MIDTERM EVALUATION
OF THE
LATIN AMERICA AND THE CARIBBEAN
REGIONAL HEALTH SECTOR REFORM INITIATIVE

VOLUME I

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ACRONYMS AND FOREIGN TERMS

C–NGOS	Contracting NGO Services
CORE	Cost revenue analysis tool
DAR	Decentralization Applied Research
DDM	Data for Decision-Making
DR	Dominican Republic
DTF	Dissemination task force
FPMD	Family Planning Management Development
FY	Fiscal year
G/PHN	Bureau for Global Programs, Field Support and Research Center for Population, Health and Nutrition
GPP	Guidelines for policy process
HSR	Health sector reform
IADB	Inter-American Development Bank
Initiative	Latin America and the Caribbean Regional Health Sector Reform Initiative
IR	Intermediate Result
KPAB	Knowledge, patterns, attitudes and behavior
LAC	Latin America and the Caribbean
MHR	Framework for Monitoring Health Reform
MOF	Ministry of Finance
MOH	Ministry of Health
MOST	Management and Organizational Sustainability Tool
MPI	Master plans of investment
MSH	Management Sciences for Health
NGO	Nongovernmental organization
NHA	National health accounts
PAHO	Pan American Health Organization
PHR	Partnerships for Health Reform
PYS	Performance incentive system
RSD	Office of Regional Sustainable Development
SO	Strategic Objective
TAG	Technical advisory group
TPI	Tool for plan investment
USAID	United States Agency for International Development
WHO	World Health Organization

CONTENTS

FIGURES

APPENDICES

APPENDICES IN VOLUME II

EXECUTIVE SUMMARY

The Latin America and Caribbean (LAC) Health Sector Reform Initiative seeks to positively influence health sector reform in 13 Latin American and Caribbean countries through the development, testing, and dissemination of methodologies, tools, experiences, and/or exchanges. Its goal is to facilitate targeted countries' ministries of health and others in the health area to integrate lessons learned into their health reform processes and to increase their institutional capacity.

The United States Agency for International Development (USAID), through a contract with Monitoring, Evaluation and Design Support (MEDS), engaged a 3–person team to conduct a midterm review of the LAC Health Sector Reform Initiative. Its goal was to assess midterm progress towards accomplishment of the following four Intermediate Results (IRs) and to reflect on whether progress to that point would enable achievement of the Strategic Objective of more effective delivery of basic health services and policy interventions. The four IRs are:

- **IR 1**: Methodologies and tools developed, tested and disseminated for analysis and design, implementation and monitoring of country health sector reforms.

- **IR 2**: Information on health reform efforts and experience gathered and made widely available to interested parties in LAC countries and to health sector donors.

- **IR 3**: Reform processes, specifically related to equitable access, and outcomes monitored and feedback provided to countries, donors and other partners.

- **IR 4**: Opportunities and means to share experience and advice among countries are established.

The evaluation team reviewed the validity of the Initiative framework and addressed three primary questions. The first is related to the effectiveness of the Initiative in achieving the Intermediate Results. The second is concerned with its management and administrative efficiency, and the third is related to the feasibility of scale-up and long-term sustainability. Recommendations deriving from the findings are presented.

The **Initiative framework** was found to be valid but with suggested changes in indicators and increased emphasis on mitigation plans for managing contingencies of the assumptions underlying it. A more focused and consistent approach of measuring results is suggested along with the recommendation that the Initiative track different types of indicators at each level. At country level 2, the Initiative should track indicators that reflect changes in behavior that occur from or through use of the methodologies, tools,

and experiences. At the regional level, the Initiative should focus on tracking indicators of the effective delivery of Initiative products and services.

An examination of the **progress and achievements** addresses the first evaluation question of effectiveness. A case study was determined to be the most effective way to carry out the country-specific study of methodologies, tools, and exchanges. The objective was to understand and describe the relationship between variables in each case and the dynamic processes that were occurring in each country. The first step, described above, was an examination of the Results Framework used by USAID in its program management of the Initiative. The second step was a study of the product life cycle of design, development, test, analysis, implementation, and monitoring in three selected countries—the Dominican Republic, Honduras, and Peru. The third step was a study and analysis of the dissemination and communication of Initiative tools, methodologies, and exchanges. Two hypotheses were developed and guided the conceptual framework of the evaluation design:

- The success of the Initiative, that is, the achievement of its Intermediate Results, depends not only on the effect of variables under its control but also on factors beyond its control but which could be influenced by Initiative efforts if reflected in a systematic way in Initiative management systems; and

- The evaluation of achievements and progress is a function of not only the four Intermediate Results and indicators that pertain to them, but also the expected results for each tool, methodology, experience, forum, or study tour at the midpoint of the Initiative.

Primary source information was gathered and analyzed from key stakeholders and Initiative partners through specifically designed interview formats. The identification and selection of individuals was based on the criteria of key actors who had participated in or were knowledgeable of Initiative activities, were active participants in the health reform process, or were in a position to influence health sector reform. The number of key actors interviewed was 17 in Honduras, 18 in Peru, and 20 in the Dominican Republic. Secondary source information from Initiative and partner documents were reviewed and analyzed.

The Initiative was found to be making varying degrees of progress towards its four intermediate goals relative to the level of development and/or use of the different tools and methodologies. Factors found promoting and inhibiting use of the tools and methodologies were:

- the degree of institutional capacity of ministries of health (MOH) and other involved organizations,

- political will,

- the existence of supportive national and MOH coalitions,

- international organization alignment with national efforts, and
- a national communication and dissemination strategy.

Field interviews revealed that the most successful experiences were those in which the Initiative influences design and implementation factors that affect country utilization of regional tools. In other words, the most successful experiences were those in which the regional approach and intervention strategy was accompanied by an in-country initiative. Moreover, the most effective institutional strategy targeted different public institutions; that is, not just the Ministry of Health but also other ministries, special reform commissions, or nongovernmental organizations (NGOs) working together with the public sector. Factors that were within Initiative control before the dissemination of the tools, methodologies, and experiences were:

- the quality of the experience and the selection of themes that are demand driven,
- the development of a training process that takes into account national expectations,
- the agreement of key actors at the country level on the best and most feasible institutional strategy for implementation purposes, and,
- the achievement of partner alignment at the headquarters level on the different tools, methodologies, or experiences.

In addition, the report identifies factors which are beyond Initiative control but which the Initiative should strive to influence. The most important are local or national adaptation of the tool, a national communication and dissemination strategy, and horizontal alignment of partners at the country level. The stability of key actors and the definition of a public policy on health reform are vital to achieving national commitment to the health sector reform agenda.

Initiative management was found to have taken an innovative approach that uses the unique talents of four partners in a synergistic way to execute its plan. A steering committee and various task forces or work teams were used to manage the various Initiative themes. The steering committee was very effective in its work, while the task groups ranged from marginal to effective. Contract completion dates of three of the contractors pose the risk of a hiatus in Initiative continuity; greater steering committee emphasis is needed for the management of task groups and risk factors. Findings regarding financial resources were mixed. Initiative financial resources total $10.2 million, of which USAID contributes $7.4 million and the Pan American Health Organization (PAHO) contributes $2.8 million. PAHO is also the recipient of $2.5 million (of the $10.2 million), giving it responsibility for $5.3 million of Initiative resources. Some partners believe that the Initiative does not have enough resources given

the enormity of its task, while data showed that the Initiative was actually underspending with respect to its planned expenditures.

Changes that are needed for long-term **sustainability** of the Initiative include an effective risk assessment of Initiative assumptions and activities and management of high-risk areas through risk mitigation. These high-risk areas include weakness in MOH institutional capacity for health sector reform and lack of or weak political will to move the health reform process forward. Specific factors in the latter include the lack of a health sector reform public policy, lack or weakness of health sector reform leadership, inability to make political decisions supportive of health sector reform or political interference in decision-making at the MOH, process management difficulties, and parallel, duplicative, and competitive reform units within the health sector.

Recommendations to increase Initiative potential in facilitating the integration of lessons learned and building increased institutional capacity for health reform in targeted countries are provided. The major recommendations are summarized below.

Methodology: A representative sample would have provided stronger data and while it might require more evaluation team preparation time, it is recommended for future evaluations.

Initiative Framework and Sustainability: The Initiative framework and sustainability are two interconnected components. To increase sustainability and to strengthen the Initiative framework, it is recommended that the Initiative Results Framework be adjusted by operationally defining key actors working on health reform, Intermediate Results be measured through a redesigned tracking system for some Intermediate Results and their indicators, and the level of risk be monitored periodically, using the recommended (or a similar) methodology to assess movement in the level of risk exposure.

Effectiveness: Intermediate Results 1, 3, and 4: To increase effectiveness and progress and achievements, it is recommended that the proposed checklist or a variation be used for assessing the introduction and use of tools, methodologies, experiences, and/or exchanges; commitment of other stakeholders be obtained for support and technical assistance of the design and development of effective and efficient training processes; a strategy be created for garnering support from different public stakeholder institutions; partner alignment be achieved at the headquarters level on the different tools, methodologies, experiences, or exchanges; additional Initiative influence be exercised over design and implementation factors, particularly partnerships, that affect country utilization of regional tools; and plans be developed for managing factors beyond Initiative control.

Effectiveness: Intermediate Result 2: A shift in paradigm from dissemination to development communications is recommended. This will affect the type of products and services provided by the strategy and management and operational arrangements. Moreover, it will be more horizontal in approach with respect to information flow, more

inclusive in terms of targeted audiences, more demand driven from the perspective of messages crafted and delivered, more global in terms of the media to be used, and more corporate in order to guarantee a new equilibrium between stronger branding and partners' individual identities. This will also have the positive effect of mitigating key risks associated with the development of political will and mobilization of resources for health sector reform in the region and will contribute to the building of coalitions for health sector reform at the national as well as the regional level. The recommendations section presents a detailed list of steps to be taken in order to broaden the present dissemination strategy.

Initiative Management and Administrative Efficiency: The recommendations include clarifying roles and responsibilities of the steering committee, partners, and task forces; reexamining the PAHO partnership; enhancing management, including preparing milestone charts for each activity and task force and reviewing them on a defined steering committee schedule linked to Intermediate Results; reviewing the 2000 work plan and requiring recovery plans when the schedule of deliverables is not adhered to, particularly where the Initiative is spending less than the planned expenditures; and rescheduling the technical advisory group to coincide with the planning cycle, and if it is willing, use it to help the steering committee manage the assumptions of the Results Package and mitigation plans.

I. BACKGROUND AND INTRODUCTION

Countries throughout Latin America and the Caribbean (LAC) are introducing reforms that can profoundly influence how basic health services are provided and who receives them. Health system reform is being undertaken to reduce inequities, improve quality, and correct inefficiencies in current systems.[1]

Governments in the region identified the need for a network to support health reform through analysis, training, and other capacity-building measures at the Summit of the Americas in 1994, and again at a Special Meeting on Health Sector Reform convened by an interagency committee of the United Nations and other multilateral and bilateral agencies in 1995.

In response, the United States Agency for International Development (USAID) and the Pan American Health Organization (PAHO) launched the Latin America and Caribbean (LAC) Regional Health Sector Reform Initiative. This Initiative promotes more equitable and effective delivery of basic health services through support of regional activities that support informed decision-making on health policy and management, health financing, health service improvement, decentralization and institutional development.

The Health Sector Reform Initiative is one of five initiatives which support the LAC Regional Strategic Objective (SO), "more effective delivery of selected health services and policy interventions." It focuses on "sustainable country health sector reforms (designed to increase equitable access to high quality, efficiently delivered, basic health services), to increase country capability to assess health sector problems, and to design, implement and monitor reforms and solutions."

The LAC Regional Health Sector Reform Initiative is implemented by the Pan American Health Organization, the Partnerships for Health Reform (PHR) Project, the Family Planning Management Development (FPMD) Project and the Data for Decision- Making (DDM) Project. PAHO is an international public health agency headquartered in Washington, D.C. It serves as the specialized organization of the Inter-American system for health and as the regional office for the Americas of the World Health Organization.

Partnerships for Health Reform is a five-year USAID–funded contract that builds capacity in policy foundation and implementation, health economics and financing, and organization and management of health systems.

Family Planning Management Development is a five-year USAID–funded cooperative agreement that helps national and local family planning and health programs and organizations develop their capability to plan and manage sustainable programs.

[1] This section of the report is taken from the scope of work for this midterm evaluation.

Data for Decision-Making is a five-year USAID–funded cooperative agreement that supports health sector reform and assists leadership in developing countries in making informed policy and financing decisions.

The Initiative provides regional support to activities in Bolivia, Brazil, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay, and Peru.

The five-year Initiative was authorized on July 29, 1997, for a total of $7.4 million in USAID funding. PAHO also committed $2.8 million of its funds to the Initiative, for a total value of $10.2 million. The allocation of USAID funds envisaged was $2.5 million for PAHO through a public international organization grant, $3.2 million for the Partnerships for Health Reform Project, $900,000 for the Data for Decision-Making Project and $750,000 for the Family Planning Management Development Project. Of the $7.4 million in USAID funds, $6 million was new funding approved at the time of authorization and $1.4 million was fiscal year (FY) 1995 carryover field support funding ($1.1 million of PHR's planned allocation and $300,000 of DDM's planned allocation).

In order to provide management oversight to an innovative approach and to enhance the achievement of the LAC Initiative, a midterm evaluation was planned. Its goal was to assess progress and achievements to date and present recommendations for adjustment, redirection, or reconfiguration. To accomplish this, the steering committee established six evaluation objectives:

- to determine if the Results Framework is valid and feasible and to recommend adjustments to the Results Framework and activities as appropriate;

- to examine progress towards achieving the SO and IRs as planned, evaluating whether the results/indicators will be met in a timely and effective manner, to identify specific internal/external constraints which may limit their accomplishment or success, and to recommend adjustments based on findings and conclusions;

- to assess how the Initiative structure as configured is working, including both the delegation of specific technical areas and activities to the partners as well as their coordination, working relationships, and collaboration in the implementation of Initiative activities;

- to assess the administration of the Initiative by USAID and the implementing partners within their organizations. The focus should be on Initiative management, meeting deadlines, monitoring, and technical assistance; adjustments in implementation based on findings and conclusions should be recommended;

- to review the resources management of the Initiative, including the use of human, material, and financial resources to achieve IRs; and

- to examine the feasibility of scale up or sustainability and mechanisms for ensuring sustainability after external funding ceases.

The evaluation team began its work in mid-February, with field work being conducted February 19 through March 17, 2000. The full scope of work is contained in appendix A and includes key questions to be answered that were instrumental in guiding the evaluation design. Appendix B contains the health sector reform Results Package indicators.

II. METHODOLOGY

The methodology used was designed to gather necessary and sufficient data in order to make inferences about effectiveness in achieving Intermediate Results and their attendant impact on health policy. It also examines management of the Initiative and the sustainability of accomplishments and benefits. Recommendations based on these analyses are offered for midterm reconfiguration and changes.

All Initiative documentation was reviewed, including annual reports, partner reports, Initiative products, working papers, and other pertinent documents. On the basis of this review and conversations with partners, a three-part methodology was developed. The first part involved gathering data in Washington, D.C., from the Initiative partners and others with authoritative knowledge of the Initiative. A standardized interview format was constructed and used that focused on the LAC Initiative in general, its operations, and its management. The second part involved gathering data from the three countries selected by USAID and the steering committee for in-country visits (appendix C):[2] the Dominican Republic, Honduras, and Peru. A standardized interview format, adjusted for country differences, was used to gather information from individuals who had experience with or were in a position to offer authoritative commentary on Initiative tools, methodologies, and exchanges. In a separate but parallel effort, the third part of the methodology involved gathering data through questionnaires regarding the Initiative dissemination and communication strategy. (Appendix D contains the interview formats model.)

A case study was determined to be the most effective way to carry out the country–specific study to evaluate methodologies, tools, and exchanges related to Intermediate Results 1, 3, and 4. Table 1 (on the following page) was used as the guide in the observation and collection of data. The different stages and degrees of progress of the Initiative's implementation were also taken into account.

The evaluation design addresses a key issue deriving from the nature of midterm evaluations; that is, the type of results that could reasonably be expected at this point in time since accomplishment indicators are written in terms of final results. The 3 countries, however, are not used as a sample of all 13 countries involved in the Initiative. Rather, the goal of the case study was to examine how factors that affect the Initiative's results operate in the three countries. The objective was to understand and describe the relationship between variables in each case and the dynamic processes that were occurring in each country. In this way, implementation patterns and trends regarding Initiative performance, progress, and achievements could be ascertained. Thus, the evaluation design (a case study) and sampling size (only key respondents) influence the

[2]Appendix C also contains specific descriptions and complementary tables regarding the case study in the Dominican Republic, Honduras, and Peru.

nature of the findings. The findings reflect the situation in the countries studied; they are not meant to be representative of the Initiative's work in its entirety.

