not contribute to sustainability" (USA-10).*

In view of equity factors, and in view of the small amount of costs that can be recovered from the lowest level of the health care system, World Bank advises in a study of cost recovery in West Africa (WB-2) to implement cost-recovery in phases, starting at the tertiary level of care, where more recovery is to be expected. (WB-2)
In spite of these considerations, UNICEF has recently launched a continent-wide initiative called the "Bamako-initiative" for community-financing of PHC through the sales of drugs (UNICEF-1). This initiative is based on the experience in an area with 12.000 inhabitants near Cotonou, Republic of Benin.

Consideration has been given to other aspects of financing that might influence sustainability. In one document (USA-10), the evaluation teams examined several of these factors:

- the progressive absorbtion of project costs within the national government;
- the recurrent foreign exchange demands;
- required shifts in priorities from existing programmes;
- cost-effectiveness.

They found the most important factor influencing sustainability was the degree to which project costs had been progressively absorbed by the government of Guatemala during the life of a project. Regarding a relationship between the other factors and sustainability, the results of this study appeared insufficient to draw substantive conclusions or recommendations.

## 1.4 Conclusions

From the donor's sector evaluations and policy documents which were received, it is apparent that considerable progress has been made in both donors' and host countries' orientation, away from hospital towards extramural care. This has created greater equity of access. Not all care is community-oriented. Although a number of sector evaluations give strong arguments for more community participation, intersectoral approach, more appropriate technology and focus on prevention, this has not always been translated into PHC- oriented projects by all donors about whom policy information was received, as will be seen in the next chapter.

The intersectoral approach is, of all PHC principles, the most weakly developed in both donor and host countries' policies and practice. This may be caused by the medical orientation of policy-makers in Ministries of Health and those responsible for the design of donors' projects. Also, the sectors relevant to PHC are spread over various ministries. Intersectoral cooperation requires the establishment and operation of inter-ministerial organisations; a task not easily accomplished.

To a certain extent, the continuing use of inappropriate technology still continues.

### 1.4.1. National Health Systems

National Health Systems in host countries subscribe to PHC as defined in the Alma-Ata Declaration. A start has been made to re-orient the systems with a greater focus on prevention, and community participation (decentralisation to lower levels).

It is a slow process in which the orientation of existing health personnel is still a constraint, as well as the fact that resource allocation is often still centralized, and mid-level management capacity is still weak in many countries.

### 1.4.2. Donor's Role

Although experience with integrated, comprehensive PHC is short, and developing countries are gradually beginning to make progress in PHC, a number of donors have turned away from it and back to a more vertical approach. Whether this new approach will prove to be sustainable remains to be seen.

- The changing of health policies have had (and are having) negative effects on the sustainability of health projects conceived under earlier health policies.

Many donor agencies want quick results of their programmes in the developing countries. Parliaments and sponsors of private organizations want to see the results of their financial or technical support. If the health care delivery system is not functioning well or the coverage is still poor, then a vertical programme with its own resources, not hindered by the bureaucracy of a poorly-functioning ministry, will give relatively fast results. One of the disadvantages of such an approach is that when the donor agency withdraws its manpower, financial or material support, the programme might collapse because the activities have not been institutionalized.
With the improvement of the health care delivery system, which can be observed in many developing countries, and the increased coverage with health services, the need for vertical programmes is being reduced. Integration in a later stage is difficult. Organization of health services, autonomy at regional levels, the "traditional tasks" of the health facilities and staff, the allocation of resources, differences between national and local priorities, quality of the service at lower echelons, the coverage, etc. have been identified as constraints for integration. Sometimes the priorities of a health centre, set with the needs of the community in mind, are crossed by the priorities of a vertical programme set at national level.

- The majority of reports state that large-scale, vertical programmes are not sustainable. Since there were only two sustainability reports presented on an integrated Primary Health Care Project, we cannot make definite conclusions on the sustainability of these type of projects. Since Primary Health Care is still too recent an approach, this may explain the relative absence of information on this item. There was no information on the potential for sustainability of the Child Survival Approach;
  The intersectoral approach is, of all PHC principles, the most weakly developed in both donor and host countries' policies and practice. This may be caused by the medical orientation of policy-makers in Ministries of Health and those responsible for the design of donors' projects.
  Also, the sectors relevant to PHC are spread over various ministries. Intersectoral cooperation requires the establishment and operation of inter-ministerial organisations; a task not easily accomplished.

### 1.4.3. Inter-donor co-ordination

A further difficulty is the fact that donors who finance a large share of the MoH in many countries, have different approaches and have no mechanisms to integrate. Where the MoH is weak, it is often accepting aid, even if it does not confirm with its policy.

- it appears from the reports that donor co-ordination would be an important advance in improving the sustainability of health projects;

Somewhat absent from the discussion was the relationship with donors working in other sectors.Very few PHC projects addressed the issue of inter-sectoral approach in their stated objectives or evaluations. It would be a matter of course to investigate how donor co-ordination can be brought about, not only for the health sector, but also with all other sectors relating to health.

### 1.4.4. Financial sustainability

Severe balance of payment and recurrent budget deficit problems manifest themselves acutely in regard to the financial sustainabiliy of PHC. Numerous schemes have focussed attention to cost recovery yet it has become apparent that such community-based financing is only a partial insurance that recurrent costs of effective programmes continue to be met. In spite of these experiences, nes initiatives like the "Bamako initiatives" are being launched, based on the assumption that the community is able and willing to pay. Reports also show that community financing can endanger the principle of equity, and that cost-recovery at higher levels should be considered first. Nevertheless, new initiatives of community financing by sales of drugs, like the "Bamako initiative" continue to be launched.
Other factors, such as the ability and willingness of the National Health System to absorb recurrent costs, must be addressed. Re-allocation of funds within the health sector or between sectors and improvement of quality is seen by some as a partial solution. Increasing the appropriateness of technologies can help to minimize the dependence on foreign exchange. Continued attention to manpower development can keep the cost of "experts" to a minimum. But perhaps most importantly, donors must accept that PHC, with all of its potential benefits, has serious long-term recurrent cost ramifications;

In summary, there seems to be a growing concern among DAC donors about the sustainability of health projects.

> *"The truth is, however, that we do not yet know what contributes to sustainability. Each project is to some extent unique, and there may be no single variable that determines the long term viability of the project" (USA-1).*

This quotation comes from a synthesis report addressing the issue of sustainability in projects carried out by USAID, UNICEF and UNDP. Similar conclusions were found in other reports (USA-3,6,7,8,10). Although no single factor, or combination of factors, could be identified as the key to sustainability, several influential factors were repeatedly mentioned and are discussed in detail above, and in the following chapter.

In relation to the context of PHC, **frequent changes of donor's policies, vertical organization of health aid** and **lack of inter-donor coordination** are mentioned as a cause of decreased sustainability, whereas **lack of management capability at all levels, and the lack of willingness to introduce cost-recovery where people can afford to pay** influences sustainability adversely at host country's level.

There seems to be a clear contradiction between the continuation and expansion of donor health sector involvement and the stress on supporting self-reliance. Donor support almost inevitably involves, at host country level, an increase in the need for personnel, financial, organisational and material resources which are either unavailable locally or in very short supply.

Donor support in the health sector has also involved the creation of project structures which are poorly, or not at all, integrated into the existing health system. In both cases, self-reliance and sustainability are endangered.

## 2. THE PROJECT CYCLE

The "project cycle" includes all related activities, starting with the identification of the project and ending with the termination of it. It includes three main elements:

- planning;
- monitoring and evaluation;
- implementation.

The **planning phase** usually consists of the identification and formulation of the project. Different donors and types of projects have different procedures for this.
**Monitoring and evaluation** take place throughout the project cycle, starting with ex-ante appraisal, continuing with monitoring and mid-term evaluations and often ending with evaluation ex-post.
**Implementation** is the period in which the project's activities are actually carried out.

PHC projects, because of the principles on which they are based, have special requirements, the most significant being that the population should be involved in all stages of the project cycle. This chapter indicates that, although participation is often attempted, numerous constraints remain. This chapter also gives examples of past and present projects, where failure to involve the target group resulted in adverse effects on the implementation phase and ultimate project benefits.

Not all phases of the project were given equal attention in the documents under review. Few appraisal reports were received, and what **was** said about the planning phase is largely restricted to the retrospective comments of mid-term and ex-post evaluators.
Evaluation and monitoring was dealt with more extensively, since most of the reports were evaluations.

Implementation of PHC was dealt with in a number of synthesis reports, and mid-term evaluations.

## 2.1 The planning phase.

In the planning phase, objectives are formulated, priorities selected, budgets proposed and resources allocated.
If community participation is taken seriously, it is important to identify the needs of the population, to involve local policy-makers and communities, to take into account the local socio-economic and cultural factors and (if the project is to be sustainable) to reach agreements between the partners (including the community) as to resources (money, material, manpower) for investment and recurrent costs.

### 2.1.1 Policy Statements of Donors on Planning

A number of health sector reports offer statements on how health projects, and PHC projects in particular, should be planned, based on "lessons learned".
A thorough study of socio-economic conditions, power structures, culture, administrative capacities, legal structures, development plans in the recipient country, experiences and views of local people and medical personnel, are suggested to be necessary parts of the planning phase (EEC-1, FRG-1,2,3,) as is the establishment of realistic objectives and time-frames (USA-3).
The experience of PHC projects is more recent, and one report in 1984 concluded: *"PHC is still young and has yet to get experience and routine in the planning of PHC projects" (FRG-3).*

The APHA report on 52 PHC projects (1982) offers the following conclusion on the planning of PHC: *"With few exceptions, project plans contain little or no discussion of what community participation is, how it can be achieved, and what kinds of activities communities can be expected to undertake to improve their health"*, and: *"It often seems that project planners expect participation to develop spontaneously.*

*In general, insufficient attention is given to the significant effort and deliberately slow pace required to gain a community's trust and support" (USA-9).*

### 2.1.2 Project reports

Quite a number of the projects under review started in the late seventies or early eighties, with the construction of hospitals or with vertical disease control (TB, leprosy and malaria eradication) programmes. Later, efforts were sometimes made to give these projects more PHC orientation, i.e. to give the constructed hospitals or health centres a more supportive role, or to integrate the vertical programme into the existing health services.

Ex-post evaluation reports (IADB-2,3,4,5, FRA-3) conclude that **more attention** should have been given in the planning phase to the socio-economic factors, logistics, health infrastructure and management capacity of the country as well as the felt-needs and perceived benefits of received health services to the population, and their traditional health system and beliefs. In view of the disappointing utilization of the hospitals, the involvement of the community is seen by evaluators as a prerequisite for project success. Evaluators also conclude that recurrent costs have not been sufficiently taken into account, and that the technology used was often inappropriate (FRA-3).

German evaluations of hospital projects, which in a later stage were re-oriented towards extramural and community oriented care in Yemen, Zaire, Malawi, Korea and Brazil, concluded that the initial problems of the implementation phase could have been prevented if the planning team had had a better insight into the organization of the services, training and financial resources.

The teams plead for a more detailed plan of operations, a more concrete formulation of objectives and continuous evaluation. And where PHC is developed in projects which started as a hospital, the planning should be detailed for both hospital- and PHC component. Especially in these combined hospital/PHC projects all participants should have the same expectations, intentions and priorities. Enough time should be given for the re-orientation of all parties concerned. *"A period of four years for a PHC project is considered to be too short" (FRG-2).*

Similar difficulties occur when the integration of single disease control projects or programmes into PHC is tried (FIN-1,2). One Finnish report says that their TB control programme was hampered by the slow development of PHC. The financial resources and available manpower were far less than had been assumed in the planning phase.

An FRG and UNICEF joint team, which evaluated water projects in Nepal, Burma and Bangladesh, identified constraints in the field of community participation, maintenance of equipment, availability of local technical staff and training facilities. It concludes: *"in order to avoid pitfalls of over-extending UNICEF and government capacities in complex programmes, careful planning and project preparation is recommended, without losing the impetus of rapid flexible action" (FRG-10).*

Even in a number of community-based PHC projects, baseline data and information on the population's felt-needs were not available when implementation started. In a project in Benin (CH-5), the project manager decided to investigate them, and found out that water-supply was a greater felt-need than health.

Inclusion of this component into the project subsequently caused "delay" in planned project implementation, but later helped to improve project acceptability. This could have been foreseen, had people's felt-needs been taken into account in the planning phase. A similar example is a project in Colombia (NL-6), where the methodology used had to be completely adapted at a later stage to suit the cultural and socio-economical situation, and "baseline" information was collected two years after initiation of the project. On the other hand, a Swiss community-based general development project in a Latin American native population took two years to study perceived needs of the population, in order to better adapt to local culture, and traditional medicine, but did not foresee how to integrate the project eventually into the government services in order to sustain it, a problem also found in some health centre and hospital projects (FIN-2).

### 2.1.3 Project Appraisals and Formulations

In the appraisal reports of the ADB in Malaysia, Pakistan, Indonesia and Papua New Guinea much information has been compiled on the existing health services and the priorities of the Ministry of Health, implying that the bank has learnt from past planning experience. Objectives and sub-projects are described in detail. Calculations have been made to ensure that the projects will be sustainable. **No information is given, however, on the felt-needs of the population,** nor on traditional medical systems which people may prefer to modern services.

### 2.1.4 Women's Role in Planning

What do the reports say about the women's role in health projects? Of the 44 project reports, 15 included MCH activities, 20 health education activities, 11 nutrition and 11 water.

Health care in the family and provision of food and water are part of the role of women in most developing countries. They are the health providers at family level. Besides, as TBAs, nurses and midwives, as VHWs in some countries (especially Latin America), and as doctors, they play an important role as health providers in modern health services.

