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# Evaluation of DFID's Health Work Programmes in Primary Care Policies & Practices and Health Economics & Financing

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DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

EVALUATION REPORT EV: 632

EVALUATION OF DFID/HPD WORK PROGRAMMES

# POLICIES AND PRACTICES OF PRIMARY HEALTH CARE AT THE LIVERPOOL SCHOOL OF TROPICAL MEDICINE AND HEALTH ECONOMICS AND FINANCING AT THE LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE

by

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In May 1997 the Overseas Development Administration (ODA) was replaced by the Department for International Development (DFID). References in this report to the ODA apply to events, actions, etc prior to the changes of title and functions.

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The opinions expressed in this report are those of the authors and do not necessarily represent the views of the Department for International Development.

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# PREFACE

Each year the Department for International Development (DFID - formerly the Overseas Development Administration, ODA) commissions a number of ex post evaluation studies. The purpose of DFID's evaluation programme is to examine rigorously the implementation and impact of selected past projects and to draw out and highlight the lessons learned from them so that these can be applied to current and future projects. It should be borne in mind that the projects concerned were inevitably the product of their time, and that the policies they reflected and the procedures they followed may in many cases have since changed in the light of changing DFID knowledge.

DFID's Evaluation Department is independent of DFID's spending divisions and reports directly to DFID's Director General (Resources).

Evaluation teams consist of an appropriate blend of specialist skills and are normally made up of a mixture of in-house staff, who are fully conversant with DFID's procedures, and independent external consultants, who bring fresh perspectives to the subject-matter.

For this evaluation the team consisted of the following:

Dr Ken Grant, Director, The Institute for Health Sector Development (IHSD), Team Leader; Mr Andrew Creese, Chief, National Health Systems and Policies Division of Strengthening of Health Services, World Health Organisation (WHO); Ms Mercedes Juarez, Independent Healthcare Consultant; Dr Peter Poore, Senior Health Adviser, Department of Policy and Practice, Save the Children Fund, UK.[1]

The evaluation involved the following stages:

- initial desk study of all relevant papers;
- consultations with individuals and organisations concerned with the work programmes, including field visits to collect data and interview those involved;
- preparation of a draft report which was circulated for comment to the individuals and organisations most closely concerned;
- submission of the draft report to DFID's Principal Finance Officer, to agree the main conclusions and lessons to be learned from the study on the basis of the draft report.

This study is one of a series of evaluations of projects in the health sector. A synthesis study which draws out the conclusions and lessons from all these evaluations will also be available from Evaluation Department this year.

Head, Evaluation Department

[1] Professor Marcel Tanner (Director, Swiss Tropical Institute) was also involved but had to drop out at an early stage due to Institutional commitments.

ACKNOWLEDGEMENTS

The evaluation team wishes to thank the many people who gave freely of their time to assist in this review of the work programmes in Health Economics and Financing and in the Policies and Practices of Primary Health Care at the London School of Hygiene and Tropical Medicine (LSHTM) and the Liverpool School of Tropical Medicine (LSTM) respectively.

In particular, the team wishes to acknowledge the collaboration and assistance of both Schools. Assistance was provided by current and former senior management, including Professor David Molyneaux of LSTM and Professor Richard Feachem, Ms Barbara Judge and Professor Anne Mills of LSHTM, as well as many present and former staff of the work programmes themselves. They include Hugh Annett, Liz Barnett, Robert Cole, Dave Harran, Tim Martineau of LSTM; Sara Bennett, Barbara McPake and Anthony Zwi of LSHTM.

In addition, the team is grateful for the co-operation of the Evaluation Department of DFID and assistance provided through Mr Nick Dyer, Ms Catherine Cameron, Mr Eamon Cassidy and Ms Olive Moran. Consultants reviewing the work programme on the policies and practices of primary health care especially wish to acknowledge the assistance provided by the Evaluation Department through the review of key documentation prior to this evaluation.

Appreciation is also extended to current and former members of the Health and Population Division of DFID, including Ms Mary Keefe, Dr Linda Humphrey, Ms Liz Gaere, Dr David Nabarro, Ms Jane Pepperall and Ms Stephanie Simmonds.

Country visits were facilitated greatly by a range of officials, including officials of the Ministries of Health and other donor organisations such as WHO and PAHO.

Last but not least the team would like to thank Dr Nancy Godfrey and Ms Jean Marion Aitken who assisted with the research and liaising with the work programmes.

## LIST OF ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| ADB | Asian Development Bank |
| CHIP | Community Health Information Project |
| CHSS | Community Health Support Services |
| DANIDA | Danish International Development Assistance |
| DFID | Department for International Development (formerly ODA) |
| EC | European Commission |
| ERG | Education Resource Group |
| GTZ | Deutsche Gesellschaft F¸r Technische Zusammenarbeit |
| HEF | Health Economics and Financing |
| HEFP | Health Economics and Financing Programme |
| HPD | Health and Population Division of ODA (and DFID) |
| HSD | Health Systems Development |
| HSRI | Health Systems Research Institute |
| INCIENSA | Costa Rican Institute of Training and Research in Health and Nutrition |
| LSHTM | London School of Hygiene and Tropical Medicine |
| LSTM | Liverpool School of Hygiene and Tropical Medicine |
| MOH | Ministry of Health |
| MPHC | Management of Primary Health Care |
| NGO | Non-Governmental Organisation |
| ODA | Overseas Development Administration (now DFID) |
| oda | overseas development assistance |
| PAHO | Pan American Health Organisation |
| PHC | Primary Health Care |
| PPME | Department of Policy, Planning, Monitoring and Evaluation |
| PPHC | Policies and Practices of Primary Health Care |
| PPPHC | The Programme concerned with these topics |
| QA | Quality Assurance |
| RAE | Research Assessment Exercise |
| SCF | Save the Children |
| SIDA | Swedish International Development Assistance |
| SIGLOS | Information Systems for Local Health Management Project, Costa Rica |
| TCML | Technical Cooperation Medical Lectureship |
| TCP | Technical Cooperation Programme |
| UFC | University Funding Council |
| UNICEF | United Nations Childrens Fund |
| USAID | US Agency for International Development |
| WAHI | Water as a Health Intervention |
| WHO | World Health Organisation |
| WP | Work Programme |

## EXECUTIVE SUMMARY

### *The Projects*

1. The evaluation examined two work programmes in health research funded by the former ODA over the period 1990-95. These were:

- Policies and Primary Health Care (PPPHC) programme at the Liverpool School of Tropical Medicine;

and

- Health Economics and Financing Programme (HEFP) at the London School of Hygiene and Tropical Medicine.

2. The overall objective of the work programmes was as follows:
"to inform, influence and improve health policies and programmes of ODA, developing governments and other donors and agencies in areas of immediate relevance to ODA's bilateral activities and to multilateral health organisations to which ODA contributes".

3. The purpose of this evaluation was to analyse the efficacy of the work programme model as a vehicle for meeting this broad objective, using the two programmes selected as representative case studies.

4. The evaluation also recognises, however, that ODA had a range of sub-objectives for the work programmes ( Paras 1.4 and 2.4) These included:

- to transform the way in which it supported the work of the two Schools;
- to transform the way in which it supported research;
- to reorient its funded research in support of its policies and targets;
- to strengthen capacity in both Schools in these research areas and in ODA's development partners.

5. Prior to 1990, there were at least four mechanisms by which ODA supported the work of the Schools. These arrangements were considered by ODA to be fragmented and unresponsive to changing needs. It perceived that research by the Schools was of limited relevance to its policy concerns and their application in developing countries. There was also a need for improved financial accountability. By 1989, ODA clearly stated a preference for project-type funding which would incorporate full economic costs for work carried out by the Schools. However, it was also recognised that any future arrangement must provide enough stability to allow the Schools to nurture and retain key staff.

6. The two work programmes under evaluation, HEFP and PPPHC, both built on existing

expertise in the Schools as well as on work previously carried out under ODA core grants. HEFP aimed to expand the application of health economics to developing countries through a substantial programme of research, training additional health economists specialising in developing countries and raising greater awareness of health economics and financing issues in national, bilateral and international agencies. Somewhat unlike other work programmes, PPPHC gave equal consideration to promoting primary health care (PHC) and assisting with its implementation whilst establishing a programme of applied research.

*The Evaluation*

7. The evaluation was undertaken by a team consisting of Mr Andrew Creese, Ms Mercedes Juarez and Dr Peter Poore, under the leadership of Dr Ken Grant. Its approach was agreed through a consultative process involving the evaluation team, a representative of DFID's Evaluation Department and representatives of the work programmes and Schools. A range of methods was employed, including reviews of documentation, semi-structured interviews, normative and focus group discussions, and peer reviews of scientific publications, reports and policy documents. Work was carried out in the UK and visits were made to three countries - Costa Rica, Ghana and Thailand. Lists of individuals consulted and key documents reviewed are provided in Annexes C and D.

*Impact*

8. The two programmes selected for examination were quite different in design and any comparison of the outputs needs to take that into account. The conclusions relate not to the individual programmes as such, but rather to the wider effectiveness of the programmes as a way of generating useful knowledge. The evaluators judge that the work programmes were successful in transforming the way in which ODA supported the work of the two Schools (Section 1 of Ch 2) transforming the way in which it supported research (section 1 of Ch.3, 4.14), reorienting its funded research in support of its policies and targets (3.6, 3.10) and strengthening both the Schools' capacity and that of its development partners (4.16- 4.21). The programmes were also successful in meeting academic goals of generating high quality and relevant knowledge through research, publication and training programmes (4.10-4.15). The knowledge generated can be seen primarily as a public good and, without doubt, has influenced policy and practice. It was, however, more difficult to demonstrate a direct relationship between the programmes' outputs and the specific policies and practices of ODA and DFID or their development partners (4.22-4.30).

9. In particular, it was difficult to demonstrate institutional impact within ODA. This was felt to be partly due to a lack of capacity within HPD which is currently being addressed (4.25-4.27).

*Findings*

10. The work programmes (WPs) constituted a distinct break with the previous forms of financial support provided by DFID to the Schools, which had chiefly comprised the funding of tenured staff posts. While the new arrangements initially meant that the Schools' received larger sums of money, they and their staff lost the institutional security previously enjoyed. In addition, moves towards open competition at the end of the first five year WPs meant that the two Schools no longer enjoyed any privilege within ODA's programme of research. This change from long-term institutional funding to project-type funding in the late eighties was a radical shift in policy which took a period of years to negotiate and it met with considerable initial resistance (2.4-2.13).

11. At the same time that ODA had started to renegotiate its support to the two Schools, both had undertaken major internal reviews which examined their current and likely future roles and how best these might be fulfilled (2.13-2.19). These reviews culminated in new leadership, organisation and management. At LSHTM, the reorganisation had taken place prior to the WP's initiation but, at LSTM, the reorganisation took place during the negotiation and first years of its WP. As a result, the LSTM's WP which is the subject of this evaluation lacked the organisational stability enjoyed by that undertaken at the LSHTM.

12. The choice of PPHC and HEF was sound, reflecting an understanding within both DFID and the Schools of the potential contribution of further work on these topics to improved health in developing countries. While the selection of topics within the WPs was initially undertaken effectively by the managers of the programmes (subject to ODA's approval), the regular review process allowed ODA to play an increasing role in refining these topics. By the first triennial review ODA had made explicit its preference for an emphasis on research rather than implementation. Over the life of the programmes, ODA increasingly provided the leadership to commission research tailored to its health policies and practices, largely through the Chief Health and Population Adviser.

13. Reviews of activities in selected countries highlighted the use of in-country training, student placements in the UK and recruitment of research fellows from practitioners working in developing countries, as contacts for establishing collaboration in developing countries by both Schools. This worked well.

14. The approach developed by HEFP pre-defined a clear research agenda, capable of application in most developing countries. The PPPHC, while having clear areas of work, appeared to rely more on discussions in-country, to clarify the WP's detailed agenda. This reflects the differing nature of the WPs, the LSTM programme being concerned, from the outset, with developing good practice and its implementation, particularly in the host country; while HEFP pursued a clear research (particularly comparative research)-based agenda. Policy influence was

a more general, second-stage outcome and not confined to (or necessarily in) the country in which the research had been undertaken.

15. The five-year reports produced in 1995 list numerous publications, collaborators and professionals associated with the WPs and are set out in Annexes G and H. Not only do these Annexes give evidence of considerable achievement in academic circles, they suggest considerable advancement more generally in the fields concerned. For both programmes their conventional outputs were impressive (4.12, 4.14 & 15).

16. The review of communications between the Schools and ODA found that annual and triennial reviews provided the key point of contact between the latter and the WPs. Through these reviews, differences in desired outcomes by DFID and the Schools were highlighted and resolved and over the first three years this worked well. The link adviser systems, however, did not. There is some evidence that link advisers saw their role more for project monitoring purposes, while the Schools were hoping for support and collaboration in their work. Contact became limited and infrequent (3.67).

17. The review process highlighted differences in desired outcomes of the WPs by ODA and the Schools. LSHTM sought primarily to ensure the generation of high quality and relevant knowledge through research, publication and training programmes. LSTM, on the other hand, initially aimed to assist more with the implementation of PHC at district level, largely through teaching, the production of relevant materials and improved practice. From a project management perspective, ODA sought to ensure more direct links between the generation of knowledge and its use in supporting policy processes, even though it simultaneously gave priority to research. This approach had implications for both Schools; it encouraged LSHTM to find strategies to ensure that research findings were used to influence policy and practice and it encouraged LSTM to strengthen the foundations of its knowledge base through research (3.68).

18. Both triennial reviews emphasised the need to better understand and to influence policy processes rather than stopping with the dissemination of knowledge. While this emphasis is understandable from ODA's point of view, it poses significant questions for each School about its own mission and purpose and how it can best achieve these. Criteria for work programmes which emphasise impact on policy may well pose a conflict of interest for academic institutions which are judged on the quality of their research (3.67 & 68).

19. Through the WPs both Schools have attracted a number of new, young professionals into international work, thus expanding the UK's experience in their areas. They have also given valuable experience in postgraduate research to a significant number of development partner nationals.

20. Ownership of work in-country, however, was sometimes unclear, reflecting the complexity

of relationships which influence policy and practice, and the WPs' need to undertake comparative research and training. The terms of reference for this evaluation included an assessment of the extent to which the WPs have contributed to the policy process in countries. Whilst a number of instances have been identified, this is not what the Schools felt the WPs were primarily designed, or funded, to do. Policy support in countries requires a continuing presence, and a high level of flexibility regarding the type and method of investigation or research that may be necessary. HEFP for example was focused on undertaking comparative research on predefined themes (3.10); thus its ability to feed directly into a given country's policy process was bound to be limited in the short time horizons with which they typically work.

21. WPs as a primary funding mechanism for the generation of knowledge and the strengthening of capacity in international health are effective and should continue. The directors of the WPs felt the time period of five years is right. The evaluators take the view that WPs should normally be of this length as this allows both for institutional stability and market testing (3.73) and also that DFID should consider increasing the upper financial limit.

22. WPs were managed centrally by ODA; in-country ODA offices were not involved in the design, implementation or use of WP activities. This was a significant lost opportunity. More involvement of field staff could give greater local prominence to knowledge generated by the programmes and advice about the selection of local partners (4.30).

23. In practice, addressing the objective of informing policies and practices within ODA relied heavily on the Chief Health and Population Adviser and the relatively small technical capacity (in quantitative not qualitative terms) within the Health and Population Division (HPD). As sponsor of the work programme, ODA had the potential to fill roles both in the purchase of knowledge and in provision of practical support for its production. Relationships with HEFP and PPPHC suggested that ODA was primarily purchasing a public good. This, in the evaluators' view, is perfectly acceptable providing the good in question is one that can be effectively used, and represents value for money for the work programme concerned (4.22).

24. Nevertheless DFID/HPD, through its partnerships with institutions such as LSHTM and LSTM, is able to draw on important intellectual capital and knowledge on a wide range of development issues, in contrast to many other donors. This almost certainly contributes to the current position whereby the United Kingdom exerts an influence on development thinking and practice out of proportion to the resources involved. By actively using the ideas and information generated through work programmes, DFID is a "thinking donor" rather than simply a funding agent. Such a role is wholly compatible with "Building Support for Development" (1997 White Paper) and with strengthening DFID's role in international partnerships (4.23).

*Lessons*

25. DFID should continue to fund WPs through a process of competition to ensure the highest quality of work and achieve value for money. DFID should, however, avoid fragmentation of UK expertise and the risk of institutions developing an unwillingness to share knowledge, by formulating clear criteria for institutional eligibility to qualify for work programme-funding. These criteria should include organisational stability and leadership, technical expertise in the area of further study and proven capacity in working collaboratively with local partners (paras 11, 12).

26. Sound design and successful implementation of WPs requires a supportive and stable environment, and continuing strong leadership. During periods of transition in leadership of institutions or work programmes, DFID should intervene and provide additional support if required, to ensure the successful implementation of agreed activities (para 12).

27. A critical mass of technical and managerial skills is necessary to develop sound work plans and related logical frameworks for WPs. The roles of School leaders and WP directors are both important in this, as credible technical authorities and as supportive managers (para 12).

28. DFID needs to have the capacity in place to commission and disseminate work effectively, and to adopt a more "active purchasing" role. In the past, the annual and triennial review, and occasional contributions to HPD's "In-week" have been the principal liaison points. WP staff could be asked to take a larger role in the preparation of briefing and position papers for DFID (para 17).

29. DFID should continue to use Annual and Triennial reviews to monitor work programme implementation. The content and format of these reviews can now be standardised, with clear objectives, methods and outcomes. In addition, the system of DFID link advisers should be reviewed to ensure that there is continuity in the individuals responsible for particular work programmes (para 17).

30. The local policy context in partner countries needs to be considered carefully in terms of a) the strength of both policy making and applied research actors and institutions, b) the level and character of existing external involvement in the health policy analysis arena, and c) the local policy agenda. DFID should recognise the difficulties which a research programme faces in establishing research links with policy makers, and be prepared to help by ensuring that local policy makers have a realistic understanding of what a WP can do (para 21).

31. DFID's regional departments and country offices should be more involved in the design and implementation of WP activities in-country. This would be useful as an input into their own strategies and programmes of work, and in helping to ensure that development partners and other donors have access to WP products. Involving regional departments should also

contribute to a greater understanding on the part of those involved in WPs of the resource constraints which hinder health improvements in partner countries, and to ensuring that research addresses the priority needs of our partners (para 23).

32. WP plans and funding proposals should incorporate a clear strategy, based on sound assessments, for the involvement of local partners and the joint management of work conducted. Commitments to working collaboratively must be matched by astute and careful selection of any organisation or individuals (3.60).

33. HPD needs to have the capacity to play a more general "programme advocate" role within DFID, ensuring the dissemination, use and application of work programme outputs. The appointment of a technical deputy in HPD and the creation of a unit for knowledge generation, creates an opportunity to re-think how DFID can more fully capitalise on work programme activity and knowledge. More consultation, of an informal kind, and occasional requests for inputs and views from WP staff, by DFID, might be attempted and evaluated (paras 24, 25).

# 1

## INTRODUCTION AND BACKGROUND

*1.1 Chapter I introduces the evaluation and outlines the conceptual framework which was used. In particular, it highlights an agreed emphasis on the interfaces between key stakeholders both at the point of commissioning the generation of knowledge and in its dissemination and use of the findings. This chapter also outlines the structure of this report and presents an overview of some of the most important advantages (and difficulties) of using this approach and the specific methods which were adopted.*

1.2 In April 1997, the Evaluation Department of DFID engaged an evaluation team consisting of Mr Andrew Creese, Ms Mercedes Juarez and Dr Peter Poore, under the leadership of Dr Ken Grant, to evaluate two of the first generation of work programmes which were operational between 1990 and 1995 - the Policies and Practices of Primary Health Care (PPPHC) programme at LSTM and the Health Economics and Financing (HEFP) programme at LSHTM. Terms of Reference for the evaluation are provided in Annex A.

1.3 The purpose of the evaluation was to examine the concept of work programmes as a means of meeting their original broad objective "to inform, influence and improve health policies and programmes of ODA, developing governments and other donors and agencies in areas of immediate relevance to ODA's bilateral activities and to multilateral health organisations to which ODA contributes". It has therefore focused on the principles of work programmes as a vehicle for meeting these objectives, using the two programmes selected rather than evaluating the individual programmes. It must be recognised that there was a range of sub-objectives which ODA wished to achieve.

1.4 These ODA sub-objectives were as follows:

- to transform the way in which it supported the work of the two Schools;
- to transform the way in which it supported research;
- to reorient its funded research in support of its current policies and targets;
- to strengthen both Schools' capacity in these research areas and the capacity of ODA's development partners.

1.5 The evaluation approach draws heavily on work carried out for the UK Department of Health on assessing the payback to health research by Professor Martin Buxton[2]. DFID, the two Schools and the evaluation team agreed that Buxton's concept of a Research Sequence, as distinct from but including the research process, allowed a wider view of research and its applications and impacts. The evaluation team was particularly interested in the importance of the interfaces between key stakeholders both in commissioning research and in the dissemination and use of its findings, and it was agreed that this evaluation would focus primarily on these two interfaces. An analytical framework for the evaluation was then designed, based on Professor Buxton's Research Sequence Model and the agreed emphasis on the commissioning and dissemination interfaces. Matrices summarising the evaluation frameworks for both Schools are provided in Annex A (ii). It was agreed that the approach summarised in these matrices elaborated on the Terms of Reference and formed the conceptual framework for this evaluation. An itinerary of the programme of work is included in Annex B.

1.6 In brief, the evaluation team used the Research Sequence Model to identify six stages relevant to the work programmes, including:

| Stages | Key Activities |
|---|---|
| 1. Needs Assessment | Planning of work programmes in DFID and the Schools. |
| 2. Interface A | Commissioning of work programmes and defining their objectives. |
| 3. Processes | Research, training, advisory services and capacity building; ways in which the programme of work was carried out. |
| 4. Primary Outputs | Products of work programmes, and effects on institutions. |
| 5. Interface B | Dissemination of programme outputs. |
| 6. Impact | Informing policy, influencing agendas of other agencies, informing in-service management arrangements and informing research; impact on health services and health status. |

1.7 The comprehensive scope of the Research Sequence Model required us to identify and agree some priority issues around which methods would be designed. The team agreed on selected activities for each stage of the Research Sequence Model. It was recognised that the scope of the evaluation would be somewhat limited in evaluating the academic content of outputs such as research and that this is more appropriately covered by the University Funding Council (UFC) Research Assessment Exercise (RAE). A limited peer review of selected publications was, however, undertaken. Furthermore, it was recognised that attributing impact

[2] BUXTON, M & HANNEY, S. How can payback from health services be assessed? Journal of Health Services Research Policy. Vol 1 Number 1 1996, pp 35-43.

to small scale programmes such as the work programmes would require a much more extensive investigation than this review by which to attribute, with certainty, change to the work programmes. The team decided to use a range of methods, including reviews of documentation, semi-structured interviews, normative and focus group discussions, and peer reviews of both scientific publications and reports and policy documents. Details of this approach are set out in Annex A(ii). Work was carried out in the UK and visits were made to three countries - Costa Rica, Ghana and Thailand. Lists of individuals consulted and key documents reviewed are provided in Annexes C and D.

1.8 This report's structure follows the agreed methodology. Thus, identification, design and appraisal considerations outlined in Chapter 2 relate to the interface associated with commissioning the work programmes. The discussion of implementation in Chapter 3 considers the process and primary outputs of the work programmes, particularly in relation to the countries visited for the evaluation and to communications between ODA and the Schools. Considerations of impact and sustainability, as outlined in Chapter 4 focus on the second interface, ie are concerned with the dissemination, use and application of work programme outputs.

1.9 Significant differences were found between the two work programmes evaluated. These differences are reflected not only in the findings and recommendations of the evaluation team but also in the report's structure and content. In particular, the work programme on PPPHC at LSTM was the more complex of the two and underwent greater change over the course of the five years. Consequently, the evaluation team found it necessary to provide more detail of this work programme in the report.

1.10 The timing of this evaluation in relation to the work programmes under review had both advantages and disadvantages. The evaluation covered work programmes from 1990 -1995 and was undertaken between the summer of 1997 and spring of 1998. The ability to place events in the context of funding arrangements prior to work programmes, as well as relating them to the second series of work programmes beginning 1995 which followed those under review was helpful. It allowed identification of important influences over time and facilitated a more objective perspective to what was a radical change in policy. Furthermore, it was only over time that greater clarity and understanding was achieved in the definition and operation of work programmes for both DFID and the Schools. Lastly, the passage of time has allayed some of the anxieties associated with the change, both with conflicts of institutional interests and misunderstandings which ensued. The evaluation team has made use of this historical perspective and the report makes mention of work carried out and influences beyond 1995.

1.11 A seven year period between work programme inception and the beginning of the evaluation did present some difficulties in locating relevant people and documents and the poor

recall of some key informants. Moreover, sensitive issues remain. The resignation of one evaluation team member in December 1997 and the busy schedules of all participants meant that great efforts were necessary by all to complete the report. Notwithstanding these constraints, the team found the evaluation an informative experience and they very much hope the following report informs future relationships between DFID, the Schools and other knowledge generating institutions.