Table 1: Country Index of Tools, Methodologies, Instruments, and Exchanges (March 2000)

TOOLS, METHODOLOGIES, STUDY TOURS, AND EXCHANGES	PARTNER	HONDURAS	DOMINICAN REPUBLIC	PERU
Tools and Methodologies				
1. Tool for Plan Investment (TPI)	PAHO	x		
2. National Health Accounts (NHA)	DDM/PHR/ PAHO	x	x	x
3. Methodology for Monitoring Health Sector Reform (HSR)	PAHO	x	x	x
4. Performance Incentive Systems (PYS)	FPMD	x		
5. Cost Revenue Analysis (CORE)	FPMD	x		
6. Management and Organizational Sustainability Tool (MOST)	FPMD		x	x
7. Guidelines for Policy Process; Health Policy Process Applied Research (GPP)[3]	DDM	x		
8. Decentralization Applied Research (Decision Space) (DAR)	DDM	x		
9. Contracting NGO Services (DR) (C–NGOS)	PHR		x	x
10.NGO in Health Reform (Policy Process) (Bolivia) (NGOS–HSR)	PHR		x	x
Study Tours				
1. Panama	PAHO	x	x	
2. Colombia	PHR	x	x	x
3. Canada	PAHO		x	
Exchanges				
NGOs in Decentralization	FPMD		x	
NGOs Quality Assurance	FPMD		x	
Forum on Provider Payment Mechanisms	PAHO		x	x
Andean Region Forum in Bolivia (Santa Cruz, Bolivia, 1999)	PAHO			x

[3] The health sector analysis tool currently is being used in two countries (Paraguay and Nicaragua). It was not evaluated since these two countries were not part of the case study. Tools and methodologies 7 to 10 are current as of this evaluation; additional guidelines, tools, or papers on the development and testing process are in progress.

The following steps were taken to gather data regarding Intermediate Results 1, 3, and 4:

- A draft analytical framework was designed for the collection and analysis of data.[4]

- In consultation with partners both in Washington and in the field, key respondents were identified who had participated in one or more of the experiences (i.e., methodologies, tools, and exchanges) and who were in a position to provide authoritative commentary on them. Once in-country, these lists were reviewed and adjusted consistent with local conditions. (See appendix C, table C–1, for a detailed list of country institutions and key stakeholders.)

- Interviews were carried out in the three selected countries. The number of key stakeholders interviewed was 17 in Honduras, 18 in Peru, and 20 in the Dominican Republic.

- The conceptual framework for data analysis was completed (appendix E).[5]

- To measure midterm results, a set of expected results was postulated by which the individual tools, methodologies, experiences, study tours and exchanges could reasonably be assessed. (See appendix F for Results Framework analysis, IRs, indicators, expected results, and indicators for the midterm evaluation of tools, methodologies, instruments, exchanges, fora, and study tours.) These projected midterm results are used to measure midpoint progress and achievements. The following steps were taken for data consolidation and analysis of Intermediate Results 1, 3, and 4:

    - The results from the three-country case study were organized, transcribed, consolidated, and aggregated by Intermediate Result, tool, methodology, exchange, and key stakeholders.

    - Data analysis was guided by the conceptual framework and relevant aspects and specific questions in the scope of work for the evaluation. The conceptual framework was used to analyze the relationship between variables and expected results for each tool, methodology, experience, or exchange.

[4] This framework focused on the design of interview formats, which were used to obtain data on variables and factors that could affect the progress and achievement of Initiative Intermediate Results. Factors that could influence the institutionalization and sustainability of Initiative tools, methodologies, and exchanges were also identified and incorporated into the interview formats.

[5] Appendix E contains a description of the conceptual and methodological frameworks used for data analysis. It also presents the tables for factors and results with their indicators, operational definition, sources of information and interview questions, and the tables for operational definitions of additional categories for data analysis.

- Findings were reviewed with the partners in a debriefing session. The completion of findings, conclusions, and recommendations took the partners' suggestions and comments into consideration.

In the separate but parallel effort focusing on the communications/dissemination strategy, three questionnaires were administered to gather data to be used for the subsequent analysis of Intermediate Result 2. The first questionnaire was administered to the partners to assess the level of consensus on the communications/dissemination strategy and its different components, such as targeted audiences, crafted messages, and media used. The second questionnaire was directed to individuals interviewed in the three countries to measure name recognition of the Initiative, message relevance, audiences to be targeted, and media to be used, and to capture new insights. The third questionnaire was directed to the same group and was used to obtain relevant data on information needs, the use of strategy information services relevant to Intermediate Result 2, and the use of Initiative electronic services compared with other available sources. These questionnaires were also distributed to 10 individuals in other countries and key personnel at the World Bank and the Inter-American Development Bank (IADB). The following process was used for consolidating and analyzing the data:

- Field test results from the three countries were consolidated and aggregated. Data gathered from partners were consolidated.

- Consolidated data were reviewed within the conceptual framework (appendix G: Assessment Criteria) and relevant aspects and specific questions of the scope of work for the evaluation.

- Basic findings were noted and validated with data received from other countries and key stakeholders in Washington.

- Findings were reviewed with the partners in a debriefing session. The completion of the findings, conclusions, and recommendations took partners' suggestions and comments into consideration.

III. INITIATIVE FRAMEWORK

A. INTRODUCTION

The internal logic of the Initiative framework is consistent. However, the distinction made between regional and national levels requires additional refinement in terms of the metrics used for tracking results, strategies for mitigating risk, and management of the Initiative through a process of continued performance improvement.

The validity of the framework is contingent upon the assumptions made regarding its potential success. (This evaluation covers this in detail in the section on sustainability.) Assessing the inherent risks derived from the assumptions and developing mitigation plans for high-risk assumptions deserves increased attention.

The Framework[6]

The Latin America and Caribbean (LAC)/Office of Regional Sustainable Development (RSD) health reform package of December 8, 1997, provides a hierarchy of objectives from a Strategic Objective (SO) level to levels of Intermediate Results (IR) at the country and regional levels. (See table 2 on the following page.) The IRs are within the specific mandate of the Initiative, while the SO is focused on the end users of Initiative products and services (with which the Initiative is only indirectly connected). In short, the regional mandate is for the Initiative to develop, test, and disseminate for use at the country level, whereas the IRs seek to change behavior through the use of the methodologies, tools, experiences, and/or exchanges.

At the regional level (Intermediate Results, level 3), the framework establishes four IRs that represent regional products and services under Initiative control. This approach is consistent in terms of causal linkages and the supplier/customer chain and includes significant relationships.

However, the Intermediate Results that were part of the scope of work (regional level 3 of the original design) and those that the Initiative used for monitoring during 1998 and 1999 were inconsistent in the way results were measured, due largely to a lack of indicator focus. This is discussed in detail in the following sections.

[6] See table 2 for the health reform Results Package indicators used by the Initiative until FY 99.

Table 2: LAC/RSD Health Reform Results Package

Agency Goal		World's Population Stabilized and Human Health Protected in a Sustainable Fashion		
LAC/RSD Strategic Objective		More effective delivery of selected health services and policy interventions		
Selected policy intervention		Sustainable country health sector reforms (designed to increase equitable access to high quality, efficiently delivered basic health services)		
Intermediate Results Level 1 (Country–level)		In–country capability to assess health sector problems, and to design, implement, and monitor reforms		
Intermediate Results Level 2 (Country–level)	2.1: Methodologies and tools adapted and used for analysis and design, implementation, and monitoring of country health sector reforms	2.2: Information on health reform efforts and experience accessible and used by interested parties in LAC countries	2.3: Internal feedback used to monitor/revise reform efforts; complete reports provided to regional collection point on schedule	2.4: In-country interested parties** share experience and advice between countries
Intermediate Results Level 3 (Regional)	3.1: Methodologies and tools developed, tested and disseminated for analysis, design, implementation and monitoring of country health sector reforms	3.2: Information on health reform efforts and experience gathered and made widely available to interested parties in LAC countries and to health sector donors	3.3: Reform processes and outcomes monitored and feedback provided to countries, donors, and other partners	3.4: Opportunities and means to share experience and advice between countries are established
	Timeframe: 1996–2001** Partners: DDM/Harvard, Abt Associates, PAHO, Management Sciences for Health	Timeframe: 1997–2001 Partners: PAHO, DDM/Harvard, Abt Associates, Management Sciences for Health	Timeframe: 1997–2001 Partners: PAHO, In-country interested parties,* Abt Associates	Timeframe: 1997–2001 Partners: PAHO, In-country interested parties, Abt Associates, DDM/Harvard, Management Sciences for Health
Projects used to implement activities	598-0825, Health Priorities Project 938-5974.13, Partnerships for Health Reform 938-5991.01, Data for Decision-making in the Health Sector 938-3055, Family Planning Management Development	598-0825, Health Priorities Project 938-5974.13, Partnerships for Health Reform 938-5991.01, Data for Decision-making in the Health Sector 938-3055, Family Planning Management Development	598-0825, Health Priorities Project 938-5974.13, Partnerships for Health Reform	598-0825, Health Priorities Project 938-5974.13, Partnerships for Health Reform 938-5991.01, Data for Decision-making in the Health Sector 938-3055, Family Planning Management Development
Critical Assumptions (for this Results Package)		Government and nongovernment health providers, professional societies, university faculty willing to participate together in reform efforts In-country interested parties can mobilize political will to re–direct resources (time, personnel, and money) to reforms that increase equitable access to basic health services Donors continue to fund capital costs for country health reform design and implementation, including technical assistance, studies, and systems design/implementation		

Source: USAID PHN/LAC/RSD, July 1, 1997

*In-country interested parties will vary by country; many LAC countries have a Health Sector Reform Team with members from the government, NGOs, universities, and/or professional societies—and in some cases, international agencies.

**Following the presentation of this Results Framework in the 1996 R4, PHR and DDM began using FY 95 x-G field support funds for these activities.

B. INTERMEDIATE RESULT CONSISTENCY AND INDICATOR FOCUS

All of the regional IRs are within the Initiative's range of capability. However, the indicators used to measure IR 1 and IR 4 go beyond the measurement of delivered products and services. These indicators seek to measure change in client behavior. Those indicators related to the number of countries using tools and methodologies (IR 1) and the indicator referring to the application of lessons learned from the study tours (IR 4) are measured by observed behavioral change. That is, are the clients doing something different as a result of Initiative activities?

The concept of use in the IR 1 indicator is different for the NHA methodology. It seeks not only use but also institutionalization. This distinction clearly indicates two levels of use: which use is to be measured by the Initiative and for which methodology or tool. Should all or only some be institutionalized?

Further complicating the measurement of IR 1 is the definition of key actors. Operationally, key actors are defined as those who can significantly affect health sector reform in each of the 13 targeted countries. This includes the selection of government versus nongovernment individuals for implementation arrangements.

It is not clear why two NGO papers (PHR[7]) are included in IR 1: Tools and methodologies, and two papers (FPMD[8]) are included in IR 4: Exchange or sharing experiences.[9] This expected result appears to be more related to IR 4 than to IR 1, to sharing experiences, creating networks, and generating scenarios for cooperation.

One indicator used to measure IR 2 also goes beyond the availability of information services by analyzing the use of electronic services by Initiative customers. This same type of problem is found with the indicator measuring achievement of IR 3. Instead of measuring the feedback provided by countries, the indicator measures the use of the methodology for monitoring health reform at the country level.

The indicator selected for measuring the achievement of IR 4 does not measure the result as such (opportunities for sharing established). Instead, the indicator measures the effect that the sharing has had on the participants in terms of applying lessons learned (taking steps based on lessons learned).

[7] PHR: *NGOs' Role in Health Sector Reform Policy* and *Public Sector Contracting of NGOs for the Provision of Health Services*.

[8] FPMD: *Public/NGO Partnerships in Response to Decentralization* and *Public/NGO Partnerships for Quality Assurance*.

[9] This observation is even more important if it is understood that the four NGO papers were produced under an overall, joint NGO strategy. The regional meeting and the papers' preparation are not isolated sets of activities. They were intended to gather regional experience with public/NGO partnerships that would provide input to a larger meeting between public sector and NGO participants. This latter meeting took place in Managua, April 3–7, 2000.

C. COMPARING THE HEALTH REFORM RESULTS PACKAGE INDICATORS[10] WITH THE ACTUAL INITIATIVE FRAMEWORK

Two changes were made in the Strategic Objective. The first changed the goal to be achieved from 50 percent of Initiative countries to all target countries. The second modified the denominator from "Initiative" to "Results Package," changed "methodologies" to "methods," and used "sharing" instead of "exchanges." That new definition of the Strategic Objective indicator has not overcome the inconsistencies found by the midterm evaluation.

In IR 1, the indicator is changed from methodologies and tools "used" to "actively used" by key stakeholders. Consequently, the limitations mentioned above with respect to this IR and its indicator have not been overcome. However, the shift from "used" to "actively used" could be interpreted as recognition by the steering committee of the difficulty in operationally defining and assessing the use of tools and methodologies by countries. "Actively used" needs to be defined.

The IR 2 indicator measuring user satisfaction with electronic services was moved to IR 4. This reflects a positive change recognizing the interactive scenario provided by the web site and related services and is consistent with findings in the section on dissemination/communication strategy in this report.

D. VALIDITY AND FEASIBILITY OF THE INITIATIVE FRAMEWORK

The evaluation data suggest that a more refined approach than currently exists for measuring results is needed. The original Results Framework is still consistent in its design but different types of indicators should be tracked at each level.

At the country level (level 2), indicators should be tracked that reflect changes in behavior, such as use of tools and methodologies, use of information and communication services, or steps taken according to lessons learned, and that will generate the necessary inputs in order to create macro indicators: *x* number of countries or *x* percent of countries using *y* methodology by *z* time.

At the regional level (level 3), the focus should be on tracking indicators for efficient delivery of products and services, such as:

- *x* number of methodologies developed, tested, ready to use, and ready to disseminate;
- number and type of publications produced and received by targeted audiences;
- articles printed and distributed;

[10] See appendix B, Health Sector Reform Results Package Indicators, Approved in February 2000.

- electronic services provided; and
- a forum on reform relevant subjects organized.

An example for IR 1 would be the following:

- Level 2 (country): Methodologies and tools adapted and used for analysis and design, implementation, and monitoring of country health sector reforms.
  - Type of indicator: *x* number of countries using *y* methodology by *z* time.
- Level 3 (regional): Methodologies and tools developed, tested, and disseminated for analysis, design, implementation, and monitoring of country health sector reforms.
  - Type of indicators:
    - *x* type of methodology developed by *z* time,
    - *x* type of methodology tested in *y* number of countries by *z* time, and
    - *x* type of methodology disseminated to *y* number of key stakeholders in *z* countries in *t* time.

Additionally, a set of criteria is needed for determining the type of information necessary for tracking the status of the indicators, including customer feedback and the methods used to obtain and objectively measure the data.

There are also external factors that are relevant to achieving expected results at the national level. The direct linkage between regional and national levels can be jeopardized if these factors are not taken into account, and in some cases, actively managed. For example, national institutional capacity is external to the Initiative, but it can be managed (influenced). For instance, creating a baseline through a rapid institutional assessment and then incorporating the results into the country Initiative design could be one step toward improving institutional capacity.

In summary, the Initiative framework is a workable instrument, but only if it is refined in scope and measures what it is responsible for measuring. There is a tendency to confuse the Initiative's regional mandate with the desire for results at the country level.

IV. EFFECTIVENESS

A. PROGRESS AND ACHIEVEMENTS

This analysis focuses on the factors affecting the effectiveness of the Initiative in facilitating targeted countries to integrate lessons learned in terms of building institutional capacity for health reform. A key hypothesis guided the analysis of the data, namely that a set of factors or variables (some of them within the control of the Initiative and others beyond its control [see appendix E for the conceptual and methodological framework]) affects the achievement of the Initiative's IRs and SO. The evaluation of achievements and progress at this point in time focuses not only on the four Intermediate Results and indicators but also on the expected results for each of the Initiative's methodologies, tools, experiences, and exchanges (see appendix F). Using proxy indicators, the following section examines each of the methodologies, tools, experiences, and exchanges and reports findings regarding progress and achievements (see appendix H for the database with data for each activity by country, institution, and key informants individually).

B. INTERMEDIATE RESULTS ANALYSIS

INTERMEDIATE RESULT 1: Methodologies and tools developed, tested, and disseminated for analysis and design, implementation, and monitoring of country health sector reforms.