Poverty and heavy workload, problems related to pregnancy, miscarriage, childbirth and poor nutritional status which results in poor health, combine to make women major health service consumers. The percentage of women consumers of official health services in reports (where it was analysed) varies from 60 to 90%. When there is a fee-for-service policy, this means that women also contribute highly to recurrent costs of services (FRA-3) - if they can afford it.

Their economic position, along with culture and tradition, determine whether or not they can actually make use of the services.

Acceptability of services for women can be hampered by beliefs and customs surrounding pregnancy and child-birth, especially where the TBA is not allowed to attend a hospital delivery. Where men are responsible for MCH services (S-1). it is in come cultlures hard to make the services accessible and acceptable to women. Some reports (USA-10, ADB-4) mention the problem of accessibility of health services to women (especially where they are run by men), and the burden of women to act as health providers (S-3, NL-5,6).

Knowledge about these factors must be gathered when planning services.

To involve women in health activities, special study of their status, health needs and felt-needs in overcoming family health problems is necessary. Although this awareness is gradually growing within donors' policy, it is too often felt that projects address women sufficiently if they are included as a risk group. The "community" is not properly involved in planning, as must be concluded from the many of the reports.

Even less so are women. Policy-makers are usually men (only one IADB report mentions women in policy-making positions at ministerial level). Specific data on the gender of health personnel, along with disaggregated socio-economic and morbidity data is absent in most of the appraisal reports. A number of evaluations report difficulties in involving women (NL-4,5, USA-2, USA-10, ADB-4), but many others show how important it is to involve them (S-2, CH-6, NL-4,5,6). Not much experience seems to have been gained in how to avoid these problems in the planning phase.

## 2.2 Monitoring and evaluation

Agreements between donor and recipient countries on project evaluation are generally made during the planning phase. The importance of baseline data during planning has already been pointed out, along with the need for community participation in planning. Without proper baseline information, and without planning progress indicators, monitoring and evaluation becomes impossible.

Study of the reports reveals that few projects have systematic ways of monitoring and evaluating health projects. Built-in evaluation is rare, and methodologies used in donor-supported evaluations are vague.

For the purpose of this report, evaluation will be defined as in the DAC compendium on Aid Evaluation:

> "as systematic and objective as possible an examination of an on-going or completed project or programme, its design, implementation and results, with the aim of determining its efficiency, effectiveness, impact, sustainability and the relevance of the objectives. The purpose of an evaluation is to guide decision-makers".

Evaluation in the health sector is carried out at different levels and at different times:

- **health sector evaluations**, on health activities in one or more countries, by one or more donors. They are carried out for policy-making purposes.

The DAC compendium on aid evaluation states that the great majority of staff in evaluation departments are economists and engineers, and only a small minority of donors have social and cultural scientists on their staff. The health sector will especially need these specialists as health care activities extend beyond the merely hospital-oriented, to the more community-oriented context;

- **evaluation of projects:** mid-term evaluations mainly for project management. Ex-ante and ex-post evaluations address mainly policy-makers. Sometimes, special ex-post studies are carried out, like the studies on sustainability;
- within the project itself, **self-evaluation by project management and population** can be carried out (here described as **built-in evaluation**). This self-evaluation is an important management tool, especially in projects where community participation is central.

In order to facilitate and improve the quality of evaluations, systematic collection of information should be carried out as a continuous follow-up of activities called monitoring.
**Monitoring** is defined in the DAC compendium as:

> "a management function which uses a methodical collection of data to determine whether the material and financial resources are sufficient, whether the people in charge have the necessary technical and personal qualifications, whether the work plan has been achieved and has produced the original objectives".

It is clear from the above definition that the difference between built-in evaluation and monitoring is sometimes hard to define. Evaluation is distinct from monitoring in that it attaches **values** to results. Monitoring, like evaluation, also takes place at all levels.

**Evaluation of PHC**

Many donors make use of the systems approach when discussing evaluation (DAC-1, USA-4). This approach can also be applied to PHC. Characteristic of the PHC system is that:

- the **inputs** are not only health service and project resources, but also the resources of community members and health agents;
- the **process** includes at community level: the changes in social awareness, community organization, degree of empowerment, acceptance of the programme, health knowledge and -behaviour, relation between traditional and modern medicine, selection and support of community health workers, mobilization of community resources; and, at service level: management, logistics, quality of care, supervision and support to community level;
  at national level: political will (expressed in statements on health policies, health legislation), resource allocation to health and within the health sector, equity in resource distribution :
- the **outputs** are an increase in coverage of effective health services, including immunizations, oral rehydration, curative care (including effective traditional care) community supported activities towards health (including intersectoral activities);
- the final **outcome**, or impact, is the improvement of health status in relation to the socio-economic and nutritional status by way of the project's intervention.

  It is known from past experience that impact- or outcome measurement is very difficult, and it is not to be expected that this will be different in PHC. Health, socio-economic and nutritional status depend on so many factors that the influence of a project is practically impossible to measure.

Evaluation of PHC activities, with reference to PHC's guiding principles, as outlined in the introduction, has some special requirements:

- involvement of the population in the evaluation procedures is important. Their opinions should be considered in planning, and they should be involved in feedback of evaluation results;
- not only purely medical activities and results are important, but the links with, and the place of, the project in the overall development process;
- outputs are important, but perhaps more importantly, the process through which outputs are achieved: community participation in decision-making, community contribution, acceptability, availability, utilization of services, knowledge, attitudes, health practices, women's participation, quality of care etc.

### 2.2.1 Policy Statements about Evaluation of Health Projects

A number of **sector evaluations** under review include, on the basis of project experience, some statements on how evaluation of health projects should be carried out and the constraints which exist. In summary, they stress the importance of well- defined targets and objectives, process indicators, and baseline data. Donors realize that evaluation is not carried out systematically at present.

The EEC comments that *"many decisions are taken without adequate information", and that "often the need for evaluation is even poorly understood" (EEC-1). Often the evaluation process is confused with the quite different role which a monitoring unit can play in providing feedback in the administrative process. Where information does exist, it is frequently not easily available to decision-makers."*

Germany points out the importance of internal project **monitoring.** Conditions for this are (FRG-1):

- *"concrete and precisely-defined targets;*
- *sufficient study of the situation before the project;*
- *reliable and punctual information about the course of the project."*

The report also stresses the importance of joint **evaluations with the developing countries, and with international organizations.**

Poorly-defined objectives and data deficiencies are observed in US funded NGO projects (USA-3). Outside evaluations were scanty, and evaluation results were rarely used as a management tool. Time-consuming record-keeping was often carried out but data not used. The reporting of a few selected, relevant statistics which will have meaning is advised.
The USAID Health project evaluation framework suggests the following issues for incorporation in health project evaluation (1982):

- *"the economic rationale for choosing the health project;*
- *health impact measures and economic benefits (with use of simple surveys or vital event registration);*
- *utilization, knowledge, attitudes and practices (KAP surveys);*
- *social evaluation of consumption and investment benefits;*
- *health project context:*
- *intraprogrammatic context (including technology utilized);*
- *situational context;*
- *economic sustainability;*
- *equity considerations".*

Three important PHC principles (equity, appropriate technology and community participation) are taken into consideration here, but the intersectoral approach is not included. Instead intersectoral conditions are seen as the situational context of the project.
Furthermore, the framework does not mention how to involve the population in evaluation.

USAID concludes that, although nearly all projects plan to evaluate outcome by measuring changes in health status, only a few of them include control groups. Field surveys are often used, but their results are often too complex for practical use, or of poor quality. Lack of baseline data hampers outcome evaluation. Output data is readily available in most projects, but is not helpful in designing future projects. Some projects have process data on changed utilization of services, but not on quality. The USAID report also notes laxity in project monitoring (USA-10).
The "child survival strataegy", now the focus of USAID's health programs, makes use of the Health Projects Data Base, which consists of information on USAID supported programs, data from health and child survival projects for each USAID-assisted country, progress indicators for health and child survival projects, and information on the different components of each project. The indicators for monitoring and evaluation of child survival are merely quantitative output indicators:
--% of well nourished infants/children
--% of diarrhoea episodes treated with ORS
--% of vaccinated children
--% of vaccinated pregnant women
--% of breastfed and properly weaned infants
--% of women (15-49 yrs) in union using contraception (USA-11)

As most of this information will have to be gathered in sample surveys, it would be desirable to include in the surveys some of the information on process mentioned above (knowledge, attudes, practices for instance). A recent (draft) USAID publication on sustainability of CCCD includes "sustainability indicators", more related to the process at service level:

--effectiveness of technical interventions (measured as the % of health workers correctly carrying out certain procedures, training capacity, attrition rate of personnel, effective supervision)
--National leadership and commitment
--Management systems and capacity
--Financial resources and systems
--Behaviour change and demand. (USA-13)

The WHO/UNDP/BMZ study on PHC observes that PHC evaluation is inherently difficult, and most reports are impressionistic and descriptive. It advises:

- *"not to set too ambitious and unrealistic goals;*
- *be sure of baseline data;*
- *carefully design comparative research;*
- *collect information, with interpretation supported by knowledge about the total health care system and environment" (FRG-2)".*

In regards with sustainability, reports indicate that a design of projects with future sustainability in mind makes it imperative to put in place evaluation procedures at the outset to gather information about preferences, results of funded activities and alternative resources (CH-6; NL-6; USA-3,7,8);

### 2.2.2. Methods utilized in Project Evaluations

The diversity of evaluation methods and objectives applied in the reports makes comparison between projects very difficult. Care should be taken for unjustified conclusions on the basis of these reports. Especially in mid-term evaluation the reports give the picture of a particular moment, which is soon passed.

Most mid-term evaluation methods utilized one or more of the following techniques:
- studies of existing documents;
- interviews with managers and policy-makers;
- field visits.

IADB has a standard procedure for ex-post evaluations. The method includes field missions, surveys, interviews and the study of existing information. The results include socio-economic impact, technical, financial and administrative aspects, and environmental and social aspects. Similar methods were used in an ex-post evaluation by French donors (FRA-3). ADB appraisals also follow a similar standardized formulation procedure.

In one Swiss evaluation (CH-3), structured interviews with health personnel at different levels of the health pyramid, and cluster sample surveys in villages were used. In another, very participatory (sector) evaluation, workshops were held with local personnel to define evaluation criteria and objectives, and local personnel participated in the evaluation (CH-6).
Very often, **project objectives** are vague, and not measurable. Where they are concrete and quantifiable (e.g. in construction and vertical disease control projects), they are not always realistic. In a number of evaluation reports project objectives were not mentioned.

Many evaluators complained about the **lack of baseline data and information about people's perceptions and needs.** Use of existing data is usually limited to official health statistics and health-service data.
Sector-evaluations are usually a synthesis of existing evaluation reports. Some countries collect this data from field visits. A Dutch sector evaluation (NL-2) made use of a number of mid-term evaluations of PHC projects, but besides a number of field visits were paid to some projects. A Swedish sector-evaluation in Kenya even made use of a household survey about knowledge, attitudes and practices, as well as acceptability of the provided services among community members, especially women (S-1). A SIDA health sector review in Zambia was carried out in 3 phases:

1. interviews and study of documents
2. a survey
3. analysis of phase 2 and supplementary documentation, discussion of possible consequences.(S-6)

**Feedback, and utilization of evaluation results**

Very little is said about the use which is made of evaluators' findings. In one PHC project in Senegal-(USA-1), suggestions were followed up. A Dutch report about a PHC project in Niger mentions several visits to the same project, where evaluators' suggestions were not followed.
Very little is said either about feedback of results to project managers, counterparts and population. Exceptions are two evaluation missions (S-3, CH-3) during which a workshop with health workers was held to discuss results. In S-6 feedback and discussion with MoH took place in phase 3 of the evaluation.
IADB sends reports to the respective executing agaencies for their information, and assures that ex-post evaluation results are taken into account in all new operations. (IADB-1)

**Composition of the evaluation teams**

Although DAC strongly advises that donor-supported evaluations are carried out with a national counterpart (DAC compendium on aid evaluation), only 11 out of 44 single project evaluations were observed to be bilateral.

Women were very rarely included in the evaluation teams.

The disciplines of the evaluators were rarely mentioned and no conclusions can be drawn regarding representation of social scientists, medical experts, experience of the evaluators, etc.

### 2.2.3 Monitoring and Built-in Project Evaluation

**Monitoring**

In a Latin-American health project, auxiliary nurses collected socio-demographic data about the target population at the start of the project. In a Danida PHC project, base-line data was to be collected and a monitoring system developed, but at a mid-term evaluation this still had not been carried out.

Few project reports mention built-in monitoring systems. One IADB project included a 6 month consultancy for setting up an information system concerned with the PHC activities, referral system, impact of ambulatory care system on utilization of a hospital, and the treatment capacity of a hospital.

A Dutch community-based PHC project utilizes a monitoring system carried out by VHWs, developed in Colombia. Other community-based projects mention monitoring systems for VHWs which will be developed (USA-2).

The APHA study on 52 PHC projects remarks that practically every project plan provides for an information system, but that during implementation this rarely functions, because it is more detailed than necessary, and produced too late to be of value, and even useful data is often ignored by managers who trust only their personal experience, or who make decisions for political reasons.