# 2

## IDENTIFICATION, DESIGN AND APPRAISAL

*2.1 The establishment of the work programme arrangement in the late 1980s and the selection of work programmes on health economics and financing at LSHTM and the policies and practices of primary health care at LSTM are considered.*

*2.2 The timing of internal reorganisations within both Schools in relationship to the inception of the work programmes appears to have favoured LSHTM since new leadership was in place to negotiate and influence the establishment of the work programme; moreover, at LSHTM, organisational change was already in process. Conversely, organisational change and transitions in leadership at LSTM took place during the final stages of negotiating the work programme arrangement and the first few years of implementation.*

*2.3 A comparison of the early stages of the two work programmes suggests that there needs to be a supportive and stable environment, including strong continuing leadership, for work programme funding arrangements to have maximum value. In addition, evidence from both Schools suggests that the design of work programmes depended on a critical mass of existing expertise.*

### *1. ESTABLISHING WORK PROGRAMMES*

2.4 The initial work programmes had several objectives which were politically complex. In addition to the prime ones of generating and applying knowledge which are set out in Chapter 1, they were seen as a means of maintaining ODA support to the two schools while introducing flexibility and performance management.

2.5 Prior to 1990, there were at least four ways in which ODA supported the work of the Schools. For more than 25 years, the salaries of selected lecturers had been provided by ODA under the Technical Co-operation Medical Lectureship (TCML) scheme. In addition, some units within the Schools received core grants for agreed programmes of work. The Schools also received grants from the research and development allocation of the Health and Population Division (HPD), and some student fees were paid under the Technical Cooperation Programme (TCP) and other scholarship schemes.

2.6 Just prior to the creation of the work programmes in 1988, more than 30% of core academic staff of both Schools were paid for under the TCML scheme. At the same time, there were at least four units within the Schools receiving core grants. ODA support for the two Schools was estimated at £1.25 million per year. By 1989 these arrangements were considered by ODA to be fragmented, unresponsive to changing needs and, for the TCML arrangement, open-ended.

*Needs within ODA to enhance relevance and financial transparency*

2.7 In an evaluation of the TCML scheme for ODA in 1987, this funding mechanism was reviewed, as were arrangements in use with other academic institutions. This evaluation concluded that while the TCML scheme may have helped maintain British capacity in the field of international health generally, it did not lend itself easily to providing ODA with the help it needed for formulating and implementing new health policies. Although TCML lectureships were entirely ODA-funded, individuals were contracted by the Schools on a tenured basis under University regulations. This arrangement was highly favoured by the academic institutions partly because it provided substantial indefinite institutional support but also because it preserved academic freedom to identify and research key issues.

2.8 Over time, the interests and expertise of many of these lecturers began to diverge from the health and population priorities within ODA; by the 1980s there was a greater need to focus on the financial and managerial aspects of the delivery of primary health care than on tropical medicine, which had been the focus of many TCML posts. While perceptions of the objectives of the TCML scheme differed between ODA, School leadership, and the individuals receiving support, by the late 1980s there was a clear desire within ODA to find ways of ensuring that the academic work it supported was relevant to the design and application of its own health policies.

2.9 In addition, there were needs within ODA for greater financial transparency. In a review of the core grants provided to the LSHTM in 1989, ODA concluded that existing financial management systems within the School did not allow it to account in detail for the use of its funds. This supported the concern that ODA might have been subsidising or double funding some activities of the Schools, such as subsidised teaching by staff employed under core or research grants, or that at times ODA paid twice for work, such as in consultancies carried out for it by staff on TCML lectureships or core grant funding, or in teaching where student fees and staff salaries were both paid by ODA. These concerns highlighted the lack of financial transparency with the then current arrangements and prompted ODA to consider alternative funding mechanisms.

2.10 Perceptions of limited relevance of research by the Schools to ODA policy concerns and their application in developing countries, as well as the need for improved financial accountability, contributed to, and stemmed from, insufficient ODA participation in the

management of the TCML scheme. The need for more active ODA management and arrangements which facilitated this were acknowledged in the reviews of the TCML scheme and core grants alike.

2.11 By 1989, ODA clearly stated a preference for project-type funding which would incorporate full economic costs for work carried out by the Schools. It was also recognised, however, that any future arrangement must provide enough stability to allow the Schools to nurture and retain key staff while maintaining sufficient flexibility to allow both ODA and the Schools to respond to changing health and population needs internationally. Five year, topic-based programmes of work were subsequently adopted.

2.12 Initially, both Schools were unhappy with the proposed change to funding work programmes rather than the TCML scheme in particular. Dissatisfaction centred around the loss of secure funding with the freedom to choose their own programmes of work independent of a donor agency. There was considerable resistance particularly in Liverpool, culminating in student protests and considerable tension in relationships between ODA and senior staff.

2.13 Further negotiations resulted in higher levels of support; eventually it was agreed that LSTM would receive £4.8 million for five work programmes and LSHTM would receive £11 million for 9 work programmes over five years. These levels of funding represented nearly a three-fold increase in previous investment.

*Needs of the Schools for continued influence in international health and greater financial stability*

2.14 At the same time that ODA began to renegotiate its support to the Schools, both Schools underwent reviews of their own. These reviews culminated in new leadership, organisation and management.

2.15 The LSTM conducted a complete External Academic Review in 1989 under the direction of Sir Arnold Burgen. Key recommendations were that the LSTM should continue to be affiliated to the University of Liverpool Faculty of Medicine but on a semi-autonomous basis. A full-time Director was to provide administrative, academic and executive leadership of a single department formed by the integration of the existing six academic departments. (This did not take place until July 1991). Financial management was to become the responsibility of a School Administrator, and the School Council was to increase its representation from the Senate and Council of the University as well as from national and international agencies concerned with health. The Review also suggested that research be focused on fewer areas and undertaken in research groups. These changes in organisation and management were accepted at the same time that ODA shifted funding from the TCML scheme and core grants to work programmes.

2.16 Planning for the merger to one single department and the creation of centralised

management occurred at the same time that the work programme arrangements were finalised and initiated. There was tension as it was felt that the former Department of International Community Health, now largely subsumed in PPPHC, appeared to benefit from the changes in ODA funding at the expense of both the more clinical and basic science departments and more senior academic staff. Processes of negotiation within the School were highly centralised, partly to contain organisational anxiety and unrest. This meant that the death of the former departmental head, Professor Ken Newell, in 1990 was particularly untimely for the standing and future of staff and programmes under his jurisdiction in the reorganisation of the School. It also meant that most junior members of staff did not appreciate the nature of the funding changes and instead were under the impression that work programmes were just another vehicle for ODA funds, much the same as before.

2.17 Relationships within the School were tense and negotiations highly sensitive, and yet despite new leadership from 1991, tensions surrounding the status of staff and activities of the work programme were compounded by the initiation of the University Funding Council's Research Assessment Exercise (RAE)[3] in 1991/92. PPPHC funds and activities did not fit easily in the RAE and required considerable skill in presentation for the School to receive credit towards the rating it required. This put the work programme in an awkward relationship with new School leadership - the change in leadership from Dean to Director took place in 1991 - who understandably gave institutional priority to activities recognised in the RAE.

2.18 This environment created some sense of uncertainty and limited support for the work programme. Many staff subsequently accepted positions elsewhere; all the five sub-component leaders had left the School by early 1994. Thus, not only were there significant changes in the School's organisation, leadership and funding arrangements but there were also important changes in leadership within the work programme over the early years of its implementation.

2.19 At LSHTM, the reorganisation had taken place prior to the initiation of the work programmes. The LSHTM also underwent review (the Reid Report), culminating in plans to reorganise the work of the School in four departments. These plans were taken forward by the new Dean appointed in 1989. The new Dean was very much aware of the need to attract additional resources and to ensure that the work of the School was of the highest quality. Throughout the transition in leadership and immediately on taking office, he was actively involved in the negotiations with ODA regarding the focus, timing and levels of funding which the new arrangements would take. Moreover, as negotiations progressed, he saw the change as an opportunity to support plans to restructure and finance the School's work, including the removal of unwanted tenured staff and the building up of expertise in areas of current need. This view reflected in part an understanding that the principle of support to the Schools was not in question.

[3] The Research Assessment Exercise is the mechanism by which funding is allocated to individual Universities. Traditionally, this exercise gives priority to levels of research funding raised and the quality and quantity of academic publications.

2.20 The work programme on HEFP was designed and placed within the new Department of Public Health and Policy. Leadership of the work programme was clearly assigned to a Reader in Health Economics in that Department.

### *2. COMMISSIONING WORK PROGRAMMES*

2.21 It was agreed by the Schools and ODA early in the negotiations that work programme subjects would be identified and proposed by the Schools, in consultation with ODA. ODA had made clear throughout the various reviews that it wanted to see greater emphasis on primary health care and less, for example, on tropical medicine. Both work programmes under evaluation, HEFP and PPPHC, built on existing expertise in the Schools as well as on work carried out under ODA core grants to units working in primary health care in the Schools prior to the work programmes.

2.22 The PPPHC work programme at LSTM built, in particular, on the work of the former Department of International Community Health: in particular, through the Community Health Information Project, Community Health Support Services, Education Methodology Unit, and the Management for Primary Health Care Group, created in 1986, which received ODA core funding from 1988/89 -1990/91. In addition, a 'Water as a Health Intervention' component was also included, based on the work of a member of staff formerly funded under the TCML scheme. Thus, the PPPHC work programme originally had 5 components:

Community Health Information Project (CHIP)
Community Health Support Services (CHSS)
Education Resource Group (ERG)
Management of Primary Health Care (MPHC)
Water as a Health Intervention (WAHI)

2.23 Not only did PPPHC build on existing expertise, it also maintained similar areas of emphasis. Unlike other work programmes, PPPHC gave equal consideration to promoting PHC and assisting with its implementation whilst establishing a programme of applied research. The purposes originally agreed were to 1) provide high quality learning opportunities for managers of health systems, 2) develop local potential to provide quality institution-based training, and 3) assist Ministries of Health and NGOs to improve the efficiency, effectiveness and appropriateness of their health systems. Similarities in this approach can be seen, for example, with the aims of the MPHC group which had been to provide a source of advice, technical assistance and training for individuals and agencies concerned with the implementation of PHC in developing countries. Moreover, the MPHC Group had a goal to become self-sustaining by the end of its three year core grant in 1991, and this influence was also seen in the PPPHC's ERG component (concerned with producing educational materials and services) which aimed to become self-supporting during the course of the work programme.

2.24 The work programme on Health Economics and Financing (HEFP) built upon work carried out by health economists in the Evaluation and Planning Centre of LSHTM which had been one of three units in the School to receive ODA core funding. HEFP aimed to expand the application of health economics to developing countries in order to help them develop cost-effective, equitable and appropriate health systems. In particular, a substantial programme of research was to be carried out; additional health economists specialising in developing countries were to be trained; and greater awareness of health economics and financing issues was to be raised in national, bilateral and international agencies. Within both the School and ODA, this work was seen to be underdeveloped but with great potential to influence better health in developing countries.

*Decision-Making Processes*

2.25 While both Schools built on existing expertise and programmes of work to design HEFP and PPPHC, continued changes in leadership in LSTM over the first two years of implementation prevented a smooth and timely transition to the work programme arrangement. The death of the former Head of the Department of International Community Health in 1990, and the departure of all leaders of the five subcomponents of the work programme by early 1994, meant that leadership of and within PPPHC changed hands frequently.

2.26 There were substantial changes in the content and organisation of key components of PPPHC during its first year of funding. In the first year, the WAHI component of PPPHC gathered information which identified priority areas for future development which required expertise LSTM did not have or which was covered in other work programmes. In March 1991, the School recommended discontinuance of this element and suggested that funds be reallocated to other work programme activities. In contrast, funding for CHESS had only been planned for one year in order to allow a review of activities and identification of new directions and objectives, and in 1990 this component was also discontinued.

2.27 Like WAHI and CHESS, the MPHC and CHIP components of PPPHC were also reorganised during the first year. These two components merged to become the Health Systems Development Group (HSD) and the scope of work was broadened to incorporate financial management and quality assurance. Only the ERG remained unchanged.

2.28 The situation at LSHTM was much different. The in-coming Dean was most supportive of the work programme arrangement and of HEFP in particular. In a professional capacity, he had worked closely with the new Head of HEFP and was increasingly incorporating health economics in his own studies. Similarly, the new Head of HEFP had a clear vision of the way forward as well as a sound understanding of the academic environment in which HEFP was to be based. Documentation reviewed by the evaluators included a clear and specific proposal with detailed Project Frameworks for the entire programme as well as for each year individually. HEFP

got off to a quick and purposeful start.

### *3. CONCLUSIONS*

2.29 The change from long-term institutional funding to project-type funding was a radical shift in policy, negotiated over a period of years and, initially, meeting with considerable resistance. Changes proposed had far-reaching implications.

2.30 The timing of the reorganisation of funding for the Schools appeared to favour LSHTM, partly because its reorganisation had been completed and new supportive leadership was in place to negotiate the work programme arrangement. In addition, the restructuring within LSHTM was finalised prior to work programme implementation and so provided a stable organisational environment. Conversely, organisational restructuring within LSTM coincided with the implementation of the new work programmes; thus, the organisational environment was one of uncertainty, great sensitivity and changing leadership in the early years of work programme implementation. Sound design and successful implementation of work programmes requires a supportive and stable organisational environment as well as continuing leadership.

2.31 There may have been scope for greater ODA involvement. Notwithstanding its need to be seen not to be interfering in academic affairs it should perhaps have stressed to the University of Liverpool the need for a stable environment for the work programme and used its role as a funder to ensure this took place. It is appreciated, however, that this might have been seen to be beyond its proper role.

2.32 Both Schools built on existing expertise and programmes of work in designing HEFP and PPPHC. This suggests that, to develop sound work plans and related logical frameworks for work programmes, a critical mass of technical and managerial skills is necessary. The role of both School leaders and work programme directors is important in this, both as credible technical authorities and as supportive managers.

2.33 The choice of PPPHC and HEFP was sound, reflecting an understanding within both ODA and the Schools, of the potential contribution of further work on these topics to improved health in developing countries if the many unanswered questions could be studied further.

2.34 The choice of topics within the work programmes was however left very much to the programme leaders. This may have been because the ones they put forward were considered by ODA to be the most appropriate. Certainly little debate took place. Alternatively HPD may have lacked capacity to become actively involved in the commissioning process. This is an area we return to elsewhere in the report (4.47, 4.48). In our view there should be greater DFID involvement in setting WP topics.

# 3

# IMPLEMENTATION

*3.1 This chapter covers the process and primary outputs of the work programmes. In particular the process looked at the impact of the WPs in host countries. This relied on country visits to Costa Rica, Ghana and Thailand. Details of collaborating countries and institutions are in Annex C. In addition, peer reviews of both refereed and non-refereed publications also took place (Annex E) as well as interviews with current and former staff members. Other primary outputs such as staff and students who gained experience in work programmes, publications, courses etc. are in Annexes G and H. The evaluators found the primary outputs impressive in both programmes.*

*3.2 Reviews of activities in selected countries highlighted the use of in-country training, student placements and recruitment of developing country nationals on staff as contacts for establishing collaboration in developing countries by both Schools. This worked well. However, ownership of work in-country was sometimes unclear, reflecting the complexity of relationships which influence policy and practice, and the work programmes' need to undertake comparative research and training. We discuss the process of selection of in-country or regional partners - both individually and institutionally - as well as of research topics. In particular, we feel management of activities needs to be more transparent within the context of the sector-wide approaches now used by many Ministries of Health. This suggests a need for greater involvement of DFID country offices, which could also be vehicles for improved dissemination of, and support for, the work programmes' findings.*

*3.3 In addition, as part of the process, this chapter also considers the relationship with ODA during implementation of the work programmes. The review of communications between the Schools and ODA found that annual and triennial reviews provided the key point of contact between the latter and the work programmes. Through these reviews differences in desired outcomes by the funder and the Schools were highlighted and resolved and over the first three years this worked well. The link adviser systems, however, did not; each party had different expectations of their roles and contact became limited and infrequent. This, however, reflected also the lack of capacity at the time within HPD and more particularly, the turnover in the individuals who were allocated this responsibility. The process for agreeing new work programmes brought clarity to needs within ODA for a transparent process which rewarded high quality of work and value for money. For the next round of WPs open competition was*

*introduced. While there are obvious advantages to this there is also a danger of fragmentation of UK capacity in International Health. We discuss this.*

3.4 Although other forums for assessment such as the University Funding Council's Research Assessment Exercise consider the merits of research, training and publications in more detail, the evaluation team noted the impressive achievements of both work programmes. The five year reports produced in 1995 list numerous publications, collaborators and professionals associated with the work programmes. These reports, apart from the full listing of publications, are reproduced in Annexes G and H. Not only do these provide evidence of considerable achievement in academic circles, they also suggest considerable advancement more generally in the fields concerned. The programmes' possible impact is considered, in Chapter 4.

## *1. PROGRAMMES OF WORK IN DEVELOPING COUNTRIES*

### *Selecting Activities and Countries*

3.5 Both work programmes, within their identified issues, undertook activities in selected developing countries.

*PPPHC: Operational Support for the Delivery of Better Primary Health Care*

3.6 After the first annual review, priorities within PPPHC centred around the proposition that district health staff would be able to tackle priority health problems more effectively, within available human and financial resources, if they

- had access to additional skills in training, assessment of health system performance through information systems and human and financial resource management,
- received relevant information and
- design of new systems for managing service delivery.

3.7 Within this remit, work initially centred around activities in several countries in Africa (Ghana, Sierra Leone, Tanzania, Zaire) and Latin America (Central America/Costa Rica, Brazil, Nicaragua). By the end of the work programme, work was primarily concentrated in Ghana, Tanzania and Zaire as well as in Central America/Costa Rica. The evaluation team visited Costa Rica and Ghana, on the recommendation of the School.

*PPPHC: Researching Quality Assurance Systems in Ghana*

3.8 As part of its Masters Degree in Community Health, LSTM sent students to Ghana each year to study subjects jointly with the Ministry of Health. Collaboration with Ghanaians was, therefore, well established and regular prior to PPPHC. Quality of care had been of concern to the Ghanaian MOH since at least 1978. During some seven years of service, the then Director

of Medical Services encouraged further study of quality of care issues. It was within this context that the Eastern Region Medical Officer undertook his own study of quality of care from patients' perspectives in 1991, and requested further work from a student in 1992. This request was of particular interest to one member of HSD who had been working on quality of care issues for local health authorities in Liverpool and provided an opportunity to extend its work to include developing countries. A pilot study which was implemented by a student in 1992 was followed in 1993 by a larger study carried out by HSD in collaboration with the regional director and his staff. Work culminated in the preparation of a national policy for quality assurance for Ghana. Clearly, the selection of quality of care from a patient's perspective as a topic for research in Ghana under PPPHC was selected jointly, in the sense that the Ghanaians themselves who were grappling with a fall in service uptake following implementation of user charges, had identified and studied it at the same time as it was being pursued by health authorities in Liverpool and, conceptually, by PPPHC staff.

*PPPHC: Training in Health Information for Local Health Management in Central America*

3.9 In Costa Rica, the development of local training in health information systems for district health managers evolved differently. During a visit by a member of PPPHC to Costa Rica, opportunities to apply for a research fellowship at LSTM were made known to officials met there. One such official applied and was accepted, taking up his post in 1991. His work initially focused on the evaluation of UK training of health managers and staff in Tanzania where he saw, among other things, the discrepancies between training conducted in the UK and the needs and environment of district health managers in Africa. Knowing of similarities within Central America, he then proposed that they design and implement an action learning course on health information for district health managers in Central America. A full proposal was prepared and accepted for funding by ODA to be implemented from 1993-1995. This proposal had two components: the first was to design and implement an action learning course on health information for district health managers and the second was to develop measures of the impact of management performance. Thus, rather like the quality assurance work in Ghana, the SIGLOS course in Costa Rica had been selected jointly, in the sense that a former official of the implementing agency of the Ministry of Health (who more recently had been a research fellow with PPPHC and had registered to read for a PhD at LSTM), designed and implemented this project, first as a Research Fellow and later as its Project Co-ordinator.

*HEFP: Drawing International Comparisons*

3.10 HEFP activities were defined around five pre-established broad research themes (evaluation of alternative sources of finance, public/private mix, economic evaluation and planning, management and related information systems and political economy). The work programme's task was to undertake comparative research on these themes, and then develop and

disseminate the knowledge derived. The themes were identified by the HEFP, although some modifications were made to the set originally proposed, during discussions with ODA. The topics were defined in the light of knowledge of what other international researchers were already studying, and through contacts with a number of policy makers in developing countries. Each topic was defined broadly enough for country-specific work to take a variety of different forms. In the specific case of work on the public/private mix, an international workshop was held to define where the work's focus should be.

3.11 In practice, the work programme found it easiest to negotiate a research agenda of joint interest to developing country decision-makers and HEFP staff in situations where there was already an established capability in policy-oriented research. Countries were originally selected on the basis of HEFP staff's knowledge of policy developments of direct relevance to the programme's research agenda; but the way the local research programme developed owed much to the dynamics of local interactions between HEFP staff and local policy or research staff. In both countries visited as part of the evaluation, HEFP had supported several pieces of research. Thailand was suggested for a field visit as it was felt to be one of the countries where collaboration with local policy makers had been relatively successful. Ghana was selected because it was less so. Detailed briefing notes on each country were prepared by HEFP for the evaluation team (Annex F). These give a very clear picture of the overall research activities and collaborators, of staff trained at LSHTM, and of meetings and publications involving nationals and HEFP staff. In addition to Thailand and Ghana, other countries where HEFP had two or more research activities were South Africa (public/private mix and contracting); Uganda (public/private mix and health worker behaviour); Tanzania (public/private mix, financing change, cost analysis and resource use); and Zambia (equity, Bamako Initiative, user fees).

*HEFP: Activities in Ghana and Thailand*

3.12 In Thailand the HEFP work agenda was developed in a highly interactive way with leading staff of the Health Systems Research Institute (HSRI). During the life of the first work programme, the status and authority of HSRI underwent important growth. It grew from fledgling, mainly technical research status, with research grounded in the operations of health facilities in both rural and urban parts of Thailand, to become a prestigious public health lobbyist and advocate, promoting the use of evidence-based research in several battles with powerful entrenched interest groups. HSRI is now an influential semi-autonomous policy research body, with funding from several sources including the Ministry of Public Health. HSRI has its own research agenda and dissemination strategy, ODA which currently includes work on national health accounts and the standardisation of insurance benefits under different public sector health insurance schemes, on both of which HEFP staff provided inputs. Other elements of the HSRI research agenda, such as quality assurance and health promotion mechanisms, were not on the HEFP agenda. Willingness to discuss and "coincident interest" were identified by one

senior health policy maker to describe the way collaborative research topics were identified in Thailand. HEFP staff were considered to have tried to respond to needs identified by Thai policy makers, even when these were outside the immediate scope of the work programme. There was thus a real technical dialogue, and negotiations from well informed positions, by both HEFP and Thai health policy staff. Collaborative research included:

- study of the characteristics of public and private hospitals through analysis of insurance scheme records
- case study of hospital competition
- assessment of payment mechanisms on efficiency and quality of care
- evaluation of clinical and non-clinical service contracting.

3.13 In addition, a study of the Thai low income card insurance scheme was carried out by HEFP staff and Mahidol University, with limited inputs from HSRI. Prior to and during this work, several Thais participated in short course, MSc or PhD programmes at the LSHTM. Over a dozen publications resulted from the research listed in paragraph 3.12.

3.14 The institutions concerned with health policy and related research in Ghana were also undergoing evolution during the life of the first 5 years of HEFP. Unlike the position in Thailand, in Ghana there were numerous changes of senior staff and, furthermore, the group of national policy decision-makers was very small. The department of Policy, Planning, Monitoring and Evaluation (PPME) was just being established at the beginning of the HEFP. There was a new Health Systems Research Unit (not reporting, at that time to the Director of PPME) with a mainly social science orientation and a history of some antagonism between the Ministry of Health and local academics who wanted to do research on health policy. Four Ghanaians took the MSc programme in health planning and financing at LSHTM during the first work programme but the selection of research topics seems rather fragmentary in comparison with the Thai experience. In Ghana the traditional gap between policy driver and academic analyst is wider than in Thailand, where HSRI successfully straddles this divide.

3.15 Senior policy staff in Ghana commented that the opportunity to participate in comparative studies offered by the HEFP had been created by that programme. Thus, the research topics offered had not been defined and selected in Ghana. Although official clearance was always obtained for Ghanaian involvement in aspects of the work programme, none of the studies was really a response to officially identified information needs. One policy maker characterised the situation as one in which Ghanaians had been offered the opportunity to participate in various pieces of comparative work - of interest to the individuals involved - but not offering research support for the policy process. There was clearly a less active dialogue between HEFP staff and top policy staff in Ghana than in Thailand. The studies carried out in Ghana are a more fragmented list than in Thailand, with several having little to do with the

central Ministry of Health, because there was no clear research agenda emerging from HEFP discussions with the Ministry of Health. One possible reason for this is that HEFP was unable to secure the level of confidence it enjoyed in Thailand.

3.16 The principal research undertaken by HEFP in Ghana was:

- Vitamin A supplementation (costs, integration)
- Cost effectiveness of mosquito nets
- Comparison of clinical and non-clinical service contracting
- Community health insurance
- Role of government in adjusting economies.

