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Evaluation of Health Sector Adjustment Project (HSAP) British Caribbean Dependent Territories 1993-96

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DEPARTMENT FOR INTERNATIONAL DEVELOPMENT

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EVALUATION OF HEALTH SECTOR ADJUSTMENT PROJECT (HSAP) BRITISH CARIBBEAN DEPENDENT TERRITORIES 1993-96

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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.

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) commissions a number of ex post evaluation studies. The purpose of the DFID's evaluation programme is to examine rigorously the implementation and impact of selected past projects and to generate 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.

The DFID's Evaluation Department is independent of DFID's spending divisions and reports directly to the 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 a fresh perspective to the subject-matter.

For this evaluation the team consisted of Catherine Cameron, Management Consultant and Dr Jennifer Sancho, Health Sector Reform Specialist.

The evaluation involved the following stages:-

- initial desk study of all relevant papers;
- consultations with individuals and organisations concerned with the project, including a field mission 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 the DFID's Director General (Resources), to note the main conclusions and lessons to be learned from the study on the basis of the draft report.

This process is designed to ensure the production of a high quality report and Summary sheet (EVSUM) which draw out all the lessons.

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

ACKNOWLEDGMENTS

This study could not have proceeded without the assistance, co-operation and support generously given by so many people. We would like to record our gratitude to colleagues in BDDC, DTRS, Evaluation Department, and IHSD. We are indebted to all those in Anguilla, BVI, Montserrat and TCI who made the time to see us and share with us their insights. We would particularly like to thank Stanley Mussington and Sevenson Serjeant in Anguilla, Dr Irad Potter in BVI, Lt Horatio Tuitt in Montserrat, and Neville Adams in TCI.

ABBREVIATIONS & ACRONYMS

BDDC	British Development Division in the Caribbean
BDT	British Dependent Territory
BVI	British Virgin Islands
CDB	Caribbean Development Bank
CMO	Chief Medical Officer
CPP	Country Policy Plan
DHS	Director of Health Services
DT	Dependent Territory
DTRS	Dependent Territories Regional Secretariat
DPU	Development Planning Unit
ECCB	Eastern Caribbean Central Bank
ExCo	Executive Council
GDP	Gross Domestic Product
HMG	Her Majesty's Government
HPA	Health & Population Adviser
HPD	Health & Population Division
HSAP	Health Sector Adjustment Project
IHSD	Institute for Health Sector Development
ISA	Implementation Support Agency
LegCo	Legislative Council
MoH	Ministry of Health
MoF	Ministry of Finance
MTR	Mid-term review

NGO	Non-Government Organisation
NHS	National Health Service (UK)
OECS	Organisation of Eastern Caribbean States
PAHO	Pan-American Health Organisation
PHC	Primary Health Care
PM	Project Memorandum
PMAG	Project Monitoring & Advisory Group
PSC	Public Service Commission
PSD/PSR	Public Sector Development/Public Sector Reform
RAR	Resource Allocation Review
RHSA	Regional Health Sector Adviser
TCI	Turks and Caicos Islands
ToRs	Terms of Reference
UWI	University of the West Indies

EVALUATION SUMMARY

The Project

1 The Health Sector Adjustment Project (HSAP) covered the four aid-receiving Caribbean British Dependent Territories (BDTs), namely Anguilla, British Virgin Islands (BVI), Montserrat and Turks and Caicos Islands (TCI). Its goal was 'to optimise health outcomes arising from the improved organisation and financing of health services'[1]. The project's purpose was:

- to develop and implement improved management structures and policies
- to develop and implement improved planning approaches and systems
- to develop and implement improved health sector financing strategies
- to improve quality of care produced by the health sector.

2 The total cost of the project was £890,000. It ran from October 1993 to September 1996. An implementation support agency (ISA) was contracted to co-ordinate and manage the inputs into this project. The main project inputs involved the funding of two Regional Health Sector Development Advisers (RHSAs). One RHSA was based in and worked full time on TCI. The other was shared among the remaining three Territories, and was based initially in Montserrat, subsequently moving to BVI. Other, short term, inputs were brought in by the ISA as necessary.