In the PHC research project in Thailand (JA-1), much research is carried out on information systems used by VHWs and other villagers. Official information systems are often characterized by collection of too much data, which is then hardly used, nor reliable. Some reports of PHC projects mention that information systems will be introduced. S-6 mentions the poor recording of activities by CJWs.
The BRAC project emphasizes the importance of process indicators:

- *"quality and content of instructions from higher levels;*
- *feedback on performance;*
- *the extent of co-operation that develops between health workers and the community".*

There are only few reports which actually mention **process indicators.** More reports mention the need for them, instead of output or outcome evaluation. BRAC also mentions the importance of process documentation and feedback of results.
S-6 mentions the need for qualitative information. In its sector evaluation in Zambia, SIDA also uses qualitative information on the process of PHC, with the following questions:

- How well are CHWs doing in terms of community demands/expectation?
- How do CHWs deal with inadequate drug supply?
- What is the relation of CHW with HC staff?
- How is the quality of care?

- What is the quality/duration of training?
- What is the quality/motivation of HC staff towards PHC and CHWs?
- How is the relationship CHW/political leaders?

**Built-in evaluation**

The sustainability studies (USA-1,5,6) point out the importance of built-in evaluation for mid-course correction. Flexibility of project design is then necessary to make these corrections.

One Dutch project (NL-6) developed an in-built participatory evaluation method, in which the community members were asked to give their opinions about the project and analysed their own(health- and health related) needs. This same process was built into a Swiss project with an Indian population in Latin America (CH-6). In both it is found that people's felt-needs are not primarily health needs.

## 2.3 Implementation of PHC

### 2.3.1 The PHC principles in relation to PHC project implementation

Forty-four reports on health projects were received, and these were analysed for their orientation regarding PHC principles.

Equity could be found in the majority of projects, since they were directed towards the rural poor, who previously had no services. There were a few exceptions of large hospitals with sophisticated technology, and without any links with outside services. The orientation towards equity, however, did not always mean this was also achieved by such projects. Quite a number of evaluations of construction projects of hospitals, health centres and health posts showed their utilization rate to be low. Better needs assessment and community participation was often recommended in these (often ex-post) evaluations.

Community participation was mentioned in some way in 27 project reports. There was no mention made by several projects which were initiated in the early seventies. Some ex-post evaluations concluded that more community participation should have been included. A number of hospital projects were started without community involvement, but later tried to expand to the periphery, sometimes with the involvement of the community. However, difficulties were usually encountered during this change of orientation (FRG-6,7,9). A small number of vertical intervention projects were included with no mention of community participation; most disease control and vaccination activities were integrated in existing health services (PHC if available), or efforts made to do so. There were three entirely vertical projects included in the reports.

A problem with community participation is that it is so differently interpreted. Participation can vary from contributing money to increasing the level of involvement in development and self-reliance. The APHA study (USA-9) differentiates between community participation in:

- organization;
- financing;
- health improvement activities.

The same study mentions the following factors as inhibiting community participation:

- lack of perceived relevance (preference for traditional medicine, lack of interest in preventive medicine);
- cultural and historical impediments;
- unfavourable government attitudes;
- bureaucratic inflexibility;
- low level of (project) effort;
- health ministries' lack of expertise;
- lack of resources and intersectorial co-ordination;
- lack of training and critical follow-up support for committees;
- lack of community input in project design;
- lack of support in communication (mass media).

In spite of this list of inhibiting factors, many examples of successful participation in the evaluated projects were given. It concludes that community involvement in those activities which are directly related to service delivery has been considerable, but: *"little headway has been made in stimulating communities to identify health problems, develop solutions and mobilize resources to solve health problems" (USA-9).*

In three West African countries (NL-4,5, USA-2, CH-4,5) the government has a policy of encouraging community involvement in selecting "health teams" (VHWs and TBAs)

and health committees. According to these reports, VHWs have to be supported by communities which already have to pay for drugs. A problem raised in some reports is the fact that free treatment is available to the better-off sections of the population. Several failures of various types of community financing are mentioned. Revolving drug funds under the responsibility of the health committee, and payment of the VHW in cash or kind has finally proved successful in at least Senegal (USA-2) (Dutch experiments in one area there were taken over by USAID, and finally became a national policy) and Benin (CH-5). The disadvantage of this system is mentioned to be that it is "drug-driven" and neglects preventive and promotive actions. The question is also raised (USA-2) as to whether community participation in this way is genuine involvement or acquiessence.

Reports give three fairly successful experiences in community participation in Latin America (CH-6, NL-6, IADB-4). These are among the few projects where intersectoral activities are attempted or achieved. In one of these, community-selected auxiliaries trained in community medicine are involved in health promotion, information collection, nutrition, sanitation and small-scale agriculture. In a special, integrated-development programme for the Latin American native population, much stress is put on traditional health concepts and medicine, while western medicine is introduced with much caution (CH-6).

USAID experience with NGOs suggests that their greatest successes in community participation are in integrated rural projects, and in those which focussed on traditional medicine (USA-3).

In a PHC project in India, community participation is sought through a contingency fund from which communities can pay for identified high priority projects.

Village health committees were not functioning well.

**Participation of women in implementation**

Women's participation in a project in India (D-5,6) is being achieved with feeding centres in every village a programme of the ministry of social welfare.

In the aforementioned West African projects, VHWs are usually male, which causes problems as they migrate a great deal and also because women are reluctant to consult males. TBAs are women and it is suggested they receive a more diverse training. Representation of women in health committees is also a problem, although solutions are being sought in separate women's committees or mother's clubs. The heavy workload of women in Sahel areas calls for an intersectoral approach in order to save women's time and to enable them to spend it on health activities (NL-4,5).

With the exception of the Latin American native population, communities in Latin America generally select female VHWs. In the native population, involvement of women is achieved by recommending the selection of couples to be VHWs (CH-6).

Preventive activities were found in most projects (except for the above-mentioned hospital projects and some rural health projects focused on construction). The balance between curative and preventive services varied. A number of community-based projects which were started with a focus on prevention were found to have much emphasis on drugs and curative services by VHWs during implementation.

Intersectoral activities were found in only six project reports out of 44, in three of which this being water-supply and/or sanitation. Links with the educational, agricultural or other sectors were only found in three projects. It is surprising that some community-based PHC projects in Sahel areas started without including a water component, even though people's priority was water.

If inter-sectoral activities take place then it is usually in those PHC projects which are integrated in rural development projects (USA-3, CH-3). In NL-6 coordination with other sectors failed despite given high priority. Reasons for the lack of coordination are seldom analysed.

Very few projects included **environmental components** which attempted to diminish adverse effects of development (like i.e. disease control in irrigation schemes, education on pollution, insecticides, pesticides, or reforestation). Hygiene education and health education in waste collection was common in community-based projects.

It was hard to judge to what extent projects made use of appropriate technology. In most hospital projects, and in a number of health centre projects, technology was evaluated as highly inappropriate. In the community-based projects VHWs were trained in simple curative and preventive tasks. No mention was ever made of how appropriate the training was. The water-supply components of some projects made use of appropriate technology. There seems to be a need to define the term "appropriate technology" more precisely for projects and programmes which do not focus on construction.

### 2.3.2 Health Services support in implementation of PHC

An issue which was repeatedly mentioned as a problem area in PHC projects was the **Health Services' Support**
Lack of health infrastructure, lack of trained manpower and institutional resistance are the limiting factors in health services support mentioned in the APHA report. The lack of functioning cold chain is mentioned in many reports.
Inability to bear the recurrent costs of supervision are mentioned in a number of reports (NL-6, CH-4, USA-2).

In the reports on community-based projects, the orientation of health personnel is mentioned as a constraint (CH-4). In most of these projects, though, re-training at these levels takes place. Several reports (FRG-2,3, UNDP-1, FRA-1,2) talk about the orientation of health professionals as a constraint in their functioning in a PHC-oriented system. This arises from training which is still curative/hospital oriented. As a result, doctors and nurses appointed at peripheral levels are not at all prepared for their task.

Many reports (FRG-1, UNDP-1, S-3, CH-4) mention the difficulties in transferring female health workers to rural areas caused by matrimonial and family obligations.

## 2.4 THE PROJECT CYCLE IN RELATION TO SUSTAINABILITY

*"The design and implementation of development efforts need to address sustainability. Implementing with sustainability in mind is broader than simply carrying out a mandate or attempting to accomplish certain objectives. It necessitates a capacity to continue activities in the future and assigns responsibility for maintaining and adopting them" (U. of M., 1987).*

In project design and implementation various factors can be isolated which, according to the literature, are important in sustainability. The list does not include all possible factors: those that are dealt with here appear to be mentioned in most reports.

- **planning of the project.** American studies on sustainbility of health projects demonstrate that the planning phase directly influences the final sustainability of projects. If health projects had been planned in close coordination with host country MoH, this seemed to influence sustainability positively. Generally, reports indicate that the classic project planning of two to three years was too short for achieving sustainable results. Reports pleaded for an extension of project duration to five to ten years (EEC-1; USA-7,8,9; NL-4); It can be concluded that the design and implementation of projects are part of a single learning process. Objectives need to be flexible enough to be altered when evaluation indicates that sustainability may be in danger. Evaluation procedures must be put in place at the outset to gather information about preferences, results of funded activities and alternative resources (CH-6; NL-6; USA-3,7,)
- **implementation of the project.** There was an indication in the sustainability papers that management must strive for institution building by trying to involve all interested parties at all levels in the

project cycle, and through training (NL-4; USA-1,6,7,8,10,EEC-1, DPMC). Reports state that training is an important component in sustainability, but care has to be taken that newly-trained staff can be paid, supervised, and continue to work in the profession for which they were trained.

Of importance during implementation is also co-**ordination between the donor office and the field office of the donor.** USA-7 relates the stifled relationships between the Gambian Ministry of Health, the USAID head office, the contractors of the project and the USAID mission. All parties had different interests in the project which were not mutually supportive. In the end: *"Unresolved and conflicting AID Washington and Field Mission agendas stifled efforts to maintain a successful development programme" (USA-7).*
NL-4 reports a similar incident where strained relationships between the field office/project coordinator on the one hand, and the desk office in the Netherlands on the other, greatly contributed to the collapse of the project;

## 2.5 Conclusions

It appears that donors have an increased awareness regarding the need for more appropriate information for the planning stage. This includes socio-economic data, and information about the recipient country's health system, management capacity etc. Unfortunately, planning procedures do not always allow for such thorough planning. Host countries' MoH, Ministry of Finance and Planning should be involved.

A problem is the change of orientation which health projects have taken from clinical medicine to community orientation (where there is little experience). The greatest lack of experience is in planning **with the population.** Donor's planning procedures are such that objectives are set and resource allocations made before the people's felt-needs are heard. Re-orientation of the programme, once these are known, is often difficult. No budget allocations have been made for this, and the project loses credibility.

It goes without saying that planning PHC projects is a time-consuming exercise and that, therefore, the most important recommendation is **to allocate enough TIME for a thorough planning phase.** A relationship between planning and sustainability was shown. Duration of the project also influences sustainability.

If donors' routine procedures concerning the project cycle do not allow for a long planning phase, then ways should be found to collect baseline information during the early implementation phase, or to allow sufficient time in implementation to start with only few interventions and gradually increase. Pilot projects can also be started with.

Time and methods should be found so that the population's felt-needs are known, and the community's active participation can be achieved. This is essential for future implementation and sustainability.

Local health personnel can be helpful in this respect, as experience in a number of projects has shown

(IADB-4, NL-6). Methods used in PHC projects to make "rapid rural appraisals", or "etudes de milieu", should be studied and interchanged.
It is also essential to involve social scientists in project formulations, encourage participation of local policy-makers, and (especially in cultures where women are excluded from public life) find women with special expertise regarding the role of women in development.

Flexibility of project design and resource allocation, and the inclusion of other than purely numeric indicators of progress, are needed.
In the process of planning, a design for monitoring and evaluation of the project should be made, which is realistic, acceptable to local policy-makers, and relevant to the people concerned. This was rarely done in the reviewed projects.
Donor-supported evaluations rarely involved the population, and self-evaluation and monitoring seldom took place. Nevertheless, in many developing countries, experience is being gained with community-based, and participatory monitoring and evaluation methods.
Where monitoring and evalution is proposed or carried out at all, it is mainly of output data in quantitative terms. Although these figures satisfy the provider of financial inputs, the relationship of these figures with improved health is not sure, and rather depends on the quality of the services provided, the knowledge of the population in regards with the interventions, the logistic support, and, in regard with sustainability, the resource allocation for maintenance and recurrent costs of the programme. More thought should be given on how to evaluate these process factors systematically.
Longlasting, sustainable impact of interventions depends on these, and not on coverage when dependant on foreign inputs.To sustain vaccination coverage, hosts countries will have to allocate resources and maintain logistics. Proper treatment of diarrhoea will depend more on the mother's knowledge than on the fact whether

she received a package of ORS. As for the measurement of quantitative indicators for monitoring child survival household surveys will be needed anyway, it would be advisable to include process factors like attitudes, behaviour, acceptability and participation in the evaluation.

As evaluations were not carried out in a systematic way, it cannot be decided whether PHC efforts of the past years have been a success or failure.
More evaluation with appropriate, standardized methods will be necessary. Development of a health aid compendium, similar to the DAC compendium on project evaluation, or the WHO minimal evaluation procedures for water-supply and sanitation which could serve for donor agencies and host countries to give guidelines on health project evaluations could help to achieve more comparability.
The main problem in implementation is how to integrate other sectors into a health project when there is no budget allocation for it. It can be assumed that the following factors play a role:

- PHC projects are usually formulated by medical people, with counterparts of the recipient MoH. Project orientation is therefore medical, and planned resources are allocated to the medical sector;
- the community, and especially the women, usually have other priorities besides health, but they are not consulted in the planning phase. If this happens during implementation, there is often no budget allocated for intersectoral activities.
- in regard with sustainability the main conclusions are: project duration (extension to 5 to 10 years), planning for recurrent costs, flexible design, monitoring of indications for future sustainability, co-ordination between field-office and donor office and inclusion of a training component in view of future take-over influence sustainability positively.