3.17 The LSTM approach put much more emphasis on a developmental, negotiated, dialogue, (especially in Ghana) whereas the LSHTM approach was structured by the main components of the work programme and looking for a) a general readiness in a country to collaborate and b) country-specific instances or opportunities in the five main areas. In Ghana it appeared that most of the preparatory discussion was with individual researchers, often people who had previously studied in London, though policy makers were consulted and correct procedures were followed to obtain authorisation. The contrast between the approach of the two programmes was commented on spontaneously in Ghana, where approval was expressed of the LSTM approach. In Thailand, in contrast, the policy and research community in health were much stronger, with their own clear agenda and activities, and LSHTM and the Thai Health Systems Research Institute entered a prolonged - and still continuing - process of consultation, discussion and collaboration, from which both parties have benefited.

*Communication with, and the Participation of, Local Collaborators*

3.18 Although topics chosen in all the countries visited appeared to be of mutual interest, ownership of the development and implementation of research and in-country training was sometimes unclear.

*PPPHC: Training in Health Information for Local Health Management in Central America*

3.19 Collaboration with the Costa Rican Ministry of Health was greatly influenced by at least three factors. First, there were five changes in leadership of the branch of the MOH (INCIENSA) through which the course was to be managed, over the five years of the training programme. This meant that, sometimes, collaboration was genuine and, at other times, relationships were distant and tense. Second, because the training of health managers throughout Central America was not within the mandate and priorities of INCIENSA, the SIGLOS course became more closely aligned to LSTM than to MoH policy makers. Thus, if the SIGLOS course was to become self-sustaining, as originally envisaged, important organisational issues would have needed to be resolved.

3.20 Third, the Project Co-ordinator increasingly worked with a newly formed think tank (ICAS) for carrying out research from mid-project onwards, becoming its Director in 1995. Even though the Project Co-ordinator had formerly been an official of INCIENSA, he had remained on the staff of LSTM upon his return to Costa Rica with grant funding from ODA. Through him, in 1994, ICAS reached an agreement with LSTM to be its representative in Central America. Thus, it appears that in practice a new organisation became involved in the institutional relationships for the implementation of the course mid-project.

3.21 Lastly, INCIENSA reported a lack of transparency in the course's management. The SIGLOS course had been conducted jointly by INCIENSA and LSTM during the first three years (1993-1995) but when INCIENSA was to assume full responsibility in 1996 the course did not take place. The evaluation team was told that this was purposeful and reflected INCIENSA's decision to end its collaboration with the Project Co-ordinator and ICAS. Officials reported a lack of transparency with regard to the selection of participants and the use of funds. A lack of transparent management together with conflicting views about the relevance, timeliness, practical value, and sustainability were the reasons given for discontinuing collaboration beyond 1995.

3.22 ICAS subsequently resumed leadership, offered the course again in 1997 and it advertised it for 1998. Despite the change in organisational base, sponsorship of participants continued to be provided, for example, by the British Council, the EC, GTZ and PAHO. INCIENSA also requested a placement for one of its staff. Continued sponsorship by funding agencies was important since the course was self-financing in 1996 and must continue to be so in future.

*PPPHC: Researching Quality of Care in Ghana*

3.23 Following on from the review undertaken by the Eastern Region Medical Officer in 1991 and the pilot study by the LSTM student in 1992, a three year Quality Assurance (QA) Project was initiated in 1993 with additional funding from the Wellcome Trust and The Sandoz Drug company. The QA Project had four phases which aimed to:

- demonstrate that patients' perceptions of quality of care can be readily measured,
- construct quality of care indicators based on patients' perceptions which could be routinely collected by health staff as part of a QA programme,
- pilot a QA programme based on the above indicators for use by multi-disciplinary teams within each health facility, and
- formulate a national QA policy for Ghana.

3.24 Work successfully progressed through each of these four phases, resulting in a clear QA policy agenda, detailed indicators for QA routine information systems, and the formation of QA teams in public facilities throughout the country. Notwithstanding these achievements, this QA system has yet to function.

3.25 Despite somewhat limited application, the evolution of the work indicates considerable collaboration with the staff of the MOH, in the Eastern Region especially but also centrally. The aims of the research were to develop indicators which could be used routinely by health staff and to raise awareness and commitment to a higher quality of care. The surveys conducted and the piloting of systems were all carried out in the Eastern Region by staff of the MOH. The use of MOH facilities and staff was a practical solution; not only was the direct involvement of staff a reasonable approach to meeting the aim of the work but at that time the School of Public Health had only some four members of staff, limiting its ability to be the implementing partner.

3.26 Centrally, the Director of Medical Services was kept informed, and other central and regional officials were informed regularly either through workshops organised by the project or at meetings of the MOH. The evaluation team received reports of dissatisfaction from some central officials over not being informed of current plans and the use of financial resources. In addition, some officials expressed concern over considerable personal benefits which accrued to selected individuals (such as in opportunities to travel, publication internationally and greater prestige in their work environment) even though the QA system was never implemented in practice. Like the work in Costa Rica, it appeared that some central officials wanted greater transparency in the management of the research; clearly this would allow them to participate more actively in it. It may also have reflected the recent move within the MOH toward a sector-wide management approach in which central officials have a much greater role in agreeing programmes of work and the resources allocated to them.

HEFP collaborative research in Thailand

3.27 This included:

- study of characteristics of public and private hospitals through analysis of insurance schemes records
- case study of hospital competition
- assessment of payment mechanisms on efficiency and quality of care
- evaluation of clinical and non-clinical service contracting.

3.28 In addition, a study of the Thai low income card insurance scheme was carried out by HEFP staff and Mahidol University, with limited inputs from HSRI. Prior to and during this work, several Thais participated in short course, MSc or PhD programmes at the LSHTM. Over a dozen publications resulted from the research listed above. HEFP staff participated in seminar and formal teaching activities at three Thai universities, in addition to MOPH activities. The long term placement (6 months) of one HEFP staff member, early in her career in the programme, was an important factor in the building of trust and confidence between the London programme and the several key Thai actors.

3.29 As mentioned above, the relative strength and stability of key Thai personnel working at the policy/research interface, particularly in HSRI but also in the Ministry of Health, made dialogue and research collaboration easy with HEFP staff. The London work programme was perceived as being pragmatic in its approach, and not seen to be advocating particular policy instruments or directions. This made it compare favourably with some other external research initiatives. The regularity of HEFP staff visits and discussions with key Thai staff, and the longer term placement of one HEFP staff member in Thailand, working with both the Centre for Health Economics at Chulalongkorn University, and with the Ministry of Health, helped build trust between the Thai analysts and policy makers and HEFP staff. Research on the low income insurance card scheme, carried out with staff at Mahidol University, provided learning opportunities for Thai academic staff which were greatly valued. Some of this material is still being used in teaching at Mahidol. The academic staff there were quite clear that the research topic had been identified by HEFP, but that the working relations between Thai and London staff were cordial, valuable and fruitful.

3.30 In Ghana, in contrast, lines of communication were mainly to individual research collaborators, rather than with the policy drivers. This may have reduced the potential value to policy-makers of the research undertaken, as their involvement was sometimes limited to the securing of formal approval. In part this reflects the relative weakness of the policy monitoring process in Ghana (substantially strengthened in recent years), and the instability and change that characterised the Ministry of Health in the early years of the HEFP work programme. In addition, external actors (donors, consultants, researchers) in Ghana are more numerous and more influential on policy than in Thailand. As a result, external initiatives (including those from local universities) are regarded with a degree of suspicion.

3.31 A more continuous presence by HEFP, and a greater readiness to negotiate the contents of the Ghana research portfolio, would probably have been necessary to achieve the confidence of policy makers. This would have required a totally different strategy by the programme (country-based, rather than international comparative work on selected topics), and substantially more resources.

*Other outputs*

3.32 These are listed in Annex G and H. Both programmes recruited younger staff members who over the course of the programmes became respected experts in their fields. This is covered further in the next chapter. Others were given experience as research fellows. Both programmes produced impressive numbers of papers and reports. As already stated, this review did not do a formal evaluation of the academic content of the publications. However, the subjective view of the evaluators is that they were relevant and that the content contributed significantly to knowledge in the programme areas.

3.33 In addition, as agreed when designing the evaluation, each programme submitted 5 publications for peer review. The results are summarised in Annex E. The difference in rating may be explained by the HEFP's having been focused primarily on research and the PPPHC having been focused on design and delivery of good practice.

## *2. COMMUNICATIONS BETWEEN DFID AND THE SCHOOLS*

### *Implementing a Regular Process of Review*

3.34 Prior to the work programme arrangements, it had been recognised that existing systems of reviewing work carried out with ODA funds had been less than satisfactory. There had been delays and this had created significant financial uncertainty and difficulty for the Schools. Annual reviews by a team of three ODA advisers had been proposed before the work programme arrangement had been agreed, and triennial reviews were later accepted as the main mechanism for assessing progress and for considering future plans and funding under work programmes.

### *Annual Reviews*

3.35 Documentation showed that annual reviews were carried out, and summaries of the findings and any suggestions for change were conveyed to the Schools in the form of a letter. This practice was well received by HEFP at LSHTM and, for example, resulted in the first few years in a sharpening of research focus, a heightened awareness of the need to consider outcomes as opposed to outputs, and the need for a more explicit plan for disseminating findings. This resulted in greater focus on broad policy issues in the four areas (evaluation of alternative sources of finance, public/private mix for health care, economic evaluation, and planning, management and related information systems); plans for a dissemination workshop to conclude the evaluation of the Bamako Initiative and plans for a network or people and organisations working on health-economics related issues in developing countries.

3.36 The first annual reviews were also influential at LSTM, resulting in more fundamental changes to the work programme, such as the discontinuation of two components; the merging of another two components and redefining key areas of focus for the remaining component. The first review was especially important because the detailed consideration of all elements was undertaken using the project framework and this enabled PPPHC staff to realise what was now required of them. The changes mentioned above were agreed and, during the second year, new project frameworks were formulated for the two remaining components.

3.37 Like HEFP, the first annual review of PPPHC highlighted the need to prepare detailed dissemination strategies together with the need to consider carefully the products of the work programme. ODA also drew attention to the need for the School to provide central direction and leadership to the work programme as a whole, with the aim of formulating a clearer, long-

term strategy. LSTM took on board most of these suggestions, although it expressed concerns about the dangers of ODA's continually realigning programmes. Perceptions that ODA was changing its position did little to dissolve tensions between ODA and LSTM.

*Joint Triennial Reviews*

3.38 At the inception of the work programmes, ODA and the Deans agreed on Terms of Reference (TORs) for joint triennial reviews. These reviews were seen as the key mechanism for assessing progress and for agreeing on funds to roll the work programmes forward for another three years while giving a five year commitment in total. The original TORs specified areas which took into account:

- the relevance and impact of the work programme in its own field, taking into account activities of other institutions working in similar areas including multi- and bi-lateral agencies,
- the scientific and technical content,
- the extent to which the work programme reflected ODA and School priorities and whether new areas of collaboration should be developed,
- recommendations for ODA support for the current and subsequent year as well as for rolling forward the work programme for a further three years (giving a 5 year commitment in total),
- the extent to which institutional capacity had been built, training capacity as been strengthened, institutional links with developing countries have been fostered, new research had been stimulated and co-operation in implementing ODA bilateral assistance programmes had been expanded,
- the adequacy of existing arrangements for monitoring.

3.39 These TORs also specified who would participate from the Schools, ODA and externally, and the documents to be prepared by the Schools. It is important to note that along with reports and project frameworks for work agreed initially and for the following two years, draft proposals for a further three years work beyond the original five, if appropriate, were included.

3.40 Following the second annual reviews, ODA had further refined its criteria for assessing the relevance of work programmes to the needs of developing countries. ODA outlined to LSTM in late 1992 five criteria which would also be used in the mid-term review of 1993. These were:

- policy relevance to the needs of developing country governments,
- a clear and coherent strategy,
- actual (or potential) impact on health policies in developing countries,
- value for money, and
- contributions to ODA policies and activities.

3.41 Having adjusted to using project frameworks as the basis for the annual reviews and interim joint meetings, LSTM was again disconcerted by what it saw as another ODA change in direction. It noted the change in title from work programmes to 'research' work programmes and queried yet another change in emphasis. This was followed by negotiations in which ODA maintained the above criteria as an elaboration of the approach it had taken it had taken in the ToRs. These negotiations led, subsequently to ODA proposals ODA regarding the format of the triennial work programme reports to cover:

- Concept
- Objectives and Strategy
- Outputs
- Capacity Development
- Skills Transfer
- Appraisal
- Impact (Actual or Potential)
- Multiplier Effect
- Future Plans
- Financial Report

3.42 In the triennial review of PPPHC, ODA queried the exclusive focus on the district, emphasised the importance of considering central levels as well as local levels in health systems, and the need to focus on the development of concepts rather than the actual practice. It also attached a higher priority to research than to teaching and consultancy work while recognising that many staff had significant consultancy workloads as well as extensive involvement in training abroad, in the UK and in the design of educational materials. Moreover, it also recognised that PPPHC had lost several key members of staff, including the work programme manager and the component manager of HSD. The change to a national systems perspective and priority on research, combined with the slow and somewhat difficult start, reflected the outcome of the PPPHC review. Not surprisingly, negotiations for funding beyond PPPHC then centred on a new research work programme on health care management and health sector reform. This new research work programme built mainly upon the work of the Health Systems Development Group and did not incorporate work undertaken by the Education Resource Group.

3.43 The HEFP was rated highly by the triennial review and a second work programme on health economics and financing was subsequently agreed for 1995-1999. Notwithstanding a young team and relatively inexperienced staff, significant research had been initiated in most of the five areas of priority (evaluation of alternative financing mechanisms; the public/private mix; economic evaluation; planning management and information systems; and political

economy). Teaching had been extended through both short and long term courses, and work had been published through 121 publications. These achievements did, however, also allow the review to identify some weaknesses and to make pointed recommendations about the programme of work in future. In particular, the review team encouraged the work programme to deepen its work in selected countries rather than broadening its focus. The review team considered this to be the best way to maximise the programme's potential to influence health policy decisions at national and international levels.

3.44 Thus, both triennial reviews, as well as undertaking detailed assessments of work, also considered at some length the influence of this work on health and population sectors in developing countries. Both reports emphasised the need to better understand and influence policy processes rather than stopping with the dissemination of knowledge. While this emphasis was understandable from ODA's point of view, it posed significant questions for the Schools around their own mission and purpose and how they could best achieve these. Indeed, a work programme designed primarily to influence, inform and support the policy process would require different skills and strategy from one geared to comparative research. HEFP, for example, always gave priority to research, and consultancy work accounted for very little of its time and income. Similarly, teaching was limited to around 20% of staff time. Any role beyond influencing policy through the dissemination of knowledge would be a significant shift in direction and would require different skills and methods to those traditionally used in academic institutions.

*Programme Managers and Link Advisers*

3.45 From the inception of the work programmes, both Schools assigned management responsibilities for each work programme to one individual. In LSTM, individuals were also named to lead individual components. In addition, it was agreed that ODA would provide a link adviser for each work programme. The Terms of Reference for link advisers specified that

- they would act as the first point of contact between the work programmes and ODA on any technical or professional matter,
- they would maintain regular contact with the work programme leader and visit the School at least twice each year to monitor progress,
- they would report in writing to the Head of HPD following each visit,
- they would feedback their findings to the work programme leaders, along with any advice on changes that were needed, and
- they would participate with the Assistant Head, HPD in joint annual work programme reviews and in the triennial reviews.

3.46 Link advisers were designated for both work programmes but these were to change often over the course of the five year period. Few LSTM staff contacted by the evaluation team were

able to name any of the link advisers for PPPHC. Documentation shows that there were at least two advisers over the course of this work programme, and that contact was infrequent. It also revealed some dissatisfaction about the duties of link advisers. The term 'adviser' was not well received by some academics; it would appear that they questioned the ability of ODA staff to advise them on the work programme topics. Traditionally, academics have been recognised for their expertise in a particular field, and some may not have welcomed or perhaps respected, technical guidance, even supervision, by ODA Moreover, it would appear that the School instead expected support and collaboration from the link advisers; they asked that link adviser responsibilities include

- the provision of information about the priorities of ODA,
- related activities of other institutions working in international health,
- additional sources of funding and appropriate contacts in ODA, and
- priority countries and collaborating institutions.

3.47 The inadequacies of this arrangement were acknowledged by ODA and, in 1992, an alternative proposal was made for joint meetings every four months.

3.48 Staff of HEFP felt that the link adviser arrangement began well but deteriorated with time. They too experienced a succession of link advisers and could name at least six - which includes those liaising with the current work programme. They also commented on the difficulty of negotiating with advisors less well versed in their area of expertise, and the infrequent and limited contact with them. For HEFP, this was felt to be a missed opportunity for ODA to make more extensive use of their work and findings.

3.49 The professional qualifications and experience of many link advisers suggests that a lack of technical understanding was unlikely to be the source of misunderstandings. This development may best be considered in the historical context in which ODA remained distant from the management of work carried out by the Schools once funds had been agreed. Perhaps neither party was fully prepared for ODA to play a more active role in monitoring progress and agreeing detailed plans of work.

3.50 Instead, there is some evidence that link advisers saw their role more for project monitoring purposes, while the Schools were hoping for support and collaboration in their work as outlined in their additional tasks list (para 3.46). The Schools did not particularly welcome extensive technical involvement but instead wanted relationships in which they would share their expertise with ODA and ODA would support them in their work - by providing information on the priorities of ODA and of other international agencies, by facilitating contacts with appropriate collaborators, and by advising on other sources of funding, for example. ODA, on the other hand, clearly felt the need to account for the funds it disbursed but

lacked the capacity to maintain the close collaboration that the Schools sought. Some link advisers estimated that no more than 10% of their time was devoted to the work programmes, and contact was often limited to two half-days each year. Communications were, in practice, infrequent and limited.

*Agreeing Future Work Programmes*

3.51 Shortly after the first triennial reviews mid-1993, LSHTM submitted 14 proposals for work programmes in 1995-1999. The existing 9 work programmes were included in this submission, and many had substantially increased budgets. This submission was not well received in ODA for at least two reasons. First, there was no foreseeable increase in available funding for research. Second, such a sizeable request from one institution raised questions about tying a significant proportion of existing funds to two UK institutions only and providing a springboard from which they could capture a substantial share of competitive research funds. Consequently, within ODA, it was proposed that some funds be set aside to establish competition for new work programmes.

3.52 ODA subsequently decided to move towards commissioning of work programmes. This entailed the selection by ODA of work programme topics, as well as competitive tendering which would be open to other academic institutions. The Schools were disturbed to learn that work programme funds were to be opened to competitive tendering, and a compromise was reached in which some funds for work programmes were made available to a wider selection of UK institutions on the basis of competition in which quality of proposals was the determining factor, and a proportion of work programme funds continued to be allocated to LSTM and LSHTM without competition.

3.53 At this juncture, LSHTM complained that ODA was changing the goalposts. The Dean expressed the School's understanding that the shift to work programme funding was legally binding and that it expected continued ODA support. In addition to opening work programme funds to competition, ODA also expressed an interest in considering work programmes of 3 and 4 years duration as well as those for a full five years. Tense negotiations continued but the outcome remained the same: ie some funds were allocated for competition while others were negotiated with LSTM and LSHTM.

3.54 In addition to proposed changes in the availability of funds and the length of work programmes, these negotiations also altered the process by which new work programmes were to be considered and agreed. Instead of submitting full proposals, five page summaries would be invited by competitive bidders who would also be asked to make a presentation to an in-house adjudication board. Successful institutions would then be asked to prepare in-depth proposals. This process was accepted by the Schools, especially since it reduced greatly the workload on staff in preparing new work programme proposals.

3.55 The second HEFP was one of three negotiated work programmes allocated to LSHTM and one of five work programmes overall awarded to LSHTM. The level of funding remained much the same, at £400,000 pa although total work programme funds for LSHTM were reduced to a total of £1.6 million per year or £6.7 million over five years. Agreement for the second HEFP was reached early in 1994, and it specified in detail the ODA understanding of the nature, characteristics, products, outputs and impacts Of the new work programme. In particular, the content and location of work indicated an emphasis on good practice in the application of health economics in developing countries and priority for research over technical assistance.

## *3. CONCLUSIONS*

*Programmes of Work in Developing Countries*

3.56 In-country training, student placements in the UK and recruitment of research fellows from practitioners working in developing countries provided important contacts for establishing collaboration in developing countries.

3.57 The approach developed by HEFP predefined a clear research agenda, capable of application in most developing countries. Country activities are identified and selected through a variety of mechanisms, including the knowledge of a country by HEFP staff (eg community health insurance, Ghana), discussion with local policy makers and researchers (eg comparison of insurance schemes, Thailand), and development of a technical agenda through organised consultation (public/private mix).

3.58 The PPPHC, while having clear areas of work appeared to rely more on discussions in-country to clarify the WP's detailed agenda. This reflects the differing nature of the work programmes: the LSTM programme being concerned from the outset with developing good practice and its implementation particularly in the host country, and HEFP pursuing a clear research (particularly comparative research) - based agenda. Policy influence was a more general, second-stage outcome and not confined to (or necessarily in) the country in which the research was undertaken. We note later (paras 3.68 & 4.29) that it was only at the triennial review that ODA introduced the emphasis on the impact on local decision-making.

3.59 HEFP often had more than one piece of research under way in the countries in which its staff work, by virtue of the fact that the programme simultaneously supports comparative research in several areas. This allowed HEFP to wield considerable influence despite the modesty of its total resources. HEFP experience points to the need to consider the local policy context carefully in terms of

- the strength of both-policy making and applied research actors and institutions,

- the level and character of existing external involvement in the health policy analysis arena, and
- what appears to be the local policy agenda.

3.60 There is a need to consider very carefully the in-country or regional partner. Work to be undertaken needs to fall within the mandate, roles and purposes of the organisation in question, and management must be carried out within the organisation's own decision-making structures and systems. Moreover, management must be transparent. There needs to be a coherent and systematic strategy for the creation of effective links with governments, multi- and bi-lateral agencies, academic, training and research groups in a country or region.

3.61 Consideration might be given to holding small in-country workshops as a way of exploring the policy agenda, to ensure that no opportunity. to maintain contact at the highest possible health policy level is missed. It is recognised, however, that collaboration which will influence policy and practice is complex and, perhaps, beyond the scope of an actual work programme component.

3.62 Avoiding conflicts of interest is also important. In Costa Rica the relationship between the Project Co-ordinator, LSTM and the new organisation ICAS raised questions of self-interest. Working through a new think tank or NGO raises questions about goals to build capacity within the existing system (for example within government or research institute), and further questions about the sustainability of the skills developed or the application of lessons learnt.

3.63 There is, furthermore, the need to ensure that the standing of developing country individuals selected as research fellows is appropriate - in particular, their ability not only to carry out the work but to influence policy and practice, whether this is for consumption internationally or locally.

3.64 Overall, it is essential that a work programme head maintains a leadership role for individual activities in-country and a relationship with senior policy makers. This can give the WP findings the maximum chance of influencing policy and that local staff who benefit from participating in the programme are the most likely ones to make a long term contribution either locally or internationally.

*Other outputs*

3.65 The programmes' conventional outputs, of the programmes in terms of knowledge generated, publications, reports, staff given experience, training programmes etc. were impressive in both cases and represented good value for money.

*Communications Between ODA and the Schools*

3.66 Given that these were the first generation of work programmes it was to be expected that they would provide a learning exercise for both sides. This proved to be the case and it was noted that lessons learnt were applied to the next set, despite the limited HPD's capacity to carry this out At the outset, progress was heavily dependent on the Chief Health and Population Adviser. It was felt that additional capacity in HPD would have enabled better interaction. This is discussed further in the next chapter.

3.67 Regular formal reviews provided the key point of contact between ODA and the work programmes. They was also the main mechanism for monitoring progress and negotiating future plans of work. Once the system of annual reviews with substantial triennial reviews was established, with agreed criteria and processes, they worked reasonably well for both parties. In contrast with the reviews, expectations of link advisers differed between the Schools and ODA. There was limited and infrequent contact between work programme staff and link advisers and this mechanism did little to enhance collaboration and exchange between the two parties. ODA's (now DFID's) purchasing role is one which requires re-thinking and strengthening for the future development of contracted research services.

3.68 The review process highlighted differences in the desired outcomes of the work programmes of ODA and the Schools. LSHTM sought primarily to ensure the generation of high quality and relevant knowledge through research, publication and training programmes. LSTM, on the other hand, initially aimed to assist more with the implementation of PHC at district level, largely through teaching, producing relevant materials and improving practice. ODA, from a project management perspective, sought to ensure more direct links between the generation of knowledge and its in supporting policy processes, even though it simultaneously gave priority to research. This approach had implications for both Schools; it encouraged LSHTM to find strategies to ensure that research findings were used to influence policy and practice, and it encouraged LSTM to strengthen the foundations of its knowledge base through research.

3.69 Thus, while both triennial reviews undertook detailed assessments of work, they also considered at some length the influence of this work on health and population sectors in developing countries. Both reports emphasised the need to better understand and influence policy processes rather than stopping with the dissemination of knowledge. This emphasis is understandable from an ODA point of view, but it poses significant questions for the Schools' own mission and purpose and how they can best be achieved. Indeed, a work programme designed primarily to influence, inform and support the policy process would require different skills and strategy from one geared to comparative research. HEFP, for example ,always gave priority to research, and consultancy work accounted for very little of its time and income. Similarly, teaching was limited to around 20% of staff time. Any role beyond influencing policy

through the dissemination of knowledge would be a significant shift in direction and would require different skills and methods than those traditionally used in academic institutions.