3 The project was monitored by a broadly based Project Monitoring and Advisory Group (PMAG) which was scheduled to meet every six months. Following the mid-term review (MTR) the project's scope was reduced and the logical framework revised. The original and revised logical frameworks are at Annex G.

The Evaluation

4 The evaluation was undertaken between March and June 1997 by Catherine Cameron, Management Consultant and Dr Jennifer Sancho, Health Sector Reform specialist. An initial file review in Bridgetown and London was followed by interviews with stakeholders in London and Keele. A field visit to the Territories was then undertaken in order to conduct interviews and review project impact on the ground.

[1] From the original logframe dated December 1992

Overall success rating

5 The evaluators found that this ambitious and innovative project had an overall success rating of C - largely unsuccessful. The project's timeframe was unrealistically short, particularly given its broad scope and ambitious objectives (para. 2.4). The evaluators concluded that there had been only limited achievement of the project's stated objectives (paras 17-20 & 2.15).

6 More positively, there has been some shift in understanding and approach to health sector reform (HSR) and the evaluators judge that further work in this area could yield some benefits by building upon the original inputs (paras 4.3 & 7, 5.3).

Findings

7 To assist in focusing the evaluation, the team examined the project relevance, objectives, design, implementation, outputs, impact and sustainability, project management and cross-cutting issues, within the framework of a SWOT (strengths, weaknesses, opportunities, threats) analysis. Whilst this framework could not always be rigorously followed it has provided a useful methodology for analysis and for preparation of the report.

Project relevance

8 The project was judged by the evaluators to have been relevant to the needs of the countries. It presented an opportunity to improve the efficiency and effectiveness of health care delivery, at a time when several ODA-funded health infrastructure projects were planned or under way (paras. 1.5-8).

Project objectives

9 There was no history of involvement in health sector reform in any of the target countries, and the project was thus a challenging opportunity for all stakeholders. In practice, the project's objectives proved over-ambitious, due, in part, to the lack of agreed national-level policies in health in the target BDTs. There were therefore no strong levers or incentives for change and this was a significant weakness given the complex nature of the institutional reform being attempted (paras. 1.5 & 2.4).

Design

10 The project adopted a process approach so the conceptual design was not prescriptive. Implementation authority was contracted to the UK-based ISA which in turn left the day-to-day progress of the project to resident RHSAs (paras 2.1 & 2).

11 Two key underlying assumptions in the project design led to problems in implementation:

- the project was based on ODA analyses completed between 1989-1992, at which time the BDT governments had expressed agreement with the conclusions of this work, and, through the Cayman and Providenciales Declarations, supported the general principles of reform. It was assumed, therefore, that the BDTs were committed to and owned the project (para. 1.5).
- the ISA had conducted the initial analysis in 1989, had supported ODA in the development of the project memorandum, and had experience of the NHS reforms. It was assumed, therefore, that the ISA had the capacity to manage and implement the project (paras. 2.1 & 2).

12 In practice, the target countries were concerned at what they perceived as the adoption of an external model of reform, which they did not consider appropriate to the BDT context. The governments felt that the resulting project was inflexible in its design and approach (paras. 2.3-5).

13 Although the national level players - the MoH and the RHSAs - bore front line responsibility, they were not in fact the only decision-makers. There were too many players involved, and their respective roles and responsibilities remained somewhat unclear. Within HMG, ODA had limited experience of managing a third party contract of the kind used in the project (although this is now much more common). ODA's London and Bridgetown offices did not always agree on the way forward and, within the Bridgetown office, the Dependent Territories Regional Secretariat (DTRS) (which was established in 1993) and BDDC were still evolving a working relationship. Within the target BDTs, no policy context had been defined outside the MoH and, as a result, no counterbalance was provided against changes either in the political direction or in the MoH. Furthermore, appropriate linkages had not been made with Public Sector Reform (PSR) (paras. 2.7, 3.1, 3.27).