# 3. THE FUTURE ROLE OF DAC MEMBERS

## 3.1 Summary of conclusions of the synthesis and the Paris meeting

### 3.1.1 The Context of PHC

It has been a brief ten years since donors and host countries agreed upon a new approach in health care. This approach would demand active participation of the community, it would strive for equity, shift the focus from curative to preventive, utilise more appropriate technology and stimulate inter-sectoral cooperation.

As this new philosophy was converted to practice, unanticipated challenges emerged for donors and recipients at all levels of intervention.

A number of projects were well-established prior to 1978 as hospital or basic health services, or as vertical disease control programmes. Following the Alma-Ata Conference, PHC components were hastily added with minimum thought to the important principles underlying the concept. As could be expected in the first years of any new initiative, translating principles into viable and sustainable activity was difficult. Those responsible for planning and implementing PHC had their fair share of frustrating experiences.

In spite of difficulties, the PHC strategy was reaffirmed by member countries at the WHO conference in Riga by member countries, and donor countries endorsed the continuing validity of the PHC - concept at the DAC PHC meeting in Paris.

From the documents sent by DAC members, it is apparent that donors are gradually shifting from curative and hospital-based services to community-oriented preventive activity.
DAC members agreed at Paris that PHC should at least include, besides health activities, education, nutrition, family planning, water and sanitation.

It can also be observed that some donors are more interested in selecting particular interventions as a focal point for their efforts while other donors concentrate on the processes through which those interventions might be accepted. In regard to sharing of interpretations of the PHC philosophy, information and other resources, inter-donor cooperation and co-ordination remains weak.

Of all PHC principles, the inter-sectoral approach has been least developed. Although communities do not think in terms of sectors, and often have priorities other than health, national governments and the donor community have so far shown little capacity to shift from sectorally thinking of health as a medical problem to thinking of health as part of development.

It must be recognized that there is a tremendous difference between the former top-down approach to providing health care services, and the horizontal, bottom-up approach, where the community takes increasing responsibility for the design and implementation of their own health system. The adaptation toward PHC requires not only a shift in activity, but more importantly, a shift in attitude. This shift in attitude means reassessing the high status traditionally associated with medicine in its curative capacity. It means a shift from vertical, disease oriented, programmes towards horizontal programmes aimed at strengthening of systems capable of providing essential

elements of PHC and this way supporting the solutions of problems which communities themselves identify.

Donors recognized in Paris the occasional need to respond urgently to acute problems, but agreed that these responses should not impede the long-term development of PHC.

This requires accepting not only that a healthy population will be economically more productive, but accommodating the reality that a healthy population is likely to demand a fair share in the development process. This is a philosophy and a way of life unfamiliar to most industrialized and developing societies. Adaptation takes time.

**Thus, an important conclusion is that the TIME required for countries and communities to translate philosophy and principles into action cannot be replaced by financial or other inputs from donors who are anxious for quick results. PHC is a process which can absorb foreign resources at a pace that depends on the community it strives to serve.**

### 3.1.2 The Project Cycle

Designing inputs to complement the process of Primary Health Care is also time-consuming and difficult. From the documents we received, it can be noted that proposals are rarely flexible enough to allow for changing conditions. Objectives and timetables, often committed to paper on a desk in Europe or North America, seldom accommodate the guarantee that the unexpected will occur. For those projects designed within a host country, formulation is often done by members of the medical profession without managerial or social science inputs. Overall, there is a lack of host country participation at the policy, planning and community level.

The most important point that becomes clear from an examination of the formulation and project reports, is that insufficient time and resources are committed to the planning phase.

Utilisation of relevant socio-economic factors in the planning phase is mentioned by many as a necessity, yet applicable data continues to be lacking.

Implementation of Primary Health Care requires appropriately trained personnel at all levels of a system. A common issue in the documents we received was the lack of such personnel, but there was also the recognition that training alone is not the answer. Curricula are not revised to accommodate changing needs. Medical schools and courses for training nurses remain weak in regard to community health and practical exposure to Primary Health Care. There has also been little consideration given to the recurrent cost burdens associated with training new staff as compared with re-training existing staff.

Community participation during implementation continues to appear as "window dressing" rather than active involvement and a serious transfer of responsibility to community members. And, it is clear that beneficiaries are more willing to participate in activities that yield immediate results.

Women in particular, (other than TBA training programmes), have not been given responsibility in planning and implementation of most DAC member support activities.

The resources and political commitment necessary to actualize greater inter and intra-sectoral co-operation during both planning and implementation remain inadequate.

During the implementation phase, there has been significant enthusiasm about extending Basic Health Service coverage by vertical activities. Such initiatives can support or undermine other community-based health activities, depending on the degree to which volunteer and/or traditional systems are complemented by this activity or whether these activities take place outside, and regardless of what is already there.

Similarly, communication between donor headquarters and regional or country offices is limited. Authorization of changes in protocol and procedures is difficult without regular contact. Policy-makers also lack the necessary PHC-orientation and experience.

There is a lack of standardized procedures to evaluate progress in PHC projects. With the re-orientation of the health sector, which previously could measure progress in numeric output terms, new experience has to be gained in the development and application of process indicators. Furthermore, the social sciences are given little consideration in the evaluation of community-based projects.

### 3.1.3 Sustainability of Primary Health Care

The reports have indicated a growing concern among DAC donors about the sustainability of health projects. However, the contradiction remains between many donors' health sector policies and self-reliance.

It appears from the reports that four major factors seem to be endangering sustainability and self-reliance:

- donor investment can in some cases lead, at host country level, to an increase in the need for personnel, organizational and material resources which are all in very short supply or unavailable after donor withdrawal;

- uncoordinated donor investments can lead to duplication, wastage of resources and other inefficiency in the national health care system;
- donor support in the health sector has created project structures which are poorly (and sometimes not at all), integrated into the health care system;
- donors' commitment to projects has in many cases been limited to the traditional 3-5 year project periods. These periods are too short to achieve sustainable results in Primary Health Care.

From the documents that focused on sustainability of health projects the following observations can be made:

- vertical programmes have not often been sustained beyond donor withdrawal;
- chances for sustainability increase as programmes are more integrated into the national health care system and/or built on existing structures;
- donor health policies have in the past caused temporary excitement over a particular approach or strategy (bandwagons such as: BHS/PHC/GOBI-FFF/Child Survival, etc.). Frequent changes in health policies have caused projects conceived and supported under previous policies to collapse;
- lack of decentralized authority (national/provincial/district/community and donor/host country counterpart) endanger sustainability;
- community-based financing can only provide a small percentage of recurrent costs requirements, yet successful community financing schemes indicate satisfaction with a given health system;
- there is often great enthusiasm in the ranks of MoH officials at the time of new initiatives. Yet, seldom is attention paid to who will ultimately be responsible for recurrent costs.
- external pressure created by adjustment policies have had a harsh impact on social welfare sectors,

and in particular on the newest initiatives such as PHC;

DAC members agreed that specific information is needed on the social impact of structural adjustment policies.

3.2 Recommendations

In order to give sustainable aid in the health sector, which is in line with PHC principles, donors will have to create more **flexible project designs**, allocating sufficient time and resources for a planning phase in which there is:

- systematic collection and sharing of relevant baseline data including information on people's felt needs;
- careful attention for the macro and micro-economic variables that will influence project financing. This must include a minimum period of the host country's development plan, and some suggest five year plans that are revised annually.
- close co-operation with Ministry of Finance and Planning (and all other relevant ministries) to insure that the proposed project design complements the host country's level of development and economic conditions.
- thorough calculation of recurrent costs, and identification of sources who have agreed to finance them;
- involvement of local policy-makers;
- involvement of the community, particularly women;
  a systematic involvement of provincial, district and local level representatives must include a mutually acceptable plan regarding responsibility for recurrent costs.
- involvement of social scientists;

It is advised that donors consider "starting small" in projects and expanding gradually as experiences grow. This may prevent resource wastage, and gradually increase community participation. While community involvement is increasing, other sectors will have to be included for which budgetary allocation for inter-sectoral activities is necessary
In order to fulfill this, the traditional identification and project formulation missions by consultants and experts will have to be replaced by an increase of pilot projects, action-research, or a combination of a planning and implemention period in which all parties involved formulate future plans, taking into account the available resources, manpower, and motivation of health staff.

In the implementation phase, care should be taken that **involvement of all parties** (the community and especially women, host country policy-makers of the levels involved, and health service staff,) is assured.
DAC members agreed that the **role of women** in health actions is crucial and that special efforts should be made to involve them in PHC development and implementation. An observed tendency to overlook problems and deaths in women, due to childbirth, should be corrected.

Support, especially to the **district level management** is necessary to help the decentralisation process, necessary for improved community involvement and adaptation to local needs. Methods for PHC management must be adapted to the national political, social and economic context and should be developed in partnership with a nation's government, its private sector and community groups, including traditional health systems.
**Re-training and re-orientation of health service staff** has proved to be necessary , as most health professionals continue to receive hospital-based, clinically oriented training.

To provide such management assistance, donors may need to **strengthen their own professional capacity** for managing aid programmes in the health sector.
Dialogue between donors and host countries can strengthen the **re-allocation of health resources** if donor's health sector policies explicitly strengthen PHC and reduce investments in specialist health care facilities.

In order to monitor this process, both by those in the field and by donor's headquarters, and to respond to needs which occur in the course of this process, it is necessary to **decentralize authority for decision-making from donor headquarters to the field.**
Furthermore, systematic interaction between qualified individuals representing donor and field staff is essential.

In periodic evaluations more attention will have to be paid to **process indicators** besides the customary, quantitative output indicators.
At community level these include: community participation and -organization, leadership, changes in knowledge and health behaviour, utilization of health resources.
At service level these involve: logistics, motivation and orientation of health staff, quality of services and support to community level.

There is **lack of standardized evaluation procedures** for health projects. Experience is scattered, and often not documented at all. Therefore the **development of a Compendium for Health Project evaluation** by the DAC Evaluation Committee, or a group of experts, is recommended.
The **development and use of above mentioned process indicators**, and methods for measuring them, equally deserves the attention of the DAC Evaluation Committee.

**Sustainability studies** must be initiated that focus on new, ongoing and ex-post Primary Health Care projects.

**Equity and quality of care should not be sacrificed to efficiency or cost recovery.** Drug revolving funds with the purpose of cost recovery should accord to the principles for good practice in drug use, developed through WHO's Essential Drug Programme.

**Donors should coordinate on international level** on how PHC can most effectively be planned/implemented, evaluated and sustained.
The rhetoric of increased donor co-ordination must be actualized. **A mechanism for regular communication** that transcends personality and philosophical differences could be instituted in the capital of every host country.
DAC members agreed the **recipients' capacity to fulfill the coordination function** should be improved. Coordination is particularly useful in a sector frame work: the use of plans and reviews for co-ordination purposes.
WHO should take a more active role in field co-ordination, for which their professional management at field levels should be improved.

A number of unresolved questions remain some of which can be suggested for more research to be supported by donors in developing countries.

## 3.3 Research needs.

### 3.3.1 Policy Formulation Research.

We know that Health Systems Research has produced extremely useful information for policy makers. Project sites, such as Matlab in Bangladesh, Narangwal in India, and the ASEAN Training Centre for PHC Development of Mahidol University in Thailand (JA-1) have all provided important information or raised additional relevant questions. Research institutes (whether linked with universities, ministries or independent) have the potential to contribute answers to the many questions being asked by policy-makers and managers.

For the formulation of policies in the health sector which are based on PHC principles, the following questions remain open:

- what is the most appropriate mix of financing inputs within different project and programme context? (i.e. increased or decreased user fees, collective/ insurance financing, changes in commitments between curative and preventive services, shifts between private and public sector, changing focus from urban to rural, etc.);
- what is the cost effectiveness and sustainability of integrated vs. vertical, or matrix designs?

### 3.3.2 Operational Research

Operational Research has become an important tool that health and health-related professionals have utilized to improve health systems. By applying analytic techniques to programme activities, operational research can offer managers the information they need to effectively introduce innovations and improvements in a given programme strategy.

A research component, built into a PHC programme at the onset, can easily yield scientifically sound answers to a broad variety of relevant questions facing decision-makers. Simple operational research can also be introduced throughout a project cycle, that produces results which can be applied directly to strengthen the health system in which the study is being carried out.

Despite the knowledge that research can play a critical role in defining strategies that are most acceptable, affordable, accessible and respect the underlying principles of PHC, very few projects have integrated this component within their activities.

Examples of issues that can be clarified by use of operational research are:

- which methods and information systems can be developed to ensure **maximum involvement of community members** in planning, evaluation and monitoring in a particular cultural and political setting;
- how can **community-based monitoring and information systems** offer relevant and valid data for decision-making;
- which **appropriate methods for rapid appraisal** can be developed with which a situation analysis is obtained with maximum input from local health personnel and population;
- is the **use of Village Health Workers and Village Health Committees** an effective way of ensuring acceptability of health interventions?
- what are the most **appropriate criteria and tools for measuring sustainability** in integrated Primary Health Care projects?
- which **appropriate methods for sustainability studies** of integrated Primary Health Care projects can be developed;
- do **"sliding scale" fees for service** create more or less of a burden for women and other vulnerable groups than a "flat rate" fee?

- what is the **optimal sustainability and cost recovery of community based drug revolving funds**, and how do these funds address the issue of equity? DAC members agreed that operational research into the **Bamako initiative and the Free Card Scheme** in Thailand needs particular attention.