INDICATOR 1: All methodologies and tools used by key actors in 50 percent of countries where introduced.[11]

National Health Accounts (PAHO, PHR, and DDM)

NHA is successfully used by two of the three countries studied but is not being institutionalized in any of them. It is a demand-driven methodology that is considered to be of good to high quality, with strong partnership at the central level. Its implementation has complemented the regional approach with country orientation and an interinstitutional strategy. The use of NHA by the Ministry of Health (MOH) in two of the countries is due mostly to NHA being part of the reform agenda and supported by a consensus of key stakeholders. In one case, NHA is being used exclusively by the Ministry of Finance (MOF) because the MOH does not have the political will to promote, support, and use NHA. Continuity and stability of key staff as well as an Initiative

[11] See appendix I for evaluation results by each activity by IRs 1, 3, and 4 and their indicators with detailed data by indicator, specific analysis, and outcomes discussion. Most of the results are the expression of key informants' perception (see the operational definition of each indicator in appendix E). Although the health sector analysis tool actually is being used in two countries (Paraguay and Nicaragua), it was not evaluated because these two countries were not part of the case study.

partnership supports its use at the national level. Headquarters and local partner offices are aligned in supporting NHA efforts. Difficulties in institutionalization appear to be related to the lack of a health reform policy, political interference in decision-making, MOH institutional weaknesses, and limited adaptation of the tool to national requirements.

Framework for Detailed Implementation Plans of HSR and Master Plans for Investment (MPI) (PAHO)

This tool is in the development and testing stage in Honduras and key MOH staff is knowledgeable of it. In this country, there is a political coalescence regarding the need for the tool. It is on the reform agenda, is perceived as high quality, and is a demand-driven methodology. There is stability and continuity of key actors favoring the use of MPI and alignment between PAHO headquarters and country office partnership efforts. Lessons learned from the analysis of experiences for implementation and institutionalization purposes are that centralized training should be accompanied by decentralized technical assistance, the MOH needs to be strengthened, an Initiative partnership needs to exist at the country level, and the methodology needs to be adapted to country circumstances. Because information was not available to the evaluation team regarding the experience in Nicaragua, broad conclusions could not be drawn and patterns or general trends could not be determined.

Decentralization Applied Research (Decision Space) (DDM)

The tool is in the development and testing process and is assessed on that basis. It is not possible to make a final evaluation of the degree of knowledge and application of this technical assistance based only on the data from Honduras. The small number of respondents does not lend itself to general conclusions or trends. In Honduras, the tool is perceived more as technical assistance than as a tool per se. Even though it is not broadly known and used by MOH staff, it is a research tool that appears to have value in promoting and supporting decentralization of the health system. The dissemination of this experience through the World Bank Flagship courses may facilitate broad regional application of the research findings to health system decentralization. This is because participation in these courses by MOH staff and reform unit consultants is encouraged and gives them the opportunity to learn and analyze the research findings on decentralization from various countries.

DDM used the preliminary results from the decentralization and policy process applied research projects to develop the decentralization module for the World Bank Flagship course in Washington and in regional courses in China, Thailand, Malaysia, Hungary, and Chile. The course is used by the World Bank to build capacity for health reform around the world—targeted toward middle and high-level officials and private sector leaders. The Economic Development Institute of the World Bank (Human Resource and Poverty Division) has promoted the Flagship course since November 1997. It is a 1–month course in Washington but usually 10 days in regional courses. “The Flagship course aims to provide an integrated and coherent learning program covering health

sector reform and financing options…" This learning is expected to improve the performance of client country participants in their work in their countries, as well as the related work of bank staff participants. It is also expected to "stimulate participation and sharing of experiences in health economics and financing networks, via the Internet" (World Bank–EDI, "Flagship Course on Health Sector Reform and Sustainable Financing," October 1997).

Health Policy Process Applied Research (DDM)

As with the above activity, this tool is in the development and testing process and is assessed on that basis. It is not possible to make a definitive evaluation based on data from a small number of respondents in Honduras. Specifically, the results show that it is known and used by a small number of key MOH staff of Honduras and that it is seen as providing technical assistance that supports the policy process. It appears to have potential value for promoting and supporting national leadership and stewardship of HSR. Consistent with the experience with the previous activity, the dissemination of the research findings through World Bank Flagship courses may facilitate the introduction and application of policy process analysis in promoting health sector reform on a regional basis.

Sustainability Tool (MOST), Cost Revenue Analysis Tool (CORE) and Management Organizational Performance Incentive System (PYS) (FPMD)

These are tools that have been field tested and successfully introduced in a number of organizations around the world. The Initiative's contribution was to provide for translation into Spanish, dissemination, and training a cadre of facilitators. Due to the small sampling size, general conclusions cannot be made about awareness or the use of these tools. They cannot be evaluated on the same basis as the rest of the tools and experiences because the approach and institutional strategy for the test and implementation of these tools is very different. In this case, the partner does not follow the regional or even a country approach or institutional strategy (for example, MOH participation). Because the focus is the NGOs but without the participation of the public sector, it gives a different perspective to the evaluation process and results. It is not possible to use the same type of respondents used for other methodologies in each country since the key actors in health reform knew neither the NGOs nor the tools. The only exception is INSALUD in the Dominican Republic. Since it was not possible to identify at the country level other respondents for the evaluation of these tools, the findings are restricted to application of the tools at the NGO level, which yielded less valid results concerning these tools.

In summary, respondents evaluated CORE and PYS as useful for improving the organization of their NGOs; they did not find MOST useful. However, an overriding issue with respect to NGOs is that they are only incorporated in a limited way into the national health system. Although the tools are valuable in increasing NGO capacity, to increase their value to the health sector, NGOs need to be incorporated into the country's health system.

Management and Organizational Sustainability Tool (MOST)

There have not been any MOST training workshops held in the three countries visited and only two informants were knowledgeable of this tool. One of the respondents interviewed perceived the quality of the tool as fair to bad. He had not received any training and was not aware of specific application of the tool to his NGO. The second respondent explained that his organization is using another tool for management and organizational purposes (Evaluación de Desarrollo Gerencial [EDG]) and does not have an informed opinion regarding MOST.

Cost Revenue Analysis Tool (CORE) and Performance Incentive System (PYS)

CORE and PYS were evaluated in one NGO in Honduras that is using the tools. They were considered to be of high quality. Staff was provided with proper training and the tools were meeting and satisfying the NGO's need.[12]

Initiative NGO Strategy

The two NGO papers of the Public Heath Reform Project (PHR), *NGOs' Role in Health Sector Reform Policy* and *Public Sector Contracting of NGOs for the Provision of Health Services*, are associated with IR 1. The two FPMD papers *Public/NGO Partnerships in Response to Decentralization and Public/NGO Partnerships for Quality Assurance* are within activities of IR 4. Since these four NGO papers were produced under a joint NGO strategy, all the NGO–related activities are reported on a one-by-one basis here. In some cases, lessons learned show different country results with the same Initiative experiences. Moreover, it would be useful to define the specific need for technical assistance by the NGO as it relates to the country policy on NGO participation. Another is related to the Initiative institutional strategy for working with NGOs. Respondents believed that it would be better to have public officials and NGO managers together in workshops. However, this requires weighing the trade-off between the present practice of including only NGO representatives in the meetings to facilitate an open exchange of views among NGO participants and achieving joint participation of public sector and NGO organizations. It would be useful if partners could agree at both the central and country levels on the strategy for inclusion of private sector and NGO participation in the health system and health sector reform.

NGOs in Health Reform Policy (PHR)

This tool is in the development and testing process and is assessed on that basis. The findings show significant differences between the two countries with the same Initiative experience. In one country, there is sharing of information with other workshop participants and workshop results are being used to help incorporate NGOs into the

[12] It is not possible to estimate the impact that a separate endeavor of FPMD has on the use and applicability of these tools.

health system. An important number of respondents acknowledged the use of workshop results for NGO participation in HSR. In all likelihood, the participants had circulated and disseminated results of the workshop widely among key actors. In this case, the workshops have been used to support a country process and respondents see the experience as highly useful to the incorporation of NGOs into the health reform process. However, in the other country, although respondents participated in this same workshop, they did not perceive these experiences as useful for supporting community participation efforts in health care. It is notable that in both countries, respondents perceive weak institutional capacity on the part of both the MOH and NGOs that limits NGO incorporation into HSR. Contributing to this is a lack of local partnership in tool development in this area. In fact, one of the partners (PAHO) perceived the NGO strategy as a PHR/USAID initiative.

Public Sector Contracting of NGOs for the Provision of Health Services (PHR)

The results for this NGO experience are similar to the previous one. This tool is in the development and testing process and is assessed on that basis. There were similar significant differences with the same Initiative experience in the two participating countries visited by the evaluation team. In one country, there is sharing of information with other workshop participants and workshop results are being used to support the inclusion of NGOs in the health sector as health providers. An important number of respondents acknowledge the use of workshop results and see the experience as highly useful. However, in the other country, although respondents participated in the same workshop, they did not perceive these experiences as useful for what they are doing in community participation in health care. Again, in both countries there is a perception of weak institutional capacity in both the MOH and NGOs. This limits the MOH in contracting NGOs for health service delivery. Similarly, there was a lack of local partnership in the development of a tool in this area.

NGOs in Decentralized Systems and NGO Quality Assurance (FPMD)

It is not possible to show general trends and patterns regarding these two experiences because there was only one key informant in the case study. As with the two tools above, they are in the development and testing process. The respondent identified the Initiative institutional strategy of directing actions exclusively to NGOs as limited to the implementation of workshop results and the opportunity and means to share experiences and advice among countries.

NGOs in Decentralized Systems (FPMD)

As a result of the workshop, NGOs in Decentralized Systems, the respondent has shared information with other NGOs and also has taken concrete steps to promote NGO participation in a decentralized health system. He evaluated this workshop as being of high quality and needed for the national decentralization process. He affirmed that only the working group on NGOs in a decentralized system had been useful.

NGOs Quality Assurance (FPMD)

As a contrast, he perceived the NGO Quality Assurance workshop as being of poor quality and not demand driven at this moment. Nevertheless, he affirmed that it could be very useful to the current health reform process in his country. He believes the lack of use and sharing of information gained from this workshop is what contributed most to its poor quality.

INTERMEDIATE RESULT 2: Information on health reform efforts and experiences gathered and made widely available to interested parties in LAC countries and to health sector donors.

INDICATOR 2a: At least five different institutions in each of the LAC Initiative target countries report receiving Initiative materials.

INDICATOR 2b: Fifty percent of electronic network users surveyed report finding network services useful. [13]

IR 2 is related to actions of the dissemination or communications strategy. This section discusses the level of achievement of each indicator and subsequently introduces concepts and mechanisms to broaden the dissemination effort towards a new development communications paradigm. It also discusses specific questions raised in the scope of work.

Five Institutions in Each Country Report Receiving Initiative's Materials

According to 1999 figures (see the Initiative 1999 report) and data gathered (see appendix J on communication issues) by the evaluation team in the three countries, this indicator has been achieved. While 50 percent of respondents reported receiving the materials, 30 percent reported irregular distribution.

The Initiative changed the focus of this indicator from individuals to institutions in 1999. However, it requires further refinement in order to measure it. Distribution lists continue to be based on key individuals at the institutions. Moreover, the indicator does not specify the number of individuals needed to report receiving materials to assume that the institution is receiving materials.

The indicator is incomplete as presently written in that it does not take into consideration a key aspect of IR 2—distribution to the donor community related to health sector reform. Beyond that, this indicator does not measure what clients do with the materials. In spite of this, the findings do substantiate the usefulness of printed materials. Within the group of respondents who reported receiving printed materials from the Initiative, more than 60 percent perceive them as useful or very useful and report that their main use is for improving performance, sharing experiences, increasing knowledge on the reform, and/or

[13] See appendix J for the results on the dissemination strategy.

becoming acquainted with new developments. There is a clear demand for printed materials (see appendix J).

A different type of product—the newsletter—is an effort that goes beyond the dissemination view and that could be an effective tool for offering an updated status of reform initiatives, successes, and challenges, if its content is improved with different types of stakeholders expressing their views. A clear effort in designing the newsletter with a more inclusive approach than it has currently is perceived, even if the first edition is still reflecting a top-down approach (see appendix K).

Fifty Percent of Electronic Network Users Surveyed Report Finding Services Useful

This indicator is intended to measure client satisfaction with the electronic provision of materials. The Initiative used different ways to measure client satisfaction with this service in 1999. The primary way was a survey that did not give a clear picture of the level of usefulness of the services. While 78 percent of individuals who responded to the survey are reported to have found the services useful, this is based only on a 10 percent return of those surveyed (more than 300). From a statistical point of view, this low a level of responses makes it difficult to validate the results for the universe selected. Another way to assess the usefulness of electronic services is to use a proxy indicator to record the number of hits on the web site. The assumption, not entirely accepted in the industry but used by PAHO in this instance, considers that an average of seven hits can be considered as constituting a user. This would lead to the conclusion that 100,000 users were visiting the site. This figure needs to be viewed with some skepticism in as much as several hits can be recorded by just opening the front page of the web site. Additionally, the use of proxy servers makes it difficult to create a clear relationship of cause and effect between the number of hits and the number of users. (See appendix L for data gathered by PAHO for the numbers of hits/users on the LAC/RSD web site.)

According to data from the three countries and the responses received from other countries to validate them, the LAC HSR web site has a 6 percent average share of the market of Internet users interested in health reform–related issues. However, when this 6 percent is asked about its perception of the Initiative's electronic services, a clear majority rates them as "good" to "very good." This means that even if the number of users is low, the regular clients of the web page value the services as useful.

In some countries, such as Peru, the World Bank's web site has almost twice the share (11 percent) of the market than the Dominican Republic and Honduras; the preferences are clearly linked to the use of search engines as a way to obtain the information needed (21 percent). In some cases, the PAHO or PHR web pages received a higher score than the Initiative's web site.

Another consideration is the open medium nature of the Internet. PAHO data suggest that there are other groups of possible users beyond the core group who could be attracted to it for different reasons. The evaluation data show that there is a need for broader marketing in order to increase the number of users of the Initiative's web page. New

services could make the web page more attractive to potential users and increase its share of the market.

Beyond IR 2: Is the dissemination strategy working? Is it contributing to a sustainable behavioral change?

Official Initiative documents characterize the effort of promoting knowledge and related activities about its tools and methodologies indistinctly as dissemination, information, or communications strategy.

According to available documents, the process of establishing such a strategy began in 1997, continued during 1998, and was refined in 1999. Yet, even with this effort, data show that the conceptual framework of the dissemination strategy was not clearly deployed. The terms communications, dissemination, and information continued to be used in a quasi-interchangeable way (see appendix M).

This conceptual lack of specificity has an impact on the relationships between the recipients of the information and the way they interact. Dissemination implies a vertical flow orientation from the sender to preselected recipients. Communications implies the establishment of at least a two-way information flow whereby the targeted audiences interact within the space of different selected media. Development communications is a synthesis of social marketing, public relations, and media advocacy applied to development projects (see appendix N).

The scope of work and the specific questions contained in it along with comments from Initiative partners at the debriefing meeting (March 16, 2000), suggest that the analysis of IR 2 should go beyond its accomplishments as noted above and answer the basic evaluation questions: Is there a better way? Is it sustainable?

Examination of the differences between the dissemination strategy generated by the project and the traditional categories or approaches used in this field constitute a basic starting point. They reinforce the understanding that the needs of the Initiative are not solved by one simple framework (see appendix N).

The Results Framework and the delivery of information and/or communications products and services are related to changes in knowledge, patterns, attitudes, and behavior (KPAB)[14] in key selected audiences. The use of information/communication services in relation to certain tools contributes to the accomplishment of IR 1. At the SO level, generating capacity building at the national level will result in the use of these services for policy development, decision-making, and other strategies.

Questionnaires used by the evaluation team focused on how the partners and their clients defined the targeted audiences, the messages selected, the media to be used for channeling the messages, the branding of the strategy, and the way it is managed. These are discussed in greater detail below.

[14] Composite index used as a standard within communication components in health-related projects.

The Audiences[15]

There is substantive agreement among the partners that the following are key targeted audiences:

- key officials involved in health sector reform,
- academics working on health sector reform–related issues,
- key decision-makers at the multilateral regional and international institutions, and
- other governmental officials related to the area.

Additional groups revealed through evaluation data to be targeted include:

- key decision-makers at NGOs,
- journalists covering health issues,
- private sector decision-makers,
- national legislators concerned and working with health issues, and
- public opinion and health personnel.