Implementation

14 The project was plagued by a series of natural disasters and with changes in personnel at all levels: Health and Population (HPA) advisers in London, political changes after elections, MoH staff at senior administrative levels, and in DTRS/BDDC in Bridgetown. Coupled with the weaknesses in the project design, these changes predictably led to

implementation problems (paras. 3.24 & 4.7),

15 Further, the inherent complexities of the BDTs made it very difficult for the RHSAs to function purely as managers of the project process and technical advisers. They were rapidly drawn into a range of unforeseen roles, including those of information disseminators and operational line managers. Unsurprisingly, the pressure to fulfil multiple roles led to conflict and to inevitable compromises (paras. 3.2 & 18).

16 The PMAG met about every six months. This large and disparate group did not really prove to be an effective mechanism for providing advice. Its emphasis was instead on reporting rather than on the provision of overall direction. For the project to be successful, there needed to be an iterative process of negotiation amongst stakeholders about priorities against available resources, culminating in the definition of a flexible programme of work, with external technical advice available as necessary. In practice, responsibility for this complex process was delegated to the ISA, with insufficiently defined parameters. (paras. 3.22-24)

Outputs against original logframe (paras. 4.3-6)

i) *Management structures*

17 The evaluation found that all of the target countries had some sort of revised senior management structure in place. However, there still appeared to be some resistance to these new structures, which had resulted in resignations and a persistence of unfilled vacancies. The structure at middle management level remained largely unchanged.

ii) *Planning approaches & systems*

18 Each country government reported a number of meetings, workshops and papers as evidence of attempts at building a process of consultation. There is no evidence that the process actually produced any discernible results against this objective. It is fair to conclude that a focus on the first objective of achieving structural change adversely affected progress in this area.

iii) *Financing strategies*

19 Some progress had been achieved under this objective, including a more informed assessment of health expenditure in relation to the overall budget, the revision of user fee schedules, and closer attention to allocation of resources.

iv) *Quality of care*

20 There had been very little progress under this objective (paras. 4.3-6).

Impact

21 Given the only limited achievement of any of the project objectives, it would appear that the impact of this project should be rated as minimal. However, the impact of institutional reform cannot always be predicted through application of simple linear cause and effect logic, or judged so soon after the project's end. Institutional and organisational reform is about breaking the reinforcing cycle of the existing paradigms - the effects of small changes can be exponential.

22 Some of these small changes include:

- a better understanding of the complexities of Health Sector Reform (HSR) by both the BDTs and HMG (territory specific context)
- expressed need for a communication programme, a more bottom-up approach, including the involvement of the public
- acknowledgement that better linkages with PSR are needed and that PSR has and will benefit from the project
- some improvements in the management capacity to lead HSR.

Thus although there has been only limited impact so far there are grounds for believing that these small changes may set in train greater long term benefit (paras. 5.26 & 27).

Sustainability

23 All those interviewed in-country expressed the view that the work done so far was just a *beginning*. Although actual outputs were still very limited when compared with the objectives, it was recognised that the work done was only the start of a complex HSR process. The changes achieved, however, we judged to be somewhat fragile, and it would be necessary to build on these limited achievements if any degree of sustainability is to result (paras. 4.3 & 5.2-4).

Project management

24 Management of project inputs was delegated to the ISA. The perceived benefit of this arrangement was its apparent simplicity and its cost-effectiveness. The drawback was that this vested a high degree of power and responsibility in one party. At the same time, the multiplicity of players involved in the project, with no clear delineation of roles and responsibilities, served to hinder proper monitoring of progress and tracking of expenditure. When problems did occur, it was difficult to get all players to agree to remedial action. With hindsight, it is not clear that

the ISA had the full range of necessary *process* skills to manage this complex project (paras 3.25-7).