DAC members also agreed that operational research is necessary to help governments design appropriate strategies, and systems for management and evaluation of PHC programmes, taking into consideration complex inter-sectoral factors.

Lastly, they agreed there is a need for operational research into social impacts of structural adjustment policies.

The research question will then be: What can DAC members do to insure that structural adjustment policies do not create additional pressure on the health and health-related sectors, especially for the poorest sections of the population?

3.4 Discussion points.

The following points remain open for discussion:

- Donor countries seem to be developing their ideas about PHC much in isolation from host countries. They are often in a hurry to start a PHC project. Is it possible to adapt the project cycle to accommodate the special needs for PHC (process indicators, community involvement in planning, inter-sectoral approach, respect for recurrent costs burdens), in co-ordination with the host country and community, and more specifically,how are donors going to do it?

- lack of donor co-ordination appears often at host country level. Competition for the "juicy slices of the pie" often leads to redundant vertical programs. Furthermore, different approaches create confusion at all levels of the recipient country.

Some approaches yield quick but temporary results. Other approaches strengthen capacity over longer periods of time. How can donors share equally in the process of planning PHC at the recipient country level?

## 3.5 Conclusion

This synthesis paper has led to conclusions indicating serious constraints remain in the design and implementation of Primary Health Care. Despite the challenges, donors appear undaunted in their belief that the principles of PHC can be realized. Evidence of this belief lies not only in the documents we have received but in the very request by DAC members for this special meeting to share experiences and to strive for consensus.

This consensus was achieved in a re-affirmation of the PHC principles, a commitment to put them into practice, and a pledge for improved coordination.
We hope this paper provided and will continue to provide a stimulus to achieve this consensus and to enhance further co-ordination and continued support.

Appendix 1

**List of abbreviations**

| | | |
|---|---|---|
| ADB | - | Asean Development Bank |
| AFB | - | African Development Bank |
| BHS | - | Basic Health Services |
| CDD | - | Control of Diarrhoeal Diseases |
| CHW | - | Community Health Worker |
| CIDA | - | Canadian International Development Agency |
| DANIDA | - | Danish Agency for International Development Aid |
| EEC | - | European Economic Community |
| EPI | - | Expanded Programme of Immunisations |
| FINNIDA | - | Finnish Agency for International Development Aid |
| FP | - | Family Planning |
| GOBI(FFF) | - | Growth monitoring, Oral rehydration, Breast feeding, Immunisation (Family planning, Female education, Food supplements) |
| GTZ | - | Gesellschaft für Technische Zusammenarbeit |
| IADB | - | Inter American Development Bank |
| MCH | - | Mother and Child Health |
| MIS | - | Management Info Systems |
| MoH | - | Ministry of Health |
| NHS | - | National Health System |
| NGO | - | Non Governmental Organisation |
| ORS | - | Oral Rehydration Salt |
| ORT | - | Oral Rehydration Therapy |
| PHC | - | Primary Health Care |
| SIDA | - | Swedish International Development Authority |
| TBA | - | Traditional Birth Attendant |
| ToR | - | Terms of Reference |

| | | |
|---|---|---|
| UNDP | - | United Nations Development Fund |
| UNICEF | - | United Nations Children Education Fund |
| USAID | - | United States Agency for International Development |
| VHC | - | Village Health Committee |
| VHW | - | Village Health Worker |
| WHO | - | World Health Organisation |

Appendix 2

## Methodology

Between October 1987 and April 1988, 76 evaluation reports were received from 10 DAC member countries, (Australia, Canada, Denmark, Finland, France, Japan, The Netherlands, Sweden, Switzerland, The United States and West Germany); 4 development banks (ADB, ADF, AIDB, and the World Bank); and background documents from DAC, EEC, UNDP and WHO. The analytic process of synthesizing these documents and extracting recommendations for DAC members required five steps.

**Classification of Documents (appendix 5)**
Following a request to all DAC member countries to send evaluation reports that reviewed PHC projects, the first step was to classify the reports into three broad categories.

- In the first, and largest, category, were those evaluation reports which reviewed a single (or a small number of) health project(s) supported by a single donor in a single country. In this category, 44 reports were received from ADB, Australia, Denmark, Finland, France, IADB, Japan, The Netherlands, Sweden, Switzerland The United States, and West Germany.

- The second category contained evaluation reports that offered a single country health sector review. These are reports that review progress and problems as a basis for establishing or revising health policy. There were 15 reports in this category submitted by France, The Netherlands, Sweden, Switzerland, The United States and West Germany.

- The third category included those reports that reviewed synthesis documents of health projects in more than one country. In this category, there were 17 documents, contributed by the Australia, Canada, DAC, EEC, Finland, IADB,

The Netherlands, UNDP, The United States and The World Bank.

**Matrix** (appendix 6)

Once the incoming documents had been classified, a more detailed analysis began with a focus on the single project/-single donor reports. A 500-1000 word summary was written for each document and a matrix was developed for cross-referencing the reports. In this matrix of single-donor supported health projects, the following dimensions were noted for each of 44 projects:

- location of project;
- duration of activity;
- type of support;
- implementing body;
- type of evaluation/appraisal (ex-ante/mid-term/ex-post);
- evaluation procedure;
- population covered;
- program elements; and
- program activity.

The majority of projects under review were in 23 African and Asian Countries, and had been initiated in the late 1970's. There were 8 project sites in Latin America.

**Checklists**

The next step in the analysis involved further description of single project/single donor orientation in specific relation to the principles of PHC. Stated objectives, the process by which project elements were introduced and the focus of activities, were analysed according to the degree to which they were in line with the basic principles of PHC as defined at the Alma Ata conference ( i.e. equity, community participation, prevention, appropriate technology, and inter-sectoral cooperation).

As part of this procedure, each evaluation document was further categorised according to the level at which project activity was focussed.

The categories that were used for this purpose included national, regional/district and community levels.
For each of these levels, a checklist was applied to further examine the relationship maintained by each project with respect to the overall health system.

The checklists were fairly easily applied to the single project/single country reports. On the other hand, in assessing those health sector evaluation documents which reviewed multiple projects with activities in several countries, the checklists could not be applied.

**Selection of Issues**
Once the summary and classification of documents was complete, specific issues were selected for more detailed analysis. Every major issue that was recorded in the discussion- or recommendations section of the evaluation reports was noted and a short list was developed. Nine issues were selected in this way and presented at a meeting in of the DAC evaluation committee in Paris during February 1988.

**Format of the Synthesis paper**
Once issues had been accepted by DAC as the basis for the synthesis, the paper was divided into four major sections:
- The Institutional Context of PHC;
- The Project Cycle;
- Sustainability of PHC;
- The Role of Donors.

As many aspects of sustainability appeared to apply to either the institutional context of PHC or to the project cycle, the chapter on sustainability was finally integrated into the first two chapters.

Within this broad framework, a number of other issues have been integrated including:
- National Health Systems;
- The Role of Women;
- Bottlenecks in Planning and Implementation;

- Inter-Donor Coordination;
- Monitoring and Evaluation of PHC;
- Cost-Analysis;
- Issues to be Further Examined by Operational Research.

The paper includes a synthesis of the reports received, as they relate to each other and to the major issues mentioned above. Points for further discussion during the September DAC meeting were presented in the final section. Under this heading general conclusions are drawn, questions are raised for further discussion, specific needs are identified regarding operational research in PHC, and recommendations for the future role of DAC members are offered.
In the final version of the paper, comments of DAC members on the first draft were included, and background material circulated at the DAC meeting in Paris was added.
This added material consisted of 4 policy documents, 5 sector evaluations, the WHO reports and another background paper for the meeting, written by DAC consultants (DAC(88)3).

**Limitations of Analysis**

- The greatest limitation of a systematic analysis of DAC member countries' contribution to PHC has been the diversity of project activity and the wide range of evaluation methodologies used. Some DAC members sent synthesis reports about many projects or about national health policies in relation to PHC. Some projects operated on a national scale, while others initiated activity at the district or village level. Projects ranged from vertical disease control projects, to support for national health systems to community-based integrated health projects. Evaluations were carried out by individuals, external teams, multilateral parties and, in some cases, the composition of the team and/or the description of the methodology used was not mentioned at all. This has made comparison very difficult.

- Another significant limitation of our analysis was the wide range of interpretations given to the concept of PHC, not

only by different donors, but by different evaluation teams and sometimes by individual members within a team.

- Yet another limitation, (and likewise difficult to circumvent) occurs in the sample of evaluation reports used in the synthesis. We do not know the size of our sample or the rationale behind a donor's decision to send the material they sent. Although the same letter went out at the same time to all DAC members, some were quick to respond, some slow and others did not respond at all.Those members that have given substantial support to PHC were more likely to have evaluation documents available immediately, while those members who have been less supportive (and who might benefit most from such a synthesis) found it difficult to contribute. In this way, it is possible that the issues discussed are not fully representative of the needs of DAC members.

Appendix 3

**Glossary**
Important terms from WHO/DAC glossaries

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Adequate:
Proportionate to requirements.

Appraisal ex ante:
The critical examination of the identification report, which selects and ranks the various solutions from the standpoints of:

- relevance
- technical, financial and institutional feasibility;
- socio-economic profitability.

Approach:
A means or method of attaining an objective or target.

Audit:
Determining whether, and to what extent, the measures, processes, directives and organizational procedures of the donor, and its missions in the Third World, conform to norms and criteria set out in advance.

Auxiliary worker:
One who has less than full professional qualifications in a particular field and is supervised by a professional worker.

Basic health services:
A network of institutions run by the government as part of the country's administrative system that provide certain indispensable medical care and preventive services to individuals. The services are rendered by professional and non-professional staff who have been selected without prior consultation with the community they serve, and the community itself is not necessarily involved in the action taken to improve its health. Moreover, basic health services usually start from the centre and extend out to the periphery;

they do not necessarily attempt to identify and use appropriate health technology and they do not concern themselves with the socio-economic aspects of health and the related intersectoral action.

Capital expenditure in health:
Expenditure on land, buildings, and initial equipment and supplies to establish or extend health facilities such as health centres, laboratories and hospitals.

Community health workers:
Trained health workers who live within the community and work with other health and development workers as a team.

Community participation/involvement:
Active involvement of people living together in some form of social organization and cohesion in the planning, operation and control of primary health care, using local, national and other resources. The term involvement is preferable to the term "participation".

Cost-benefit:
A form of economic analysis that takes into account the benefits and costs in commensurable and actual monetary values and arrives at a single index to determine the value of a project.

Cost-effectiveness:
An economic or social cost-benefit analysis that quantifies benefits without translating them into monetary terms. This type of analysis allows one to select among alternative activities the one that will accomplish the objective at the least cost.

Cost-efficiency:
The extent to which the resources are being used as well as possible, for example in terms of the amount of adequate services provided in relation to the cost.

Criterion
A standard by which something is judged. It may be technical or social.

Development objective:
The reason for a programme or project, or the basic objective of producing the outputs.

Effectiveness:
A measure of the extent to which an aid programme attains its objectives.

Efficiency:
An economic term which means that the aid uses the least costly resources necessasry to achieve its objectives. In other words, the aid can gain the most results for its economic contributions.

Evaluation:
An examination as systematic and objective as possible of an on-going or completed project or programme, its design, implementation and results, with the aim of determining its efficiency, effectiveness, impact, sustainability and the relevance of the objectives. The purpose of an evaluation is to guide decision-makers.

Ex-post evaluation
Evaluation of an intervention after it has been completed. Its purpose is to study how well the aid served its purposes, and to draw conclusions for similar interventions in the future.

External evaluation:
An evaluation of an aid action by persons outside the central organization that is giving the aid.

Financial control:
Verifies if financial documents are exact, whether expenses have been authorized and recovered, and whether they conform to rules and contracts.

Goal:
General aim towards which to strive, for example to have an environment which is conducive to health or to have primary health care available to everybody.

Health system:
The complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places, and communities, as well as in the physical and psychosocial environment and at health related sectors. A health system is usually organized at various levels, starting at the most peripheral level, also known as the community level or the primary level of health care, and proceeding through the intermediate and central levels to the central level.
A comprehensive health system denotes one that includes all the elements required to meet all the health needs of the population

Identification:
A technical activity which , via the completion of feasibility studies, determines the alternative methods and approaches for aid interventions. These feasibility studies cover the technical, financial, social and institutional aspects.

Impact:
A term indicating whether the project has had an effect on its surroundings in terms of technical, economic, socio-cultural, institutional and environmental factors.

Incorporated, built-in evaluation:
An approach to implementation that involves fairly continuous self-evaluation by principal actors and participants, according to pre-established criteria related to the purpose and goal. Usually included in the project plan during the design stage and given funding as part of the project.

Indicators:
Variables that help to measure changes directly or indirectly and to assess the extent to which the objectives and targets of a programme are being attained.

Input:
The means by which the aid is provided. The set of means (resources and activities) to be mobilized to produce the output.

Inspection
A management function in which a special on-the-spot investigation is done, sometimes unexpectedly, in order to resolve problems which may or may not have been detected earlier.

Intangables:
Costs and benfits which are thought to be pertinent but which cannot be measured and which therefore cannot be included in the economic analysis. These costs/benefits are taken into account by sociological analysis as one example.

Internal evaluation:
Evaluation of an aid intervention by the central oraganization which gives the aid.

Logical framework:
Management tool consisting of a set of interlocking concepts which must be used together in a dynamic fashion to permit the elaboration of well-designed, objectively described and evaluable (programme or) project. It makes it possible to summarise the elements of a programme or project (inputs, ouputs, purpose, goal), the cause-and effect relationship among the operational aspects (resources, activities, outputs) and development consideration (purpose, goal), and thus facilitates planning, execution and evaluation of a programme or project.