Evaluation data document that different perceptions of audiences to be targeted will affect the type of communications products and services to be delivered and the kind of media to be used in an outreach effort such as this.

There is a broad perception that the audiences are much more segmented than originally thought and that other audiences need to be taken into account and given attention by the strategy.

Beyond the audiences defined by the Initiative, a clear majority of respondents agree that the following new audiences should be taken into account:

- national legislators dealing with health issues,
- key individuals in the media who work with health issues and who have access to the targeted audiences,
- private sector representatives involved with health, and
- professionals (physicians and health personnel).

Many of the respondents included public opinion as a whole as a new audience.

[15] See *Guidelines for Dissemination and Communication*, April 1998, and appendix O for partners' opinions on targeting audiences and media selected by the Initiative.

Main Messages and Media Defined by the Strategy

The first step in message development derives from audience screening or stakeholder analysis that defines the type of problems and topics that interest each selected audience in relation to specific themes relevant to health sector reform. Audience screening provides important data for developing key messages to be delivered through the strategy and different media channels.

The basic criteria should be that messages crafted and delivered respond to audience problems and interests. If not, a communications gap or blockade between the sender and the recipient(s) may result.

In the case of the dissemination strategy (see appendix J), partner interviews indicated that both the messages and the selected dissemination media were the result of the dissemination content of the strategy. This means that the messages created by the strategy are general, for the most part, and not tailored to the information needs of the audiences. Most contain a basic explanation of the Initiative's services. Some messages are related to a brief explanation of specific tools and methodologies developed by the Initiative (see appendix M).

From a dissemination point of view, the idea is to make information on Initiative products and services available to a core list of defined Initiative targeted audiences. The assumption is that targeting potential users would increase access and facilitate the use of information on Initiative tools and methodologies and, in the long term, increase health sector capacity and service delivery.

From the customer's point of view, evaluation data reveal two main findings regarding their information needs. Respondents report that

- key areas of concern related to health reform are aligned with the areas covered by Initiative tools and methodologies; and

- the following additional information needs are not covered by Initiative information or should be covered in greater detail:

    - information related to experiences of health reform,
    - health information systems,
    - reproductive health,
    - legal framework, and
    - social participation.

Even assuming that the tools/methodologies developed are customer demand driven, the changes in KPAB expected within the key audiences seem to be related to a more sophisticated set of factors, that is,

- how other decision-makers (political, opinion leaders, civil society) interact and if they can create synergy favoring a positive scenario for the use of Initiative tools and methodologies;

- how these influencers affect the core health sector reform group;

- how the use of information/communication tools increases name recognition and bargaining capacity of key actors who are willing to move forward but need to ease local resistance; and

- the adequacy of the media selected for carrying the messages. (This is discussed further in the following sections.)

The media selected by the strategy include printed series, brochures, an Internet web page, and newsletters.

Some individual and sporadic interventions leading to publications in international media, although encouraging, were not part of the original strategy (reports from CNN–En Español, channeled through PAHO).

Of the four media selected, both the printed materials and the brochures are consistent with the dissemination view. However, the web page and the Internet are interactive communication tools and should be designed and managed accordingly.

The potential of the Internet as a communications media has not been fully exploited by the web site. Strategy weaknesses here, similar to findings in printed media, derive from a restricted view of targeted audiences and a lack of audience screening and stakeholder analysis for message development.

In terms of the media to be used in the future, interview data show that all partners and a clear majority of respondents in the three countries favor including other types of media (see appendix J). Other media selected, in order of priority, were

- opinion editorials in regional and national newspapers and magazines,
- short videotapes,
- participation in television programs,
- teleconferences, and
- radio programs.

Brand Recognition

The evaluation team was asked to assess whether Initiative brand recognition is a contributing factor for attaining the Initiative and Intermediate Results. Partners and respondents in the three countries concurred that there is weak brand recognition of the Initiative (see appendix J and data processed from interviews with the partners).

A successful communications strategy needs to establish consistency between targeted and key messages to be delivered, media to be used, and corporate image. Brand recognition is vital to communicating the Initiative's comparative advantage in the health sector market and in differentiating its services and products from others. Some of the reasons for weak brand recognition are discussed below.

USAID and PAHO have established regional and sectorwide brand recognition. Project leadership and the dissemination task force perceive the task of creating brand recognition mainly as communicating the cooperative effort between the Initiative and its partners. The goal is for customers to recognize the involvement of PAHO/USAID and their partners and to attach importance to the cooperative and value-added scope and nature of the Initiative. However, many customers already have established working relations with one or more Initiative partners. This limits present Initiative brand recognition as a unique regional framework because in some instances, a partner's brand is more recognized than the Initiative's brand.

The majority of Initiative partners, with the exception of PAHO, believe that brand recognition is occasionally present. Only PAHO staff perceives that the Initiative presents a corporate image. Country data show that brand recognition is weak and that branding is primarily related to Initiative partners and secondarily with the Initiative itself. An unresolved (and challenging) issue is how to develop a corporate branding while preserving individual partner identity. (This is discussed in the recommendations section.)

Health sector reform champions are not identified and used for branding. A way to strengthen the Initiative brand and to promote Initiative identification is related to the identification of reform champions in the differently targeted audiences. The words and actions of those champions will echo strongly at the regional level. Interaction at that level would have an impact at the national level. That will further reinforce identification and perceptions about the Initiative and its unique regional advantage.

The marketing strategy has a limited scope. Consistent with the dissemination view, the marketing component includes the web site, the newsletter, study tours, forums, and the efforts conducted by PAHO and USAID at the national level. However, there was no structured marketing campaign addressing regional media, regional professional magazines, national media outlets as unpaid advertisements (press releases distributed to selected media), institutional exchanges, and others. The lack of this type of marketing diminishes the probability of clear brand positioning.

In order to develop brand recognition, the logo and acronyms are important elements. If this is an Inter-American project, it also includes North America and the Caribbean. The logo map gives the impression of a South American project. In addition, the use of

acronyms is heavy and not self-explanatory, making brand recognition even more difficult. LAC is not an acronym used in Latin America and its combination with RSS makes it more complicated to understand. To achieve the best results, both the logo and the acronym need to be explicit, comprehensive in terms of messages conveyed, and self-explanatory.

A simple logo idea such as the above, even if it does not relate immediately to the reform issue, is clear in terms of the scope of the project and the countries involved. It is easier to remember and promotes the Strategic Objective related to improved health in the whole region.

The colors selected for the brochures and other printed materials are part of the branding and are a key input in the type of messages that the strategy would like to convey. An aggressive message is consistent with the colors selected (pinkish orange/blue); a persuasive message will be more consistent with varieties of beige or similar colors. The three triangles used in the printed documents do not convey any special message and may actually confuse the reader.

Lessons Learned at the National Level

Even if the dissemination strategy is regional in nature, developments at the national level have shown that communication actions can accelerate the process of achieving IR 1. In the Dominican Republic and Honduras, there is an ongoing process of consultation. It targets several audiences with the objective of building a national coalition to establish a participatory approach for health sector reform and related development. This is especially true in the case of the Dominican Republic, where the impact in the national media reinforces and contributes to the process of building a national consensus among decision-makers.

Furthermore, the number of audiences targeted in the Dominican Republic includes new groups beyond those previously defined by the strategy. Actions associated with these new groups include

- consultation workshops,
- development of newsletters,
- media coverage,
- opinion editorial articles, and
- television coverage.

Lessons emerging from the field show that a broad communications policy at the regional level can have an effect on strengthening coalition building at the national level.

INTERMEDIATE RESULT 3: Reform processes, specifically related to equitable access, and outcomes monitored, and feedback provided to countries, donors and other partners.

INDICATOR 3a: All LAC Initiative countries monitor health sector reform using framework established by PAHO. [16]

INDICATOR 3b: Regional monitoring system for comparative analysis for health sector reform institutionalized by PAHO. [17]

Monitoring Health Reform (PAHO)

The framework for monitoring health reform (MHR) is well known but is used in only one of the three countries evaluated—the Dominican Republic—where it is being adapted to national conditions and the Dominican health reform process. The methodology is perceived as needed and of high quality. The training and technical assistance met national expectations, and its implementation has complemented the regional approach with a country orientation along with a participatory consensual development process with key stakeholders. There is a strong alignment of Initiative partners at the local level and an alignment of headquarters and local partner efforts. The methodology is part of the country's partner-consultant specific tool-related terms of reference. There is a national consensus on the need for monitoring health reform and the key stakeholders acknowledge that the theme is on the reform agenda. Stability and continuity of key actors support the use of the MHR. Specifically in this country, the MOH is perceived as having the institutional capacity to drive and perfect the use of the methodology. The framework has not been institutionalized in any of the three visited countries. The general impression is that lack of institutionalization appears to be related to weak political will to monitor health reform, absence of a public policy on health reform, and political interference in decision-making at the MOH.

Some divergence was found between the midterm evaluation results and the Initiative's FY 99 annual report. The evaluation shows that one country out of three is employing the PAHO framework. But the Initiative's annual report states that 11 countries have achieved this goal: "The LAC Initiative has had a significant impact on the target countries' capability to assess health sector problems and to design, implement and monitor reform."[18] To support this statement, the Initiative uses the approval of this methodology by the ministers of health in Resolution CD41.R12 by the 41st Directing Council of PAHO (San Juan, Puerto Rico, September 1999[19]). Two hypotheses are

[16] See appendix I for the evaluation results by activity by IR 3 and its indicator with detailed data by indicator, specific analysis, and outcomes discussion. Most of the results are the expression of key informants' perceptions (see operational definition of each indicator in appendix F).
[17] This indicator was not considered because it is in the development stage.
[18] *LAC Health Sector Reform Initiative*, Annual Report FY 99, p. 1.
[19] This resolution states: 1) recognize the efforts to design and implement the methodology for monitoring and evaluating health sector reform in Latin America and the Caribbean (methodology that was designed and implemented by the LAC Initiative) and 2) urge member states to institutionalize the monitoring and evaluation of their health sector reform processes and apply policies that take into account the results of those processes.

offered to explain this contradiction. The first one is related to the indicator that is used by the partners to track the use of the methodology. Thus, while there is recognition of the need for the methodology by the ministers of health—as shown by the 41st Directing Council of PAHO—this has not been translated into acceptance or action by their ministry teams. Using acceptance of the resolution by the ministers of health is the prerequisite for tracking the use of this methodology. Indeed, this could bias results and brings into question whether the right metric for use or full application is being tracked. The second hypothesis is that the structure or quality of the instrument and the process through which it is deployed may have inhibited implementation and institutionalization.

INTERMEDIATE RESULT 4: Opportunities and means to share experience and advice among countries are established.

INDICATOR 4: Fifty percent of participants surveyed report taking steps based on lessons learned in fora. [20]

Payment Mechanisms Forum (PAHO)

Two of the three countries—Peru and the Dominican Republic—participated in the workshop. Respondents reported that no steps had been taken as a result of this forum. In the Dominican Republic, two informants were aware of the actual implementation of new payment mechanisms in the health system. In Peru, even though a significant number of informants were aware of the implementation of new payment mechanisms to providers, only one actor recognized the forum as input, that is, having provided information, for the implementation of these mechanisms. The evaluation case study results show a tendency that deserves further study: namely, that no steps had been taken using forum experience as input. Respondents perceived that the forum was not demand driven. In fact, they reported that the regional workshop did not take into account their national needs, previous technical conditions, and health system particularities. There was no clear institutional strategy in choosing the participants for the forum, and no communication or dissemination strategy subsequently at the national level. There were indications that at the time of the forum, headquarters and country partners were not aligned. The fact that one country is implementing new payment mechanisms and the other has not yet initiated any action can be associated with the following factors: in the former, there has been a political decision to support payment mechanisms; it has put the topic on the health sector reform agenda and achieved a national consensus regarding the need for new payment mechanisms in the health system. Moreover, there is an Initiative partnership at the national level regarding payment mechanisms. Key actors of both countries, however, perceived a weak legal framework and/or institutional capacity for introducing new payment mechanisms in health services.

Study Tour to Colombia (PHR)

[20] See appendix I for the evaluation results by activity by IR 4 and its indicator with detailed data by indicator, specific analysis, and outcomes discussion. Most of the results are the expression of key informants' perceptions (see operational definition of each indicator in appendix F).

MOH officials and hospital directors from two of the three countries evaluated perceived that they were promoting hospital autonomy and reported taking steps based on lessons learned on the study tour. Some possible explanations of this outcome are that the study tour was perceived in this country as pertinent and applicable, there was an Initiative partnership at the national level on hospital autonomy, and there was a political decision and national policy promoting hospital autonomy. Moreover, the tour was perceived as being of high quality. In the other participating country, MOH officials stipulated that they were working on hospital autonomy but not as a result of the study tour experience. In this case, respondents perceived that the quality of the tour was between fair to good. In both countries, the hospital autonomy issue is on the health reform agenda and there is headquarters and local hospital alignment in the hospital autonomy effort. However, there was no communication and dissemination strategy at the national level. Moreover, respondents did not perceive that they had a legal framework to support hospital autonomy nor was the study tour designed to be adapted to national needs for implementation purposes.

Study Tours to Panama (PAHO)

The key actors in two participating countries in the study tour to Panama perceived themselves as promoting and taking actions to increase hospital autonomy. In both cases, the key informants recognized the use of the study tour as providing input for implementing steps in hospital autonomy. Some of the possible explanations of this outcome are that, in both cases, the hospital autonomy issue is on the health reform agenda and the tours were perceived by MOH officials and hospital directors as being of high quality, pertinent, and applicable. Moreover, there is an Initiative partnership at the national level and also a headquarters and local alignment regarding the hospital autonomy effort. But, as with the study tour to Colombia, there is no national communication and dissemination strategy. Moreover, respondents perceived that there was no legal framework to support this policy and that the study tour was not designed to be adapted to their countries, thus limiting implementation.

Study Tour to Canada (PAHO)

Only one case was reviewed and although the experience is evaluated as being of high quality and applicability, perceived constraints at the country level make application of the study tour experience difficult. Among them are the lack of a public policy on health reform and the limited institutional capacity of the MOH. The informants also perceived an additional constraint; the study tour experience was not accompanied by an in-country orientation for implementation purposes.

C. SUMMARY OF FINDINGS AND ANALYSIS OF THE STRATEGIC OBJECTIVE

Is the Initiative facilitating countries in achieving effective policy interventions and delivery of selected health services? Have countries studied integrated lessons learned from the Initiative? Have they been useful in building institutional capacity for health

reform and consequently delivering country health reforms more effectively and providing selected health services and policy interventions in a more effective manner than they had been? (It is important to note that the evaluation team was asked to focus the evaluation design on the progress towards Intermediate Result achievement more than on accomplishment of the Strategic Objective.) With this guidance, no evaluation of changes in health service delivery was made in the three countries. In most cases, results are useful for drawing meaningful lessons regarding factors that have affected attainment of Intermediate Results and are valuable for guiding the second half of the implementation of the Initiative towards the accomplishment of the Strategic Objective.

Although the evaluation did not explicitly focus on service delivery, one can still examine whether achievement of the Intermediate Results is leading towards the accomplishment of the Strategic Objective. The process of capacity building that is aimed at improving service delivery can be analyzed. From this perspective, the following commentary can be made.

The results of the midterm evaluation with respect to the introduction and use of NHA suggest the hypothesis that this is a tool that has improved the institutional capacity for informed decision-making on health financing and health policy. Two countries are working on the definition of a specific unit responsible for NHA at the MOH. In addition, the NHA methodology has been introduced in the three countries studied and two of them have increased their use of data for health policy decisions and interventions as a result of using the NHA tool.

The tools and methodologies—Master Plans for Investment, Decentralization Using Decision Space, and Guidelines for Assessing the Policy Process—are in the development and testing stage; experience in only one country was evaluated. For this reason, it is not viable to state an opinion regarding their impact in building institutional capacity for health reform. However, the evaluation results suggest the hypothesis that these three tools have potential value in strengthening MOH capacity for delivering more effective investment planning, to promote a decentralization process of the health system, and to endorse and support leadership and stewardship of HSR, respectively.

Because there was a small number of respondents with knowledge or experience with the Management Organizational Sustainability tool, the Cost Revenue Tool, and the Performance Incentive System, it is not possible to substantively comment on them. However, the evaluation results suggest that CORE and PYS are valuable in increasing NGO institutional capacity. An important question for Initiative Strategic Objective accomplishment is whether it is valid and reasonable to consider this approach and institutional strategy for the introduction of these tools: do they contribute to institution and capacity building for HSR? This analysis is not related to the degree to which NGOs are major stakeholders in health sector reform, nor are they viewed as having the potential to be major stakeholders in the health sector. Some stakeholders do not consider some of the NGOs studied as part of the country health system. The Initiative would be more effective in achieving its Strategic Objective and more efficient in using its

resources if it facilitates NGO active incorporation into health system reform as providers of innovative services.