Cross-cutting issues

25 Gender, poverty and environmental considerations were not an explicit part of identification, design or appraisal, although this is not untypical of projects of the time. It is not surprising therefore that it is difficult to identify whether the project had had an impact in any of these areas. It may be that there will be an impact in the longer term as a result of changes in the approach to HSR but it is too early to form a reasonable judgement on this (para. 5.24).

Lessons

26 The lessons derived from the experience of the project should be useful in informing:

- the design and management of HSR Programmes and initiatives globally
- the management of the relationship between donors and their partners, particularly when, in projects involving the BDTs, that relationship is inevitably complicated
- future work in the BDTs as they continue to take forward some of the institutional objectives of HSAP, and particularly in the context of future investment in hospital infrastructure by HMG and the BDT governments themselves.

i. All projects undertaken in the BDTs should explicitly recognise the unique relationship between HMG and the BDTs, in particular, that HMG is effectively the donor of first and last resort. Incentives for both donor and recipient are very different to those encountered in the mainstream bilateral programme. (Paras. 1.2 & 3, 5.1)

ii. All key stakeholders should be included at the design and appraisal stage to promote ownership. At the beginning of this project HMG and the BDT were entering new territory with the establishment of DTRS in Bridgetown, and, consequently, the latter was not involved in the critical design stages. (Paras. 1.3 & 6, 51 & 2)

iii. DFID's internal management issues need to be resolved at the outset, particularly where complex projects are to be implemented in as complicated a political context as that of the BDTs. Smooth implementation of the project was impeded by the multiplicity of actors with roles to play in its management and direction and the absence of a clear delineation of responsibility. (Paras. 3.5 & 6, 5.1 & 2)

iv. The willingness and capacity of country governments to take the lead on health sector

reform is a critical factor. The design of reform projects of this type needs to be informed by a more rigorous and realistic analysis of the political obstacles to change. That reform often requires governments to make unpopular decisions renders it difficult in any political context, but particularly so in small island states. (Paras. 1.5, 4.7, 5.5 & 6)

v. Other initiatives which might have positively influenced the pace of change were not as fully explored as they could have been. These include:

- linking HSR and PSD in terms of timing and resources
- linking HSR and the macro-economic policy framework (possibly through the Country Policy Plan)
- more regionally-focused activity, rather than pure BDT programmes, to ensure better complementarity with relevant Regional developments e.g. OECS Drug Procurement, PAHO Telemedicine Project
- exploring more regionally-based technical co-operation support e.g. PAHO, UWI (Paras. 5.15-20).

vi. HSR is not like traditional health service-strengthening projects in that it involves fundamental institutional change. While many of the players involved in HSR recognised that it was necessary, the possibility that change would adversely affect them directly may have reduced their support for it in practice. Some stakeholders, and particularly those in Ministries of Health, tend to see HSR as largely a technical issue, and therefore, mainly of interest to them. Experience of reform shows, however, that without consistent political support above and beyond the purely technical level - which includes HMG in this context - no real and lasting change is possible. (Paras. 5.15 & 16)

vii. The attempt to introduce, in any sector, strategic thinking, objective setting and prioritisation of resource use should be welcomed. The obstacles to achieving this should have been identified as far as possible and an assessment made in any SWOT analysis before embarking on any project which sought to amend the status quo. Without this, the necessary institutional change across adjustment projects can be overlooked. (Paras. 5.12 & 13, 5.16 & 17).

viii. More attention needs to be given to:

- clarification of the objectives of an HSR Programme or Project;
- agreeing a phased approach to HSR and the policy framework for implementation;
- identification of country-specific milestones or benchmarks for project progress and relating to policy framework;

- clarification of appropriate roles and functions of stakeholders in and out of the health sector;
- development of 'prospective' monitoring and review mechanisms;
- implementation of a communication strategy aimed at building political will and public involvement. (Paras. 5.5-14)