Management:
The sum of the measures taken to plan, organize, operate, and evaluate all the many interrelated elements of the system.

Mid-term evaluation:
An evaluation carried out during implementation. Its principal goal is to draw conclusions for administering the project. Sometimes referred to as "on-going" project evaluations.

Monitoring
A management function which uses a methodical collection of data to determine whether the material and financial resources are sufficient, whether the people in charge have the necessary technical and personal qualifications, whether activities conform to work plans, and whether the work plan has been achieved and has produced the original objectives.

National health policy:
A set of decisions to pursue courses of action aimed at achieving defined goals for improving the health situation.

National strategy:
Lays down the broad lines of the action required in all the sectors concerned to give effect to the national health policy and indicates the problems and ways of dealing with them.

Objective:
The end result a programme seeks to achieve.

Operational objective:
The immediate reason for a programme or project. An objective is similar to the quantifiable and measurable aspect of an objectively verifiable indicator in the Log Frame approach. In this broad sense, there can be objectives for inputs, outputs, purpose and goal.

Outputs:
The result of the aid. The set of concrete results to be produced through sound management of the inputs.

Intermediate results necessary to achieve the purpose. Goods, services produced or directly controlled by the programme personnel.

PHC-approach:
The establishment of a health system as described in the Alma-Ata conference, with PHC as the central function and main focus supported by the rest of the health system.

Process evaluation = evaluation of procedures:
The evaluation of a permanent administrative function, in which the administration plays a supporting role; at community level process evalution involves the changes brought about in social structure, believes, economics through the interaction between project and community.

Programme evaluation:
Evaluation of aid actions of several kinds and in different economic sectors which converge to attain the same development objectives.

Programme:
An organized aggregate of activities directed towards the attainment of defined objectives and targets, which are progressively more specific than the goals to which they contribute.

Project:
An aid action or of activities integrated to attain designated goals, in a determined time span, and following an established plan of action.

Recurrent expenditure
Covers items that recur year after year, such as the tenumeration of health workers and other staff, the cost of food and other goods and services, the cost of vaccines, medicines, the replacement of equipment and the maintenance of buildings and equipment.

Relevance:
The degree to which the needs and social and health policies and priorities are met.

Sector evaluation:
Evaluation of a variety of aid actions all of which are located in the same economic sector.

Self-care:
Largely unorganized health and health-related decision-making carried out by individuals, families, neighbours, friends and workmates. These include the maintenance of health, prevention of disease, self-diagnosis, self-treatment, including self-medication, and self-applied follow-up care after contact with the health services.

Self-evaluation:
An evaluation by those who are administering a programme or project in the field.

Self-reliance:
The initiative of individuals, communities and national authorities in assuming responsibility for their own health development, adopting measures that are understood by them and acceptable to them, knowning their own strengths and resources and how to use them and knowing when and for what purpose to turn to others for support and cooperation.

Self-sufficiency:
Depending solely on one's own strengths and resources.

Sustainability:
The extent to which a project is able to deliver an appropriate level of benefits for an extended period of time after major financial management and technical assistance from an external donor is terminated.

Target:

An intermediate result towards the objective that a programme seeks to achieve. It is more specific than an objective and the period within which it is to be attained is usually specified. It also lends itself more readily to being expressed in quantitative terms.

Technical control:

A management function to determine if materials conform to technical specifications and to international norms in effect.

Appendix 4

**List of documents received**

ADB-1: **Project Performance Audit Report Sha Tin Hospital-Polyclinic Project in Hong Kong**, 7/85.
hospital-clinic, audit report, hospital construction + equipment Hongkong;

ADB-2: **Project Performance Audit Report Kent Ridge Hospital-Polyclinic Project**, 5/86.
hospital-policlinic, audit report, academic hospital + improvement medical training;

ADB-3: a. **Technical Assistance to Malaysia for the Health Services Development Project**, 12/85;
b. **Appraisal of the Health Services Development (Sector) Project in Malaysia**, 11/86.
appraisal report of nation wide project to extend coverage, improve management and information system;

ADB-4: **Appraisal of a Second Rural Health Services Project in Papua New Guinea**, 10/85.
rural health services, Papua New Guinea; includes PHC units + water supply + training, TBA training, logistics; nationwide;

ADB-5: **Appraisal of the Third Health Project in Pakistan**, 10/87.
preparatory document for 5 year health + population plan, in Pakistan, outlining the result of a formulation mission;

ADB-6: **Technical Assistance for the Health and Population Project in Indonesia**, 11/83.
project formulation document; country: Indonesia;

ADF-1: **Project Performance audit Report on the Development of Health Services Project, Kingdom of Lesotho**, 8/87.
project performance audit report by the ADF on the EPI programme in Lesotho;

AUS-1: **Acute Respiratory Infection (ARI) Research Project, bohol: project review report**, 2/87, Research Institute for Tropical Medicine (RITM), Ministry of Health and Australian Development Assistance Bureau (ADAB), Dept. of Foreign Affairs.
evaluation of one project by one donor in one country (Philippines), Acute Respiratory Infection Research Project;

AUS-2: **Eastern Islands Provincial Diagnostic Laboratories: project evaluation summary**, 9/82, ADAB.
project evaluation summary of Australian support for a provincial livestock department in Indonesia;

AUS-3: **Voluntary Medical Aid Support (Gull Force): project evaluation summary**, 3/82, ADAB.
an ex-post unilateral evaluation of an Australian bilateral and charity funded hospital support project in Indonesia;

AUS-4: **A Profile of the Health Sector in Australian Development Assistance**, 9/86, ADAB-Sectoral Studies Section.
(synthesis reports of health projects) a synthesis of 45 bilaterally funded Australian projects in 14 countries, providing training, infrastructure, curative services, family planning and nutrition;

AUS-5: **The Health sector in Australia's Aid Program.**
Revieuw of Austrialian aid in the Health Sector with analysis of the reasons for relatively low priority for health and recommendation for improvement of health aid;

AUS-6: **Healthier, wealthier, wiser?** AIDAB'S health sector strategy one year later shows improvements in Australia's Health Sector strategy with focus on PHC and "Women and their children's Health" (WATCH);

CAN-1: **Bilateral Information Feedback System (BIFS) Corporate Memory, Lessons learned - health**, 6/86, Canadian International Development Agency (CIDA).
policy document Canada;

CAN-2: **Development - Health**, summer/85, magazine published by CIDA.
magazine on health care Canada;

CAN-3: **Sharing our future Canadian Development Assistant Policy document on CIDA's Development Asssistance.**
Includes all sectors, both governmental and non-governmental;

CH-1: **Report on the Evaluation Mission "GMIM Health Services, Minahassa, North Sulawesi"**, 1985.
support for a provincial hospital and health centres with growing PHC component;

CH-2: **Evaluation of the ORT Extension Program (OTEP), Phase 2 (1983/1986) of the Bangladesh Rural Advancement Committee (BRAC)**, 1986.
a review of the Oral Therapy Extension programme of BRAC with recommendations for integration with other child survival activities;

CH-3: **Evaluation of the Swiss Funded Health Projects in Tanzania**, 1987, Swiss Development Cooperation.
evaluation of 6 Swiss funded health projects in Tanzania. Projects content: laboratories, NTP, hospital, research, dispensaries;

CH-4: **Projet d'Amélioration des Services de Santé de Base dans les Cercles de Bougouni Yanfolila et Kolondieba,** 1984, Bamako, Mali, Swiss Development Cooperation.
evaluation of one project addressing PHC activities, one donor in Mali;

CH-5: **Assistance Médico-Sanitaire au Benin 1982-1984,** Swiss Development Cooperation.
evaluation of PHC project in Benin, one donor, many PHC activities in two districts;

CH-6: **Reflexiones a Base de l'Evaluacion de 4 Proyectos de Salud de la Cruz Roja Suiza en Bolivia y Paraguay,** 1984, Direccion de Cooperacion al Desarrollo del Gobierno Suizo.
evaluation of 4 PHC projects in 2 countries, one donor;

CH-7: **Health Policy and Donor Support in Tanzania,** 11/87, Swiss Development Cooperation.
sector evaluation report on health policy and donor support in Tanzania;

D-1: **Tanzania/DANIDA Dental Health Programme: Review and appraisal report,** 3/86, Danish International Development Agency (DANIDA).
review and appraisal of the DANIDA dental health programme in Tanzania;

D-2: **Expanded Programme on Immunization: review report,** 2/85, DANIDA.
evaluation of EPI programme in Tanzania/Zanzibar by Denmark;

D-3: **Essential Drugs Programme: joint evaluation report,** 3/85, DANIDA.
evaluation of essential drug programme in Tanzania/Zanzibar by DANIDA;

D-4: **Kenya Expanded Programme on Immunization (KEPI), Ministry of Health, programme evaluation,** 2/84, DANIDA.
evaluation of EPI in Kenya, Danish government;

D-5: **Health Care and Family Welfare Project, Tamil Nadu: report on final evaluation, Vol. 1: summary and main report, Vol. 2: appendices,** 8/86, DANIDA.
evaluation report, of one project in one country, 2 districts, mainly MCH; Danish financed;

D-6: **Health Care and Family Welfare Project, Madhya Pradesh: report on final evaluation, Vol. 1: summary and main report, Vol. 2: appendices,** 8/86, DANIDA.
evaluation report of one project in 8 districts of one state in India, mainly MCH;

EEC-1: **Proposal for Basic Principles: Derived from an Evaluation of ACP-EEC Health Projects and Programmes**, 9/87.
synthesis report health projects in 23 countries, discussing policy and management issues; EEC donors;

FIN-1: **TB-Control Programme, Report of the evaluation mission**, 11/83, Ministry for Foreign Affairs, Finnish International Development Agency (FINNIDA).
tuberculosis project in Somalia;

FIN-2: **Finnish Development Cooperation in the Health Sector**, 1987, FINNIDA.
policy booklet FINNIDA;

FIN-3: **TB-Control Programme in Somalia, Report of the evaluation mission**, 7/87, FINNIDA.
tuberculosis project in Somalia;

FIN-4: **Finland Primary Health Care Programme in Western Province of Kenya (Phase II), Report of support mission**, 4/87, FINNIDA.
district health survey, role of Kenya's district health management team;

FRA-1: **Evaluation du Système Malien de Formation Médicale: Son Adoption aux Objectifs du Système de Santé**, 9/84, Ministère des Relations Extérieures.
intern evaluation report on the training of MD in relation to tasks in Mali;

FRA-2: **Evaluation du Système de Formation Médicale au Sénégal**, 7/86, Ministère de la Coopération.
evaluation by France of Senegalese health system + training doctors;

FRA-3: **Evaluation Socio-économique du Centre Hospitalier de Sokode au Togo: Conclusions**, 5/83.
describes functions, recurrent costs and population served of a regional hospital (built in 1975). the hospital has little role as referral or support centre of the region;

FRG-1: **Learning from Mistakes: 9 Years of Evaluating Project Reality, Findings and Conclusions**, 6/86, Federal Ministry for Economic Cooperation.
- cross-sectional analysis of evaluation reports of 6% of development projects,
- study of audits + progress reports.
  Type of projects: 262 development projects of different sectors, among which 10 health projects, addressing operational issues;

FRG-2: **Bericht: über die gemeinsame Evaluierung UNDP/WHO/BMZ in ausgewahlten Ländern zur Förderung von Basisgesundheitsdiensten (Human Resource Development for PHC),** 1/84.
multilateral evaluation of human health resource development, in particular for health sector + PHC, in 6 countries;

FRG-3: **Querschnittsanalyse: Projekte der Primären Gesundheidsversorgung,** 3/84, Bundesministerium für Wirtschaftliche Zusammenarbeit.
synthesis report of 14 monolateral and 5 multilateral evaluation reports of PHC projects + programmes; projects take place in 14 countries;

FRG-4: **Inspektionsbericht des Projektes der Hanns-Seidel-Stiftung: Förderung des Ländlichen Gesundheitswesens in der Sous-Region Nord-Ubangi/Zaïre,** 6/84, Bundesministerium für Wirtschaftliche Zusammenarbeit.
rural health Zaïre, support for PHC activities in a subregion;

FRG-5: **Deutsche Gesundheitsprojekte im Staate Santa Catarina der Föderativen Republik Brasilien,** 11/85, BWZ.
health infrastructure in a district in Brasil + rural water supply;

FRG-6: **Krankenhausprojekten in der Republik Korea: Finanzielle Zusammenarbeit,** 3/86, BWZ.
evaluation of hospital project Korea; the evaluation is analysing the objectives with PHC oriented criteria;

FRG-7: **Aufbau von Basisgesundheitsdiensten in der Republik Korea,** 1/86, BWZ.
sector evaluation Basic Health Services, Korea;

FRG-8: **Ländliche Regionalentwicklung Al Mahwit: Pilotprojekt für Erosionsschutz und Aufforstung in der Region Haraz, Basisgesundheitsdienst Amran,** 12/86, BWZ.
evaluation PHC units, Yemen;

FRG-9: **Distriktkrankenhaus Ntcheu in Malawi,** 7/86, BWZ.
evaluation district hospital, Malawi;

FRG-10: **How Useful are Rural Water Supply Programmes? - Joint FRG/UNICEF Assessment of UNICEF-assisted Rural Water Supply Projects in Bangladesh, Nepal and Burma,** 5/83.
evaluation UNICEF assisted rural water supply projects, Bangladesh, Nepal, Birma; includes health, nutrition + hygiene;