3.70 A focus on research was crucial to the funding of both Schools. Universities are not assessed on the basis of changes in policy processes but rather through respected expertise in research capacity and publication, primarily through the Universities Funding Council's Research Assessment Exercise (RAE). Criteria for work programmes which emphasise impact on policy may well pose a conflict of interest for academic institutions.

3.71 Accountability for public funds requires a transparent process which both rewards work of high quality and achieves value for money. Open competition is the preferred method to achieve this. There is a clear trend within DFID to move towards open competition for all work programme funds. There requires to be a clearer understanding, however, of the criteria on which proposals and programmes would be judged. It also requires well planned and managed processes of communication to ensure that both DFID as commissioners and institutions as contractors are in full agreement. Such a shift also potentially withdraws DFID's commitment to financial support for the two Schools.

3.72 There is a danger of fragmentation of UK expertise in international health. Work programmes need to have a solid institutional base if they are to be successful. The competitive tendering process should, however, allow this to be taken into account, by making it one of the selection criteria. Any need for avoiding fragmentation should be capable of being demonstrated in the proposal being submitted by the concerned Institutions.

3.73 Both schools felt that five years gave sufficient institutional stability to allow high calibre staff to be recruited and to develop and produce a satisfactory programme of work. While any judgement on the length of a programme is inherently subjective, the evaluators agreed that five years did allow for both stability and market testing.

# 4

# IMPACT AND SUSTAINABILITY

*4.1 This chapter focuses on the second interface - associated with the dissemination, use and application of work programme outputs. The evaluators considered both programmes to be coherent, in that the outputs were designed and delivered in ways that could make a wider impact on policy and practice. Differences in the two programmes were noted which reflected their different designs. The quality of the work of both programmes was felt to be high. Both built up a wide range of institutional relationships and, in terms of developing human resource capacity in their respective fields, both were effective.*

*4.2 Although at the time of commissioning of the programmes impact on gender and poverty was not assessed separately, they are covered briefly here.*

*4.3 Neither programme had at its outset a specific strategy for the dissemination of the knowledge gained, in terms of who the target audiences were and how they could be reached. It may well be that ODA expectations of the programmes' own impact on policy were unrealistic. As first-generation work programmes, however, many lessons were learnt which have since been applied in commissioning and managing programmes.*

## *1. DISSEMINATION, USE AND APPLICATION OF OUTPUTS*

### *Coherence[4] Of Activities*

4.4 Very early on in the implementation of the work programmes, ODA gave priority to the impact of work programme products on health policies and practices. By the second year of both HEFP and PPPHC, there was considerable coherence in the programmes of work generally.

### PPPHC

4.5 Although both the Quality Assurance Project in Ghana and the Local Management Training in Health Information Systems in Costa Rica built on previous work, they were both the first of their kind to be carried out in developing countries. Unlike many activities of HEFP,

[4] For the purposes of the evaluation, coherence of activities refers to the logical connection between individual activities. The team was interested in the consistency of individual activities within individual countries and internationally as well as in their contribution to a greater whole.

they were not designed as part of a larger comparative research effort, but instead aimed to conduct and pilot basic system initiatives.

4.6 Ghana's Quality Assurance Project was a coherent and comprehensive set of activities within the context of the development of a national policy and system. Not only did it incorporate applied research, it developed practical tools on the basis of the research findings, it piloted their use in MOH facilities and it culminated in the preparation of a national quality assurance policy for Ghana. At every stage of the work, efforts were made to inform and involve all relevant parties, for example through workshops organised through the project or by presentations at MOH meetings. The way in which LSTM worked with health managers at all levels through a series of stages to develop a quality assurance system was commended by the Ghanaians themselves. Short of involvement in the provision of funds and in on-going management of the new system, LSTM was instrumental in the development of the system. Furthermore, the approach designed and tested in Ghana was later used to develop quality assurance systems in three Central American countries.

4.7 Unlike the quality assurance work in Ghana, activities carried out in Costa Rica did not constitute a coherent programme of work which later influenced national or regional health policies and practices; it did, however, establish institutional relationships for the development of subsequent quality assurance programme development in three Central American countries. There was considerable synergy between the research component and the content of the training course throughout the work programme, but neither appeared to influence policy or practice, either within Costa Rica or regionally.

HEFP

4.8 HEFP activities were designed to be coherent as an international work programme; that is, they were structured so as to reflect a selection of the major policy trends to which the application of economics might make an analytical contribution. In any individual country setting, HEFP research is unlikely to provide a coherent (representative) whole when judged against the concerns of national health policy. Overall, the output from HEFP has been substantial in each of the five designated areas, with perhaps a greater emphasis on financing issues and a lesser volume of published work in the area of cost-effectiveness. Responses to the peer review exercise suggest that the programme scores most highly (very good to great) in relation to perceived "relevance to health sector policy", indicating that overall coherence is high. Internationally, HEFP is seen as authoritative, and the programme has a real effect in defining the domain of contemporary analytical work in this area.

4.9 From the country visits, there is little doubt that the working partnerships between HEFP staff and their Thai counterparts has been a source of influence in the latter's thinking about policy options and directions, and on one or two occasions HEFP staff have made direct

contributions to official statements and documents (this also applies to Ghana). But it is not possible - nor, probably, reasonable, to expect to quantify the impact of these small programmes on health policy in countries.

*Quality of Work Carried Out*

4.10 Part of the agreed methodology for the evaluation included peer reviews of both academic and policy documents produced by the work programmes. Responses, though limited in number, provide some indications of perceptions of the quality of work undertaken through the work programmes. These responses are summarised in Annexes D & E. In addition, the evaluators have made the following qualitative comments based on the field visits and discussions with the individuals mentioned in Annex C.

HEFP

4.11 By its nature, the work programme on health economics and financing is an area of applied science. It offers little scope for purely theoretical development and entails a heavy emphasis on case studies using well established methods, such as cost-effectiveness analysis. Given the small number of choices in health care which have actually been analysed in terms of their economics, this is justified. In the financing area, however, HEFP has made important conceptual contributions: for example in defining the issues and territory on the public/private mix. The emphasis has been firmly on health economics mainstream with relatively little development at the frontiers of traditional health economics into such related areas as political science; the decision-making process; and the linkages between the health sector and the overall economy.

4.12 The peer review exercise placed perceived quality of the HEFP work programme's activities and outputs as high to very high. This perception was also clearly shared by in-country collaborators in both Thailand and Ghana, although relevance to the policy process in Ghana was questioned. The work programme has now accumulated a substantial international network of collaborators, through former teaching links and in-country research projects, and this makes the total output of research through, or linked with, the work programme, very substantial. A total of forty four publications, 37 by work programme staff and 7 by country staff trained by HEFP or involved in HEFP activities, were identified for Thailand and Ghana alone.

4.13 HEFP publications appear in major journals concerned with health and development policy (Lancet, Social Science and Medicine, International Journal of Health Planning and Management, Public Administration and Development) as well as in what is seen as the "house" journal, Health Policy and Planning, and in commercially published books. Indeed, in a very real sense, the publications from the HEFP work programme can be said to set the agenda by their continual prominence. The ease and frequency with which HEFP staff undertake attachments

to other academic and international agencies is further testimony to the status of the work programme and its staff.

PPPHC

4.14 By contrast the PPPHC was much more focused on improving the practical delivery of primary care at District level and below. System strengthening is notoriously difficult to research and much of the published work relies on descriptive studies. This is reflected in the publications which are often single-country based and are more in the form of non-refereed articles and reports and presentations than articles in main stream publications. It also must be recognised that the programme took place towards the end of a twenty year period of activity in primary care and internationally, the focus was moving towards central reform and health care financing which may well have influenced selection of articles by journal editors. Although the peer evaluation of the reports scored lower than that of HEFP this was counter-balanced by the extremely positive feedback from the country visits.

4.15 Although, perhaps of less current international interest at the present time, improving the delivery of primary care is still the key to improving the health status of the poor and the work carried out was extremely valuable and respected by colleagues in that area. This is reflected in the movement of staff referred to below and the reputation of current staff.

*Institutional Relationships (Annexes G and H)*

4.16 Both organisations established an impressive number of institutional contacts. PPPHC established important links with international and local agencies involved in the provision of primary health care. These include other bilateral agencies, such as GTZ and DANIDA. They also had close contacts with multilateral organisations such as the European Union, WHO and PAHO. They also built on their network of university and individual contacts which were developed primarily through the School's teaching and clinical work.

4.17 HEFP also had extensive contacts with other international agencies involved in health financing research and policy advice. These included such other bilateral agencies as SIDA, DANIDA, and USAID, and such multilateral organisations as the European Union, WHO, the World Bank, and UNICEF. Like LSTM, it also has an extraordinary network (developed primarily through the teaching side of the LSHTM work) of university and individual contacts but also through efforts to initiate research, for example in the public/private mix.

*Building Capacity in the UK and Internationally*

4.18 Throughout the annual and triennial reviews as well as the mechanisms for considering and agreeing new work programmes both the Schools and ODA agreed funding needed to be for a minimum of three and a maximum of five years. This period of time allowed sufficient stability

for capacity to be built in both the Schools and collaborating developing countries.

4.19 Expertise within the fields concerned was clearly built, in both Schools, through the work programmes. Expertise in the various aspects of health care management and health sector reform was built in staff of PPPHC at LSTM. However, while many of the original staff members are now recognised as international experts, most are no longer employed by LSTM. For example, former leaders of the subcomponents have since been in positions of great influence, including 1) senior special health policy adviser to DFID, 2) head of the Aga Khan Health Services, 3) country representative of SCF/UK in Nepal, 4) senior consultants to DFID, the World Bank and EU in health sector reform, and 5) a Professor in the Faculty of Medicine in Pretoria, South Africa. However, those staff who remained at the LSTM and those who joined during the first work programme form the core of the current work programme in health sector reform, and they are recognised internationally as leaders in their respective fields: for example in human resource development and quality assurance in developing countries.

4.20 Similarly, HEFP expanded from two to eight professionals, many of whom are now recognised for their work internationally. Within Britain, HEFP is the strongest and largest group in its field and, internationally, it is comparable to few other groups. Although it began as a new team, with relatively junior staff, by the triennial review it had raised nearly £800,000 in additional funds. By the end of the first work programme, HEFP was in a position to second staff to other agencies and at least four members of staff have since been seconded to UNICEF, the Ministry of Public Health in Thailand, Abt Associates in the USA and the Centre for Health Policy in South Africa. Secondments have been for periods from several months to two years. It is noteworthy that there has been virtually no turnover of staff from the work programme. Interviews with HEFP staff reveal that, for the economists at least, the programme has been a major factor in their professional development and opportunities.

4.21 Although work programme funding provides opportunities to offer academic staff contracts for longer periods of time, the Schools have not always extended this benefit, either to junior or senior members of staff. HEFP has made an effort to accommodate exciting and profitable work opportunities for staff members through secondments and LSHTM now has policies to provide funding to bridge employment between specific research contracts. The evaluation team was not made aware of similar arrangements at LSTM which may partly explain the high turnover of staff on PPPHC.

*Work Programme Influence on DFID Policies and Practices*

4.22 Perhaps the most complex relationship, inevitably, was with ODA. As sponsor of the work programme, ODA had the potential to fill roles in both purchasing knowledge and in providing practical support for its production. Relationships with HEFP and PPPHC suggested that ODA was primarily purchasing a public good. This is perfectly acceptable and would, in itself,

represent value for money for the work programmes. Nevertheless one of the objectives was to inform policies and practices within ODA. In practice, as discussed in Chapter 3, this relied on the Chief Health and Population Adviser and the relatively small technical capacity ( in quantitative not qualitative terms) within HPD.

4.23 DFID/HPD, in contrast to many other donors, is able through its partnerships with institutions such as LSHTM and LSTM, to draw on important intellectual knowledge on a wide range of development issues.. This gives the United Kingdom a chance to exert an influence on development thinking and practice out of proportion to the resources involved. By actively using the ideas and information generated through work programmes, DFID can be a "thinking donor" rather than simply a funding agent. Such a role is wholly compatible with "Building Support for Development" (1997 White Paper) and with strengthening DFID's role in international partnerships.

4.24 A much more "active purchasing" role is possible for DFID in its relations with work programmes. Hitherto, the annual and triennial review, and occasional (appreciated) contributions to HPD "In-week" have been the principal liaison points. Work programme staff could be asked to take a larger role in the preparation of briefing and position papers for DFID, on such topics as health sector reform, policy to the private sector, and provide commentaries on such statements as the recent World Bank Sector Strategy Paper, or the Asian Development Bank's draft Health Policy paper.

4.25 The link adviser arrangements have become weak and one-way in recent years. With the planned appointment of a technical deputy in HPD and the creation of a unit for knowledge generation, the opportunity occurs to re-think how DFID can more fully capitalise on work programme activity and knowledge. More, informal, consultation and occasional requests by DFID for inputs and views from work programme staff by DFID might take place and the outcome evaluated.

4.26 Work programme staff and DFID overseas staff both commented on the lack of useful communication between them. Overseas staff seldom received work programme documents and publications and work programme staff seldom found DFID overseas staff helpful in providing administrative support for their overseas visits and work.

4.27 The team found that ODA Country-based staff had been more directly supportive of WP activities where these were funded from the bilateral country programme (such as Costa Rica) or where relationships had previously been established with LSTM staff. There was, however, no evidence of any formal mechanisms for collaboration between DFID country-based staff and the work programmes. This may partly reflect the differences in the nature of these two kinds of ODA-financed activities. Moreover, some in-country staff had been directed not to involve themselves in the work programmes.

*Policy formulation in the countries in which the programmes worked*

4.28 The terms of reference for this evaluation included an assessment of the extent to which the work programmes have contributed to the in-country policy process. Whilst a number of instances have been identified, this is not what the Schools considered the work programmes were primarily designed, or funded, to do. In-country Policy support requires a continuing presence, and a high level of flexibility regarding the type and method of investigation or research that may be necessary. HEFP, for example, was focused on undertaking comparative research on predefined themes, thus its ability to feed directly into a given country's policy process was bound to be limited. It is, therefore, not surprising that policy-makers in some countries should have felt that they had had little, directly, to gain from HEFP, at least within the short time horizon in which they typically worked.

4.29 It may be unrealistic for DFID to expect a research programme to make substantial inputs into local decision-making. Furthermore, DFID should recognise the difficulties faced by such a programme in establishing research links with policy makers, and be prepared to help by ensuring that the policy makers have a realistic understanding of what a work programme can do. The natural local partners for research activities are, in many cases, researchers, but the nature of the research means that, without a sympathetic understanding from the policy side, unnecessary difficulties and hostility may arise.

4.30 Work programmes were managed centrally by ODA; in-country ODA offices were not involved in the design, implementation or use of work programme activities. Greater involvement could give greater local prominence to knowledge generated by the programmes and advice about the selection of local partners.

*Cross-Cutting Issues of Poverty and Gender*

4.31 When the programmes were commissioned the objectives did not explicitly incorporate current DFID priority policies, particularly those regarding poverty reduction and gender.

4.32 Although poverty alleviation and women issues were important within the then ODA's policy, only a few of the WP proposals specifically addressed these areas of concern. The Schools' WP staff and WP-related staff operating at country level were, however, well aware of the need to focus on helping the poor and ensuring that women were not disadvantaged. By focusing on improving the delivery of primary health care the PPPHC concentrated on the area of health care of most relevance to the poor and women and, with its focus on equity, the HEFP highlighted the effect of policy on the poor in many of its studies.

4.33 The LSTM Triennial Review Report from October 1993, annual reports of the three preceding years and link adviser's reports do not specifically address these cross-cutting themes. In addition the programmes did not specifically recruit staff with particular skills in social

development. As a result, there were a number of gender and poverty issues and concerns that were not addressed in the formulation and implementation of each work programme. For example, women's and men's different positioning as users and providers of health services were not within of the scope of either WP.

4.34 These cross cutting issues are, however, very much part of DFID culture now and this is not likely to be an issue for future work programmes. The Guidelines for Evaluators published in 1994 include impact on women and poverty impact as part of the cross-cutting issues of ODA's evaluations.

4.35 On a positive note, the HEFP recruited a high percentage of women and the work on user charges was of particular relevance to ensuring that the poor were not disadvantaged by them.

## *2. CONCLUSIONS*

4.36 This evaluation has examined the concept of work programmes as a means of meeting their original objectives which were "to inform, influence and improve health policies and programmes of ODA, developing governments and other donors and agencies in areas of immediate relevance to ODA's bilateral activities and to multilateral health organisations to which ODA contributes".

4.37 The purpose was to be attained by ODA support of a range of outputs in each of the work programme areas supported:

- enhanced School and overseas institutional capacities
- strengthened training capacities in new fields and short courses
- new knowledge generated and disseminated through applied and basic research
- expanded co-operation between the school and ODA, through increased consultancy work and advice.

4.38 It has done so by examining two work programmes. The two programmes selected were quite different in design and any comparison of the outputs needs to take that into account. The conclusions therefore relate to the overall concept of the work programme rather than the individual programmes themselves.

4.39 The work programme arrangement provides for a critical level of human and financial resources needed to develop an area of work and allows time to do this. To capitalise on this, the work programmes need to be based in a stable organisation with existing technical capacity and well-defined and strong leadership. If they change during the course of a work programme then DFID needs to work with the parent institution to ensure the programme is not affected.

4.40 While the time period of five years is right, the level of funding of individual work programmes is small by international standards. Both work programmes gave good value for money for the sums invested. However, the length of contracts and the level of funding could not be reduced below their present level and a modest increase in funding would give a significant return.

4.41 These were first generation work programmes and valuable lessons were learnt which were applied in subsequent programmes. Changes which took place in ODA's priorities during the course of the programmes caused difficulties for the PPPHC. These may be unavoidable but serve to emphasise the need for strong liaison between DFID and the WPs and, wherever possible, continuity at a personal level in the link adviser role.

4.42 The quality and quantity of the work programmes' outputs are both high. These were hard-working programmes of skilled and enthusiastic professionals, whose time at the Schools added substantially to their individual market value, as evidenced by the ease with which many staff obtained placements internationally. Both Schools selected good staff. Remarkably little turn-over of HEFP staff has occurred to date, thanks in part to secondment opportunities. Through the work programmes both Schools have attracted a number of new, young professionals into international work, thus expanding the UK's experience in their areas. They have also given valuable experience in postgraduate research to a significant number of development partner nationals.

4.43 It is important to recognise the difference between generating knowledge *per se* and generating knowledge about its application. Some subjects are more researchable than others. Health Economics and Financing probably has a much greater share of these than Primary Health Care. This is important in setting the objectives of work programmes and in particular setting the proposed outputs. The White Paper implies some redefinition of work programme focus, for example on equity in access, sector wide approaches and the roles of the private sector. Generating knowledge in these areas should be fully compatible with work programme methodology.

4.44 There is a clear trend within DFID to move towards open competition for all work programme funds. This could possibly undermine efforts within Institutions to build capacity priority areas. In Chapter 3 we set out how this might be avoided (paragraphs 3.70-73).

4.45 Two important areas need to be considered while agreeing criteria for future work programmes and to be included in the terms of reference and logical framework:

- to what extent is DFID expecting work programmes to contribute to policy in the countries in which the programme works?
- to what extent does DFID itself wish to make use of the knowledge and experience accumulated by the programmes.

4.46 The former could be enhanced by greater involvement of DFID representatives overseas. DFID offices should be involved in the design and use of work programme activities. Greater involvement could give greater local prominence to knowledge generated by the programmes at policy level.

4.47 The latter would involve a much more "active purchasing" role for DFID in its relations with work programmes. Work programme staff could have a role in the preparation of briefing and position papers for DFID on topics in their field and provide commentaries on such statements as the recent World Bank Sector Strategy Paper, or the draft Health Policy paper of the Asian Development Bank. It would require much greater capacity within HPD than is currently available. It is recognised this is being addressed and that with the planned appointment of a technical deputy in HPD and the creation of a unit for knowledge generation, the opportunity occurs to re-think how DPID can more fully capitalise on work programme activity and knowledge.

4.48 In addition, DFID should be aware of the knowledge being generated by the programmes, use this in its policy formulation, and have a strategy for disseminating it within DFID, as part of a wider strategy for knowledge dissemination for the work programmes. This wider strategy would be fully reflected in the commissioning process, by specifying target audiences and the various means of reaching them. HPD capacity needs to he strengthened to include a "programme advocate" role within DFID, ensuring the dissemination, use and application of work programme outputs.

TERMS OF REFERENCE ANNEX Ai

EVALUATION OF ODA, HPD WORK PROGRAMMES

POLICIES AND PRACTICES OF PRIMARY HEALTH CARE (LIVERPOOL SCHOOL OF TROPICAL MEDICINE): AND
HEALTH ECONOMICS AND FINANCING (LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE)

*Background*

1. In 1990 ODA lecturing support to the London and Liverpool Schools was terminated and replaced with 5 year funding for work programmes in areas of specific developmental interest. Five work programmes were supported in Liverpool (total commitment of £4.8 million), and 9 in London (£11.2 million).

2. No overall logical framework was developed for the work programmes. From correspondence between ODA and the Schools and within ODA the strategic objective (purpose) of the work programmes can be characterised as "to inform, influence and improve health policies and programmes of ODA, developing governments and other donors and agencies in areas of immediate relevance to ODA's bilateral activities and to multilateral health organisations to which ODA contributes".

3. The wider goal can be considered to be "to improve the health status of people in developing "countries".

4. The purpose was to be attained by ODA support of a range of outputs in each of the work programme areas supported:

- enhanced School and overseas institutional capacities
- strengthened training capacities in new fields and short courses
- new knowledge generated and disseminated through applied and basic research
- expanded co-operation between the school and ODA through increased consultancy work, and advice.

5. Over the 5 year period the ODA emphasis of the work programmes shifted towards developing research with a focus on policy relevance, impact and value for money.

6. This study will evaluate two of the 14 work programmes. Both developed their own logical frameworks.

*OBJECTIVES OF THE EVALUATION*

7. The evaluation will consider the relevance, efficiency, impact and sustainability of the work programmes. In particular it will:

a. Assess the relevance of project design;

b. Assess how effectively the ODA input was designed and appraised;

c. Assess the impact and sustainability of the work programmes in relation to their stated objectives;

d. Determine whether the funding arrangements adopted for the work programmes were the most cost efficient/effective approach to achieving the objectives, in particular whether:

- the same outputs/impacts could have been achieved at lower cost;
- whether the same outputs/impacts could have been achieved through alternative institutional and or funding arrangements.

e. Make a judgement on success, in particular whether the costs are justified by the benefits that have accrued;

f. Contribute appropriate lessons and conclusions to assist with:

- consideration of the appropriate funding arrangements for work programmes and research;
- identifying the factors for enhancing the policy influence of research both in aid agencies and aid recipients;
- identifying the value of such work programmes to the development, and application of, aid policy;
- considering how best to strengthen research capacity overseas;
- the development of an Evaluation Department synthesis study on health management and system reform.

*SPECIFIC REQUIREMENTS*

8. The evaluators should produce a report according to the standard format specified by evaluation department. Specific recommendations should be separate to the report. A two page evaluation summary (EVSUM) should also be produced.

9. The emphasis of the evaluation will be on determining the impact and sustainability of

the inputs provided. The terms of reference, however, are not exhaustive. Other issues of importance identified during the evaluation study may be included in the report.

*A. Relevance*

10. a. Examine how

i) the overall work programmes and

ii) the two sub programmes were identified as a priority area for ODA funding.

b. Assess the relevance of the programme to:

- ODA health and population practice
- the health and population needs of developing countries
- the institutional development of the two schools.

*B. Design and Appraisal*

11. a. Assess whether or not the ODA inputs were adequately designed and appraised with respect to institutional, economic, social and gender considerations.

b. Consider the appropriateness of the work programme objectives and the outputs and indicators identified.

c. Assess how the two sub programme objectives have been modified since the start of the programme, why and their relevance.

*C. Efficiency*

12. a. Assess whether coherent strategies were identified and whether implementation targets as set out in the logical frameworks were met and whether targets fully reflected potential for achievement. Identify the main reasons for under-achievement.

12. b. Consider the extent to which the two sub programmes reflected wider ODA policies in health and population.

Process:

c. How were

- research priorities
- country focus

- institutional collaboration and;
- methodologies used

chosen (including the extent of consultation with ODA HPD staff, and with expected final users)?

d. What was the extent of user and collaborative commitment to the sub programmes?

e. Consider the degree of interaction with the other work programmes.

f. Examine whether the correct balance was struck between i) research and capacity building and ii) basic and applied research.

g. Consider whether the research coverage was considered too broad.

*Monitoring*

h. The evaluators will:

- assess how effective was the monitoring and review system in informing ODA of progress and appraise how monitoring information was utilised;
- the role and effectiveness of the link adviser arrangement;
- the role played by the two schools in managing the work programmes.