EVALUATION SUCCESS RATINGS

The Overall Success Rating for a project is allocated on a scale from A+ to D according to the following rating system:-

Highly Successful (A+): *objectives completely achieved or exceeded*, very significant overall benefits in relation to costs

Successful (A): *objectives largely achieved*, significant overall benefits in relation to costs

Partially Successful (B): *some objectives achieved*, some significant overall benefits in relation to costs

Largely Unsuccessful (C): *very limited achievement of objectives*, few significant benefits in relation to costs

Unsuccessful (D): *objectives unrealised*, no significant benefits in relation to costs, project abandoned

The judgement on the Overall Success Rating is informed by a tabulated series of judgements on individual aspects of performance, including the project's contribution to achievement of ODA's priority objectives (listed in the upper section of the table). First an assessment is made of the relative importance in the project of each criterion or objective, which may be Principal or Significant; or, if not applicable, it is marked " - " . Where no specific objective was established at appraisal, the importance assessment is given in brackets. Each performance criterion is then awarded a rating, based only on the underlined sections of the five-point scale above.

Project Performance Criteria	Relative importance	Success Rating
Economic Liberalisation	-	-
Enhancing Productive Capacity	-	-
Good Governance	(Significant)	C
Poverty Impact	-	-
Human Resources: Education	-	-
Human Resources: Health	Principal	C
Human Resources: Children by Choice	-	-
Environmental Impact	-	-
Impact upon Women	-	-
Social Impact	-	-
Institutional Impact	Principal	C
Technical Success	Principal	C
Time Management within Schedule	Significant	B
Cost Management within Budget	Principal	A
Adherence to Project Conditions	-	-
Cost-Effectiveness	Principal	C
Financial Rate of Return	-	-
Economic Rate of Return	-	-
Institutional Sustainability	Principal	C
Overall Sustainability	Principal	C
OVERALL SUCCESS RATING ODA PROJECT		C

1

BACKGROUND

1.1 The four aid-receiving British Dependent Territories (BDTs) in the Caribbean have a combined population of less than 50,000 people. They enjoy a relatively high average standard of living, with a GNP per capita in the middle income range, and certainly far higher than that of most recipients of UK bilateral aid. As small island states, they face a range of well-documented problems in an acute form, including the need to provide basic infrastructure and social services with limited physical, human and financial resources. The BDTs receive aid disbursements which are high in per capita terms compared to their independent neighbours in the Caribbean, the reasonable needs of the Dependent Territories having for some time had a first call on the aid programme (a commitment reiterated in the 1997 White Paper on International Development). Proximity to the USA is thought to contribute to high expectations about the possible level of service provision.

1.2 The HMG-appointed Governor has responsibility for external affairs and for the civil service. The Chief Minister and Cabinet (Executive Council) are elected, and are responsible for internal affairs.

1.3 Until 1993 aid was channelled through DFID's regional office, the British Development Division In the Caribbean (BDDC), based in Bridgetown. In 1993, an attempt to promote a more integrated HMG approach towards the BDTs led to the establishment of the Dependent Territories Regional Secretariat (DTRS), also in Bridgetown. The objectives of the DTRS went beyond aid delivery to include external considerations, such as compliance with UN conventions. The vehicles for this new integrated approach were to be the individual Country Policy Plans, each of which was to be agreed annually between the BDT and DTRS, on a three-year rolling basis.

1.4 HMG assistance to the health sector in the DTs until this project had been relatively unstructured. It consisted largely of infrastructure projects (mainly hospitals), often with accompanying technical assistance, and a mix of training and consultancy inputs. Because there was no ODA health and population adviser (HPA) based in Barbados, practically every issue,

whatever its importance, had to be referred to London for advice. There was little analysis of the needs of the health sector or options for health care. This project was thus a bold departure from the norm and should have allowed a rationalisation of health sector inputs.