FRG-11: **Länderevaluierung Zaïre: Analyse und Perspektiven der Entwicklungspolitischen Zusammenarbeit mit der Republik Zaïre unter Besonderer Beachtung der Sektoren Landwirtschaft, Verkehr und Gesundheit,** 7/84, BWZ.
sector evaluation Zaïre;

IADB-1: **Annual Report on Operations Evaluation during 1986**, Office of the Controller.
evaluation of documents/project completion reports, ex-post evaluations by borrowers of IADB projects; some related to health: National Health Delivery Services + sanitation;

IADB-2: **Programa de Extension de los Servicios de Salud Publica Rural: evaluacion ex post**, 8/87, Office of the Controller.
evaluation of health project in Latin America by IADB; activity: construction infrastructure/training staff/MCH;

IADB-3: **Ex Post Evaluation of the National Health Services Program (Pronassa)**, 4/87, Office of the Controller.
evaluation of one project in Central America: construction of Rural Health centres + hospital emergency centres;

IADB-4: **Ex Post Evaluation rural Health Programme**, 4/87, Office of the Controller.
evaluation of one project in Latin America: loan for medical infrastructure + training of auxiliaries;

IADB-5: **Proyecto de Mejoramiento de Servicios de Salud: evaluacion ex post**, 6/87, Office of the Controller.
evaluation of one project in Central America: loan for construction of health infrastructure;

JA-1: **Asean Training Centre for Primary Health Care Development: Progress Report, Research Division**, 5/87, Mahidol University + WHO + Japanese Government, Salaya, Thailand (+ objective of the project, minutes of discussions).
evaluation of the research project and activities; operational research on different aspects of PHC is carried out;

NL-1: **Samenvattend rapport inzake Nederlandse activiteiten op het gebied van ziekenhuis-gezondheidszorg, 1975-1985**, 8/87, DGIS/IOV.
summary of Dutch activities in the field of hospital health care;

NL-2: **Samenvattend Rapport inzake Nederlandse Activiteiten op het Gebied van de Primaire Gezondheidszorg** (Synthesis Report on Dutch Activities in Primary Health Care), 10/87, DGIS/IOV.
synthesis report adressing 22 countries, discussing planning + operational issues, with special attention whether projects match Netherlands development strategy; Dutch + co-financed;

NL-3: **Health Care Delivery in Tanzania**, 8/83, DGIS.
Tanzanian health sector evaluation report by Dutch government;

NL-4: **Standaardgezondheidszorg PHC Senegal** (concept), 3/86, DGIS.
ex post evaluation of a community based PHC project five years after termination of Dutch aid;

NL-5: **Concept-IOV-rapport Medisch Team Niger (1974 tot heden)**, 3/86, DGIS.
mid-term evaluation of a community based PHC project in one province in Niger;

NL-6: **Eerstelijnsgezondheidszorg Colombia**, 4/86, DGIS.
mid-term evaluation of a community based PHC project in four of the poorest districts in Colombia;

NL-7: **PHC/MCH: An Integrated Approach, Report of a programme evaluation visit**, 11/86, DGIS/ICCO/CEBEMO.
findings and recommendations towards strengthening of church CB/PHC programmes in Tanzania;

NL-8: **The Church MCH Programme in Tanzania**, 10/86, DGIS/ICCO/CEBEMO.
a study in relation to the MCH and PHC programmes of the Ministry of Health, Tanzania;

S-1: **From Hospitals to Health Centres: A Joint Evaluation of Swedish Assistance to Health Sector Development in Kenya**, 1/86, SIDA (parts 1, 2 & 3).
evaluation report of one project in 1 country, 1 activity: RHCs, by SIDA;

S-2: **Health Centres - In Need of Treatment. A joint evaluation of Sweden's Support to Health Sector Development in Tanzania**, 3/87, SIDA.
evaluation by SIDA on the construction and functioning of Rural Health Centres in Tanzania;

S-3: **Vietnamese-Swedish Cooperation in the Health Sector: Planning the Future**, 10/85, SIDA.
evaluation of PHC project, hospitals and a workshop for medical equipment in Vietnam;

S-4: **Report of a Short Term Consultant Assessment of SIDA Supported Multidrug Therapy Program in India**, 5/87, SIDA.
an external mid-term review of SIDA's support for a multi-drug therapy programme for leprosy control in 15 districts of India;

S-5: **In-Depth Evaluation Report of the Modified Plan of Operation under the National Malaria Eradication Program of India**, 10/85, SIDA.
an evaluation by SIDA of the National Malaria Eradication programme in India with proposals for continued support;

UNDP-1: **Mise en Valeur des Ressources Humaines aux Fins des Soins de Santé Primaires, Etude d'Evaluation no. 9,** 12/83, UNDP.
evaluation of PHC activities of UNDP; discusses problems with issues like community participation, resource development, national policies and external aid;

UNICEF: **International Working Paper,**
Notes on CSDR/UCI and PHC; A Preliminary Analysis of UNICEF Experience.
Discusses the impact of the Child Survival Revolution in terms of vaccination coverage and in reduced disease incidence during the past five years.

USA-1: **Development Assistance and Health Programs: Issues of Sustainability,** 10/87, U.S. Agency for International Development (USAID).
discussion paper on USAID programme evaluation, focusing on issues of sustainability;

USA-2: **Prospects for Primary Health Care in Africa: Another Look at the Sine Saloum Rural Health Project in Senegal,** 4/84, USAID.
evaluation of PHC project in Senegal;

USA-3: **PVOs Reach Out: A Summary of Thirteen Primary Health Care Project Evaluations,** 5/87, Management Sciences for Health.
a summary of 13 PHC project evaluations in 12 countries by 8 organisations (private voluntary organisations), mainly on functioning of PVOs in project development;

USA-4: **Toward a Health Project Evaluation Framework,** 6/82, USAID.
technical paper by USAID on an evaluation framework for PHC interventions in developing countries;

USA-5: **AID's Experience with Primary Health Care Projects: A review of CDIE and APHA evaluation findings,** 6/86, USAID.
a synthesis of USAID supported Primary Health Care projects.

USA-6: **Sustainability of Health Services in Honduras,** 7/87, USAID.
ex post evaluation study on the sustainability of US supported health programmes in Honduras;

USA-7: **An Evaluation of the Factors of Sustainability in the Gambia Mass Media and Health Practices Project,** 12/87, USAID.
ex post evaluation of the factors of sustainability in a mass media and health practices project in Ghana;

USA-8: **An Evaluation of the Factors of Sustainability in the Lesotho Rural Health Development Project**, 12/87, USAID.
ex post evaluation of factors of sustainability in a project focused on training of "physician-extenders" for rural areas in Lesotho;

USA-9: **Primary Health Care: Progress and Problems, an analysis of 52 AID-assisted projects**, 8/82, American Public Health Association.
a synthesis of USAID supported Primary Health Care projects.

USA-10: **Sustainability of USAID Supported Health Programmes in Guatemala**, 9/87, USAID.
ex post evaluation study on the sustainability of US supported health programmes in Guatemala;

WB-1: **Health Sector Policy Paper**, 2/80, World Bank.
indicators of health status of different countries.

WB-2: **Cost Recovery in the health sector. Technical paper no. 82**, Discusses different ways of cost-recovery in Ghana, Senegal, Mali and Ivory Coast.

Appendix 5

## Classification of documents

### I. Evaluation reports on one health project by one donor

| Level of care | Report no. |
|---|---|
| community | CH-6 |
| hospital/community | FRG-6/7 |
| sub-district/community | CH-4 |
| district/community | CH-2 |
| district/community | CH-5 |
| district/community | D-5 |
| district/community | D-6 |
| district/community | FIN-4 |
| district/community | FRG-4 |
| district/community | FRG-5 |
| district/community | FRG-8 |
| district hospital/community | FRG-9 |
| district/community | NL-4 |
| district/community | NL-5 |
| district/community | USA-2 |
| district | AUS-3 |
| district | S-4 |
| province/district/community | AUS-1 |
| province/district/community | CH-1 |
| province/district | AUS-2 |
| regional | FRA-3 |
| national/community | NL-6 |
| national/district | IADB-5 |
| national/province | ADB-1 |
| national/province | ADB-2 |
| national/province | ADB-4 |
| national | ADB-3a+b |
| national | ADB-5 |
| national | ADB-6 |
| national | ADF-1 |
| national | D-1 |
| national | D-2 |
| national | D-3 |
| national | D-4 |
| national | FIN-1/3 |
| national | IADB-2 |
| national | IADB-3 |
| national | IADB-4 |
| national | S-2 |
| national | S-5 |
| PHC research, university | JA-1 |

## II. Sector evaluation of health projects in one country

| | |
|---|---|
| CH-3 | NL-8 |
| CH-7 | S-1 |
| FRA-1 | S-3 |
| FRA-1 | S-6 |
| FRA-2 | USA-1 |
| FRG-11 | USA-6 |
| NL-1 | USA-7 |
| NL-3 | USA-8 |
| NL-7 | USA-10 |

## III. Sector evaluation of health projects in more than one country, policy formulation documents and background information

| | |
|---|---|
| AUS-4,5,6 | FRG-10 |
| CAN-1 | IADB-1 (development projects) |
| CAN-2 | NL-2 |
| DAC-1 | UNDP-1 |
| DAC-1 | UNICEF-1 |
| EEC-1 | USA-3 |
| FIN-2 | USA-4 |
| FRG-1 (development projects) | USA-5 |
| FRG-2 | USA-9 |
| FRG-2 | USA-11,12,13 |
| FRG-3 | WB-1 |
| FRG-3 | WB-2 |

Appendix 6

**Evaluation reports on Primary Health Care related projects supported by DAC member countries**

| Project code: | | Total projects:41 | ADB-1 | ADB-2 | ADB-3 |
|---|---|---|---|---|---|
| Donor: | | 13 | Asian Dev. Bank | Asian Dev. Bank | Asian Dev. Bank |
| Location: country(ies) | | 29 | Hong Kong | Singapore | Malaysia |
| Period: | ongoing/appraisal | 25 | | | appraisal |
| | completed | 17 | X | X | |
| | planned project period: | | 1979-1984 | 1981-1985 | 1986-1991 |
| Funding: | bilateral | 29 | | | |
| | multilateral | 12 | X | X | X |
| | financial assistance | 40 | X | X | X |
| | technical assistance | 28 | | | X |
| Implementing body: | non-governmental organisation | 5 | | | |
| | governmental organisation | 36 | X | X | X |
| Type of evaluation/ appraisal: | (pre)formulation/ex ante | 5 | | | X |
| | mid-term | 20 | | | |
| | ex-post | 17 | X | X | |
| Evaluation procedure: | bipartite | 12 | | | |
| | unilateral | 29 | X | X | X |
| | time in field: | | not specified | not specified | not specified |
| Population covered: | national | 18 | X | X | X |
| | provincial/regional | 13 | X | X | |
| | district | 17 | | | |
| | community | 11 | | | |
| Programme elements: | infrastructure | 30 | X | X | X |
| | logistics | 13 | | | |
| | training/education | 28 | X | | X |
| | supplies/equipment | 25 | X | X | X |
| | manpower development | 20 | | | X |
| | data collection | 16 | | | X |
| | MIS | 8 | | | |
| | supervision | 10 | | | |
| | handing over | 2 | | | |
| | other | 14 | | | |
| Programme activity: | health education | 20 | | | |
| | food + nutrition | 12 | | | |
| | MCH/FP | 17 | | | |
| | water and sanitation | 11 | | | |
| | essential drugs | 13 | | | |
| | immunisation | 18 | | | |
| | curative care | 23 | X | X | X |
| | vector control | 3 | | | |
| | other | 6 | | | |
| Comments: | | | curative care hospital in a region, but with facilities of medical training | specialist care with medical training, but training not started at time of evaluation | national health system support |

| ADB-4 | ADB-5 | ADB-6 | ADF-1 | AUS-1 | AUS-2 | AUS-3 |
|---|---|---|---|---|---|---|
| Asian Dev. Bank | Asian Dev. Bank | Asian Dev. Bank | African Dev. Fund | Australia | Australia | Australia |
| Papua New Guinea | Pakistan | Indonesia | Lesotho | Philippines | Indonesia | Indonesia |
| appraisal | X | X | X | | | |
| | | | | X | X | X |
| 1986-1991 | 1988-1993* | 1984* | 1975*-1990 | 1983-1987 | 1975-1982 | 1972-1982 |
| | | | | X | X | X |
| X | X | X | X | | | |
| X | X** | X | X | X | X | X |
| X | | X | X | | X | X |
| | | | | | | |
| X | X | X | X | X | X | X |
| X | X | X | | | | |
| | | | X | | | |
| | | | | X | X | X |
| | X | X | | | | |
| X | | | X | X | X | X |
| specified | 18 days | 4 days | not specified | not specified | 4 weeks | not specified |
| X | | X | X | | | |
| X | X | | | | | X |
| | | | | X | X | |
| | | | | | | |
| X | X | X | | | X | |
| X | | | | | | X |
| X | | | | X | X | |
| X | | | | | | |
| X | X | X** | | X | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | X*** | X*** | loan** | research | | |
| X | | | | X | | |
| | | | | | | |
| | X | X | | | | |
| X | | | | | | |
| | | | | | | |
| | | | X | | | |
| X | | | | | X | X |
| | | | | | | |
| | | | | | | |
| support to national health system, concentrated in six provinces; second phase five provinces more | *) ex ante evaluation<br><br>**) support to national health system in two provinces<br><br>***) maintenance and repair of medical equipment | *) a 4 months' technical assistance project formulation mission<br><br>**) particular focus on nursing staff<br><br>***) upgrading physical facilities | *) first identification mission: implementation started in 1980.<br><br>**)first of goods and services envisaged for the EPI were:<br>- personnel;<br>- vehicles;<br>- vaccines;<br>- immunization equipment;<br>- supplies for mobile teams. | | | |