*D. Effectiveness and Impact*

13. a. Examine the extent to which the project has achieved its stated objectives.

b. Assess the actual or potential impact of the two work programmes.

c. Examine the effect of the shifting emphasis of the work programmes on the development and impact of the two sub programmes and the institutional impact on the two Schools.

d.. The precise methodology and indicators used in assessing impact will be drawn up by the evaluation team after consultation with the two Schools. In assessing impact a distinction will be drawn between:

outputs new knowledge generated and disseminated; increase in institutional capacity in UK and overseas

purpose utilisation of new knowledge by decision-makers in bilateral and international development agencies and at central and local levels within developing country health systems; strengthened institutional capacities

goal improvements in the health status of people in developing countries and the efficiency with which health care is delivered

In assessing the impact of research it is unlikely any meaningful data can be gathered on final outcomes at the goal level. Particularly so, given the time scales involved (impacts on health outcomes will take much longer to emerge than the 5 years of the programmes, or even shorter periods since any adoption by decision makers).

A distinction will be made between two types of intended user of the outputs of research; end users resulting in tangible benefits (health professional decision makers, other researchers) and intermediate users (those who may further modify the research).

In assessing impacts the evaluators should try to identify and describe types of impact and, if possible, quantify them. Where impacts are not evident, or are less than expected, the evaluators should identify the constraints and reasons why.

e. The evaluators should attempt to make a judgement as to whether there is a clear cut case that the cost of the project is justified by the level of benefit attributable to the project.

*E. Sustainability and Replicability*

14 Comment on, and assess the effectiveness of, the strategies adopted to ensure that project activities and achievements, in particular research and institutional capacity development, will be sustainable beyond the provision of ODA and other donor involvement.

*F. Methodology*

15 The evaluation will use a variety of information to reach its conclusions. The detailed methodology will be agreed in the early stages of the study. The methodology will include a combination of the following:

a. Desk reviews of available reports;

b. Questionnaires sent to, and semi-structured interviews with:

- past and current work programme staff
- donor health and population staff
- other UK research institutions

c. Field visits to 2 research sites for each programme including:

- interviews with decision makers at central and local level
- examination of official statements
- visits to collaborating institutions

d. Discussion with project implementers, managers and participants.

The choice of research site to visit will be agreed at an early stage with the two schools and participating institutions.

16. Suggested evaluation indicators will be shared with key project stakeholders. The following are examples of indicators that might be used to measure achievements:

*Outputs*

a. Number and types of research outputs

b. Quality of research outputs. Proxies:

- number of publications in refereed journals
- number of citations
- funds attracted into the research area (multiplier effects) - source, size and focus
- views of other research organisations/health staff in donor agencies including ODA and country partners.

c. The number of new programmes related issues that have been placed on the research and policy agenda.

d. Strengthening Institutional capacity:

- number of collaborating institutions
- extent to which collaborating institutions have been enhanced
- net number of new research staff and whether still working in the field
- net number of trained people and whether still working in the field
- external views on the quality and capacity of the two Schools in the programme areas
- strengthened capacity to do research

e. Process indicators:

- types and numbers of users consulted
- categories of project supported eg. funding to others, direct management, UK based versus in-country located staff.

f. Dissemination:

- how and where outputs are being disseminated and to whom
- informal presentations of key findings to user groups (networks/ news letters/ workshops/ individual meetings/ correspondence/ grey literature).

g. Purpose

It is recognised that impact may be as much indirect as direct (partly determined by the type of training/research adopted) and that the focus has not necessarily been on meeting the immediate short term needs of policy makers.

- examples of citation of research in donor and developing country government policy documents
- views of ODA HPD staff
- views of developing country government staff
- production of guidelines/ manual being adopted.

h. Where application and final outcomes can be identified these will be identified.

Evaluation Department

10 January 1996

## MATRICES - CONCEPTUAL FRAMEWORK (LSHTM & LSTM) ANNEX Aii

Health Economics and Financing work programme, London School of Hygiene and Tropical Medicine (LSHTM)
Policies and Practices of Primary Health Care, The Liverpool School of Tropical Medicine (LSTM)

### AN APPROACH TO EVALUATING THE WORK PROGRAMME[5] ON HEALTH ECONOMICS AND FINANCING

| Stages based on Research Sequence Model[6] | Description of Activities for Work Programme | Key Questions (Based on Terms of Reference) | Priority Issues | Possible Sources of Information | Suggested Evaluation Methods |
|---|---|---|---|---|---|
| Work Programme (WP) Needs Assessment | Planning of Work Programmes (WPs) in ODA | Who selected WP subjects and what criteria were used?<br>Relevance of topics to:<br>a) ODA policies<br>b) Health & Population needs in developing countries<br>c) Institutional development of Schools<br>Were alternative subjects considered?<br>Why the WP arrangement, and were alternatives considered?<br>What were the objectives of setting up WPs?<br>What needs were met? (Institutional, political etc.) | 1. Criteria used for selection of subjects<br><br>2. Number of Decision-making processes<br><br>3. Communication with partners | ODA:<br>David Nabarro<br>Barbara Kelly<br>Mary Keefe<br><br>LSTM:<br>Richard Feacham<br>Barbara Judge | Interviews, review of files (including those on TCML scheme) |
| | Identification of WP subjects by School | Who selected WP subjects and what criteria were used?<br>Were alternatives considered?<br>Relevance of topics to the mission of, and expertise within, the Schools | | LSHTM:<br>Anne Mills<br>Richard Feacham<br>Barbara Judge<br>Patrick Vaughan or Charles Normand | Interviews<br><br>Review of files |
| Interface (a) | Commissioning of WPs<br><br>Defining WP objectives | What was the process of design & appraisal of WPs?<br>- who was involved?<br>- were cross cutting factors (e.g. gender, poverty) adequately considered?<br>- how have WP objectives changed since the start of the WP? Why and what is their relevance?<br>- what were the effects of changing ODA objectives and monitoring formats on the relationship with the WP & the impact on LSTM<br>- how were countries/ overseas partners selected? (ODA guidance/ priorities/ existing partners?)<br>- what negotiations with country partners affected WP objectives & approaches?<br>- was WP coverage appropriate?<br>- was balance appropriate between<br>a) basic & applied research<br>b) research, capacity building & technical assistance. | 1. Criteria for selecting objectives<br><br>2. Incorporation of cross-cutting themes<br><br>3. Negotiations with partners<br><br>4. Coherence of planned activities<br><br>5. Capacity building | ODA:<br>- HPD<br>- link advisers<br><br>LSHTM:<br>- Dean's Office<br>- Project's Office<br>- WP Staff<br><br>Country partners involved in designing WP activities | Interviews<br><br>Questionnaires<br><br>Focus Group Discussions<br>Normative Group Approach<br><br>Review of documentation |

[5] A Work Programme is a combination of research, training and consultancy activities.

[6] This is based on the Research Sequence Model as designed by a group led by Professor Martin Buxton of Brunel School.

| Stages based on Research Sequence Model | Description of Activities for Work Programme | Key Questions (Based on Terms of Reference) | Priority Issues | Possible Sources of Information | Suggested Evaluation Methods |
|---|---|---|---|---|---|
| Inputs | Research<br><br>Training<br><br>Advisory services<br><br>Capacity building | Costs<br>Staff numbers & involvement<br>Activities<br>Timing of work<br>Resources provided by other agencies and collaborating partners | | Research reports<br><br>Programme documents eg. budgets<br><br>WP Staff<br><br>Overseas researchers | Interviews with WP staff & collaborating partners<br><br>Review of documents |
| Processes | Ways in which programme of work was carried out | How were collaborators & stakeholders involved in research/training/capacity<br>How was their involvement maintained?<br>Were methodologies appropriate?<br>Were activities appropriate to WP objectives, ODA policies & School Mission.<br>Did the tension between the needs of the WP & School affect how work was carried out?<br>What was the degree of interaction with other WPs?<br>What were the initial liaisons/brokerage of the WP with<br>- ODA<br>- Country policy makers & researchers<br>- International policy makers, researchers & donors? building?<br>- contributions of staff/costs<br>- involvement in planning<br>- 'buying in'/commitment to WP<br>Was there continuity of support from WP customers<br>- ODA<br>- Country Partners<br>- other collaborating partners<br>Were the funding arrangements cost efficient/effective? | 1. Participation<br><br>2. Decision-making | WP Staff<br><br>Research partners<br><br>Policy makers & staff in country & internationally<br><br>ODA HPD advisers | Interviews<br><br>Review of reports & documentation |
| Primary Outputs | Products of WP<br><br>Effects on institutions | What was the quality of work done?<br>Were outputs relevant, appropriate & timely? Did working with local institutions/researchers require any compromises in quality? Were WP implementation targets met?<br>Did targets reflect the potential for achievements?<br>Were institutions strengthened?<br>Did the WP achieve its stated objectives?<br>Did the WP contribute to Human Resources in this field?<br>Did WPs provide advisory services? | | Collaborating partners & peers<br><br>Programme reports eg. Triennial review<br><br>Publications<br><br>Documents for research assessment exercise<br><br>Other WP outputs | Structured questionnaires<br><br>Peer review of scientific publications/reports<br><br>Review of documentation<br><br>Review careers of students and former staff |
| Interface (b) | Dissemination of programme outputs, eg. research | How did relationship between local researchers & policy makers affect WP dissemination?<br>What were the mechanisms for feeding back to ODA?<br>- link advisers<br>- workshops, discussions<br>- monitoring & review procedures<br>How effective were they & how was monitoring information used by ODA?<br>What is awareness of WP activities among international & in-country policy makers? | 1. Contacts | ODA HPD & other economic advisers<br><br>Local & international policy makers<br><br>WP Staff<br><br>Country partners | Review of key policy & planning documents to see if guidelines/ recommendations were adopted<br><br>Qualitative & quantitative assessment of contacts<br><br>Phonecalls to ODA desk officers |

| Stages based on Research Sequence Model | Description of Activities for Work Programme | Key Questions (Based on Terms of Reference) | Priority Issues | Possible Sources of Information | Suggested Evaluation Methods |
|---|---|---|---|---|---|
| Secondary Outputs & Applications | Informing policy<br><br>Influencing agendas of other agencies<br><br>Informing in-service management arrangements<br><br>Informing research<br><br>Cross-cutting themes:<br>- sustainability<br>- poverty reduction<br>- gender equality | What are perceptions of the WP's relevance, usefulness, quality & credibility by<br>- other international agencies<br>- policy makers<br>- other organisations working<br>- in this field?<br>Has the WP subject area attracted further funds?<br>- sources<br>- amounts<br>- Has the capacity of the institutions to carry out further/similar work been enhanced?<br>- Is there evidence of policy informed by this WP?<br>What strategies were adopted to ensure sustainability & how effective were they?<br>Can examples be found of explicit/ implicit influence based on this WP IN:<br>- policy<br>- in-service management arrangements?<br>Impact of WP in relation to stated objectives<br>Have WP activities contributed to reducing poverty, promoting gender equality & more sustainable health services? | | Programmes of work of:<br>- multi & bilateral agencies<br>- collaborating partners in country<br>- oda advisers<br>- other WP donors/partners<br><br>Proportion of funding provided by ODA<br><br>Policy makers, ODA staff, WP staff & overseas researchers<br>WP reports & documents | |
| Impact | Impact on health services<br><br>Impact on health status | Is there any evidence of improved health status as a result of health status as a result of WP activities/outputs/recommendations? | | ODA documents | In country or site-specific in-depth case study |

Final Question: "Will the costs of the WPs be justified by the benefits which will accrue to it?

PROGRAMME OF WORK ANNEX B

| June 1997 - March 1998 | JUN | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| UK-based work: Meeting to consider approach to the HEFP | ■ | | | | | | | | | | | | |
| UK- based work: Meeting to consider approach to the PPPHC | | ■ | | | | | | | | | | | |
| UK-based work: Meeting to consider methodologies and evaluation instruments and tools for both WP. | | ■ | | | | | | | | | | | |
| UK-based work: Reviewing documents and interviewing for the HEFP | | ■ | ■ | ■ | | | | | | | | | |
| UK-based work: Launching the evaluation of the PPPHC | | | | ■ | | | | | | | | | |
| UK-based work: Reviewing documents and interviewing for the PPPHC | | | | ■ | ■ | ■ | | | | | | | |
| Visit two countries for HEFP | | | | | ■ | ■ | | | | | | | |
| Visit two countries for the PPPHC | | | | | | | ■ | | ■ | | | | |
| Writing full reports | | | | | | | | | ■ | ■ | ■ | | |
| Meetings to finalise evaluations | | | | | | | | | | | ■ | | |
| Submission of draft reports to DFID | | | | | | | | | | | | ■ | |
| Presentation to Schools | | | | | | | | | | | | | ■ |

## LIST OF INDIVIDUALS CONSULTED ANNEX C

### *i) Interviews in the UK*

The London School of Hygiene and Tropical Medicine
A. Mills
B. Judge
B. McPake
A. Zwi
S. Bennett

The Liverpool School of Tropical Medicine
D. Molyneaux
D. Haran
R. Cole
T. Martineau
V. Doyle
H. Annett
L. Barnett
J. Martinez

Department for International Development
D. Nabarro
M. Keefe
L. Greve
L. Humphries
J. Pepperall

Others
S. Simmonds
R. Feacham
P. Sandiford

### *ii) The London School of Hygiene and Tropical Medicine*

Thailand, Ken Grant & Andrew Creese, October 1997

*Monday 6 October 1997*
Dr Sanguan Nitayarumphong, Dr Anuwat Supachutikul, Dr Porntep Siriwanarangsum, Health Planning Unit, Ministry of Public Health
Dr E B Doberstyn, WHO Country Office

*Tuesday 7 October 1997*
Dr Somsak Chunharas, Dr Viroj Tangcharoensathien, Health Systems Research Unit
Dr Kaemthong Indaratna, Manisiri Puntalarp, Dr Sothitorn Mallikamas, Centre for Health

Economics, Chulalongkorn University

*Wednesday 8 October 1997*
Dr Oratai Ruayajin, Dr Thawatchai Boonchote, Department of Social Sciences, Mahidol University

*Thursday 9 October 1997*
Dr Suspasit Pannarunothai, Public Health Specialist, Buddachinnaraj Hospital

Ghana, Ken Grant & Andrew Creese, November 1997

*Tuesday 18 November 1997*
Dr Fred Binka, Navrongo Field Res. Station (Epidemiologist)
Dr Linda Humphrey, Dr Liz Gaere (DFID)
Dr Mandara (WHO)
Dr Asamoah-Baah (MOH/PPME)

*Wednesday 19 November 1997*
G. Dakpallah/MOH/PPME
K. William (UNICEF)
Dr D'Almeida (Selassie) (WHO)

*Thursday 20 November 1997*
Irene Agyepong (MOH/HSRM)
Sam Adjei (MOH/HSRM)
Dr Adibo (MOH/HSRM)

*Friday 21 November 1997*
Sam Adjei (MOH/HSRM)
Dyna Arhin (MOH/HSRM)

*iii) The Liverpool School of Tropical Medicine*

Costa Rica, Mercedes Juarez, December 1997

*1 December 1997*
Interview with Ing Zil Rojas
Introduction to participants of Siglos '97

*2 December 1997*
Working session with Ing Zil Rojas

Documents review

*3 December 1997*
Interview with Dr Jorge Elizondo, Hospital México, Dermatology section.
Interview with Dr León de Meserville, Hospital San Juan de Dios. Gastroscopía, Cátedra de Medicina.
Interview with Dra Navas y Dra Sánchez, INCIENSA

*4 December 1997*
Interview with Dr Paticia Allem, Health Services Director, MoH.
Interview with Dr Oscar Porras, Hospital de Ninos, Immunology.

*5 December 1997*
Interview with Dr Federico Holtz, Director Medico del Ebais de San Miguel Sarapiqui, Norte Guetar (1995 Siglos participant)
Interview with Dr Carlos Munos, Planning Division, MoH.

*6 December 1997*
Documents review
Draft preliminary notes

*7 December 1997*
Departure to Guapiles

*8 December 1997*
Attendance to Siglos 97 morning sessions
Field visit in Horquedas and Rio Frio Clinics
Interview with Nurse Vera Herrera, Siglos 97 facilitator
Interview with Mr Marvin Cervantes Loaiza, Siglos 97 facilitator

*9 December 1997*
Field visit in Cariari Clinic
Interview with Dr Alvaro Duran, Medical Director and Coordinator of the Cariari Area
Interview with Anniina Tammisto, SIGLOS 97 coordinator
Focus Group with Siglos 97 students from Venezuela

*10 December 1997*
Focus Groups with Siglos 94 returning students from Nicaragua, Chile and Guatemala
Working session with Ing Zil Rojas

*11 December 1997*
Interview with Dr Rodolfo Martinez, Regional Director de la Region Atlantica and Mr Marvin

Cervantes Loaiza, Siglos 97 facilitator
Departure to San Jose

Ghana, Mercedes Juarez & Peter Poore, February 1998

*2nd February 1998*
Meeting with Dr Linda Humphrey and Liz Gaere, DFID
Documents review
Arrival of Peter Poore

*3rd February 1998*
Interview with Dr Linda Humphrey and Liz Gaere, DFID
Interviews with Edith Wellington, Senior Research Officer, Health Research Unit;
Mercy Abbey, Research Fellow, HRU; Bertha Garshong HRU
Interview with Dr N. Enyimayew, HPO
Interview with Dr Sagoe, HRDD

*4th February 1998*
Interview with Dr Kwame Adogboba Institutional Care Directorate and responsible for Quality Assurance
Interview with Dr Moses Adibo, Health Research Unit and ex Director of Medical Services.
Interview with Professor Ofusu Amaah, Dr Phyliis Antwi and Dr. Omar Ahmad, School of Public Health.

*5th February 1998*
Departure for Koforidua
Interview with Dr Aaron Offei and colleagues, Eastern RHA including Dr Tom Awau-Siaw, Kwahu District Hospital,
Dr Reynolds Gunu, (the Director), Mr Derry Lurio, (the hospital Manager), Ms Beatrice Kpalritey, (Senior Matron), Mr L.O.Baah (Statistics officer), Dr I.D Ani (Dental Surgeon), Mr Gyanfi Yeboah, (Health service administrator), Mr Kwasi Brenyah, (Pharmacist), Atua Government Hospital

*6th February 1998*
De- brief with Dr Linda Humphrey and Liz Geare (DFID)
Interviews with Nigel Nicholson (CD SCFUK)
Dedo Nortey, Assistant Programme Director SCFUK
Viky Okine, Family reproductive health project coordinator, SCFUK
Alice Lamptey, Project Development Officer, SCFUK
Ms Hanne Thorup, Senior Health adviser, (Danida)
Dr Nicholas Tweneboa, Danida.

## DOCUMENTS REVIEWED ANNEX D

### *i) General*

"The Contribution of the ODA Technology Development and Research Programme to the advancement of ODA aims". A Study by Pamela Hilton & David Crapper, August 1996

"ODA Evaluation Studies: Guidelines for Evaluators". Overseas Development Administration, August 1994

Terms of Reference for Link Advisers, ODA Work Programmes with London School of Hygiene and Tropical Medicine and Liverpool School of Tropical Medicine

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Martin Buxton, Rachel Elliott, Steve Hanney, Mary Henkel, Justin Keen, Mark Sculpher & Penny Youll, "Assessing Payback from Department of Health Research and Development: Preliminary Report". Volume 2: Eight Case Studies, HERG Research Report No. 19, December 1994, Health Economics Research Group, Brunel University

Miguel A. González-Block, "Indexed Scientific Publications on Health Reform in Developing Countries". Informing Reforming, January-March 1997, No.1

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Dr J Farrington & Prof. D Edwards (Overseas Development Institute) & Ms J Ler (ODA Evaluation Department), "Review of the Factors Influencing the Uptake and Impact of ODA-supported Renewable Natural Resource Research". Overseas Development Administration Evaluation Report EV: 580, December 1993

M Surr, H Fabian & V Bram, "An Evaluation of Polish Banking Training". Overseas Development Administration Evaluation Report EV: 575, January 1995

C Nicolson, B Holton & M Li, "Polish Pilot Privatisation Project Evaluation". Overseas Development Administration Evaluation Report EV: 576, January 1995

Simon Caxton, Paul Balogun & Frank Moore, "From Aid Funded Research to Commercialisation: The case of the Whole Crop Harvester". Overseas Development Administration Evaluation Report EV: 590, March 1997

Background to ODA support for Work Programmes at the Liverpool School of Tropical Medicine (LSTM) and the London School of Hygiene and Tropical Medicine (LSHTM)

Dr Lucy Gilson, "Taking Research forward through Partnership". The Newsletter of the Council on Health Research for Development (COHRES), Issue 3, October-December 1995

ODA-sponsored Research Meeting on Management and Health Sector Reform, Programme. Participants list and summary of David Nabarro's introduction, 23 April 1997

Evaluation of TC Medical Lecturers Scheme Report

*ii) The London School of Hygiene and Tropical Medicine (LSHTM)*

"Future ODA support for Health and Population-related work at the London School". Letter from Mrs BM Kelly, Health and Population Division (ODA) to Professor Richard Feacham, World Bank, 10 March 1989

Review of ODA Support to Units at the London School of Hygiene and Tropical Medicine, 1989: Evaluation and Planning Centre (EPC) March 1989; Nutrition Policy (NPU) March 1989; Centre for Population Studies (CPS) April 1989

Terms of Reference: Joint Triennial Programme Review, London School of Hygiene and Tropical Medicine and Overseas Development Administration Work Programmes

Health Economics and Health Financing, A Programme submitted to the Overseas Development Administration. A.J. Mills, Department of Public Health & Policy, London School of Hygiene and Tropical Medicine, January 1990

"Health Initiative for Third World Announced". ODA/London School of Hygiene and Tropical Medicine Co-operation, Summary for Press Release, 9 May 1990

First Annual Report, Joint Work Programmes, London School of Hygiene and Tropical Medicine and Overseas Development Administration, April 1991

"Work Programme Reviews: Health Economics and Financing". Letter from David Nabarro, Health and Population Division (ODA) to Professor Richard Feacham, The Dean, London School of Hygiene and Tropical Medicine, 9 July 1991

"Work Programme Reviews: Health Economics and Financing". Letter from Professor Richard Feacham, The Dean, London School of Hygiene and Tropical Medicine to David Nabarro, Health and Population Division (ODA), 15 August 1991

Clarifications arising out of discussions at the Board of Management, London School of Hygiene and Tropical Medicine, 27 November 1991

Letter from Lynda Chalker (ODA) to Professor Richard Feacham, 13 December 1991

Second Annual Report, Joint Work Programmes, London School of Hygiene and Tropical Medicine and Overseas Development Administration, April 1992

"Work Programme Reviews: Health Economics and Financing". Letter from David Nabarro, Chief Health and Population Adviser (ODA) to Professor Richard Feacham, The Dean, London School of Hygiene and Tropical Medicine, 28 July 1992

"Work Programme Review 1992: Health Economics and Financing". Letter from Professor Richard Feacham, The Dean, London School of Hygiene and Tropical Medicine to David Nabarro, Health and Population Division (ODA), 7 August 1992

Summary Record of Overview Meeting, 1992 LSHTM/ODA Annual Review of Work Programmes, 1 October 1992

"1992 Work Programme Review". Letter from David Nabarro (ODA) to Dr Barbara Judge (LSHTM), 15 December 1992

"1993 Triennial Reviews". Letter from David Nabarro & Stephanie Simmonds, Health and Population Division (ODA) to Professor Richard Feacham, Dean (LSHTM) & Professor David Molyneaux, Director (LSTM), 3 March 1993

1993 Triennial Review of ODA Work Programmes, The Health Economics and Financing Programme, Anne Mills, Health Policy Unit, Department of Public Health & Policy, London School of Hygiene and Tropical Medicine, April 1993

Triennial Review of the ODA/School Programmes. Report and letter from Professor Richard Feacham, The Dean (LSHTM) to Baroness Chalker, Minister for Overseas Development (ODA), 7 May 1993

Joint ODA/London School of Hygiene Triennial Review. Initial comments on the Joint Work Programme from Andrew Creese, Responsible Officer, National Health Systems and Policies (WHO) to Stephanie Simmonds, Senior Health and Population Adviser (ODA), 27 May 1993

"Joint ODA/School Programmes, 1995-2000: Preliminary Proposals". Letter & Report from Professor Richard Feacham, The Dean, London School of Hygiene and Tropical Medicine to David Nabarro, Chief Health & Population Adviser, Health and Population Division (ODA), 28 May 1993

LSHTM Work Programmes: Joint Triennial Programme Review. Minutes from Gillian Holmes to Stephanie Simmonds, 15 June 1993

LSHTM Work Programmes: Joint Triennial Programme Review, David Nabarro (ODA), 18 June 1993

Report of the Triennial Review of the Joint Work Programmes at the London School of Hygiene and Tropical Medicine. Letter from David Nabarro (ODA) to Stephanie Simmonds, 19 August 1993

ODA/London School of Hygiene and Tropical Medicine Triennial Review 8-21 June 1993. Letter from Stephanie Simmonds, Senior Health and Population Adviser (ODA) to David Nabarro, 31 August 1993

Note for the File: Future of the Work Programmes at the London and Liverpool Schools of Tropical Medicine, David Nabarro, 17 September 1993

London School of Hygiene and Tropical Medicine (LSHTM) and Liverpool School of Tropical Medicine (LSTM). Letter from David Nabarro, Chief Health and Population Adviser to Lady Chalker, 23 September 1993

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Note of a meeting with Professor Feacham, Dean of the London School of Hygiene and Tropical Medicine: 28 September 1993, Health and Population Division (ODA), 29 September 1993

Note for the File: Points made to Senior Staff of the London School of Hygiene and Tropical Medicine on 30 September and to Professor David Molyneaux, Liverpool School of Tropical Medicine, 4 October, David Nabarro, 5 October 1993