The Project

1.5 The groundwork for this project began in 1989 and it was identified by the HPA as a priority area for ODA funding. It was recognised that there was a need for a more coherent approach to interventions in the health sector in the BDTs, particularly given that capital investment in the sector was projected to rise. This approach was accepted by the BDTs, and elucidated at the annual conferences of Health Ministers and Officials of the Caribbean Dependent Territories in September 1991 and September 1992 (the so called Cayman Declaration and the Declaration of Providenciales respectively). With hindsight, the approach appears over-ambitious, and clearly required a great deal of work to define the project specifics.

1.6 The project predated the adoption of Country Policy Plans, which as explained above, were to facilitate the integration of HMG's assistance strategy and broader policy towards the BDTs. At the time of project approval, TCI was beginning what became a CPP and Anguilla was undertaking a "strategic review" as a first step in this direction. As DTRS was created only in 1993, it was not involved in the extensive preliminary work for this project. The HSAP was, in a sense, the prototype of a more structured approach to BDT aid delivery, a move away from the more traditional blueprint infrastructure -plus-TA projects. Thus it was a somewhat high risk intervention in a sector in which there was an ODA regional history of significant capital investment, TA and occasional training awards, but little or no experience of reform.

1.7 The project was in line with ODA's wider development objectives. The original project concept in the late 1980s was an attempt to move away from a traditional colonial medical and lay administration in the BDT health sector to more general and professional management of and within the sector. By the early 1990s ODA was very interested in the ongoing reforms within the NHS, and this may have encouraged increased expectations for this project. There was by then a shift in donor approach to the health sector, as reflected, for example, in the World Bank's 1993 World Development Report 'Investing in Health', and a growing interest amongst donors in health sector reform.

1.8 The project was relevant to the recipients' declared developmental priorities. A definitive need for change had been identified at the Cayman and TCI meetings referred to above and thus the project was described as both timely and welcome. Conceptually it was regarded as a good project, with the need for restructuring and change consistently identified. Ministry of Health staff regarded the project as a real opportunity to improve services. One concern expressed,

however, was that despite the declarations there were no clear national policies to support change in the health sector. A heavy burden thus fell upon this project.

The Evaluation

1.9 This evaluation is one of a series of DFID evaluations on health management and system reform. The results will be fed into a synthesis study on the sector. Details of the Evaluation Team's membership are given in the preface. Terms of reference are at Annex A. The itinerary of the evaluation team's visit to the Caribbean is at Annex B. A list of the persons consulted by the evaluation team is at Annex C. There is a bibliography at Annex D.

Evaluation Process

1.10 The evaluation was conducted against the original logical framework rather than the revised version produced after the mid-term review. Annex G gives both logframes. This decision was taken for two reasons. There was only about one year left of the project to run by the time the revised logframe was produced. Most importantly, there was no consensus amongst stakeholders on the new logframe's terms.

1.11 Two main methods were used to generate information for the evaluation:

- desk review of project files, project monitoring and review documents and consultancy reports in London and Barbados
- semi-structured interviews with key informants in London, Barbados and the four Dependent Territories.

2

DESIGN & APPRAISAL

2.1 The evaluation found widespread dissatisfaction with the level of stakeholder involvement in the project's design and appraisal. Although the ISA had been involved since 1989 and had made follow-up visits to all countries, consultation seems to have gone no further than with Ministers and senior officials (usually the Permanent Secretary). Little evidence was found of a formal review of the pilot sector work undertaken by Keele University prior to its appointment as the ISA by BDDC/DTRS.

2.2 The ISA Project Manager made a preparatory visit to each of the Territories two months before the project's start. Once the Regional Health Sector Advisers (RHSA) arrived, a number of meetings and workshops were held but there was a perception in-country that these were intended to present an established way forward rather than to discuss or review the project design. There was no assessment of the potential costs and benefits of the proposed reforms to the different primary shareholders, beyond a generalised expression of the need for improved efficiency of health care delivery.