Appendix 6

Evaluation reports on Primary Health Care related projects supported by DAC member countries

| Project code: | | CH-1 | CH-2 | CH-4 | CH-5 |
|---|---|---|---|---|---|
| Donor: | | Switzerland | Switzerland | Switzerland | Switzerland |
| Location: country(ies) | | Indonesia | Bangladesh | Mali | Benin |
| Period: | ongoing/appraisal | X | X | X | X |
| | completed | | | | |
| | planned project period: | 1976-1985 | 1983-1986 | 1978-1986 | 1981-1986 |
| Funding: | bilateral | X | | X | X |
| | multilateral | | X | | |
| | financial assistance | X | X | X | X |
| | technical assistance | | | X | X |
| Implementing body: | non-governmental organisation | X | X* | | |
| | governmental organisation | | | X | X |
| Type of evaluation/ appraisal: | (pre)formulation/ex ante | | X | | |
| | mid-term | X | | X | X |
| | ex-post | | X | | |
| Evaluation procedure: | bipartite | | X | X | X |
| | unilateral | X | | | |
| | time in field: | 2,5 weeks | 1 month | 3 weeks | 4 weeks |
| Population covered: | national | | | | |
| | provincial/regional | | X | | |
| | district | X | X | X | X |
| | community | | | X | X |
| Programme elements: | infrastructure | | | X | X |
| | logistics | | X | X | |
| | training/education | X | X | X | X |
| | supplies/equipment | X | X | | X |
| | manpower development | X | | | |
| | data collection | X | X | | |
| | MIS | | | X | |
| | supervision | X | X | | X |
| | handing over | | | | |
| | other | | monitoring | | |
| Programme activity: | health education | X | X | | X |
| | food + nutrition | X | | X | |
| | MCH/FP | X | | X | X |
| | water and sanitation | | | X | X |
| | essential drugs | | | X | X |
| | immunisation | X | X | | X |
| | curative care | X | | X | X |
| | vector control | | | | |
| | other | | ORT | | |
| Comments: | | VHW component | *) Bangladesh Rural Advancement Committee (BRAC) | | |

| CH-6 | D-1 | D-2 | D-3 | D-4 | D-5 | D-6 |
|---|---|---|---|---|---|---|
| Switzerland | DANIDA | DANIDA | DANIDA | Denmark | Denmark | Denmark |
| Bolivia, Paraguay | Tanzania | Tanzania | Tanzania | Kenya | India | India |
| X | X | X | X | X | | |
| | | | | | X | X |
| 1976-1984 | 1986-1989 | 1980-1990* | 1981-1986 | 1980-1987 | 1981-1986 | 1981-1986 |
| X | X | X | X | X | X | X |
| | | | | | | |
| X | X | X | X | X | X | X |
| X | X | X | X | X | X | X |
| X | | | | | | |
| | X | X | X* | X | X | X |
| | | | | | | |
| X | X | X** | X | X | | |
| | | | | | X | X |
| | | X | X** | X | | |
| X | X | | | | X | X |
| ...t specified | 7/14 days | 9/20 days | not specified | 3 weeks | 1 month | 1 month |
| | X | X | X | X | | |
| | | | | | state | state |
| | | | | X | X | X |
| X | | | | X | X | X |
| | | X | X | X | X | X |
| | | | | X | X | X |
| X | | X | X | X | X | X |
| | X | X | X | X | X | X |
| | X | | | | X | X |
| | | | X | X | X | X |
| | X | | X | | | |
| | | | | X | X | X |
| | | | | | X | |
| | | | | | | |
| X | | | | | X | X |
| X | | | | | X | X |
| | | | | | X | X |
| | | | | | | X |
| X | | | X | | X | X |
| X | | X | | X | X | X |
| | | | | | X | X |
| | | | | | | X |
| trad. medicine | dental health | | | | | |
| part of inter-sectoral development projects. It concerns four similar projects with similar indigenous populations, integrated into general development projects. | | *) originally: 1980-1985<br>**)originally: ex-post, but rec.: continue until 1990 | *) UNICEF<br>**)DANIDA<br>UNICEF<br>WHO<br>Tanzanian MoH | | | |

Appendix 6

**Evaluation reports on Primary Health Care related projects supported by DAC member countries**

| Project code: | | FIN-1/3 | FIN-4 | FRA-3 | FRG-4 |
|---|---|---|---|---|---|
| Donor: | | FINNIDA | FINNIDA | France | BMZ |
| Location: country(ies) | | Somalia | Kenya | Togo | Zaïre |
| Period: | ongoing/appraisal | X | X | | X |
| | completed | | | X | |
| | planned project period: | 1980-1984* | 1984-1988 | 1976-1981 | 1977-1988* |
| Funding: | bilateral | X | X | X | X |
| | multilateral | | | | |
| | financial assistance | X | | X | X |
| | technical assistance | X | | | X |
| Implementing body: | non-governmental organisation | | | | X |
| | governmental organisation | X | X | X | |
| Type of evaluation/ appraisal: | (pre)formulation/ex ante | | | | |
| | mid-term | X | X | | X |
| | ex-post | | | X | |
| Evaluation procedure: | bipartite | X | X | | |
| | unilateral | | | X | X |
| | time in field: | 2-3 weeks | 3 weeks | not specified | 3.5 weeks |
| Population covered: | national | X | | | |
| | provincial/regional | | | X | |
| | district | | X | | X |
| | community | | | | |
| Programme elements: | infrastructure | X | X | X | X |
| | logistics | | | | |
| | training/education | | X | | X |
| | supplies/equipment | | | | X |
| | manpower development | | X | | |
| | data collection | | | | |
| | MIS | | | | |
| | supervision | | | | |
| | handing over | | X | | |
| | other | | construction | | |
| Programme activity: | health education | | | | X |
| | food + nutrition | | | | X |
| | MCH/FP | | | | X |
| | water and sanitation | | | | X |
| | essential drugs | | | | X |
| | immunisation | | | | X |
| | curative care | | | X | X |
| | vector control | | | | |
| | other | TB control | | | |
| Comments: | | PHC is described as delivery system for TB-programme<br><br>*) to be extended until 1991 | | regional hospital with curative functions. No support from rural health care. Technology not appropriate to conditions | all activities are on paper included, but not yet put into practice.<br><br>*) to be extended |

| FRG-5 | FRG-6/7 | FRG-8 | FRG-9 | IADB-2 | IADB-3 |
|---|---|---|---|---|---|
| West-Germany | BMZ | BMZ | BMZ | IADB | IADB |
| Brazil | Korea | Yemen | Malawi | Lat. Am. country | Centr.Am. country |
| X | X | X | | | |
| X | | | X | X | X |
| '73-'83 + '80-on | 1978-1989 | 1978-1986 | 1979-1985 | 1977-1984 | |
| X | X | X | X | | |
| | | | | X | X |
| X | X | X | X | X | X |
| | | X | | X | X |
| | X | | | | |
| X | | X | X | X | X |
| | | | | | |
| | X | X | | | |
| X | | | X | X | X |
| | | | | | |
| X | X | X | X | X | X |
| 3 weeks | 3 weeks | 3 weeks | 1 week* | not specified | survey |
| | | | | X | X |
| X | X | | | 3 regions | |
| | | X | X | | |
| | | X | | | |
| | X | X | X | X | X |
| | | | | | X |
| | | X | | X | X |
| X | | X | | | X |
| | | X | | X | X |
| | X | X | | X | X |
| | | | | X | X |
| | | | | | |
| | | | | | |
| | | | construction | | construction |
| X | | X | | X | |
| X | | | | X | |
| X | X | X | | X | |
| X | | X | | | |
| X | | X | | | |
| X | | X | | X | |
| X | | X | | X | |
| | | | | | |
| | TB control | | | | |
| this is primarily a hospital development plan with financial aid for the construction of health centres | the PHC activities are delayed and in an early stage. The hospital development is o.k. (financial aid). | | this is primarily a hospital project; hardly any interest in PHC of the community<br><br>*) leader of evaluation team stayed 6 weeks | aimed at increased utilisation. Recommendation in all IADB projects: include more community participation. | |

Appendix 6

Evaluation reports on Primary Health Care related projects supported by DAC member countries

| Project code: | | IADB-4 | IADB-5 | JA-1 | NL-4 |
|---|---|---|---|---|---|
| Donor: | | IADB | IADB | Japan | Netherlands |
| Location: country(ies) | | Lat. Am. country | Centr.Am. country | Thailand | Senegal |
| Period: | ongoing/appraisal | | | X | |
| | completed | X | X | | X |
| | planned project period: | 1978-1982 | 1973-1985 | 1982-1989 | 1977-1981 |
| Funding: | bilateral | | | X | X |
| | multilateral | X | X | | |
| | financial assistance | X | X | X | X |
| | technical assistance | X | | X | X |
| Implementing body: | non-governmental organisation | | | | |
| | governmental organisation | X | X | X | X |
| Type of evaluation/ appraisal: | (pre)formulation/ex ante | | | | |
| | mid-term | | | X | |
| | ex-post | X | X | | X |
| Evaluation procedure: | bipartite | | | X | |
| | unilateral | X | X | | X |
| | time in field: | not specified | not specified | 8 days | not specified |
| Population covered: | national | X | | university | |
| | provincial/regional | | X | | |
| | district | | | | X |
| | community | | | | X |
| Programme elements: | infrastructure | X | X | | |
| | logistics | | | | X |
| | training/education | X | | X | X |
| | supplies/equipment | X | X | | |
| | manpower development | X | | X | |
| | data collection | X | | X | |
| | MIS | X | | X | |
| | supervision | X | | | X |
| | handing over | | | | |
| | other | | construction | X* | construction |
| Programme activity: | health education | X | | X | X |
| | food + nutrition | X | | X | |
| | MCH/FP | X | | X | X |
| | water and sanitation | X | | X | |
| | essential drugs | X | | X | |
| | immunisation | X | | X | X |
| | curative care | X | | X | |
| | vector control | | | X | |
| | other | | | | |
| Comments: | | aimed at increased utilisation. Recommendation in all IADB projects: include more community participation | | 2 years prolongation recommended<br>*) research, community finance | |

| NL-5 | NL-6 | S-2 | S-4 | S-5 | USA-2 |
|---|---|---|---|---|---|
| Netherlands | Netherlands | SIDA | Sweden | Sweden | USA |
| Niger | Colombia | Tanzania | India | India | Senegal |
| X | X | | X | | X |
| | | X* | | X | |
| 1974-1987 | 1980-1988 | 1972-1986* | 1984-1988 | 1977-1985 | 1977-1986 |
| X | X | X | X | X | X |
| | | | | | |
| X | X | X | X | X | X |
| X | X | X | X | | X |
| | | | | | |
| X | X | joint SIDA-MoH | X | X | X |
| | | | | | |
| X | X | | X | X | X |
| | | X* | | | |
| | | X | | | |
| X | X | | X | X | X |
| specified | not specified | not specified | 2 weeks | 2 months | not specified |
| | X | X | | X | |
| | | | | | |
| X | | | X | | X |
| X | X | | | | X |
| X | X | X | | X | X |
| | X | X | X | | X |
| X | X | X | | X | X |
| X | X | X | X | X | X |
| X | X | X | | X | X |
| | X | | | X | X |
| | X | | | | |
| | X | | | | X |
| | | | | | |
| | | construction | | research | comm. finance |
| X | X | | X | X | X |
| X | X | | | | |
| X | X | | | | |
| | X | | | | X |
| | | | Rifampicine | X | |
| X | X | | | | |
| X | X | | X | X | X |
| | | | | X | |
| | | | leprosy treatment | | |
| | it concerns community based projects in four different areas of the country | *) recommendations as to the future of the project will be made after discussions with the MoH of Tanzania | | | |

Appendix 7

**Bibliography**


DAC Expert Group on Aid Evaluation
1988 Sustainability in Development Programmes, draft document, DAC/EV(88).

DAC Expert Group on Aid Evaluation
1986 Methods and Procedures in Aid Evaluation, DAC/EV(86)

DAC (88) 33 Background paper for meeting on strengthening development coopereation for PHC Aid for Primary Health Care:
A decade of experience.

DAC (88) 48 Strengthening Development Co-operation for Primary Health Care:
Conclusions of a DAC discussion.

University of Michigan
1987 Sustainability of Development Assistance Efforts. Development Programme Management Center, US Department of Agriculture; and International Development Management Center.

Walsh, J.A., K.S. Warren
1979 Selective Primary Health Care: an interim strategy for disease control in developing countries. In: New Engl. J. Med., 301, 18.

Walt, G., S. Rifkin
1986 Why Health Improves: Defining the issues concerning "Comprehensive Primary Health Care" and "Selective Primary Health Care". In: Social Sciency and Medicine, Vol. 23, No. 6.

Walt, G., P. Vaughan
1981 An Introduction to the Primary Health Care Approach in Developing Countries. Ross Institute of Tropical Hygiene Publication No. 13, London.

World Health Organization
1987 Evaluation of the Strategy for Health For All by the Year 2000", Seventh report on the world health situation. In: Global Review WHO, Vol. 1.

- Region of the Americas Vol. 3
- South-East Asia Region Vol. 4
- Eastern Mediterranean Region Vol. 6
- Western Pacific Region Vol. 7

World Health Organization
1988 Alma-Ata Reaffirmed at Riga