The Initiative has produced four papers[21] to promote public sector/NGO partnership contributions to HSR and to create the conditions for public sector understanding and awareness as well as NGO capacity to respond. It is not feasible to accurately judge the impact of the introduction of these experiences because they are in the development and testing process. However, the evaluation showed differences in the process of building institutional capacity at the MOH and in NGOs that are related with the Initiative's institutional strategy. In this sense, the Initiative could be more effective in achieving its Intermediate Results and Strategic Objective when NGOS are incorporated into health system reform, when workshops for NGOs support specific country reform processes, and when workshops have the private and public sectors participating and collaborating together.

The dissemination of printed materials and electronic services (IR 2) is making available a range of information services that, if used, will provide impetus for policy decision-making. However, an expansion of the dissemination effort into a development communications strategy will contribute to more sustainable achievement of raised levels of knowledge, attitudes, patterns, and behavior associated with the successful introduction of health reform in the region. It will develop a different scenario that is more interactive, open to all stakeholders in health sector reform, and regionally supports and reinforces the development of local coalitions that favor health sector reform in each of the targeted countries.

The midterm evaluation showed that one of the key tools needed for delivering more effective country health reforms is a methodology for monitoring and follow up. Acknowledging the relevance of the PAHO framework, the structure or quality of the instrument and the process through which it is deployed could explain its apparent lack of implementation and institutionalization. In the country where the framework for monitoring HSR is being adapted and applied, it is employed as a means of obtaining consensus on HSR policy. In this case and for this country, this is an important step for the delivery of more effective health services.

The midterm evaluation of the effect of the Payment Mechanisms Forum in two countries showed that the majority of the key stakeholders who were knowledgeable of this forum did not recognize it as input for the implementation ("taking steps based on lessons learned") of new payment mechanisms in the health system. Using this indicator, it can be said that this activity is not perceived as strengthening public institutional capacity for health financing. Moreover, while the Initiative's annual report (FY 99) located fora among networking activities, no data were collected during the evaluation to verify whether the forum supported the opportunities and means to share experiences and advice among countries on this topic.

[21] *NGOs' Role in Health Sector Reform Policy*, *Public Sector Contracting of NGOs for the Provision of Health Services*, *Public/NGO Partnerships in Response to Decentralization* and *Public/NGO Partnerships for Quality Assurance*.

The Initiative has been innovative in using the study tours to expand knowledge of best practices within the LAC region. A substantial number of key informants recognized the use of the study tour as providing input for taking steps toward hospital autonomy. The evaluation team perceived indications that these experiences were being used for building hospital institutional capacity and, by extrapolation, may increase health care services. However, to improve hospital institutional capacity and consequently to deliver health services more effectively, participation in the study tours requires MOH executive commitment to action afterwards and a dissemination/communication strategy.

V. INITIATIVE MANAGEMENT EFFICIENCY AND ADMINISTRATION

This section discusses whether the effectiveness, progress, and achievements described in the previous sections are being achieved efficiently. Initiative leadership, structure, management, and resource utilization are reviewed.

A. INITIATIVE LEADERSHIP

Initiative leadership includes vision, a mission, and the value-added nature of the Initiative. Initiative leadership is shared among the different partners, with USAID taking the lead. Partners described USAID leadership as excellent, fair, equitable, and one that listens. It was not found to be systematic and concern was expressed regarding its dependence on one USAID person.

There is no published Initiative vision or mission statement. However, project documents and partner comments appear to reflect the Initiative vision as "sustainable country health sector reforms in effect in the Americas that increase equitable access to high-quality, efficiently delivered, basic health services." Complementing this vision is a mission that makes new tools and methodologies available, provides information on health reform efforts and experiences, monitors national reform processes and outcomes, provides feedback to countries, donors, and other partners, and provides the means to network and share experiences regarding health reform best practices.

Partners' comments regarding the vision ranged on a continuum from a sense that the vision was not definitive to one of an extremely productive context. One partner summarized it by stating that "the Initiative is to promote health sector reform activities that lead to improvements in equity, efficiency, and quality of services. It is to do this by developing and disseminating knowledge about effective health reform activities and by partnering with local actors who participate in the design and deployment of health policy."

The value-added nature of the mission was perceived as the synergistic result derived from bringing together unique partner strengths and adding to the greater whole. It communicates to country officials that they are not alone in their pursuit of health sector reform and complements other efforts, such as those by the World Bank and the Inter-American Development Bank. In summary, the value added element is creation and dissemination of Initiative knowledge, tools, and activities to promote an improved regional means of designing, adopting, and implementing health sector reform.

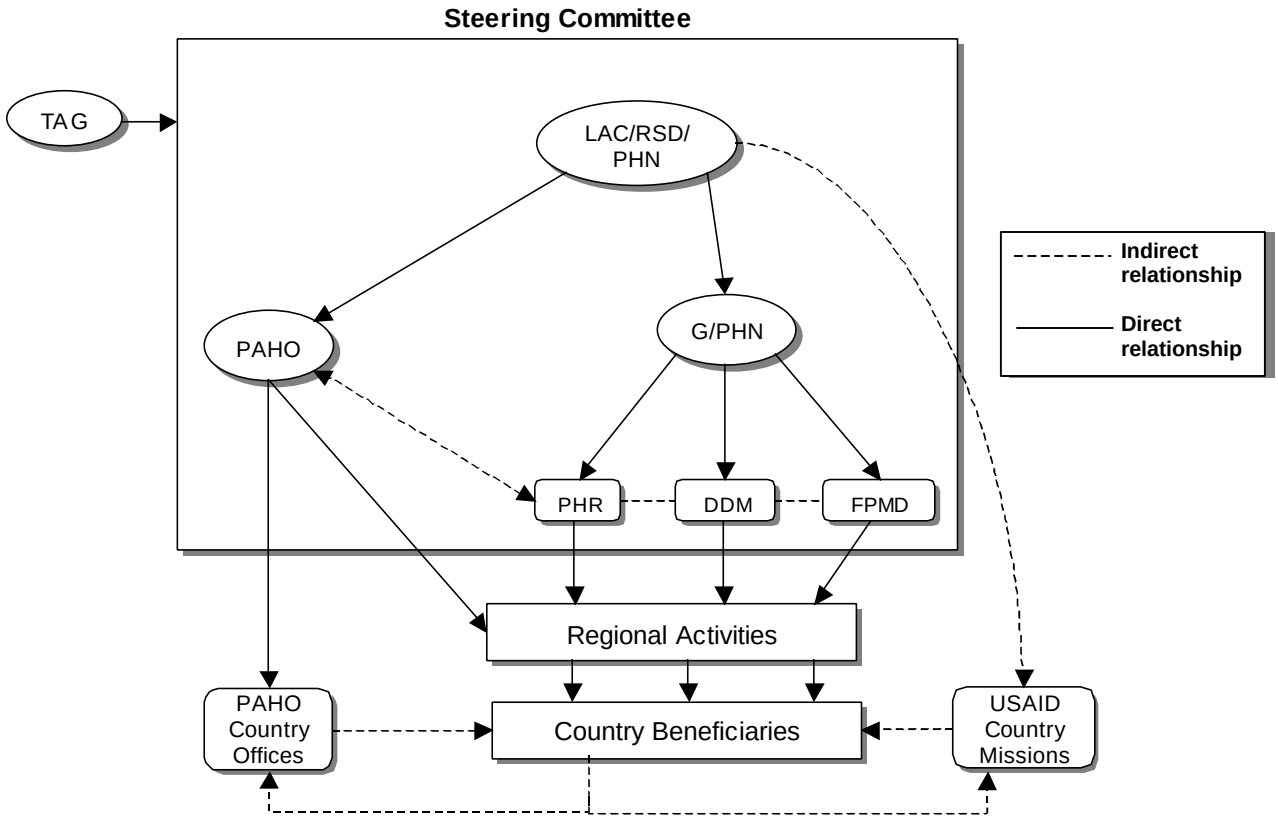
Partners also perceived that Initiative leadership was important because of the existing competitive relationships of the partners.

B. INITIATIVE STRUCTURE

Initiative structure examines the strengths and weaknesses of the management structure. This includes the delegation of specific technical areas and activities to partners as well as their coordination, working relationships, and collaboration in the implementation of Initiative activities.

The Initiative structure represents a unique and innovative approach to the challenge set forth in its vision and mission. The actual structure of the Initiative is not graphically represented in any of the documents and one would be useful (see figure 1). In the interest of seeking to provide further clarity to this innovative approach, the evaluation team and USAID staff have collaborated and offer the following prototype structure as one that can be improved over time. It does not adequately address the feedback loop and how the Initiative can learn from itself. This is identified as an issue for further deliberation.

Figure 1: Prototype Structure



TAG = Technical Advisory Group
G = Bureau for Global Programs, Field Support and Research (Global Bureau)
PHN = Center for Population, Health and Nutrition

The structure, while perceived by partners as innovative and creative, was also perceived as creating problems, or as some prefer, opportunities. Opportunities exist at a number of levels. At the USAID level, there is a perceived competitiveness between the LAC Office and the Global Bureau. This is seen in USAID country Missions acceptance or lack of acceptance of Initiative efforts. Missions in two of the three countries perceived the Initiative to be a value-added contribution to their health reform efforts. The other country perceived it to be a distraction and detour of resources that should have been invested into its national efforts instead of into a regional Initiative.

The structure also creates some interesting partnership concerns. There are two major partners of the $10.2 million Initiative: USAID and PAHO. USAID provides $7.4 million and implements through various contractual and grant arrangements. PAHO contributes $2.8 million and is also the recipient of $2.5 million of the $7.4 million USAID funding. This gives it management responsibility for $5.3 million—more than half the Initiative funding. While this should be a win-win situation, the structure creates ambiguity regarding the partnership issue. USAID believes that it is the lead partner while PAHO believes that it is not given sufficient credit or status for its investment. From USAID's perspective, it is a USAID Initiative. From PAHO's perspective, it is a joint partnership, even if the partnership is not equal in terms of monetary contribution. This ambiguity is not a serious threat to the Initiative. However, it creates unnecessary distraction to the Initiative's purpose. Lack of understanding by the other partners of who has authority and where decisions are made are other results that derive from this issue. Partner perceptions of Initiative leadership and structure effectiveness are shown in table 3.

Table 3: Perceived Strengths and Weaknesses of USAID Leadership and the Management Structure

Strengths	Weaknesses
USAID leadership is excellent, fair, equitable, and listens.	Leadership is not systematic; it is very personalized and poses a danger if the leader leaves.
The steering committee and ad hoc task forces appear to be an innovative approach.	Different task forces operate at different levels of quality resulting in micromanagement at times.
The management structure fosters participation and collaboration.	Lines of authority are sometimes ambiguous and leave open to question who has approval authority.
There is a complementarity in the development of annual work plans.	There is a lack of clarity about how decisions are made.

Part of the reason for this sense probably derives from the complexity of contracting arrangements, shown below in table 4. By its very nature, it is more complex because it must take into account two funding sources. However, USAID implements through contractual and grant arrangements while PAHO has direct implementing responsibilities. Moreover, three other partners have implementing responsibility under the different types of USAID contracting arrangements.

Table 4: Initiative Contracting Arrangements

Organization	Contracting Arrangement	Responsibility
ABT Associates/PHR Project	Performance-based contract through USAID's Global Bureau	Public health reform tools, methodologies, and exchanges
Harvard University/Data Dimensions Management	Cooperative agreement	Research on health systems—decentralization, policy process kit, and comparative analysis of health sector reforms
Management Sciences for Health (MSH)/Family Planning Management Development (FPMD)	Cooperative agreement	Nongovernmental management and organizational development
Pan American Health Organization	Public international organization grant	Monitoring and investment methodologies, collection and dissemination of information regarding tools, methodologies, and exchanges; networking

The question that arises is why complicate a fairly straightforward mission with this kind of arrangement. The answer is opportunity. U.S. government contracting is a complicated and involved process requiring an infrastructure. The LAC Initiative has minimal staff and compensates for this through leadership of the Initiative and the various implementation arrangements. The validity of the adage that "necessity is the mother of invention" is borne out by these arrangements. Innovative contracting arrangements and resources already in place were used to fund Initiative projects under its responsibility. The four partners bring existing products and services to the Initiative as well as an infrastructure for delivering them. The challenge for management is the creation of interorganizational cooperation in an arena where partners have been and will continue to be competitors.

However, as one partner commented, "the fact that all these contracts are working with different fiscal years with different expiration dates poses a problem that should be resolved." These are further described in table 5 below.

Table 5: Initiative Timeline

Year / Partner	1997	1998	1999	2000	2001	2002
PAHO	-----July					June
PHR	----------			Sept	March*	
DDM	----------			June		
FPMD	----------			Sept	March*	

*There is a potential for extension of the contract with no increase in funding.

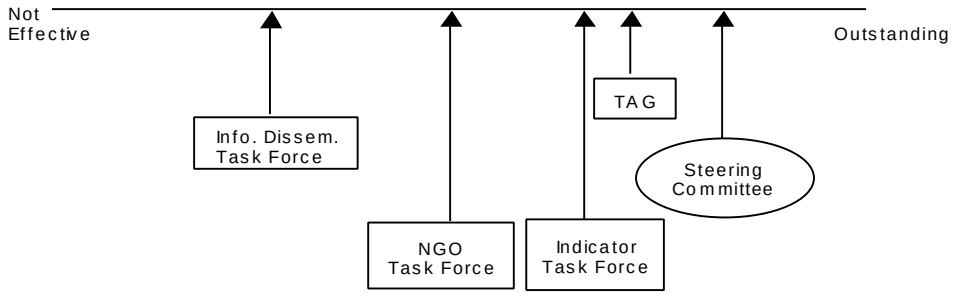
PAHO was the first partner to begin Initiative work, followed by PHR, DDM, and FPMD, who already had existing Global Bureau contracts prior to the start of the Initiative.

C. INITIATIVE MANAGEMENT AND ADMINISTRATION

Initiative management and administration examines the coordination of partners and Initiative work; meeting deadlines; monitoring whether reports, work plans, and other products have been of adequate quality and on time; new work; and scale up and sustainability of the Initiative.

In order to manage effective coordination, various mechanisms were created. The Initiative established a steering committee of all partners that meets once every 6 weeks. The steering committee is supported by a technical advisory group (TAG) and other ad hoc task forces set up to guide individual areas, such as information dissemination, NGO participation, indicators, study tours, and information systems. Each partner is assigned certain responsibilities and takes the lead for a particular tool or methodology that it may have designed and/or for which it is the owner or copyright holder. Figure 2 below shows the partners' collective sense of how well these are working, with a favorable overall impression of the steering committee.

Figure 2: Perceived Effectiveness of Initiative Coordinating and Task Forces



The TAG has met once and is reported to have been useful in helping the Initiative reset priorities. It recommended focusing on Initiative coordination for completing activities already initiated. However, the TAG meets in the spring of the year and is out of sequence with the planning that occurs in the latter part of the year. It is perceived to have the right membership, except for one member who did not attend the first meeting. Most agree that the TAG has not been incorporated into the Initiative to the degree it should be in order to be as effective as possible.

The steering committee is perceived to be highly effective. However, it does this in an ad hoc manner and was not always perceived as providing administrative guidance to the various task forces or groups it uses for operational management of various parts of the Initiative. Lack of complete delegation to the various task forces, lack of a clear mandate for decision-making, and slow approval were cited as concerns. Moreover, it is not always clear to the partners how steering committee meetings are set nor how the

participants are selected. Even with these limitations, work is accomplished. At times, it is perceived that the steering committee has focused on operating details to the detriment of coordination.

The performance of the dissemination task force (DTF) is a case in point in the use of task forces. Partners perceived it as the weakest of all the structures created by the Initiative. It was ranked between noneffective and moderately effective. Reasons given were that the DTF dedicated too much time defining technical questions resulting in delayed implementation, and as a result, limited effectiveness.

Adjustments were made to the work through the assignment to PAHO and PHR of different work packages to be developed cooperatively. However, even with these assignments, the DTF confronted several constraints in its work:

- changing partner representation and participation in the DTF (skills of the DTF and in PAHO were heavily oriented to information technology instead of development communications);
- implementation arrangements were the result of a weak overall strategy design;
- no management tools were found for planning, implementing, monitoring, and evaluating the strategy by the DTF;
- the decision-making process in the DTF was slow, and in several cases, the DTF was micromanaged by the steering committee; and
- the DTF confused its roles and responsibilities and ended up being neither an implementing nor a decision-making unit.