Health Economics and Health Financing: 1995-2000. Letter from Victoria Ware to David Nabarro, 22 December 1993

Health Economics and Financing Work Programme 1995-1999. Letter from Julia Watson, Health and Population Division to David Nabarro, 24 January 1994

Health Economics and Financing Work Programme: Negotiations. Letter from David Nabarro, Chief Health and Population Adviser to Dr Anne Mills, London School of Hygiene and Tropical Medicine, 11 February 1994

Health Economics and Financing Work Programme 1995-1999. Letter from Julia Watson, Health and Population Division to Victoria Ware, 29 March 1994

Note of a visit to the London School of Hygiene and Tropical Medicine: 30 March 1994, Health and Population Division

Support for Research Work Programmes from 1995. Draft letter from Dr PJ Key, Health and Population Division to Professor RGA Feacham, The Dean, London School of Hygiene and Tropical Medicine, 1994

Note of a meeting held on 25 February 1994 to discuss negotiated support with the London School of Hygiene and Tropical Medicine for a health economics and financing work programme: 1995-1999. Health and Population Division, Revised version, May 1994

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Annual Report 1995/96, ODA Programme on Health Economics and Financing, London School of Hygiene and Tropical Medicine, May 1996

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Correspondence, from Anne Mills, LSHTM to Nick Dyer, Evaluation Department (ODA), 21 November 1996

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"Health care in South Africa - 1997 and Beyond", Paper presented at conference in South Africa by Dr O Shisana, Director-General, National Department of Health

Background to Thailand visit (Annex F)

Background to Ghana visit (Annex F)

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Bennett S, McPake B and Mills A (eds)., *Private health providers in developing countries: serving the public interest?*, Zed Press, London, UK, 1997, (Chapter 1: *The public/private mix debate in health care*); (Chapter 18: *Future research directions*)

McPake B, Hanson K and Mills A, *Community Financing of health care in Africa: an evaluation of the Bamako Initiative*. Social Science and Medicine, 36, 11, 1993, 1383-1395

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Aikins M, Fox-Rushby J, D'Allesandro U, Langerock P, Cham K, New L, Bennett S, Greenwood B, MILLS A, *The Gambian National Impregnated Bednet Programme: costs, consequences and net cost-effectiveness*. Social Science and Medicine, 46, 2, 1997, 181-191

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Zwi AB, Forjuoh S, Murugusampillay S, Odero W, Watts C., *Injuries in developing countries: policy response needed now*. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 90, 593-595, 199

*iii) The Liverpool School of Tropical Medicine (LSTM)*

"Towards improved health in the developing world", Final Report of the Joint Work Programmes 1990-1995, Overseas Development Administration and the Liverpool School of Tropical Medicine

Policies and practices of Primary Health Care, Liverpool School of Tropical Medicine, March 1990

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Central America - Regional Project on "Health Information Systems for District Primary Health

Care" at Inciensa, Costa Rica. Letter from Dr Mukesh Kapila, Senior Health and Population Adviser (ODA) to John Harris, LACAD (ODA), 14 January 1992

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- Correspondence related to the Siglos training course
- ODA and LSTM "Joint Work Programmes", Triennial Review Report 1993
- Reforming Health, Health Sector Reform Work Programme, issue 2, August 1996. ODA and Liverpool School of Tropical Medicine
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- Rojas, Z and Sandiford, P, "Health Information Systems for District Primary Health Care in Central America", Third Report, September 1 - August 31, 1994, Siglos Project
- Rojas, Z and Sandiford, P, "Health Information Systems for District Primary Health Care in Central America", Fifth Report, March 1 - August 31, 1995, Siglos Project
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- Rojas, Z and Sandiford, P, Coyle, E and Allen, P. "Aprendizaje en la acción es este el medio para capacitar gerentes de salud de los paÌses en desarrollo?", pages 189-204 in Educación Medica y Salud: vol. 29 no. 2, April/June 1995. ed. Organización Panamericana de la Salud, Oficina Sanitaria Panamericana, Oficina Regional de la Organización Mundial de la Salud
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*Background to Ghana visit*

- A collaborative WP between MoH, Eastern Region & LSTM. "Dissemination Forum and Workshop of Quality of Care Activities in the Eastern Region", 11th-12th April 1996
- Bowie, C. and Adogboba, K., "The Institutional Care Directorate Quality and Utilisation of Hospital Services Current Issues and Future Direction", A consultancy report prepared for the MoH in Ghana. 26 November 1997
- Cassels, A. and Janovsky, K., "A time of Change: Health policy planning and organisation in Ghana", Current Concerns, SHS Paper number 4. WHO/SHS/CC/91.2. December 1991
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- Draft Position Paper of the Ministry of Health on Community Participation in Health
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- Ghana-Denmark Health Sector Support Programme, MoH-Ghana, Upper West Region, "Quality of Care in the Upper West Region, December 1994-June 1996", September 1996
- Haran, D., "Quality Assurance in Health Services in Ghana, West Africa: A report on the first year of a 3-year programme of projects investigation the assessment of quality of health care services", LSTM March 1993
- ODA and LSTM "Joint Work Programmes", Triennial Review Report 1993
- Quality Assurance project training manual

PEER REVIEWS ANNEX E

*i) London School of Hygiene and Tropical Medicine*

Peer reviews:

Bennett S, McPake B and Mills A (eds)., *Private health providers in developing countries: serving the public interest?*, Zed Press, London, UK, 1997, (Chapter 1: *The public/private mix debate in health care)*; (Chapter 18: *Future research directions*)

- Andrew Green, Nuffield Institute of Health, Leeds (declined)
- Prof Joseph Brunet-Jailly (no response)

McPake B, Hanson K and Mills A, *Community Financing of health care in Africa: an evaluation of the Bamako Initiative*. Social Science and Medicine, 36, 11, 1993, 1383-1395

- Di McIntyre, Health Economics Unit, Department of Community Health, Cape Town, South Africa
- Prof. Peter Berman, School of Public Health, Harvard University, Cambridge MA, USA

Gilson & Russell, *A Wolf in sheep's clothing*

- Dr Julio Frenk, Mexican Foundation for Health, Tlalpan, Mexico DF,
- Cristian Baeza (no response)

Aikins M, Fox-Rushby J, D'Allesandro U, Langerock P, Cham K, New L, Bennett S, Greenwood B, MILLS A, *The Gambian National Impregnated Bednet Programme: costs, consequences and net cost-effectiveness*. Social Science and Medicine, 46, 2, 1997, 181-191

- David Evans, TDR, World Health Organisation, Geneva, Switzerland
- Mr Joan Rovira, SOIKOS, Barcelona, Spain (no response)

Arhin DC., *Health Insurance in rural Africa*. The Lancet, January 7, 1995, 345

- Dr Juan Perez, Director, Local Government Assistance and Monitoring Service (LGAMS), Office of the Secretary of Health, Department of Health, Manila, Philippines (no response)
- Anders Nordstrom

Zwi AB, Forjuoh S, Murugusampillay S, Odero W, Watts C., *Injuries in developing countries: policy response needed now. Transactions of the Royal Society of Tropical Medicine and Hygiene*, 90, 593-595, 199

- Dr Timothy Stamp, Minister of Health, Ministry of Health, Harare, Zimbabwe (no response)
- Dr JJ Banda, Central Board of Health, Lusaka, Zambia

These are the comments from 7 replies

*Opinion of the paper*

1 = poor 3 = adequate 5 = very good

| | 1 | 2 | 3 | 4 | 5 | OVERALL RATING |
|---|---|---|---|---|---|---|
| 1. Originality | | | 1 | 5 | 1 | Good |
| 2. Relevance to health sector policy | | | | 3 | 4 | Good |
| 3. Relevance to health research agendas | | | | 4 | 3 | Good |
| 4. Relevance to teaching agendas | | | 1 | 4 | 2 | Good |
| 5. Potential contribution of the concepts or outcomes to improved health status in developing countries | | | 2 | 3 | 2 | Good |
| 6. Potential contribution to improved service delivery in developing countries | | | | 5 | 2 | Good |
| 7. Methodology and analytic quality | | | 1 | 3 | 3 | Good |
| 8. Style and presentation | | | 1 | 2 | 4 | Very good |

Further comments:

*The Gambian National Impregnated Bednet Programme: costs, consequences and net cost-effectiveness* A number of studies on this subject have already been carried out though this is one of the few which review a specific programme.

*Community Financing of healthcare in Africa: an evaluation of the Bamako Initiative* (2 replies) A well-written and fair presentation of a major multi-country evaluation study. As the only major review of its kind, it was useful and an important contribution to knowledge. The paper provided the most comprehensive evaluation of the BI at that point in time. Provided information which was critical in informing implementation strategies through a balanced, critical evaluation within a coherent conceptual framework. Unfortunately the original study was only modestly successful for several reasons; subjects of study (BI) was not uniform, several of the cases were immature, methodology did not allow very rigorous assessment of the key questions. The paper honestly reflects these limitations. However the basic material was not up to a rigorous

evaluation of the BI or of its successes or importance in health policy.

*A Wolf in Sheep's Clothing*
no additional comments given

*Injuries in developing countries: policy responses needed now*
no additional comments given

*Health Insurance in rural Africa*
no additional comments given

*Private health providers in developing countries: serving the public interest?*
No response to questionnaire received

*Health Economics and Financing Work Programme between 1990-1995*

1. Are you familiar with the Health Economics and Financing Work Programme at the London School of Hygiene and Tropical Medicine?

Yes - 6 No - 1

2. When did you first hear of the Health Economics and Financing Work Programme at the London School of Hygiene and Tropical Medicine?

Date - 1990 (inception) - 2 Cannot recall -
1991 - 1
1992 - 2
1993 - 1
1998 - 1

3. How did you first hear of the Health Economics and Financing Work Programme at the London School of Hygiene and Tropical Medicine?

*Comments:*

- Following ODA's funding program and communication/professional links with colleagues in London; eg. Anne Mills at TDR (WHO); Kara Hansen worked with the Health Planning Unit at UNICEF to test unit costs for primary health care services in Zambia and; through Carlos Cruz, a former student of LSHTM, who was invited to join the collaborative research network on the Public/Private Mix for Health Care (PPM network)
- Through contacts with ODA/DFID and at international meetings on health financing issues
- Through invitation to take part in peer review

4. What forms of contact have you had with the Health Economics and Financing Work Programme (participation in seminars or courses, use of publications, collaborative research, technical advice, etc.?)

*Comments:*

- Read and used many of their reports (for teaching and research purposes) and taken part in publications
- Employed graduates from their programmes
- Invited faculty to seminars, conferences and research projects and jointly participated in meetings with their faculty and staff
- eg. Attended public/private mix network workshops
- eg. A. Mills & Julia Fox-Rushby have been advisers/consultants for research and teaching initiatives at WHO
- eg. Have funded research co-ordinated through the LSHTM programme (on an international competitive basis) (WHO)
- eg. Sara Bennett involved with evaluation of decentralised budgets and more recently cost sharing schemes in Zambia
- eg. A. Mills has contributed to Health Economics Unit training programmes (Department of Community Health, South Africa) as a visiting lecturer and providing access to case study material
- eg. A. Mills and other staff have provided technical advice on certain research projects and more recently are involved in collaborative research projects (South Africa)
- National Institute of Public Health of Mexico, LSE and LSHTM carried out two short courses on Health Economics in Mexico (early 1990s), and Carlos Cruz participated in two of the short courses offered in London. Three colleagues (Mexican Health Foundation) carried out research and participated in meetings of the PPM network. Project of the National Institute of Public Health received technical advice from Dr Steven Russell in 1994. Some articles in the recent book “Private Health Providers in Developing Countries” have been used for teaching purposes.

5. Were you aware that DFID (formerly known as the Overseas Development Administration, ODA) was involved in the Work Programme as a core funder?

Yes - 6 No - 1

(but had some knowledge of ODA activities through work in Latin America and meeting of ODA professionals/consultants)

6. In what ways do you think that the placement of the Work Programme in the London School of Hygiene and Tropical Medicine may have contributed to, or limited, its achievements?

*Comments:*

- Placement at LSHTM has contributed to its achievements - LSHTM has an excellent track record of collaboration with counterparts in less developed countries and with institutions in Africa and Asia. eg. in Zambia, the school is well placed as the Central Board and LSHTM have a long history of collaboration.
- The reputation of the school and of Anne Mills opened doors in countries that would have been difficult to open otherwise.
- LSHTM network of researchers was invaluable to generating multi-centre research
- Strong linkages with training activities at LSHTM are strengthened by the research programme. Leadership at LSHTM is well-informed and connected with international health policy concerns, assuring relevance. This has benefited the people greatly and enhanced its developmental impact. eg. location (Bamako Initiative/Africa) contributed importantly to its success.
- Given the extensive group of former students and the collaborative research carried out by its staff, the LSHTM was able to start a working network and involve many interested parties. LSHTM training programmes strive to develop collaborative projects with graduates.
- Main limitation is the distance from cutting edge of health economics/financing work in the UK/EC which could inform the work more.
- Representation of Latin American countries is still small compared to the participation of Africa and Asia
- In an environment with a broader interest for health systems development and manpower issues, the programme might have developed differently.

7. Are you aware of the collaborative working relationships of the Health Economics and Financing Work Programme with developing country institutions/researchers?

Yes - 6 No - 1

8. If YES, in what ways do you think these relationships have contributed to the building of research and teaching capacity in the field of Health Economics and Financing?

*Comments:*

- In an international field such as this one, opportunities in field work and hands-on collaboration with national counterparts are essential to a useful and significant result.
- Trademark of the programme is the collaborative way in which they interact with institutions in developing countries.
- Collaboration is a very important vehicle for technology transfer to national counterparts and to complement training activities; eg. collaboration between the school and SIDA is

helping build capacity of the Department of Economics at the University of Zambia (Institutional Collaboration); eg. visits to Mexico by faculty staff from LSHTM for seminars have supported the expansion of health economics training, and have helped to build the national capacity to the point that there is now a Master in Health Economics offered jointly by the National Institute of Public Health and the Mexican Centre for Research and Education in Economics.

- Very useful in providing inexperienced researchers and teachers from developing countries with hands-on experience.
- Good emphasis on equal partnerships, with a concern to identify capacity needs and seek mutually acceptable ways of addressing these needs. In this way, capacity is developed instead of perpetuating historical dependence on "Northern" institutions.
- Work programme enables researchers from the South to work in collaboration with those from the North.
- The equity focus in the work has meant a balance in the relation to the Bank's more private/ efficiency oriented policy work.

9. In your opinion, what is the relevance of the work of the Work Programme to health policy and health and population needs in developing countries?

*Comments:*

- The area of health economics and healthcare financing is crucial to the development of sustainable, affordable health service provision. Of the DFID work programmes, this one is probably the most vital to health system development.
- Despite attention in recent years, health care systems issues are still not receiving sufficient support. Strengthening systems - especially through the use of economics and financing tools - is essential to the success of investments in expanding coverage and application of appropriate disease control technologies. DFID (and formerly ODA) has made a sustained and very reliable investment in this work via this work programme.
- Provides countries with data and experiences documented in a way that has been important both directly and indirectly (through eg. WHO). The focus on households, micro-economy and capacity has been appreciated.
- Work contributed to the development of health planning capacity in the Ministry of Health, Zambia.
- Has relevance to health policy and population needs in developing countries (eg. Department of Community Heath, South Africa).
- Helped to build some teaching and research capacity in Mexico in the areas of health economics and health financing.
- Published work has provided empirical evidence especially regarding the evaluation of health policy. However this has not reached the point where it affects the development

and implementation of health policy.

10. Can you provide any examples of explicit and/or implicit influence of the Health Economics and Financing Work Programme on:

- HEALTH POLICY
  Activities have helped to focus attention of policy-makers on key questions, such as the public-private mix. Important policy attention achieved in Thailand.
  Work on contracting has influenced policy toward the private provision of hospital services in South Africa. It is also likely that the seminars run for the World Bank on this topic will modify the Bank's policy toward contracting.
  For Zambia, involvement has had a direct influence on the development of the health financing policy.

- HEALTH SERVICE MANAGEMENT
  Initial work on contracting has opened up important new areas of work.
  Managers are more aware of the need for cost-effectiveness.
  LSHTM has contributed with useful work on malaria and HIV prevention.
  Benefited in the development of decentralised budget management at district level (Zambia).

- HEALTH SERVICE DELIVERY
  STD treatment is increasingly used as an efficient method of preventing HIV, partly as a result of work showing its cost-effectiveness undertaken by Lucy Gilson in Tanzania.

- RESEARCH AGENDAS
  Interest in the public/private mix was greatly stimulated by programme work.
  Evaluation of experience with user charges.
  Julia Fox-Rushby and team have been showing that perceptions of health-related quality of life can be culture-specific, leading to a widespread re-examination of quality of life scales and outcome indicators for cost-effective analysis.
  Working with LSHTM to study autonomous hospital initiatives to inform further development of the hospital sector in Zambia.
  As an internationally recognised academic group, the faculty of the programme has influenced the research agenda (Mexico).

- BUILDING INSTITUTIONAL AND PROFESSIONAL CAPACITY
  Publications of educational/training materials are useful for many other programmes.
  Graduates of the school are leaders in health policy in their countries and increasingly presented in international and national literature.
  Provides support for training capacity in less developed countries eg. Thailand, South

Africa. Work with people from developing countries who received training on activities supported by the work programme. All are excellent.

Working jointly with LSHTM, the Institute of Health Economics in Sweden and the Department of Economics in Zambia to build capacity of the University of Zambia in health economics.

The main influence of the programme in Mexico has been in building capacity to teach and carry out research in the areas of health economics and health financing.

One weakness of the programme is that not enough focus has been given to institutional development in developing countries. Too much of the work has been initiated from London.

11. Is there any evidence of the impact of the Work Programme's activities on health status?

*Comments:*

- Too difficult to answer for any research/work programme
- Not aware of any direct evidence of this
- Too early for Zambia to assess
- Would not expect to see any impact given that most of the effect would be indirect and confounded by other influences.

*ii) Liverpool School of Tropical Medicine*

Peer reviews:

Aitken, JM., *Voices from the inside: managing district health services in Nepal*. International Journal of Health Planning and Management, 9, 309-340

- Dr Yves Genevier, The World Bank, Washington DC, USA (no response)
- Dr Rifat Atun, The Management School, Imperial College of Science and Technology, London

Barnett E and Ndeki S., *Action-based learning to improve district management; a case study from Tanzania*. International Journal of Health Planning and Management, 7, 1992, 299-308

- Professor Trudy Harpham, Professor of Urban Development & Policy, School of Urban Policy, South Bank University, London (no response)
- Dr Sarah Atkinson, Lecturer in Human Geography (Health Care Policy), Department of Geography, University of Manchester (no response)

Sandiford P, Annett H and Cibulskis RE., *What can information systems do for primary health care?*: an international perspective. Social Science and Medicine, 34, 1077-1087

- Professor Peter Streefland, The Royal Tropical Institute, Amsterdam, The Netherlands
- Professor Marcel Tanner, Director, Swiss Tropical Institute, Basel, Switzerland

Martinez J and Martineau T., *Strategic review of the health sector in Orissa*. Report for DFID (formerly ODA)

- Dr Stuart Tyson, DFID Health and Population Adviser, Harare, Zimbabwe
- Dr Bruce Dick, Adolescent Health Unit, UNICEF, New York, USA (declined)

Weakliam D., *Development of quality indicators based on patients' perceptions of quality for health service monitoring at health centres in Ghana*. Report for Wellcome Foundation

- Dr Anita Hardon, Faculty of Social Sciences, Medical Anthropology Unit, University of Amsterdam, The Netherlands (no response)
- Dr John Seaman, Independent Healthcare consultant, UK

Sandiford P and Martinez J., *Health sector reforms in Central America*. Report for DFID (formerly ODA)

- Dr Richard Feacham, Senior Adviser, Human Development Department, The World Bank, Washington DC, USA (no response)
- Ms Katja Janovsky, Division of Analysis, Research & Development, World Health Organisation, Geneva, Switzerland (no response)

These are the comments from 5 replies

*Opinion of the paper*

1 = poor 3 = adequate 5 = very good

| | 1 | 2 | 3 | 4 | 5 | OVERALL RATING |
|---|---|---|---|---|---|---|
| 1. Originality | | 1 | 3 | 1 | | Average |
| 2. Timeliness and relevance to health sector policy, planning and management needs | | 1 | 1 | 3 | | Good |
| 3. Addresses practical needs and problems faced by technical experts and service planners and managers | 1 | | 2 | 2 | | Average |
| 4. Relevance to health and population needs in developing countries | | 1 | 2 | 2 | | Average |
| 5. Were issues of gender and poverty adequately considered | 1 | 1 | 3 | | | Average |
| 6. Potential contribution of the concepts or outcomes to improved health status in developing countries | | 2 | 2 | 1 | | Average |
| 7. Potential contribution to improved service delivery in developing countries | | 1 | 4 | | | Average |
| 8. Quality of work | | 1 | 2 | 2 | | Average |
| 9. Style and presentation for technical experts | | 1 | 3 | | 1 | Average |

Further comments:

*Managing district agents in Nepal*

The case is more relevant to HRM issues in particular to performance management, incentive systems, appraisal.

Motivational issues need to be explored further eg. non-financial motivators should have been identified given the country context and solution offered in discussion and conclusion.

Management literature is not adequately explored. A very interesting and relevant link could be between 'prescriptive' and 'emergent' strategies as a way of developing strategy and to discuss the "top-down" approach adopted by some donor agencies and why these strategies may fail given the local human resource issues.

*What can international systems do for primary health care? An international perspective*

The paper deals with a very important issue by contrasting the "epidemiological" with the "managerial" approach and information needed for health planning and services management. However the paper was a bit wordy and could have been clearer.

While the theoretical framework is well presented, the more practical operational aspects are not clearly developed. This would have been useful in order to achieve a higher relevance for planners and decision-makers of health services. The paper is a useful and important contribution with a great potential for further developments in concepts and strategies.

*Strategic review of the health sector in Orissa*

Dense text with few diagrams/maps.

Not presented in a style which will facilitate access to Indian policy-makers.

Key findings/recommendations is 30 pages long - neither easy or user-friendly. Recommendations are important but lost in the text. A one page summary of the main findings would have been useful.

Assumes a high degree of prior knowledge (eg. exchange rates).

*Development of Quality indicators based on patients' perceptions of quality for health services monitoring in Ghana*

A well thought out and well conducted study. Values of these types of study could be in their educational use eg. providing case material for teaching and useful for the training of the researcher.

Doubts whether it is worth doing studies of this type - we know that services provided by the rural health services of poorer developing countries are more or less deficient in quality and why eg. health staff are generally underpaid, morale is low, supervision, in-service support and retraining is limited and other disincentives operate such as charging for poor people for medicines which they cannot afford.

Not convinced that the routine use of quality techniques of this kind, in the absence of the

preconditions for providing an effective health service can serve any real purpose in improving service quality or that it is good value for money.

*Action-based learning to improve district management - a case study from Tanzania*
no additional comments given

*Health Sector Reforms in Central America*
no response to questionnaire received

*Primary Health Care Policy and Practice Work Programme between 1990-1995*

1. Are you familiar with the Primary Health Care Policy and Practice Work Programme at the Liverpool School of Tropical Medicine?

Yes - 5 No -

2. When did you first hear of the Primary Health Care Policy and Practice Work programme at the Liverpool School of Tropical Medicine?

Date - 1990 - 1 Cannot recall - 1
1991 - 1
1994 - 2

3. How did you first hear of the Primary Health Care Policy and Practice Work Programme at the Liverpool School of Tropical Medicine?

*Comments:*

- Through ODA
- On joining ODA as a regional health adviser in Central Africa
- Professional contacts in the medical field and through publications
- Through various interaction with staff of LSTM as well as LSHTM
- Member of mid-term evaluation for the LSHTM programme

4. What forms of contact have you had with the Primary Health Care Policy and Practice Work Programme (participation in seminars or courses, use of publications, collaborative research, technical advice, etc.)?

*Comments:*

- Professionals involved in health sector reform work
- Visits to LSTM and meetings with LSTM staff at seminars and meetings
- Reading publications and literature/reports
- Minimal contact with PHCPWP, more with HIV/AIDS/STD work programme. Not aware of having received summaries of work completed or in progress.

5. Were you aware that DFID (formerly known as the Overseas Development Administration, ODA) was involved in the Work Programme as a core funder?

Yes - 4 No - 1

6. In what ways do you think that the placement of the Work Programme in the Liverpool School of Tropical Medicine may have contributed to, or limited, its achievements?

*Comments:*

- It is important to strengthen institutions outside the London School of Hygiene and Tropical Medicine
- Considers the Work Programme as backbone of many scientific achievements of LSTM. The Work Programme contributed to more coherence and consistency within avenues of research and teaching/training of LSTM
- The site of the work programme is irrelevant if the work is carried out and an effective system exists to disseminate results.
- Enhanced potential achievements due to extensive international network of Liverpool staff and alumni.
- School has a "developing country" focus. However the dissemination of outputs could be improved for a wider audience working in this field.
- Academic institutions, mainly non-operational are poorly placed to do operational research.

7. Are you aware of collaborative working relationships of the Primary Health Care Policy and Practice Work Programme with technical experts for health in developing countries, such as donors, the World Bank, UN agencies, government officials?