In summary, this task force was found to have a poorly defined scope of work and suggests review of other existing or new task forces.

Initiative administrative management also covers areas such as quality of reports, systems to track output or interim outcome measures and achievement of Intermediate Results, shaping annual work plans, defining new areas of work, and scale up and sustainability of the Initiative.

Quality of Reports

Quality of reports and products submitted to USAID range from excellent to adequate and are very good on average, particularly the technical reports. However, timing has presented a problem from several perspectives. For research projects, there has been delay due to conflicting demands and the desire to assure quality research. For work plans, the rounds of revisions and reviews are perceived to take an inordinately long time. As was noted in the section on effectiveness, Initiative customers perceived printed

papers on various topics, including tools, methodologies, experiences, and other instruments, as one of its most valuable products. Some partners believe that the process is long, cumbersome, and frustrating.

Tracking Systems

Opinion varied considerably regarding whether systems are in place that can track output or interim outcome measures. The project is at the point where major products are being completed. The clearinghouse and web site tracking were noted as two major methods being used for measurement. The evaluators' additional perspective is that the annual report provides the forcing function to track accomplishment.

Management of Intermediate Result Achievement

Closely related to systems for tracking outcome measures is the partners' perception of their achievement of Intermediate Results by successfully accomplishing specific activities in their work statements. In confirmation of the progress and achievements reported in the section on effectiveness, partners believe that extensions and follow-up contracts will be important to achieve the Intermediate Results. In addition, work completed with the World Bank and the Inter-American Development Bank will contribute to the sustainability of results. It was noted that research projects have taken longer than anticipated to complete and achieving measurable results was not anticipated until the completion of and dissemination of the research projects. One partner commented that preliminary results have been used in a variety of unanticipated ways that have contributed to project achievement: "Specifically, the research design for decentralization studies has been published in a well-respected journal (*Social Science and Medicine*), preliminary results have been incorporated in the well-attended World Bank Flagship course both in Washington and in other regional centers, and preliminary results have been presented in symposia and conferences in Washington."

Scale Up of Initiative Efforts

Partners perceived that a number of the tools are sustainable and that their use could be increased. These include national health accounts, the policy tool kit, and others where partners have a long-term relationship with national institutions. One partner expressed the belief that the knowledge gained on policy process and decentralization should be sustained through important publications and incorporation in the World Bank Flagship course. Other training materials will contribute to health reforms for many years to come. Increased sharing between countries and monitoring and evaluation of health sector reform should reinforce increased scale up.

Resource Management

Partners acknowledged the importance of stewardship of Initiative resources in meeting the challenges of its mission. According to project documents, the Initiative is operating within the resources allocated to it, although some partners believe that the statement of

work is greatly under resourced, that is, the magnitude of effort, particularly for creating behavior change, eclipses the available resources. They also commented that while financial resources are important, nonfinancial resources may be more critical to the Initiative's ultimate success. The human resources involved will determine how robustly the Initiative continues to garner resources for its efforts.

The project has accumulated an account of social capital or good will with its various partners. It is at the point where they should begin to pay off in a significant way. Ironically, because of the unique manner in which the Initiative was structured, it is limited now because of the expiration of contracts and cooperative agreements which fund three of the partners. DDM will expire in June and cannot be renewed or extended. FPMD and PHR expire in September and can be extended until March with no increase in funding. Given the positive response to most of the tools, it will be costly to the Initiative to have a hiatus.

USAID staff reports that procurement for follow-on activities for PHR and FPMD are under way. Once these are completed, the Initiative will choose appropriate mechanisms for its continuation.

In reviewing the Initiative management efficiency section, some overriding issues bear reemphasizing. These are summarized below and commented on in the recommendations section.

Think Regionally, Act Locally

The Initiative is based on the concept that tools and methodologies could be developed, tested, and disseminated at the regional level. Once these have been completed, there are choices the Initiative must make to assure adaptation at the country level. This is at variance with the findings of this evaluation. Only in one instance was there a truly regional result and that was with the use of some of the instruments in the Flagship course of the World Bank. Greater attention is required for successful analysis, design, implementation, and monitoring of health sector reforms at the country level; to create greater alignment between headquarters and field offices and at the country level; and with onsite partner staff terms of reference for a successful life cycle of tools or methodologies.

Project management requires constant stewardship. The detailed review by the evaluation team during its visit of the use of Initiative tools at the country level appeared as a management function.[22] A country review at least annually or semiannually would be of added value to Initiative management.

[22] Of particular value was insight provided about health sector reform across country borders. Individuals interviewed were directed to other country experiences as well as to resources they had not considered. The experience indicated that more Initiative management of this type would be helpful.

Initiative Administration Could Be Improved

Plans for the year 2000 for some of the tools are instructive with respect to this point. Consider the PAHO tools, methodologies, and activities that in many instances indicate work in progress and, in others, expansion of Initiative activities (see table 6).

Table 6: PAHO Work Plan 2000

Tool or Methodology	Work Planned	Budget
Health Sector Analysis	Two subregional workshops	$107,416
Master Plans of Investment	Two subregional workshops	115,000
Dissemination	Publications/web site	105,592
Monitoring Health Reform	Two subregional workshops	102,385
Monitoring Equitable	Two subregional workshops	91,640
Networking	Subregional forum	50,299
Exchange of Experiences	Study tour to Canada	56,929
Financing Social Insurance	Two country workshops	41,000
Impact of Social Security	Expert panel	122,500
Social Security Reform	Expert meeting	45,000
Research	Half-day professional meeting in Los Angeles	30,000
Intensive course on HSR	Merge with World Bank or affiliate with Latin American institution	No budget given

This is an imposing workload. It includes an intensive course on health sector reform and a new focus on social security with the establishment of a new task force to develop it. Available documents do not indicate that all are scheduled or funded, but at the same time, do indicate that it is underspending planned expenditures.

Initiative Visibility

The Initiative is not marketed well. This is covered in the dissemination and communication section but bears repeating here.

Partner Alignment

Greater partner alignment is needed than currently exists. Where USAID Missions and PAHO offices work together in managing Initiative activities, the potential for success is much greater than when they do not work together. When this alignment is complemented by crossfunctional work with other partners at the country level, it is an even more potent force. This is particularly important in creating the capacity for continuing to manage the health sector reform effort when the external funding ceases.

There are other stakeholders in the field. Other organizations, such as FunSalud, in cooperation with the Inter-American Development Bank, were found to be working on similar efforts. Work is reportedly underway in trying to create an alliance at this level to increase the benefits of these complementary efforts to client countries. This is a positive step and the Initiative should use it in moving the level of interaction up another level from partnership to alliance.

VI. SUSTAINABILITY

Sustainability of Initiative services and product delivery is related to the assumptions used in formulating the Initiative framework and design. While these assumptions are largely outside the Initiative's control, this does not prevent the Initiative from vigorously pursuing ways to influence them as a means to ensure long-term sustainability (see appendix E for factors affecting project success within and beyond the control of the Initiative). A more effective due-diligence sustainability analysis is critical to the successful deployment of Initiative Intermediate Results and the Strategic Objective.

The three critical assumptions identified were:[23]

1. Government and nongovernment health providers, professional societies, and university faculty willing to participate together in reform efforts;

2. In-country interested parties can mobilize political will to redirect resources (time, personnel, and money) to reforms that increase equitable access to basic health services; and

3. Donors continue to fund capital costs for country health reform design and implementation, including technical assistance, studies, and systems design/implementation.

While the Initiative is regional in scope, the expected achievements take place mostly at the national level. Common external factors that influence the institutionalization of the Initiative's tools, methodologies, and results of exchanges were identified through field interviews. (Institutionalization is the incorporation of these tools, methodologies, or results of exchanges into routine or everyday use in the health sector.) Table 7 on the following page contains the factors that affect the probability of sustained capacity.

The table reflects two main aspects from the majority of key respondents: concern over the weakness in MOH institutional capacity and/or lack of or weak political will to move the health reform process forward. These were further broken down into four factors perceived as most difficult to overcome in making Initiative benefits sustainable over time:

- lack of a health sector reform public policy: definition and formulation of problems and internal and external constraints to public policy formulation;
- lack of health sector reform leadership, political decisions, and process management difficulties;

[23] See Results Framework, December 8, 1997.

- limitations of MOH institutional capacity in the area of health sector reform; and

- parallel, duplicative, and competitive reform units within the health sector and political interference in decision-making at the MOH.

Table 7: Factors Hindering Institutionalization and Sustainability* of Tools, Methodologies, and Exchanges

Tool, Methodology, or Experience**	Requirements for Institutionalization and Sustainability		
	Peru	**Dominican Republic**	**Honduras**
Master Plans for Investment	1. MOH institutional capacity 2. MOH political will 3. Agencies' support for technical assistance		
National Health Accounts	1. Information, communication, dissemination, and training 2. Institutional capacity 3. Political will		1. Institutional capacity 2. Political will
Monitoring Health Reform	Political will		MOH institutional capacity
NGOs in HSR, NGOs Contracting, Health Policy Process Applied Research, and Decentralization Applied Research	1. Political will 2. Institutional capacity		
Provider Payment Mechanisms (Peru and Honduras only)	1. Information systems on costs and production 2. Implementation systems of payment in place and functioning		
			1. Political will
Study Tours on Hospital Autonomy	1. Technical assistance 2. Study tours for MOH officials	Political will	1. MOH strengthening 2. MOH and hospital capacity building

*See appendix H for responses regarding requirements for sustainability.
**The three interviewees for MOST pointed out that this methodology has not been applied in their NGOs. The interviewee for *NGOs in Decentralized System* and *NGOs Quality Assurance* pointed out that the key for sustainability is that the NGOs continue the process and increase the demand to the public sector. The two interviewees for CORE identified two factors affecting the sustainability of the tool: a general agreement and commitment with USAID about the tool's implementation and the availability of cost data from regional offices. Finally, the interviewee for *Use of Performance Incentive System* identified the availability of financial resources as the key requirement for sustainability.

The three Initiative assumptions need to be updated and refined using these factors. Making them more explicit will allow the Initiative to influence them and ensure the achievement of the Intermediate Results and Strategic Objective.

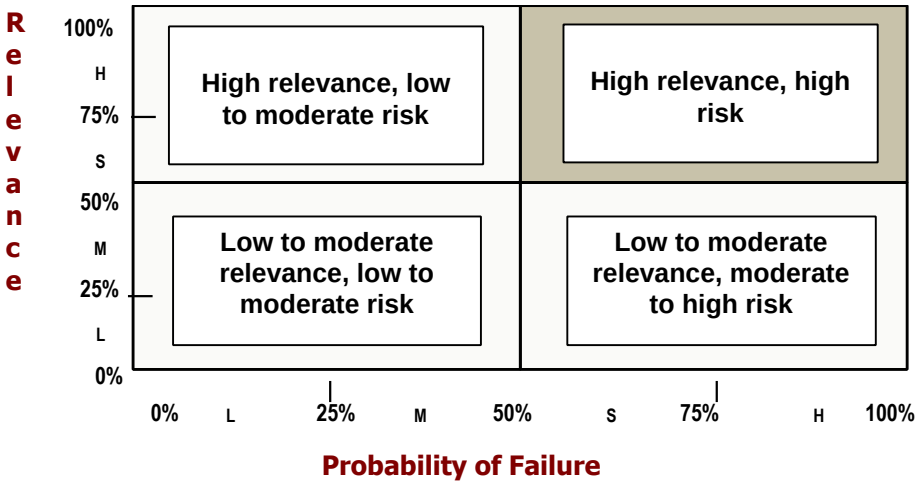
Factors that contribute to long-term sustainability and effective risk assessment of Initiative efforts include the following:

- **Make assumptions as specific as possible**. Instead of using a general assumption (for example, donors continue to fund capital costs for country health reform design and implementation, including technical assistance), a more specific assumption using performance indicators such as the following

would be better: The World Bank and the Inter-American Development Bank commit at least $xxx over the next five years to the design and implementation of health sector reform.

- **Be more realistic in Initiative risk assessment**. This could be accomplished by analyzing the probability that the assumption will hold. Assumptions having a high failure probability represent the higher risk. Figure 3 proposes a methodology for assessing risk for the Initiative.

Figure 3: Establishing the Level of Risk of the Assumptions



The shaded area indicates high risk and where mitigation strategies by the steering committee would be useful in increasing the effectiveness of the Initiative. By establishing a mitigation strategy, management can better influence the assumption, thus lowering risk to the Initiative.

The suggested development communications strategy, described earlier in the section on effectiveness, used an expansion of the dissemination strategy as an example of how risk could be mitigated. It promotes coalition building at the national level by increasing key stakeholder participation and commitment.

Such a strategy would also be more clearly connected to the Results Package by addressing the creation of viable political regional scenarios, favoring coalition and consensus-building efforts at the national level and reinforcing the capacity of those who can champion the reform at the national level. The role of international and regional cooperation agencies and banks is critical and the definition of a course of action to influence decision-makers in those organizations would be necessary.

VII. RECOMMENDATIONS

The recommendations are divided into the following sections:

- Initiative framework and sustainability;
- effectiveness (this section is divided into two parts to provide continuity: it first considers the tools, methodologies, experiences, and/or exchanges included in Intermediate Results 1, 3, and 4, and then discusses IR 2, which covers a different but directly related area—dissemination, information, and communication);
- Initiative management and administrative efficiency;
- methodology and study design; and
- considerations for the next work plan.

A. INITIATIVE FRAMEWORK AND SUSTAINABILITY

The Initiative framework and sustainability are two interconnected components. Sustainability is a result of the degree to which the Initiative framework and the assumptions it is based on hold.

1. Adjust the Initiative Results Framework by operationally defining key stakeholders working on health reform, working with Initiative policy tools or other policy reform analysis[24] methodologies in each of the 13 targeted countries.

2. Redefine Intermediate Results and indicators as well as their tracking system to establish the difference between indicators that generate impact (i.e., use of services) and those that reflect basic delivery of services. It is one thing to create and deliver a tool on a timely basis and another to have it used by clients.

3. Redefine assumptions, making them as specific as possible, including measurement indicators.

4. Identify and analyze assumptions or external factors influencing attainment of the next level of the hierarchy.

[24] These include the PHR Policy Tool Kit (June 2000), the Harvard policymaker (M.R. Reich and D. M. Cooper, 1996–98), and the PAHO *Lineamientos para la realización de un análisis estratégico de los actores de la reforma en salud* (Junio 2000).

5. Consider using the risk mitigation model to generate mitigation strategies to be incorporated into the framework as new actions. In some cases, for example, the communications strategy is part of the Intermediate Results.

6. Periodically monitor the level of risk, using the recommended (or other) methodology to assess movement in the level of risk.

B. EFFECTIVENESS

Intermediate Results 1, 3, and 4

1. Reassess each tool as part of the 2001 work plan exercise in October 2000. The proposed checklist (see table 8) for assessing the introduction and use of tools, methodologies, experiences, and/or exchanges or some variation would be helpful in this regard. The scores, with adjustments, could be applied to the risk assessment model (described in the section on sustainability).

Table 8: Proposed Checklist for Assessing the Introduction and Use of Tools, Methodologies, Experiences, and/or Exchanges

Factor	Values Low----------High				
	1	**2**	**3**	**4**	**5**
Quality of methodology					
Need for the tool, methodology, experience and/or exchange					
Training and technical assistance support planned and consistent with national expectations					
Potential for national adaptation					
Regional approach complemented by country implementation					
Alignment of Initiative partnership at headquarters					
Alignment of Initiative partnership at the country level					
Alignment of headquarters and local staff					
Country partners/consultants have specifically related terms of reference					
A national participatory, coalition-building development process that favors use of the tool					
Stability and continuity of key stakeholders supporting Initiative activities					
The activity, tool, methodology, or experience is included on the health sector reform agenda					
The MOH will commit to introducing and using the tool, methodology, and/or experience					
Total Points					
Score					

32 and lower	**33-40**	**41-48**	**49-54**	**55-60**
Low Potential	**Fair Potential**	**Average Potential**	**Good Potential**	**High Potential**

2. Use the reassessment of each tool in achieving consensus regarding future plans and the collective investment of Initiative resources. For example, given the level of

resources and contract schedules, consider whether some should be dropped. If the goal is institutionalization of the tools, then create a plan for this to occur.

3. Reassess the indicators used to measure the methodology for monitoring health sector reform because the present ones are not accurate. Use of the tool at the country level by MOH staff and others should be the metric.

4. Develop a process that will assure that tools, methodologies, and exchanges respond to the health priorities of targeted countries.

5. Obtain commitment of other stakeholders for support and technical assistance[25] for the design and development of effective and efficient training processes.

6. Create a strategy for garnering support for the LAC Initiative in Health Sector Reform from different public stakeholder institutions: national institutions, such as the MOH, Ministry of Finance, reform units, NGOs, and other governmental organizations, such as Congress and state reform units; international institutions, such as other donors and agencies (i.e., the World Bank and the IADB).

7. Create agreements with key stakeholders at the country level on the best institutional strategy and plan for implementation. This reinforces an Initiative design premise of subsequent assumption of regional work by others for country-level implementation and adaptation.

8. Exercise more Initiative influence over design and implementation factors that affect country utilization of regional tools. The Initiative's approach in this area crucially and significantly affects its success. Midterm evaluation data reveal that the most successful experiences are those in which the regional approach and intervention strategy are accompanied by an in-country initiative. The regional nature of the Initiative requires that it influence country utilization of regional tools. This factor and the means to influence it should be considered in the design of Initiative work plans.[26]

9. Identify and influence factors beyond Initiative control that affect Initiative results. Identify and use alliances and agreements with key stakeholders in health sector reform in target countries to assure that:

   - tools, methodologies, and experiences are adapted and/or customized to local or national requirements;

   - there is a national communication and dissemination strategy; and

[25] The design of the training mechanisms is managed by the Initiative but the technical assistance is not. Under the mandate of a regional Initiative, the partners are prohibited from providing technical assistance at the country level.

[26] Another option is a second-generation project—a follow-on Initiative—that could provide country-specific technical assistance with Mission funding as part of a regionally organized scheme.

- a stronger alliance is forged among Initiative partners and other agencies, such as the World Bank and the Inter-American Development Bank.

10. Initiative partnerships are a critical strategy for Initiative implementation. Four kinds of increased partnership alignment are recommended:

    - an Initiative partnership at headquarters: the Initiative's approach to designing and introducing NHA is a good example of such an alignment;

    - an Initiative partnership at the national level:[27] two examples that were mentioned were the adaptation of monitoring health reform in the Dominican Republic through the strong alignment of Initiative partners PAHO and PHR, and the Initiative partnership among PAHO, USAID, and PHR regarding the introduction, use, and institutionalization of NHA in Honduras;

    - PAHO and USAID headquarters aligned with local partnership efforts for each tool and activity: an example is the strong USAID position of the NGO strategy in Honduras and the Dominican Republic and PAHO alignment with PHR in support of monitoring health reform in the Dominican Republic; and

    - country partners' consultants (PHR or FPMD) with specific tool-related terms of reference provide stronger support for Initiative activities: for example, the PHR consultant in the Dominican Republic has terms of reference specifically related to the MHR methodology.

11. Develop plans to manage factors beyond Initiative control. Among these are plans for

    - increased stability and continuity of key stakeholders favoring Initiative activity; for example, the Initiative could encourage continued involvement of some key stakeholders through special agreements or contracts with them for specific products or services that would also move the agenda of health sector reform forward;

    - increased channeling of Initiative efforts through partners to increase support of specific country programs; for example, the Initiative could help expand use of the Master Plans of Investment tool in Honduras through other partners in other countries with similar multicountry programs to increase health coverage;

[27] Based on the evaluation process, it is not possible to discern whether the country coordination among the partners (i.e., USAID and PAHO, PAHO and PHR, or USAID and PHR) is a result of unrelated bilateral activities or a result of Initiative efforts. There is also no way to demonstrate whether coordination among the partners already existed or whether it came with Initiative activity. What the report suggests is that the Initiative's partnerships at headquarters and the local level, and the alignment between headquarters and local staff, affect the achievement of the Initiative's objectives.

- influencing political health reform decisions regarding Initiative tools, methodologies, or experiences; for example, at the Initiative level, partners could agree on a common strategy that would be implemented by partners through channels available to them individually or collectively in a given country, such as relationships with key health officials and bilateral projects;

- strengthening political will to introduce Initiative tools, methodologies, or experiences to bring change to the health system; following through on many of the recommendations on dissemination would help strengthen political will through increased public awareness and influence on key political figures;

- ensuring that Initiative activities are on the national health reform agenda in targeted countries; for example, by strategizing together at the regional level and then using partners' linkages in individual countries; and,

- assessing the level of institutional capacity at the country level before introducing the tools, methodologies, experiences, and/or exchanges, and periodically monitoring the degree to which it has strengthened national institutional capacity for health reform, such as trained personnel, strengthened public administration, and institutional design. Examples are found in the recommendations on effectiveness and in particular, specific use of the proposed checklist (page 50).

Intermediate Result 2: Dissemination and Communications Strategy

1. The steering committee should adopt a new methodological approach for dissemination and communication. The products and services already provided should be continued, improved, and focused accordingly on new objectives, and a set of new services should be added. This requires transforming the dissemination effort into a development communications strategy that would improve both regional and national impact. This key recommendation is based on customer and partner perception of ways to strengthen and reinforce interaction between Intermediate Results (described elsewhere in the report). The Initiative should shift paradigms to increase achievement of the Strategic Objective. Such a shift would mean a more horizontal communications structure between the Initiative and the targeted audiences, increased feedback, and a more interactive web site, newsletter, and other media. It represents a dramatic conceptual move to make messages more consistent with Initiative offerings through expanding media used for channeling messages and reorienting them to problems and interests of the audiences. (See step 12 of the development communications strategic cycle in appendix P.) Moving through the different steps of the cycle would refocus and expand the strategy.

2. Apply the cycle (see appendix P) to gain

   - closer linkage between the strategy and the overall Results Framework, thus mitigating the risk of failure of critical assumptions related to political will;[28]
   - redefinition of targeted audiences;
   - redefinition and tailoring of messages to redefined audiences;
   - broadening of selected media;
   - change in the content of some existing media, mainly the web site and newsletter;
   - establishment of a management system based on clear institutional and implementation arrangements;
   - development of an Initiative learning system through transparent monitoring and evaluation to improve performance; and
   - improving brand recognition while maintaining partner identity.

This development communications package is described in greater detail below.

Audiences

Focus the strategy on decision-makers, including the new groups identified (legislators, journalists, private sector representatives, health professionals). However, it should not focus directly on the public or public opinion, as suggested by many respondents in the field testing. This goes beyond the scope and customer base of the Initiative. The process of influencing public opinion is national in character and should be addressed at that level. Targeting the new groups referenced above given their frequent interaction with the core group of decision-makers could generate scenarios for national and regional coalition building.

Messages

Hold a message development session based on the new audience screening and its identification of key interests and problems. The new messages should be thematic and tailored to each audience. The following format is recommended:

- a short basic statement (5 lines),
- factual support, and
- anecdotal and/or historical/geographic linkage with the audience.

[28] For a broader discussion of risk mitigation, see the section on sustainability.

Each message should be classified by theme and audience and made available for Initiative spokesperson(s) so that everyone will have the same core messages.

Media Channels

Web Site

The web site should be more interactive than it is and should include the recent initiatives from the PAHO implementation team. Other ideas that could be explored are:

- creation of a news section on health reform–related issues in the Americas;
- create a section with articles from regional health reform leaders to foster the idea of champions (voices of the reform);
- develop a network of journalists that specialize in health issues, targeting key media in the region; the web site could be used for access and interaction by the new journalist network; and
- consider the development of chat rooms using health reform personalities, question and answer sessions, and other interaction alternatives.

Television and Radio

Prepare newsworthy materials for regional television outlets, such as CNN en Español, Televisa, Telemundo, or Univision. They are increasingly interested in health and now have segments dedicated to medical and health issues. The Initiative has many attractive stories to offer to these carriers. Organizing regional and national press conferences and interviews with television/radio outlets in connection with field visits, workshops, forums, and other activities should be planned as part of the strategy.

Videotape Production

Produce an institutional videotape (4–5 minutes) that presents the present health reform situation and uses local and national key stakeholders to show how Initiative tools and methodologies have been used successfully in mitigating this situation.

Produce 30–second spots for distribution through regional television stations and other regional media that accept public information messages at little or no cost.

Opinion Editorials in Regional and National Magazines/Newspapers

Generate articles written by both regional and national Initiative allies that support the development of health reform champions. They could be instrumental in creating positive scenarios for debate and generating favorable trends on specific issues. Regional specialized magazines and health sections in newspapers should also be targeted.

Additional New Direction Actions

An Annual Report on Health Sector Reform Status

Develop an annual report on the status of health sector reform in the Americas. This would improve Initiative brand recognition and reinforce its regional character. Ideally, it would become a yearly announcement of the state of health sector reform in the Americas. A press conference in Washington with simultaneous events in two or three cities in the region should be implemented.

The Annual Journalist Prize on Health Reform

Award an annual health reform journalist prize to a member of the new journalist network. This would accent the Initiative's comparative regional advantage, reinforce

links with journalists throughout the region, and increase knowledge of the Initiative's unique regional brand.

Organize Workshops for Journalists on Health Reform

Organize subregional or national workshops based on problems and results achieved to gain recognition and presence in the media and to generate simultaneously knowledge on health reform issues.

Develop and introduce a Tool Kit on Communications for Health Reform in Each Targeted Country

Have some of the partners produce a simple tool kit to improve capacity and increase local impact. The tool kit should address issues ranging from how to design a national communications strategy for health reform to how to implement different types of actions and manage the strategy. An accompanying operations manual should be a substantive part of the tool kit. Technical assistance may be required to introduce it and assure sustainability.

Increasing Brand Recognition[29] and Maintaining Partners Identities

Formulate a new strategy for increased brand recognition. Using the Initiative's corporate communications strategy umbrella for proposed activities would contribute to

[29] Brand recognition will certainly be improved if the new proposed activities are conducted under the umbrella of the Initiative. The formulation of a new strategy for increased brand recognition is dependent upon the horizon (projected longevity) of the Initiative. If the Initiative is going to be renewed, the best alternative would be to redesign the branding with new logo colors, design, etc. It would be best to combine the corporate branding in a different way, establishing a new equilibrium between corporate branding and individual (institutional) name recognition.

establishing a new equilibrium between the corporate brand and partner name recognition.

The following approach and course of action is suggested for rolling out a new phase of the Initiative for the next two years and for increasing brand recognition in the process:

1. Define a set of actions that will be presented in the future as entirely corporate (press releases, press conferences, institutional videotape, television spot).

2. Create a new Initiative news service sponsored by USAID and PAHO to deploy the new Initiative corporate communications strategy.

3. Do not radically alter the logo and colors. Use the colors of the newsletter instead of the orange/blue color combination of the logo. Make the logo more consistent by taking away LAC and adding an I, so that it will be IRSS (Iniciativa Regional del Sector Salud or Iniciativa Reforma del Sector Salud).

4. Boost brand recognition through definition of a leading phrase to be used in the different campaigns.

5. Develop a set of complementary communications actions in which the name recognition of the different partners is emphasized and include them as part of the yearly work plan to maintain a desirable equilibrium between institutional identity and Initiative branding.

A New Strategy Design and Implementation Arrangements

Reorient the strategy from dissemination to a development communications approach by sequencing the different steps of the cycle in the following way (see appendix P):

STEP 1

Organize a communications development mini-workshop for key stakeholders of the Initiative and the dissemination task force (DTF) in order to:

- move from Step 12 to 7 in the development communications cycle; thus, the sequence is from audience screening to message development, media identification, expected KPAB impact, product, and services to be delivered, and the first draft of an implementation plan;

- add internal or external development communications skills to a re-appointed PAHO team;

- redefine the statement of work of the new implementation team and its relationship with the steering committee; establish clear roles and responsibilities and allow the new team to outsource services, if needed; and

- reorient the budget in accordance with new priorities (pricing of these changes is included in appendix P).

STEP 2

Require the new implementation team to develop a monitoring and evaluation system and an overall management system, including a work breakdown structure, Gantt charts and responsibility charts. Technical assistance should be provided as needed.

STEP 3

The steering committee approves the new strategy, the implementation plans for the first year, the monitoring and evaluation processes, and its annual events and assigns a budget.

C. INITIATIVE MANAGEMENT AND ADMINISTRATIVE EFFICIENCY

1. Clarify the roles and responsibilities of the steering committee, partners, and task forces. Use responsibility charts to show who is responsible, who needs support, who must be communicated with, and the latitude of decision-making authority.

2. Reexamine the PAHO partnership. Given the completion dates of USAID agreements with other partners, PAHO may need to assume increased responsibility for Initiative activities.

3. Prepare milestone charts for each activity and task force, review them on a defined schedule in steering committee meetings, and link them to Intermediate Results. A standardized set of charts that shows what is on schedule and what is not on schedule, what is within the budget and what is not within the budget, should be included. Where there is schedule slippage on deliverables, require a recovery plan. Begin with a review of the 2000 work plan.

4. Reschedule the TAG to coincide with the planning cycle and if it is willing, use it to help with the recommended mitigation plans for managing assumptions.

5. Use the steering committee to manage the assumptions of the Results Package and mitigation plans described above.

6. Simplify and expedite the publications process.

D. METHODOLOGY AND STUDY DESIGN

Use a representative sample approach for succeeding evaluations. In the present LAC Initiative midterm evaluation, USAID and the steering committee, for various reasons, limited the field study to three countries, which prevented generalizing conclusions drawn from the three-country case study. If representative findings of the regional

activity are desired to evaluate the majority of the products produced, in future evaluations it would be advisable to visit more countries and to work with a representative sample of informants by activity.[30] (An alternative to the present study would have been to send two people to three countries each to gather data. However, to have done so would have required more evaluation team preparation time.)

E. SPECIFIC CONSIDERATIONS FOR THE NEXT INITIATIVE WORK PLAN

The work plan for FY 00 continues with ongoing activities that the Initiative has implemented during the past two years and new activities that it is developing in the areas of NHA, social insurance, research on health sector reform, and capacity building. To support the implementation of ongoing activities, the following priorities are suggested:

1. Introduce the PAHO framework for monitoring health reform at the national level of the MOH (and in some cases in reform units) through a participatory development process, building a coalition that favors the use of the framework.

2. Institutionalize NHA by incorporating the following requirements identified in the midterm evaluation for institutionalization and sustainability: promotion of MOH political will; institutional capacity; reinforcement of information, communication, dissemination, and training on NHA at the country level and reinforcement of the Initiative network or alliance among the World Bank, IADB, PAHO, and USAID that has been operational since 1995.

3. Increase emphasis on crossfunctional deployment of policy tools in the development process: guidelines for assessing the policy process/DDM and policy tool kit/PHR.

4. Expand the dissemination effort into a development communications strategy.

5. Reinforce the Initiative joint NGO strategy, applying it to the experiences related to public/NGO partnership and also to the introduction of managerial tools to NGOs.

6. Work with clients in the development, testing, dissemination, and implementation of tools, methodologies, fora, and study tours, with the understanding that other donors and agencies at the central and local levels (i.e., World Bank and IADB) are among the clients for the Initiative's actions).

7. Use the proposed checklist (table 9) to assess risk when initiating new activities, such as the process for social insurance practice, guidelines and technical assistance, and the new study tour to Canada.

[30] When the sample of key informants is too small, for example, in the case of key stakeholders interviewed for the evaluation of MOST, it would have been suitable to interview—by telephone or e-mail—a wider group of participants in the Initiative activity. This evaluation approach would have yielded more definitive results than it did.

8. Incorporate tools, methodologies, and experiences in the World Bank Flagship course to increase dissemination and technical assistance.

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APPENDICES

APPENDIX A

SCOPE OF WORK
(FROM USAID)

Scope of Work
Midterm Evaluation
Health Priorities Project, 598-0825
LAC Regional Health Sector Reform Initiative
August 30, 1999

Background

Countries throughout Latin America and the Caribbean are introducing reforms that can profoundly influence how basic health services are provided and who receives them. Health system reform is being undertaken to reduce inequities, improve quality and correct inefficiencies in current systems.

Governments in the region identified the need for a network to support health reform through analysis, training and other capacity-building measures at the Summit of the Americas in 1994 and again at a Special Meeting on Health Sector Reform convened by an interagency committee of the UN and other multilateral and bilateral agencies in 1995.

In response, the United States Agency for International Development (USAID) and the Pan American Health Organization (PAHO) launched the Latin America and the Caribbean Regional Health Sector Reform Initiative. This Initiative seeks to promote more equitable and effective delivery of basic health services by supporting regional activities. The regional efforts of the Initiative support informed decision-making on health policy and management, health financing, health service improvement, decentralization and institutional development.