Yes - 3 No - 2

8. If YES, in what ways do you think these relationships have influenced and contributed to developing health policy in the field of Primary Health Care?

*Comments:*

- By addressing priority issues for research/evaluation
- By aiming at creating a partnership and by pursuing a lot of demand-driven research
- Made more relevant, appropriate and less theoretical
- Unaware of examples where the programme has influenced wider policy
- There is a risk (but Liverpool is not to blame for this) that academics view World Bank and UN policy as the yardstick and fail to recognise/reflect national and other views eg. NGOs.

9. In your opinion, what is the relevance of the work of the Work Programme to health policy and health and population needs in developing countries?

*Comments:*

- Identification of the local context. Helpful to prevent a rigid approach to policy development and generic plan for health reform and create understanding of people issues.
- Assisting the health reform process and planning process
- Training future decision makers
- Key documents on policy issues emerging from other work programmes, research programmes and through contracted work from resource centres
- Questionable but this may be due to ignorance of the achievements of the programme
- Have not seen extensive output from the Liverpool programme.

10. Can you provide any examples of explicit and/or implicit influence of the Primary Health Care Policy and Practice Work Programme on

- HEALTH POLICY:
  At many levels LSTM staff have contributed to international discussions such as decentralisation, quality of care and health management information.
  It is difficult to know which of the outputs were a result of the primary care policy and practice work programme. It is hence difficult to separate those publications which are the result of the work programme from those that are outputs from the school from separate programmes.
  If an academic is not closely involved with the school then it is difficult to see how one can identify this work unless it is explicitly stated in the articles.

- HEALTH SERVICE MANAGEMENT:
  eg. The work done in PHG and Ghana

- HEALTH SERVICE DELIVERY:
  eg. The work done in PHG and Ghana
  eg. Cross-fertilisation of Dar-es-Salaam Urban Health Project as LSTM staff acted as consultant to the Tanzania project

- RESEARCH AGENDAS:
  Mainly an international level through publications and in project sites such as in Ghana
  Change management agenda

- BUILDING INSTITUTIONAL AND PROFESSIONAL CAPACITY:
  The influence is substantial owing to the LSTM teaching programmes into which a great number of work programme experience/case studies was brought, discussed and also developed further.

Many key policy makers met have been trained by the programme staff
Change management issues
HRM issues not generic and specific to country concerned (Nepal).

11. Is there any evidence of the impact of the Work programme's activities on health status?

*Comments:*

- Difficult to answer without in-depth studies
- An ambitious goal for any institution or programme which is so distant from implementation of health services delivery
- Even if a change in health status is observed in work programme project sites, attribution is difficult to establish

INFORMATION FOR COUNTRY VISITS ANNEX F

*GHANA*

*1. Research*

1.1 *Vitamin A research in Bolgatanga*
Principal HEFP investigator: Dyna Arhin
Collaborating institution: Ms F Kufour, Planning Unit (now PPME), Ministry of Health
Duration: 1990-2

The objectives were: a) to assess the cost implications of integrating vitamin A supplementation with existing immunization services; and b) to assess the integrated service's potential for achieving adequate supplementation coverage.

Information on immunization and vitamin A supplementation of infants was obtained through a household survey of sixty communities. A health services study provided data on costs of immunization and vitamin A supplementation activities of the Presbyterian Rural Health. The preliminary findings were discussed in a workshop in Kumasi attended by decision makers including the Director of Medical Services. A paper was published in Health Policy and Planning.

1.2 *Cost-effectiveness of impregnated mosquito nets*
Principal investigators: Anne Mills
Collaborating institution: Dr F Binka, Navrongo Health Research Centre
Duration: 1993-7

Advice has been provided to four sites, including Navrongo, on the conduct of the economic component of the trials of the impact of impregnated mosquito nets on child mortality. Costs of the interventions have been calculated, in order to assess cost-effectiveness. The costings of the four sites are currently being compared, and a comparative analysis prepared for publication. The Ghana study is forthcoming in Health Policy.

1.3 *Public/private mix country paper*
Principal HEFP investigators: Anne Mills, Sara Bennett, Dyna Arhin
Collaborating institutions: Dr Asamoa-Baah, Mr J Adusei, Mr G Dakpallah, Ministry of Health
Duration: 1992-3

As part of the collaborative research network on the public/private mix, a paper was prepared presenting the mix in Ghana and identifying key issues. The paper was

presented at a workshop organised by HEFP in 1993.

1.4 *Evaluation of contracting of clinical and non-clinical services*
Principal HEFP investigators: Anne Mills, Sara Bennett, Lucy Gilson
Collaborating institutions: Ken Sagoe and Joseph Adusei, Ministry of Health
Duration: 1994-6

The main aim of the comparative study was to compare the performance of public provision with provision by a private contractor. The prime concern was efficiency, but other aspects were studied such as preferences of employees and patients. In three of the countries, including Ghana, the focus of the research was the contract (explicit or implicit) between government and mission health care providers: publicly provided district hospitals have been compared with mission district designated hospitals. In other countries a variety of contracts were studied: for laundry, catering, diagnostic services etc. Papers have been published in a book.

The studies of the relationship between government and mission health care providers indicated that there were likely to be both advantages and disadvantages in making agreements more explicit. In the comparison between district hospital and district designated hospital performance, in only one country (Zimbabwe) were the mission providers clearly less costly with no obvious detrimental effect on quality. The three country case studies on mission/government relationships have been published as a book chapter.

1.5 *Community Health Insurance*
Principal investigator: Dyna Arhin
Collaborating institution: Dr M E K Adibo (then Director of Medical Services), Dr Irene Agyepong, District Medical Officer, Dangme-West District, Ministry of Health
Duration: 1992-5.

The objectives of the fieldwork in Ghana included the following:

a) to determine the preferred specifications of community-based risk sharing for health care and the "Willingness to Pay" (the maximum premiums/contributions that households would be willing and able to pay);
b) to estimate the proportions of the population in the study area who would seek western type health care during the dry season and the wet season, for serious and mild illness, if such care were physically accessible and affordable;
c) to estimate average costs for outpatient and inpatient episodes in health facilities preferred by households in the study area.

The research developed a Willingness to Pay (WTP) instrument and used a contingent

valuation approach. It had two main components: 1) serial focus groups (exploratory" and "expandatory"), and 2) a two-stage household survey. The exploratory focus group discussions were conducted at the start of the fieldwork to provide information on the perceptions and discourse relating to solidarity and risk sharing in the study community. Findings were used to refine and tailor the household questionnaire. The expandatory focus group discussions were conducted after the first round of household survey data collection and household heads who had taken part in the household survey were randomly selected to take part. To take into account seasonality of both income and illness occurrence, the household survey collected data for both the dry and wet seasons in 1993/4.

A workshop was held in Ministry of Health headquarters, Accra to discuss the findings of the research and its policy implications. Papers have been published. A new research project funded by the EU (1997-2000) resulting from the earlier research is evaluating the introduction of rural insurance schemes in Ghana and Burkina Faso.

1.6 *The role of government in adjusting economies*
Principal HEFP investigators: Anne Mills, Sara Bennett, Steven Russell
Collaborating institutions: Dr Asamoa-Baah, Ministry of Health; Paul Smithson, Financial Adviser, Ministry of Health
Duration: 1994-7

This is a research programme coordinated by DAG, Birmingham involving a comparative analysis of 4 sectors of which health is one. The overall aims are to evaluate alternative supply arrangements in different sectors and different national contexts; to understand the regulatory and enabling roles of government under alternative arrangements; and to identify constraints on performance of these roles, particularly those relating to government capacity. The health sector study has selected particular models of purchaser/provider relationship to evaluate (user fees, autonomous hospitals, contracting), and is also assessing the regulatory role of government. Conceptual work has been completed and field work is underway.

A review of the subject area has been published and the Ghana report is at final draft stage.

*2. Technical assistance (paid for as consultancy)*

None.

*3. Teaching*

3.1 *MSc students*

Dr Jennifer Brown-Aryee, MSc Health Planning and Financing, 1991-2
Dr Joseph Annan, MSc Health Planning and Financing, 1992-3
Dr Prince Albert Sackey, MSc Health Planning and Financing, 1993-4
Mr Napoleon Tayviah, MSc Health Planning and Financing, 1993-4

3.2 *PhD students:*
Moses Aikins, MRC The Gambia, on secondment from the Population Council.

*4. Meetings*

Conference seminar papers based on research done in Ghana:

ARHIN DC *Health Insurance in Sub-Saharan Africa: what are the options?* Paper presented at the Symposium on Health Care Financing at the European Conference on Tropical Medicine, Hamburg, Germany. 22-26 October 1995.

ARHIN DC *Health insurance for the non-formal sector: evidence from three African Countries*. Paper presented at the Seminar on Health Insurance in Developing Countries, Uppsala, Sweden. April 1995.

ARHIN DC *Health Insurance Demand in Ghana: A Contingent Valuation*. Paper presented at the International Health Economist Association Conference (iHEA), Vancouver. 19-23 May 1996.

*5. Publications:*

5.1 *By HEFP staff*

Aikins M, et al. The Gambian National Impregnated Bednet Programme: costs, consequences and net cost-effectiveness. Social Science and Medicine, forthcoming 1997.

ARHIN DC. *Willingness to pay for rural health insurance: Evidence from three African countries*. PhD thesis submitted to the University of London. 1996.

ARHIN DC The health card insurance scheme in Burundi: a social asset or a non-viable venture? *Social Science and Medicine*, 39(6), 861-870, 1994.

ARHIN DC Health insurance in rural Africa. *The Lancet*, January 7, 345, 1995.

ARHIN DC. *Rural Health Insurance: A Viable Alternative to User Fees?* PHP Departmental Publication No 19. London School of Hygiene and Tropical Medicine. 1995.

BENNETT S, Dakpallah G, Garner P, GILSON L, Nitayarumphong S and ZWI A. Carrot and stick: state mechanisms to influence private provider behaviour. *Health Policy*

*and Planning* 9(1): 1-13, 1994.

ARHIN DC, Ross DA, Kufuor F. Costs of vitamin A supplementation: the opportunity for integration with immunization in Ghana. *Health Policy and Planning*, 8 (4) 339-348, 1993.

ARHIN DC. *Vitamin A supplementation in Bolgatanga-Frafra district of Ghana: costs and the window of opportunity for integration with the immunization programme*. Report to the Ministry of Health, Ghana. 1992.

GILSON L, Travis P. *Health system decentralisation in Africa: An overview of experiences in eight countries*. Paper prepared for WHO regional seminar on decentralisation, Bamako, January 1997.

Binka F, Mensah O, MILLS A. The cost-effectiveness of permethrin-impregnated bednets in preventing child mortality in Kassena-Nankana district of Northern Ghana. *Health Policy*, forthcoming 1997.

GILSON L, Adusei J, ARHIN D, Hongoro C, Mujinja P, Sagoe K. Should African governments contract out clinical health services to church providers? in BENNETT S, McPAKE B AND MILLS A (eds). *Private health providers in developing countries: serving the public interest?* Zed Press, London, UK. 1997.

Smithson P, Asamoa-Baah A, Mills A. *The role of government in adjusting economies: The case of the health sector in Ghana*. Working Paper Series on the Role of Government, Development Administration Group, University of Birmingham. Forthcoming 1997.

5.2 *By country staff trained by HEFP or involved in HEFP activities*

Adusei J and Dakpallah G. *The public/private mix for health care in Ghana*. Paper presented at the workshop The Public/Private Mix for health care in developing countries, 11-15 January 1993, London. Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine, 1993.

Aikins M. Cost-effectiveness analysis of insecticide-impregnated mosquito nets: a study from the Gambia. PhD thesis submitted to the University of London. 1995.

*6. Collaborators*

Ms F Kufour
Dr A Asamoa-Baah, Director
Mr J Adusei
Mr G Dakpallah

| | |
|---|---|
| Mr K Sagoe | PPME<br>Ministry of Health<br>P O Box M-44, Accra<br>Tel: 233 21 665421<br>Fax: 233 21 665133 |
| Dr M E K Adibo | |
| Dr Irene Agyepong, | Health Research Unit<br>Ministry of Health<br>P O Box M-44, Accra |
| Dr Fred Binka | Navrongo Health Research Centre<br>PO Box 114<br>Navrongo<br>Upper East Region<br>Tel: 233-72-3425<br>Fax: 233-21-401550<br>Email: fbinka@gha2.healthnet.org |
| Paul Smithson | formerly Financial Advisor, MoH Ghana |

*THAILAND*

*1. Research*

1.1 *Public/private mix country paper*
Principal HEFP investigators: Anne Mills, Sara Bennett
Collaborating institutions: Dr Sanguan Nitayarumphong and Dr Viroj Tangcharoensathien, Ministry of Public Health, Thailand
Duration: 1992-3

As part of the collaborative research network on the public/private mix, a paper was prepared presenting the mix in Thailand and identifying key issues. The paper was presented at a workshop organised by HEFP in 1993 and published in *Health Policy and Planning* in 1994.

1.2 *Investigation of Records held by Insurance Schemes in Thailand*
Principal HEFP investigators: Sara Bennett, Anne Mills
Collaborating institutions: Viroj Tangcharoensathien, Health Policy and Planning Division, MOPH; and Dr Sothitorn Mallikamas, Centre for Health Economics, Chulalongkorn University.

Funded by WHO, SEARO and HEFP.
Duration: 1992-4

Collecting data on private provider behaviour is notoriously difficult. Initiated in 1990 this study used records held by the Social Security Scheme (SSS), the Civil Servant's Medical Benefit Scheme (CSMBS), the Workmen's Compensation Fund (WCF) and the Insurance Division, Department of Commerce to provide insights into the nature of care provided by the private health care sector in Bangkok. In addition the study examined the different incentives offered by the various health insurance schemes operating in Thailand and offered policy recommendations about how to improve the functioning of such schemes.

Through a random sampling process records held by the relevant government departments were selected and retrieved. Approximately 7,400 inpatient records from the CSMBS, 12,000 from the WCF, 1,000 emergency cases from the SSS and 3,000 maternity cases from the SSS were retrieved and analysed. Records contained data on personal characteristics of claimant and of patient, place where care was provided, diagnosis, length of stay, price paid for care, and amount reimbursed. The funds under SSS also contained more specialised data.

The study provided the first reliable data on differing patterns of care between public and private sectors in Thailand. For example under the CSMBS average length of stay in the private sector was 4.4 days compared to 13.1 days in the public sector. Mean charge per day in the public sector was Baht 866 compared to Baht 3194 in the private sector. The study of the CSMBS also highlighted significant differences between public and private sectors in patterns of utilisation. The private sector appeared to have a much lighter case load, made up predominantly of infectious and parasitic diseases along with diseases of the respiratory system. The public sector had a high workload coming from neoplasms, pregnancy and diseases of the nervous system.

At the time of the study the Social Security Scheme was relatively recently established and the study provided some of the first direct feedback as to how well two specific funds under the Scheme were operating. For example, it was found that the emergency fund was offering a very low rate of coverage, particularly for patients requiring surgery. After reimbursement from the SSO 50% of surgical patients still paid out-of-pocket more than their monthly income. As a result of this finding reimbursement levels for emergency patients covered by the fund were increased. Papers have been published.

1.3 *Hospital competition in developing countries: a Bangkok case study*
Principal HEFP investigator: Sara Bennett
Collaborating institution: Dr Viroj Tangcharoensathien, MOPH, Thailand
Duration: 1992-5

In industrialised countries there has been a long debate about the extent of market failure in health care. Recently similar questions have arisen in developing countries as international organisations have advocated a greater role for the private sector. In many developing countries the private health care sector is already substantial, yet limited information is available about the behaviour of private providers. Empirical evidence is essential both to the formulation of policies about, and regulation of, the private sector. This study explores the nature of hospital competition in Bangkok and in particular the impact which consumer information and behaviour have upon hospital competition.

The nature of hospital competition is analysed using:-

i. assessment of the impact of market concentration upon prices, profitability, intensity and quality of care provided. This is done through the formation and analysis of a hospital database covering approximately forty hospitals in the greater Bangkok area.

ii. assessment of the underlying market conditions leading to different forms of competition, based primarily on a survey of consumer knowledge and behaviour in the health care market in Bangkok, supported by interviews and document review.

A substantial degree of product differentiation is observed amongst hospitals in Bangkok. Consumers appear to be relatively well-informed about these differences, willing to seek further information and are quite sophisticated in their choice of hospital, however only limited price sensitivity is apparent. Non-price competition is dominant; hospitals facing higher competition have both higher prices and higher levels of profitability. It is difficult to conclude exactly what form this non-price competition takes; evidence of both quality competition and supplier induced demand is found.

The study supports existing concerns in Thailand about cost inflation and problems associated with a poorly regulated health care market. Current forms of hospital competition do not promote efficiency; government intervention to strengthen complaint mechanisms, educate consumers about appropriate health care and to structure provider incentives is required. Publications are being prepared and a chapter has been published in a book. A PhD has been submitted on the research (SB) and papers published.

1.4 *Assessing the Low Income Card scheme of Thailand*
Principal HEFP investigators: Steven Russell and Lucy Gilson
Collaborating institutions: Dr Somsak Chunharas, Health Systems Research Institute (HSRI), Bangkok, Thailand; Dr Oratai, Department of Social Sciences, Mahidol University, Thailand.
Duration: 1994-7

In the face of economic recession, population growth and declining health care budgets, user fees have become an accepted health care financing policy around the world. Fees are also seen as a means to better incentives and improvements in the quality, efficiency and equity of public health services, but the equity argument in favour of fees depends critically on targeting free care to those who cannot afford to pay. Despite the rapid implementation of fee systems since the 1980s, few countries have developed clear targeting policies and there is little information about the effectiveness of targeting or the factors that influence effectiveness.

Thailand is one of the few countries with experience in implementing a nationwide and formal health sector exemption mechanism. The Low Income Card (LIC) scheme, first introduced in the 1970s, has undergone considerable changes over time, and so represents a valuable experience from which other countries may learn. It is currently subject to considerable scrutiny within the country as policy-makers consider how to develop existing health care financing alternatives, including the LIC scheme, to expand population coverage. There is also concern about the effectiveness of the card in terms of protecting those on low incomes from paying for health care, and the efficiency and equity of resource allocations under the free health care card budget. Although previous evaluations have assessed the coverage of the card, none exist which have examined in detail implementation processes and outputs.

Evaluation of the existing card will, therefore, inform both Thai health sector policy development and international health policy debates. Research has been conducted at the community level (rural and urban), focusing on card allocation structures and processes, and user/non-user perceptions of the card and the factors influencing their use of cards in obtaining health care. Research methods are predominantly qualitative. The report is being finalised.

1.5 *Payment mechanisms, efficiency and quality of care in public and private hospitals in Thailand*
Principal HEFP investigators: Sara Bennett, Anne Mills
Collaborating institutions: Dr Sanguan Nitayarumphong, Dr Viroj Tangcharoensathien, Mr Anuwat Supachutikul, Ministry of Public Health; Dr Godfrey Walker, WHO country office; Dr Ullrich Prokosch, Dr Christophe, University of Munster, Germany (formerly University of Giessen).
Duration: 1994-7

The purpose of the research is to assess the impact of alternative payment mechanisms for care on hospital behaviour in terms of efficiency, quality of medical care, and provision of equal treatment for equal health status, and identify how hospital ownership affects this relationship. Nine hospitals are being studied: 3 government, 3 not-for profit,

and 3 for-profit. Payment status includes social security patients paid on a capitation basis, civil servants whose care is (partially) reimbursed, indigent patients who get free care, and those who pay out-of-pocket. Phase I of data collection has been completed, including detailed sub-studies on the cost, activity and outputs of the nine hospitals. Data collection instruments included a bed census survey and survey of patient satisfaction. A study of hospital characteristics included: use of staff and their training; methods of paying doctors; productivity of resource use; workload; use of capital, such as operating theatres; bed occupancy rates; levels of unit cost; drug mark up rates; lengths of patient stay; management systems; specialisation of treatment; technical quality; patient perceived quality.

In terms of hospital clientele, the private sector tended to serve more educated and higher income clients than the public sector; civil servants were a major user of public hospitals, while very few patients classified as indigent used any of the hospitals. Information was collected on the influence of payment systems and it seems that patients paying fees out of pocket impose some measure of cost control on hospitals. Many hospitals are deciding to focus on particular segments of the market. Ownership seems to have less strong influences on hospital behaviour and while payment practices are influencing hospital management, insurers do not appear to be important actors as yet.

Some tentative policy issues arising from Phase I include:

1. The danger of increasing inflationary pressures with the rising share of the elderly in the population, expansion of health insurance, and fee-per-service payment of doctors.
2. A strong client preference for the private sector which will increasingly affect the use of public hospitals unless public hospitals can be made more attractive.
3. The vital importance of payment mechanisms in ensuring cost containment.

Phase II is exploring in greater depth the influence of payment mechanisms on patient treatment patterns.

1.6 *Evaluation of contracting of clinical and non-clinical services*
Principal HEFP investigators: Anne Mills, Sara Bennett, Lucy Gilson
Collaborating institutions: Dr Viroj Tangcharoensathien, MOPH, Thailand;
Duration: 1994-5

The case study fits within a comparative study whose main aim was to compare the performance of public provision with provision by a private contractor. The prime concern was efficiency, but other aspects were studied such as preferences of employees and patients. In three of the countries the focus of the research was the contract (explicit

or implicit) between government and mission health care providers: publicly provided district hospitals were compared with mission district designated hospitals. In other countries a variety of contracts have been studied: for laundry, catering, diagnostic services etc. Papers have been published in a book.

The Thai case study looked at contracts for private sector provision of high cost medical equipment in public hospitals, and contracts for cleaning services in hospitals. On the whole the private sector appeared able to provide good quality service at a cost at least comparable to the public sector, though the design and implementation of contracts was often not optimal.

A comparison of the studies suggests that a number of conditions need to be met for contracting with for-profit firms to be likely to produce efficiency gains. These conditions include private sector firms interested in and able to take on government contracts, sufficient public funds to finance a contract of acceptable quality, difficulties in improving public sector provision and use of labour, and government capacity to design, negotiate and monitor contracts.

*2. Technical assistance (paid for as consultancy)*

None in the period 1990-5; in 1996 involvement in EU DGI funded project on health care reform (AM, SB) which came out of earlier work with MOPH.

*3. Teaching*

3.1 *MSc students:*
Dr Parkpien, MSc Health Planning and Financing, 1992-3
Mr Anuwat Supachutikul, MSc Health Planning and Financing, 1991-2

3.2 *Short course students*.
Restructuring the health sector in developing countries: Economic perspectives
(organiser BM)
2-20 September 1991
Komol Chochuenchom (WHO-funded)

Restructuring the health sector: Economic perspectives in developing countries
(organiser BM)
24 August - 11 September 1992
Chaweewan Pakdethanakul (British Council-funded)
Rujira Suriyavanagul (British Council-funded)
Songvuth Tuongratanaphan (WHO-funded)

Restructuring the health sector: Economic perspectives in developing countries (organiser JFR)
23 August - 10 September 1993
Nara Nakawattananukool (British Council-funded)

3.3 *PhD students:*
Viroj Tangcharoensathien, MOPH (completed 1990)
Supasit Pannarunothai, MOPH (completed 1995)
Porntep Siriwanarangusan, MOPH (completed 1996)
Manisri Puntalarp, Faculty of Economics, Chulalongkorn University (yet to complete)

3.4 *Other*
SB - Guest lecturer, Health Care Financing, International MSc in Health Economics, Chulalongkorn University, Bangkok, Thailand (August 1993)
AM - Guest lecturer, Health Care Financing, International MSc in Health Economics, Chulalongkorn University, Bangkok, Thailand (various occasions)

*4. Meetings*

International conference on research and health care reform, 1996. (AM on scientific committee and presented paper)
Biennial meeting of Health Systems Research Institute, 1996: AM presented paper.
Presentation of findings from SEARO funded study at meeting of Rose Garden group in 1992 (SB)
Various presentations on Thai work.
First meeting of the public/private mix collaborative research network in London (Tangcharoensathien and Nitayarumphong)
Second meeting of the public/private mix collaborative research network in Worthing (Tangcharoensathien).

*5. Publications:*

5.1 By HEFP staff

BENNETT S, and Tangcharoensathien V. A shrinking state? Politics, economics and private health care in Thailand. *Public Administration and Development*, 14, 1-17, 1994.

BENNETT S, and Tangcharoensathien V. Health insurance and private providers: A study of the civil servants' medical benefit scheme in Bangkok. *International Journal of Health Planning and Management*, 8(2): 137-152, 1994.

MILLS A Exempting the poor: the experience of Thailand. *Social Science and Medicine*, 33(11), 1241-52, 1991.

Nitayarumphong S, Tangcharoensathien V and BENNETT S. *Payment of inpatient services under the civil servant's medical benefit scheme*. Health insurance monograph series number 5, Ministry of Public Health, Bangkok. (In Thai).

Nitayarumphong S, Tangcharoensathien V and BENNETT S. *Payment of outpatient services under the civil servants' medical benefit scheme*. Health insurance monograph series number 4, Ministry of Public Health, Bangkok. (In Thai).

Nitayarumphong S, Tangcharoensathien V, Supachutikul A and BENNETT S. *The public private mix in the health system: a policy analysis*. Health insurance monograph series number 6, Ministry of Public Health, Bangkok. (In Thai).