The Health Sector Reform Initiative is one of five initiatives which support the LAC Regional Strategic Objective (SO) "more effective delivery of selected health services and policy interventions', by focusing specifically on "more effective delivery of sustainable country health sector reforms (designed to increase equitable access to high quality, efficiently delivered basic health services). In country capability to assess health sector problems, and to design, implement and monitor reforms and solutions".

The LAC Regional Health Sector Reform Initiative is implemented by the Pan American Health Organization, the Partnerships for Health Reform Project, the Family Planning Management Development Project and the Data for Decision Making Project. PAHO is an international public health agency headquartered in Washington, D.C. It serves as the specialized organization of the Inter American System for health and as the Regional Office for the Americas of the World Health Organization.

Partnerships for Health Reform is a five–year USAID-funded initiative that builds capacity in policy foundation and implementation, health economics and financing, and organization and management of health systems.

Family Planning Management Development is a five–year USAID-funded initiative that helps national and local family planning and health programs and organizations develop their capability to plan and manage sustainable programs.

Data for Decision Making is a five–year USAID-funded initiative that supports health Sector reform and assists leadership in developing countries to make informed policy and financing decisions.

The Initiative provides regional support to activities in Bolivia, Brazil, the Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru.

The five–year Initiative was authorized on July 29, 1997, for a LOP of $7.4 million in USAID funding. PAHO also committed $2.8 million of its funds to the Initiative for a total value of $10.2 million. The allocation of USAID funds envisaged was $2.5 million for PAHO, $3.2 million for the Partnerships for Health Reform Project, $900,000 For the Data for Decision Making Project and $750,000 for the Family Planning Management Development Project. Of the $1.4 million in USAID funds, $6.0 million was new funding approved at the time of authorization and $1.4 million was FY95 carryover field support funding ($1.1 million of PHR's planned allocation and $300,000 of DDM's planned allocation).

Results and Performance Indicators

The **Strategic Objective of the Health Priorities Project** is: More effective delivery of selected health services and policy interventions.

The aspect of the SO that is the objective of this Initiative is: More effective delivery of sustainable country health sector reforms (designed to increase equitable access to high quality, efficiently delivered basic health services).

The indicators for monitoring and assuring the results of the Initiative are:

Strategic Objective 3 Indicator:

- 50% of Initiative countries' reform processes substantially integrate lessons learned from the Initiative (methodologies and tools, information, monitoring and sharing).

The Intermediate Results and their corresponding indicators are:

Intermediate Result 3.4.1: Methodologies and tools developed, tested and disseminated for analysis and design, implementation and monitoring of country health sector reforms.
Indicator 3.4.1: All methodologies and tools used by key actors in 50% of countries where introduced.

Intermediate Result 3.4.2: Information on health reform efforts and experiences gathered and made widely available to interested parties in LAC countries and to health sector donors.
Indicator 3.4.2.a: At least 5 different institutions in each of the LAC Initiative target countries report receiving Initiative materials.
Indicator 3.4.2.b: 50% of electronic network users surveyed report finding network services useful.

Intermediate Result 3.4.3: Reform processes, specifically related to equitable access, and outcomes monitored and feedback provided to countries, donors and other partners.
Indicator 3.4.3.a: All LAC Initiative countries monitor health sector reform using framework established by PAHO.
Indicator 3.4.3.b: Regional monitoring system for comparative analysis for health sector reform institutionalized by PAHO.

Intermediate Result 3.4.4: Opportunities and means to share experience and advice among countries are established.
Indicator 3.4.4: 5O% of participants surveyed report taking steps based on lessons learned in fora.

Evaluation Objectives

- To determine if the results framework is valid and feasible and to recommend adjustments to the results framework and activities as appropriate.

- To examine progress towards achieving the SO and IRs as planned evaluating whether the results/indicators will be met in a timely and effective manner. To identify specific internal/external constraints which may limit their accomplishment or success and to recommend adjustments based on findings and conclusions.

- To assess how the Initiative structure as configured is working including both the delegation of specific technical areas and activities to the partners as well as their coordination, working relationships and collaboration in the implementation of initiative activities.

- To assess the administration of the initiative by USAID and the implementing partners including the status of coordination and communication within their organizations specifically between headquarters and field operations and host country governments. The focus should be on initiative management, meeting deadlines, monitoring, and technical assistance. The team should recommend adjustments in implementation based on findings and conclusions.

- To review the resources management of the initiative including use of human, material and financial resources to achieve IRs.

- To examine the feasibility of scale-up or sustainability and mechanisms for ensuring sustainability after external funding ceases.

Key questions to be answered

The evaluation team should answer the following questions and make recommendations as to how USAID can improve and/or strengthen the activity to increase the likelihood of achieving objectives/results as defined in these questions. Final revisions to the evaluation questions will be made within two days of signature of the amendment to the task order.

Results Framework

Does the results framework (intermediate results or indicators) need to be changed or adjusted in any way?

What recommendations does the evaluation team have about changes?

Are the partners tracking the right indicators at the local level to measure intermediate changes that occur before the results are achieved? Are systems in place at the demonstration sites that can track output or interim outcome measures?

Progress and Achievements

Has the initiative made good progress toward achievement of the IRs and results by successfully accomplishing specific activities as described in key project documents?

What is the vision or value-added of this initiative?

What is the feasibility of sca1e-up or what if any elements should be or have the possibility of being sustained?

Has the project had an impact or is it likely to on regional, national, and local policy

Initiative Structure

What are the strengths and weaknesses of the management structure as implemented and how responsive have the partners been to USAID management, USAID missions, and each other during the course of Initiative implementation?

To what extent are related structures functioning adequately e.g., TAG? NGO Task Force? Information Dissemination Task Force? Indicator Task Force? Study Tour working group? Has the work of these groups moved the initiative forward in its achievement of the IRs?

Have different components been coordinated? Has there been coordination among the partners.

Administration

How effective has the management and oversight of the Initiative been by USAID/LAC?

Has there been coordination with USAID both in the regional bureau and in the missions?

Is there good communication between the headquarters and the field staff or all partner organizations? Is there good communication between partner staff and host country of officials?

Have reports, work plans and other products been of adequate quality and submitted to USAID on time with appropriate levels of information?

Use of Resources

Have the project resources been used appropriately and effectively e.g. staff and other inputs? Have all planned staff been hired and have staff and job descriptions been approved by USAID?

Materials and Procedures

1. Data Sources

The LAC HSR Initiative evaluation team will review relevant documentation including but not limited to the following; The results package, Authorization, Grant to PAHO, R4s, Indicators Paper, Memorandum of Understanding, Trip Reports, Monthly Reports, Quarterly Financial Reports, Committee (TAG, NGO Task Force, Information Dissemination Task Force) Minutes and Reports and other project documents and publications, etc. Interviews will be conducted with staff from USAID/LAC, USAID/G, PAHO, PHR, DDM, FPMD, USAID field missions, PAHO field offices, NGOs involved with the initiative and the MOH.

2. Methods of Data Collection

This will be primarily a process evaluation. The data will be collected through document review, key informant interviews, e-mail surveys, telephone interviews, field site visits and group discussions. The LAC HSR Initiative evaluation team will interview USAID, PAHO, PHR, DDM and FPMD staff and health reform stakeholders. The team will travel to 3 countries in the LAC region and interview field staff, MOH counterparts, community members and visit project field sites.

3. Duration and Timing of the Evaluation and LOE

The final schedule will be agreed with the consultants selected prior to initiation of the assignment; the evaluation process will include:
-Review of project documentation
-Meetings with Initiative staff and US-based stakeholders, final planning of field visits (in Washington DC)
-Visits to 3 Initiative countries to meet with USAID, PAHO, PHR, DDM, PPMD staff (as available), representatives of key institutions working on health sector reform.
-Clarifications/consultations with US-based Initiative staff, processing of information and preparation of draft evaluation report. (Washington DC)
-Presentation of draft evaluation report to LAC HSR Initiative Steering Committee (Washington DC)
-Steering Committee comments on draft report.
-Preparation of final evaluation report

Team Composition

We anticipate that the evaluation team will consist of three members, each of whom would be fluent in English and Spanish. The additional skills and expertise listed below are necessary but may be fulfilled in a different team configuration:

1. A Health Sector Reform Specialist with expertise in the design, implementation, and/or evaluation of substantial health sector reforms in Latin America and the Caribbean. The ideal candidate would have a combination of at least seven years of national and international experience in health sector reform in the region with an emphasis on the policy process and the management of change, be able to read and write fluently in both Spanish and English and be familiar with USAID's policies and priorities in PHN.

2. A Project Management Specialist with a track record of successful management of complex international (non-engineering) projects with multiple implementing agencies, including financial management and the development and implementation of project tracking systems. This person would have at least 5 years of experience overseeing projects with programming of at least $1 million annually or extensive experience as an international management consultant. Ideally, this person would have a master's degree in business or public administration.

3. An International Communications Specialist with expertise in the development and evaluation of information dissemination strategies, design and production of print and electronic materials for reaching international audiences and design and implementation of audience research. This person would have at least 5 years of experience in international communications, preferably in the LAC region. Alternatively, the set of tasks related to assessing the project's information dissemination strategy could be subcontracted to a public opinion firm.

Funding and Logistical Support

All funding and logistical support for the assessment will be provided through this SO using a Task Order to the MEDS (Monitoring, Evaluation, and Design Services) activity. Activities that will be covered include, recruitment of the team members; distribution of background documentation provided by USAID; arrangements for travel and logistical support; secretarial and office assistance as needed, support for all personnel and business expenses related to the evaluation; and assistance as required with editing, printing, and distributing the final report.

APPENDIX B

HEALTH SECTOR REFORM RESULTS PACKAGE INDICATORS
FEBRUARY 2000
(FROM USAID)

HEALTH SECTOR REFORM RESULTS PACKAGE INDICATORS, 2/2000

BASELINE and PLANNED VALUES IDENTIFIED

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions.
APPROVED: 7/29/97; Health Sector Reform Results Package
COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: SO #3; Health Sector Reform Results Package: More effective delivery of sustainable country health sector reforms (designed to increase equitable access to high quality, efficiently delivered basic health services)

SO 3 INDICATOR 6: Target countries with reform processes that substantially integrate lessons learned from this results package (methods and tools, information, monitoring, and exchanges).

UNIT OF MEASURE: Number
SOURCE: PAHO Reports using information from PHR, DDM and FPMD.
INDICATOR DESCRIPTION:
COMMENTS: Target countries are the USAID presence countries with PHN objectives: Bolivia, Brazil, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru.

[1]Ecuador, Guatemala, Paraguay, Dominican Republic, Honduras, and Jamaica.

YEAR	PLANNED	ACTUAL
1997	NA	NA
1998	(B)	0
1999	4	6[1]
2000	6	
2001	7 (T)	

1

1

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions
APPROVED: 7/29/97; Health Sector Reform Results Package
COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.4.1; Health Sector Reform Results Package: Methodologies and Tools developed, tested and disseminated for analysis, design, implementation and monitoring of country health sector reforms.

INDICATOR 3.4.1: Methodologies and tools actively used by key actors in 50% or more of target countries where introduced.

UNIT OF MEASURE: Percent of methodologies and tools
SOURCE: Each partner agency will report on the methodologies it introduces (DDM, FPMD, PAHO & PHR).
INDICATOR DESCRIPTION: The denominator includes only methodologies and tools that were introduced by the year prior to measurement.
COMMENTS: Target countries are the USAID presence countries with PHN objectives: Bolivia, Brazil, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru.
[1]National health accounts are being used in Bolivia, Ecuador, Guatemala, Mexico, and Nicaragua, but not in Peru, Dominican Republic, or El Salvador.

YEAR	PLANNED	ACTUAL
1997	100%	100%
1998	100%	100%
1999	100%	100%[1]
2000	100%	
2001	100%	(T)

1

1

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions
APPROVED: 7/29/97; Health Sector Reform Results Package
COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.4.2; Health Sector Reform Results Package: Information on health reform efforts and experience gathered and made widely available to interested parties in LAC countries and to health sector donors.

INDICATOR 3.4.2: Target countries where at least 5 different institutions report receiving materials through this RP.

UNIT OF MEASURE: Number
SOURCE: PAHO, PHR
INDICATOR DESCRIPTION:
COMMENTS: Target countries are the USAID presence countries with PHN objectives: Bolivia, Brazil, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru.

Partner agencies surveyed a sample of people on their mailing lists to test for recall of receipt of materials disseminated.

[1]Bolivia, Brazil, Dominican Republic, Ecuador, El Salvador, Mexico, Nicaragua, and Peru.

YEAR	PLANNED	ACTUAL
1997	--	--
1998	5	5
1999	8	8[1]
2000	11	
2001	13 (T)	

1

1

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions
APPROVED: 7/29/97; Health Sector Reform Results Package
COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.4.3; Health Sector Reform Results Package: Reform processes and outcomes monitored and feedback provided to countries, donors and other partners.

INDICATOR 3.4.3a: Regional monitoring system for comparative analysis of health sector reform institutionalized by PAHO.

UNIT OF MEASURE: Level of development (see Key)
SOURCE: PAHO Reports
INDICATOR DESCRIPTION:
COMMENTS: Target countries are the USAID presence countries with PHN objectives: Bolivia, Brazil, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru.

Key: 1=System has been initiated.
2=System is functional.
3=System has been institutionalized.

The regional monitoring system, operated by PAHO, will analyze and report data on principal indicators of health sector reform process and outcomes to country program managers, donors, and other partners.

YEAR	PLANNED	ACTUAL
1997	(B)	--
1998	--	0
1999	1	0
2000	2	
2001	3	(T)

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions
APPROVED: 7/29/97; Health Sector Reform Results Package
COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.4.3; Health Sector Reform Results Package: Reform processes and outcomes monitored and feedback provided to countries, donors and other partners.

INDICATOR 3.4.3b: Target countries that monitor health sector reform using framework established by PAHO.

UNIT OF MEASURE: Number
SOURCE: PAHO assessment
INDICATOR DESCRIPTION:
COMMENTS: Target countries are the USAID presence countries with PHN objectives: Bolivia, Brazil, Dominican Republic, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Paraguay and Peru.

Monitoring health sector reform using the framework established by PAHO means full application of the methodology including the entire regional monitoring framework. PAHO will assess annually whether each target country is monitoring reform using the regional framework.

YEAR	PLANNED	ACTUAL
1997	(B)	--
1998	0	0
1999	6	11
2000	10	
2001	13	(T)

ADDITIONAL INDICATOR

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions
APPROVED: 7/29/97; Health Sector Reform Results Package
COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.4.4; Health Sector Reform Results Package: Opportunities and means to share experience and advice between countries are established.

INDICATOR 3.4.4a: Electronic network users surveyed who report finding network services useful.

UNIT OF MEASURE: Percent
SOURCE: Each partner agency which operates an electronic network.
INDICATOR DESCRIPTION: Implementing partners operating electronic networks will survey users annually to identify what percentage find them useful.
COMMENTS: Target countries are the USAID presence countries with PHN objectives: Bolivia, Ecuador, Peru, Paraguay, Brazil, Mexico, El Salvador, Guatemala, Honduras, Nicaragua, Dominican Republic, Jamaica, and Haiti.

YEAR	PLANNED	ACTUAL
1997	--	--
1998	50%	0%[1]
1999	50%	78%[2]
2000	50%	
2001	50%	(T)

[1]Network of key actors on health reform was not in operation as of the end of FY 98.

[2]46 of 59 persons surveyed found the Results package's Web services useful.

1
1
2
2

OBJECTIVE: Strategic Objective #3: More effective delivery of selected health services and policy interventions
APPROVED: 7/29/97; Health Sector Reform Results Package
COUNTRY/ORGANIZATION: LAC/RSD-PHN

RESULT NAME: Intermediate Result 3.4.4; Health Sector Reform Results Package: Opportunities and means to share experience and advice between countries are established.

INDICATOR 3.4.4b: Participants surveyed who report taking steps based on lessons learned in workshops and study tours.

UNIT OF MEASURE: Percent
SOURCE: Each partner agency which organizes workshops and study tours.
INDICATOR DESCRIPTION: Participants in workshops and study tours will be surveyed in the following year to identify the percent taking steps based on the lessons learned in such activities sponsored by this Results Package.
COMMENTS: Target countries are the USAID presence countries with PHN objectives: Bolivia, Ecuador, Peru, Paraguay, Brazil, Mexico, El Salvador, Guatemala, Honduras, Nicaragua, Dominican Republic, Jamaica, and Haiti.

[1]No workshops or study tours took place during FY 98.

YEAR	PLANNED	ACTUAL
1997	--	--
1998	50%	0%[1]
1999	50%	91%
2000	50%	
2001	50%	(T)

1

1