Supachutikul A, Tangcharoensathien V, BENNETT S. *Emergency claims under the social security act*. Health insurance monograph series number 3, Ministry of Public Health, Bangkok. (In Thai).

Tangcharoensathien V, Nitayarumphong S, BENNETT S. *Maternity benefits under the social security act*. Health insurance monograph series number 2, Ministry of Public Health, Bangkok. (In Thai).

BENNETT S. (1995) *Hospital competition in developing countries: a Bangkok case study*. Paper presented at the Second Meeting of the Collaborative Research Network on the Public Private Mix, 4-8 September 1995, Worthing. Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine.

BENNETT S. *Imperfect information and hospital competition in developing countries:* A Bangkok case study. PhD thesis submitted to the University of London. 1996.

BENNETT S. The nature of competition among private hospitals in Bangkok, in BENNETT S, McPAKE B AND MILLS A (eds). *Private health providers in developing countries: serving the public interest?* Zed Press, London, UK. 1997.

Pannarunothai S, MILLS A. The poor pay more: health related inequity in Thailand. *Social Science and Medicine*, 44(12), 1781-1790, 1997.

Pannarunothai S and MILLS A. Characteristics of public and private health care providers in a Thai urban setting, in BENNETT S, McPAKE B AND MILLS A (eds). *Private health providers in developing countries: serving the public interest?* Zed Press, London, UK. 1997.

Pannarunothai S and MILLS A. Researching the public-private mix in health care in a Thai urban area: methodological issues. Submitted to *Health Policy and Planning*.

5.2 *By country staff trained by HEFP or involved in HEFP activities*

Nitayarumphong S (ed) *Health Care Reform: At the frontier of research and policy decisions*. Thailand: Office of Health Care Reform, Ministry of Public Health 1997.

Nitayarumphong S and Tangcharoensathien V. *Thailand: Private health care out of control*. Paper presented at the workshop The Public/Private Mix for health care in developing countries, 11-15 January 1993. Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine, 1993.

Nitayarumphong S and Tangcharoensathien V. Thailand: Private health care out of control. *Health Policy and Planning*, 9(1), 31-40, 1994.

Pannarunothai S. *Equity in health: the need for and the use of public and private health services in an urban area in Thailand*. PhD thesis submitted to the University of London. 1995.

Siriwanarangsun P. *The response of the private sector to competitive contracting: a case study of a private health provider network in Thailand*. PhD thesis submitted to the University of London. 1996.

*6. Collaborators*

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|---|---|
| Dr Godfrey Walker | Formerly at WHO country office, Thailand. Now UNSPA, Nepal. Email: walkerg@walkerg.wlink.com.np |

DFID/LIVERPOOL SCHOOL OF TROPICAL MEDICINE JOINT WORK PROGRAMMES ANNEX G

*Policies and Practices of Primary Health Care*

Staff Contributions to the Work Programme

| | |
|---|---|
| Ms JM Aitken • | Lecturer in Health Services Management |
| Dr H Annett | Senior Lecturer in International Health |
| Dr E Barnett | Lecturer in Human Resource Development |
| Ms A Brown • | Lecturer in Health Information Systems |
| Dr A Cassels • | Senior Lecturer in Health Services Management |
| Dr R Cibulskis • | Lecturer in Health Systems Development |
| Mr R Cole • | Information Officer, Education Resource Group |
| Ms S Dawson • | Research Fellow, Health Systems Development |
| Ms V Doyle • | Research Fellow, Health Systems Development |
| Ms C Ellis • | Secretary, Health Systems Development |
| Ms H Goodman | Lecturer in Health Economics |
| Dr D Haran | Senior Lecturer in Health Services Development |
| Ms K de Koning | Lecturer in Health Promotion |
| Mr T Martineau | Lecturer in Human Resource Development |
| Dr J Martinez • | Lecturer in Health Management |
| Prof K Newell | Middlemass Hunt Professor of International Health |
| Dr D Prozesky • | Research Fellow, Education Resource Group, Joint Programme Manager |
| Mr T Qassim | Temporary Consultant in Health Promotion |
| Mr Z Rojas • | Research Fellow, Health Systems Development |
| Dr P Sandiford • | Senior Lecturer in Epidemiology and Health Systems Development, Joint Programme Manager |
| Dr R Shoo • | Lecturer in Health Management |
| Ms P Waugh • | Secretary, Education Resource Group |
| Dr D Weakliam | Research Fellow in Quality Assurance |
| Mr D Wells • | Informatics Development Coordinator |

• Staff fully or partially funded by the Programme

Collaborating Institutions and Individuals

*Institutions*

Institute National de Ia Santé et de Ia Recherche
Médicale, Paris, France
Italian Cooperation, Italy
International Health Exchange, UK
Kenyam Medical Research Institute, Kisumu, Kenya
Makerere School of Puhuc health, Makerere
University, Uganda
Ministry of Health, Afghanistan
Ministry of Health, Cambodia
Ministry of Health, Cuba
Ministry of Health, Ghana
Ministry of Health, Mozamhique
Ministry of Health, Peru
Ministry of Health, Sudan
Ministry of Health, Yemen
Ministry of Health, Zimbabwe
National Institute of Epidemiology, Peru
National Institute for Health and Family Welfare, Delhi, India
National TB Control Programme, Addis Ababa, Ethiopia
Office de Ia Recherche Scientifique et Technique d'Outre-Mer, France
Ogun State University Teaching Hospital, Nigeria
Pan American Health Organization
Save the Children, Hong Kong
Sarvodaya Shramadana Movement, Sri Lanka
School of Health Sciences, Eritrea
United Nations Children's Fund
United Nations High Commission for Refugees
United Nations Population Fund
United Nations Relief and Works Agency
University of Health Sciences, Andhra Pradesh, India

*Institutions*

African Medical and Research Foundation, Kenya
Amatikulu Primary Health Care Centre, KwaZulu-University of Khartoum, Sudan
University of Sana'a, Yemen
University of San Carlos, Guatemala
University of the Western Cape, South Africa
World Bank
World Health Organization Afghanistan
World Health Organization

Division of Epidemiological Surveillance and Health Situation and Trend Assessment
Emergency Relief Organization
Onchocerciasis Control Programme

*Individuals*
Ms R Bhjaria, United Nations High Commission for Refugees
Prof A De Muynck, Tropical Institute, Antwerp
Ms D HoweII, University of Newcastle
Prof D Jones, Department of Community Health, University of Leicester
Dr Adrian Longstaffe, Wellcome Videodisc Project
Dr Jan Marshall, Wellcome Videodisc Project
Prof I Murali, National Institute of Health and Family Welfare
Prof LM Nath, All lndia Institute of Medical Sciences, New Delhi
Dr R Peeters, Tropical Medicine, University of Antwerp
Dr NA Quimper, Institute of Tropical Medicine, University of Cayetano Heredia
Prof R Rada, Department of Computer Sciences, University of Liverpool
Dr R Waldman, Strengthening of Epidemiological and Statistical Services, World Health Organization, Geneva

*Institutions*
Institute for Management in Government, India
Institute of Ophthalmology, UK
lstituto Centroamericano de Ia Salud
Natal, South Africa
Centre for Educational Development in Health, Arusha (CEDHA), Tanzania
Chaiama CoIIege of Health Sciences, Zambia
DANIDA, Denmark
Department of Health, KwaZulu-Natal Region, South Africa
Department of Health, Northern Transvaal Region, South Africa
Health Manpower Systems, UK
Institute Pan Africain de Santé Communautaire
(lPASC), Zaire
Ministry of Health, Kenya
Ministry of Health, Malawi
Ministry of Health, Nepal
Ministry of Health, Nicaragua
Ministry of Health, Panama
Ministry of Health, Papua New Guinea
Ministry of Health, Peru
Ministry of Health, Sierra Leone
Ministry of Health, South Africa
Ministry of Health, Tanzania

Ministry of Health, Uganda
Ministry of Health, Zambia
Ministry of Population Welfare (Directorate of Clinical Training, Pakistan
Overseas Development Administration (Education Lusaka Division), UK
Pan American Health Organization
Radda Barnen, Yemen
Regional Health Team, Kilimanjaro District, Tanzania
UNICEF, Yemen
Instituto Costarricense de Investigacion y Ensenanza
en Nutricion y Salud, Costa Rica
Insstituto Superiore de Sanita, Italy
Ministry of Health, Bolivia
Ministry of Health, Costa Rica
Ministry of Health, Dominican Republic
Ministry of Health, El Salvador
Ministry of Health, Ghana
Ministry of Health, Guatemala
Ministry of Health, Honduras
Ministry of Health, India
University of Cape Town, South Africa
University of Papua New Guinea (Department of Community Medicine), Papua New Guinea
University of the North (Department of Health Sciences), South Africa
World Health Organization
Division for Strengthening Health Services

*Individuals*
Ms Grindi Dockery, Liverpool
Ms Victoria Francis, London
Ms Jane Purse, Eastern Transvaal, South Africa
Dr PM Haynes, Howick, KwaZulu-Natal, South Afrtca
Mrs BM Karukula, EPI Section, Ministry of Health,
Mrs Roselyn Mazibuko, Hlatloianang Centre, South Afrtca
Dr K Mensah, Akwatia, Eastern Region, Ghana
Dr Ndeki, CFDHA, Arusha
Prof PM Nickson, IPASC, Nyankunde

*Co-funding agencies*
Asian Development Bank
Pan American Health Organization
British Council
SCF (UK)
Childwick Trust

Sandoz Drug Company
Commission of the European Communities, and
Shell Petroleum Development Company
Directorate General XII, Science for Technology, USA
UNICEF, Yemen
Development Programme Danish Bilharziasis Laboratory
UNRWA, Jordan
Deutche Gesellschaft für Technische Zusammenarbeit (GTZ)
United Nations High Commission for Refugees
United Nations Population Fund
Food and Agriculture Organization
Gunther Foundation
Wellcome Trust
Gatsby Foundation
World Health Organization
- African Regional Office
- Eastern Mediterranean Regional Office
- Global Programme on AIDS
- Headquarters, Zaire
- Headquarters, Geneva
- PEEM (panel of Experts in Environmental Management)
- TropicaI Diseases Research
- Western Pacific Regional Office

Harvard Business School
ICCO, Netherlands
Institut Pan Africain de Sant (Communautaire, Zaire)
International Development Research Centre
Italian Cooperation
Joseph Captain Fund
WK Kellogg Foundation
LiverpooI Health Authority
Office de Ia Recherche Scientifique et Technique d'Outre Mer
Overseas Development Administration
- Central American Desk
- Education Division
- Evaluation Department
- HP ACORD
- Seedcom

Overseas individuals and institutions impacted
*Significant*
Ministry of Health, Ghana

Dr Asamoah Baah, Ghana
Dr Ken Sagoe, Ghana
Dr Dela Dovlo, Ghana
Dr Aaron Offei, Ghana
ICAS (instituto Cenbtroamericano de Ia Salud), Costa Rica
Dr Zillyham Rojas, ICAS
IPASC (Institut Pan Africain de Sant
(Communautaire), Zaire
Government of Orissa
Eastern Region Primary Health Care project, Nepal
Tony Bondurant, ERPHC, Nepal
CEDHA, Arusha, Tanzania
Dr S Ndeki, CEDHA
Dr Kwadwo Mensah, Ghana
Ministry of Health, Zambia
Mintstry of Health, Nepal
University of the North, South Africa
Taher Ali Qassim, Yemen

*Others*
Regina Gorgen, Institut for Tropenhygiene, Germany
ALERT, Germany
Dr Guido Groenen, Director, ALERT
Dr Ghazi al Qatari, Saudi Arabia, PhD student
British Council, India
Ministry of Health, Bolivia
Ministry of Health, Peru
Mrs BNA Katukula, Zambta
Institute of Tropical Medicine, Antwerp
Students attending courses:
- Masters in Community Health
- Teaching Primary Health Care
- Management for Primary Health Care
- Health Education/Promotion for Primary Health Care
- Information Systems for Primary Health Care
- Certificate in Tropical Community Medicine and Health
- Diploma in Tropical Medicine and Health

Some 2500 recipients of *Learning for Health*, the programme's magazine on health promotion and training

ODA/THE LONDON SCHOOL OF HYGIENE AND TROPICAL MEDICINE
JOINT WORK PROGRAMMES ANNEX H

*Health Economics & Financing Programme*

Staff

| | | |
|---|---|---|
| Anne Mills • | Reader & Head of Programme | Health Economics |
| Anthony Zwi • | Senior Lecturer | Epidemiologist |
| Dyna Archin • | Lecturer | Health Economics |
| Sara Bennett • | Lecturer | Health Economics |
| Julia Fox-Rushby • | Lecturer | Health Economics |
| Lucy Gilson • | Lecturer | Health Economics |
| Barbara McPake • | Lecturer | Health Economics |
| Steven Russell • | Research Fellow | Social Sciences |
| Stella Fletcher • | Secretary | |
| Jane Pickup • | Secretary | |
| Jeannine Fraser • | Computing Adviser | |
| Tina Parfitt • | Computing Officer | |
| Jane Peterkin • | Clerical Assistant | |

Staff employed for short periods on specific projects

| | | |
|---|---|---|
| Jonathan Broomberg | Research Fellow | Health Economist |
| Kent Buse | Research Fellow | Health Economist |
| Priti Dave-Sen • | Research Fellow | Health Economist |
| Leo Deville • | Research Fellow | Epidemiologist |
| Hilary Goodman | Research Fellow | Health Economist |
| Kara Hanson • | Research Fellow | Health Economist |
| Shabbar Jaffar • | Research Fellow | Statistician |
| Anthony Kinghorn • | Research Fellow | Political Economist |
| John Lavis | Research Fellow | Epidemiologist |
| Joanna Macrae • | Research Fellow | Social Scientist |
| Tom Marshall | Research Fellow | Health Economist |
| Melissa Parker | Research Fellow | Anthropologist |
| Jane Pepperall | Research Fellow | Health Planner |
| Margaret Phillips • | Research Fellow | Health Economist |
| John Picard • | Research Fellow | Health Economist |
| Neil Soderlund | Research Fellow | Epidemiologist |
| Gill Walt • | Research Fellow | Health Economist |
| Charlotte Watts • | Research Fellow | Epidemiologist |

• Staff fully or partially funded by the Programme

Visiting/Honorary Fellows

| | |
|---|---|
| John Chalker | Save the Children Fund, Hanoi, Vietnam |
| Halima Mwensi | Kenya Medical Research Institute, Nairobi, Kenya |
| Peter Thompson | Save the Children Fund, Hanoi, Vietnam |

Research Degree Students

| | |
|---|---|
| Moses Aikins | (The Gambia). Cost-effectiveness of the Gambian national bednets programme |
| Syed Alijunid | (Malaysia). Use of private practitioners in a health district. |
| Nimal Attanayake | (Sri Lanka). Cost-effectiveness of anti-malaria activities in Sri Lanka. |
| Gebre Ab Barnabas | (Ethiopia). Health policy issues in post-revolutionary Ethiopia. |
| Jonathan Broomberg | (South Africa). Contracting and competition for health care in South Africa |
| Cheng Lan Su | (Taiwan). The effects of cost-sharing on outpatient utilization in Taiwan. |
| Joâo Costa | (Brazil). Evolution of the health sector in Salvador metropolitan region, Bahia State. |
| Steven Fabricant | (USA). Community financing in Sierra Leone: affordability and equity of primary health care costs. |
| Lucas Omondi | (Kenya) Utilization of antenatal services in Botswana. |
| Wilson Odero | (Kenya). Alcohol and road traffic injuries In Kenya. |
| Supasit Pannarunothai | (Thailand). Equity in health: the need for and use of public and private health services in an urban area in Thailand. |
| Manisri Puntularp | (Thailand). Economic evaluation of the village malaria volunteer programme. |
| Sandra Reyes-Frausto | (Mexico). Changes in health policy for elderly people at the Mexican Institute of Social Security. |
| Porntep Siriwanarangsun | (Thailand). Evaluation of a private provider network in Thailand. |
| Andy Tembon | (Cameroon). The demand for outpatient care in a health district in the North West province of Cameroon: an empirical investigation into the potential effects of introducing community financing in public health centres. |
| Inavat Thaver | (Pakistan). The role of private practitioners in urban primary health care. |
| Laksono Trisnantoro | (Indonesia). Policy analysis of the dengue haemorrhagic fever prevention programme in Indonesia, 1990-92. |
| Charlotte Watts | (UK). Evaluation of an HIV-prevention programme in Mutare, Zimbabwe. |

Collaborating Institutions

| | |
|---|---|
| Afghanistan | WHO Kabul |
| Argentina | Hospital Italiano, Buenos Aires |
| | Instituto Nacional de Investigación de la Infermedad de Chargas, Buenos Aires |
| Australia | University of Queensland Medical School, Tropical Health Programme |
| Austria | International Institute for Applied Systems Analysis (BASA) |
| Bangladesh | Action Aid, Bangladesh |
| | Associates for Community and Population Research, Dhaka |
| | Bangladesh Rural Advancement Committee Ford Foundation, Dhaka |
| | International Centre for Diarrhoeal Disease Programme |
| | Jahangirnagar University, Department of Statistics |
| | Mitra Associates, Dhaka |
| | National Institute for Population Research and Training |
| | University of Dhaka, Centre for Urban Studies |
| | University of Dhaka, Department of Economics |
| Belgium | Institute of Tropical Medicine, Antwerp |
| | International Union for Scientific Study of Population |
| | Université Catholique de Louvain, Institute de Démographie |
| Benin | Institute Régionale de l'Education de Santé Publique |
| | Ministére de l'Education, Centre Régionale pour le Développment et la Santé |
| | Ministére de la Santé |
| Botswana | Health Research Unit, Ministry of Health |
| | National Institute of Research |
| | University of Botswana, Nursing Education Section |
| Brazil | Centre for Studies of Contemporary Culture (CEDEC) |
| | Centro Aggeu Magaihaes, Recife |
| | City Hall of Porto Alegre |
| | Escola Paulista Medicina, San Paulo |
| | EMLURB (Urban Sanitation Agency, Recife) |
| | Fundaçao Sistema Estadual de Dados, Sâo Paulo |
| | Hospital Servidores, Sâo Paulo |
| | Institute of Social Medicine, State University of Rio de Janeiro |
| | Latin American Association of Gerontology, Belo Horizonte |
| | Malaria Programme, Rondonia State |
| | Ministry of Health, Sâo Paulo |
| | Municipal Secretariat for Health, Ceara |
| | National School of Public Health, Rio de Janeiro |
| | Open University of the Third Age, Rio De Janeiro |
| | Pontifica Universidade Católica de Sâo Paulo |

| | |
|---|---|
| Brazil | Public Health Department of Rio Grande do Sul State |
| | Secretariat of Health of the State of Sâo Paulo |
| | Statistical Office |
| | Urban Municipal Secretariats of Health, Ceara |
| | Universidade de Brasilia |
| | Universidade de Sâo Paulo |
| | Universidade Estadual de Campinas |
| | Universidade Federal da Bahia |
| | Universidade Federal do Ceara |
| | Universidade Federal de Minas Geruis, Belo Horizonte |
| | Universidade Federal de Pelotas |
| | Universidade Federal de Pernambuco |
| Bulgaria | Iskrez Hospital |
| Burkina Faso | Centre pour la Lutte contre le Paludisme |
| | Centre Muraz, Bobo-Dioulasso |
| | Ministére de la Santé et de l'Action Sociale, Bobo-Dioulasso |
| Burundi | Burumbura Hospital |
| | Ministry of Health |
| Chile | Institute of Urban Studies, Catholic University of Chile |
| | Latin American Demographic Centre (CELADE), Chile |
| China | Chengdu Family Planning Research Institute |
| | Institute of Parasitic Diseases, Hubei Academy of Medical Sciences, Wuhan |
| | Institute of Anti-Parasitic Diseases, Sichuan Academy of Medical Sciences, Chengdu, Sichuan |
| | Institute of Malaria Prevention and Treatment of Yunnan Province, Simao, Yunnan |
| | Ministry of Health |
| | Ministry of Public Health |
| | Shanghat Institute of Planned Parenthood Research |
| Côte d'Ivoire | West African Rice Development authority |
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| | Danish Bilharziasis Laboratory, Caopenhage |
| | Statenssuminstitut, Copenghagen |
| Equador | Hospital Vozandes, Quito |
| Egypt | University of Cairo Medical School |
| Ethiopia | Economic Commission for Africa |
| | Iimma Institute of Health Sciences |
| | Malaria Control Organization |
| | University of Addis Ababa, Institute of Development Research |
| Finland | University of Helsinki, Department of sociology |
| France | Comite Internationale pour la Coopération dans les Recherches |

| | |
|---|---|
| | Nationales en Démographie |
| | Independent Commission on Population and the Quality of Life |
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| | Epidemiology and Statistics Unit, Ministry of Health |
| | Medical and Health Department |
| | MRC Laboratories |
| Germany | Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) |
| Germany | Jusrus-I Jebig-Universitat Geissen |
| | Ruprecht-Karis-Universitat Heidelberg |
| Ghana | Accra Metropolitan Assembly |
| | Department of Births and Deaths |
| | Kinramma Health Research Centre |
| | Ministry of Environment, Department of Town and Country Planning |
| | Ministry of Health |
| | Ministry of Health Research Unit |
| | Ministry of Health, Policy and Planning Unit |
| | Navonga Health Research Centre |
| | University of Science & Technology, School of Medical Sciences, Kurnasi |
| Guatemala | University of San Carlos, Urban Health Project, Centre for Urban and Regional Studies |
| Guinea-Bissau | Ministry of Health |
| Guinea-Con | Ministry of Health |
| Hong Kong | Clinical Pathology Unit, Princess Margaret Hospital |
| India | All-India Institute of Medical Sciences |
| | Andhra Medical College, Vishkhapatnam |
| Korea | Korean Institute of Health and Social Affairs (KHASA) |
| Lesotho | City Council, Maseru |
| | Ministry of Health |
| | Queen Elizabeth II Hospital, Maseru |
| Malawi | Chancellor College |
| Mali | Institut National de Recherche en Santé Publique, Bamako |
| Malaysia | Institute for Medical Research, Kuala Lumpur |
| | Universiti Kebangsaan |
| | Universiti Malaya |
| | Universiti Sains Malaysia, Penang |
| Malta | University of Malta Medical School |
| Mauritius | Ministry of Economic Planning and Development |
| | Ministry of Health |
| Mexico | ABC Hospital, Mexico City |
| | Ministry of Health |

| | |
|---|---|
| | National Institute for Public Health |
| | Centro Interamericano de Estudios de Seguridad Social |
| | Centro Investigación de Enfermedades Tropicales, Acapulco |
| | Centro Investigación de Paludismo, Tapachula |
| | Instituto Mexicano del Seguro Social |
| | Mexican Institute of Water Technology, Cuernavaca |
| | National Institute of Nutrition, Mexico City |
| | National Institute of Public Health, Cuernavaca, Centre for Public Health Research |
| | National Water Commission |
| Mozambique | Department of Care of the Elderly & Disabled, State Secretariat for Social Welfare |
| | Help the Aged, Mozambique |
| | National Institute for Social Security, Ministry of Labour |
| | Universidade Eduardo Mondlane, Maputo |
| Nepal | Ministry of Health, Malaria Control Department |
| | Tribhuvan University, Central Department of Population Studies |
| Netherlands | European Value Systems Study Group |
| | Health Net |
| | Institute of Social Studies, The Hague |
| | International Water and Sanitation Centre, (IRC), The Hague |
| | Médecins sans Frontiéres |
| | Nederlands Interdisciplinair Demografisch Institut (NIDI) |
| | Noordhoek Public Health Laboratories |
| | Royal Tropical Institute |
| | University of Nijmegen |
| | University of Wageningen |
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| | University of Auckland, Department of Geriatric Medicine |
| Nicaragua | Department of Parasitologyu, CNDR-MINSA, Managua |
| Nigeria | Ahmadu Bello University |
| | Enugu State University of Science Technology |
| | Ministry of Health |
| | Obvafermi Awolowo University |
| | Rivers State University of Science and Technology, Port Harcourt |
| | University of Calabar |
| | University of Ibadan |
| Pakistan | Aga Khan University |
| | Federal Burear of Statistics |
| | Municipal Council, Lahore |

The Department for International Development (DFID) is the British government department responsible for promoting development and the reduction of poverty. The government elected in May 1997 increased its commitment to development by strengthening the department and increasing its budget.

The policy of the government was set out in the White Paper on International Development, published in November 1997. The central focus of the policy is a commitment to the internationally agreed target to halve the proportion of people living in extreme poverty by 2015, together with the associated targets including basic health care provision and universal access to primary education by the same date.

DFID seeks to work in partnership with governments which are committed to the international targets, and seeks to work with business, civil society and the research community to encourage progress which will help reduce poverty. We also work with multilateral institutions including the World Bank, United Nations agencies and the European Commission. The bulk of our assistance is concentrated on the poorest countries in Asia and sub-Saharan Africa.

We are also contributing to poverty elimination and sustainable development in middle income countries, and helping the transition countries in Central and Eastern Europe to try to ensure that the widest number of people benefit from the process of change.

As well as its headquarters in London and East Kilbride, DFID has offices in New Delhi, Bangkok, Nairobi, Harare, Pretoria, Dhaka, Kathmandu, Suva and Bridgetown. In other parts of the world, DFID works through staff based in British embassies and high commissions.

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