2.3 The target BDT governments were concerned at what they perceived to be the wholesale adoption of an external reform model which they were not convinced was appropriate to the BDT context. The broad-brush needs analysis undertaken by the ISA had not involved all levels and a wider process of consultation was required. Changes of Government and staff between the project design and project inception did not help. Although ISA documents refer to "the need to recognise the peculiarities of small island states both institutionally and economically", the project design and appraisal did not address the specific and crucial institutional and economic context of the target BDTs. Social and gender considerations are not mentioned to in the design and appraisal, although this is not unusual for projects of the time. The design effort focused largely on the content of the proposed reforms, and paid insufficient attention to the need to understand the process of reform and the difficulties governments faced in implementing new policies and institutional change. The overall result was a lack of ownership at the national level of the project design. Ultimately, the project's scope proved over-ambitious in a country context where there was no previous experience of health sector

reform. It must be clearly stated, however, that this project appeared at an early point in the donor and partner learning curve in this difficult area.

2.4 It is not clear that alternative options for achieving the same design objectives were considered, other than the purely logistical and financial considerations regarding the number and location of the RHSAs. The evaluators thought that a phased approach, with clearly identified markers or milestones for assessing progress along the way, might have been more appropriate. Each of the target country governments expressed the view that the project did not cater sufficiently for the differences between the countries, including single versus multi-island provision, the existence of insurance systems which favoured off-island providers against public provision, and the use of offshore facilities in Jamaica or Miami. The project design was, however, not prescriptive in this area so this may be more a matter of perception and the effects of that perception on implementation.

2.5 Theoretically, the project's broad objectives were appropriate to the national situations. However, what is now better understood is that HSR is a highly political process, often fiercely contested by different stakeholders. In this project, these considerations were particularly important. In small island states, the allocation of budgets, staff and responsibility (with concomitant power, influence and respect) can become public issues very rapidly.

2.6 The model of technical support was accepted by the BDT governments, who agreed that the workload did not justify an Adviser resident in each country. The governments perceived a link between the provision of this technical support and ongoing and planned infrastructure investments, although such a link was not made explicit in the project document or in other papers.

2.7 At the time of project inception, there was an ongoing PSD programme in TCI and a move towards PSD in both Anguilla and Montserrat. No formal links were established, however, between these programmes, and an opportunity was thus lost to develop a synergy between what should have been complementary activities. At country level concern was expressed that the potential for collaboration between PSD and HSAP was not adequately exploited.

2.8 There was provision in the project for short-term consultancy inputs to supplement and complement the ongoing work of the resident advisers. (See Box 1). Few, if any, of these up to thirty short-term inputs were regarded as successful, in terms of what was achieved, by the BDT governments. The balance between long and short term inputs was determined by the ISA (within the limits of the financial framework) as was the selection and supervision of those inputs. The BDT governments' perception was that these resources were controlled by the ISA and that the governments had little influence over what was provided, and by whom. Some of the short-term consultants had limited overseas experience, and were perceived in some cases to have an incomplete understanding of issues specific to the BDTs.

Box 1: Examples of some of the short term consultancy inputs

All BDTs	Health information strategy needs analysis
	Health financing workshop
TCI	Education and Training review
BVI	Mental health strategy consultancy
Montserrat	Review of financial baseline for health strategy
Anguilla	Care of the elderly strategy

3

EFFICIENCY

3.1 The project's scope proved over-ambitious. This was partly due to the absence of an agreed national level policy context and the consequent lack of strong levers or incentives for change. Another critical factor affecting the project, given the complex nature of the reforms to be attempted and the open-ended process approach adopted, was the lack of clear strategic *process* for identifying the specific inputs needed to achieve particular outputs. Feedback from BDT stakeholders suggests that local input was not fully reflected in this decision-making.

3.2 The RHSAs were the main input into the project provided by the ISA. Both these advisers had extensive experience as health services managers, but were involved in a project which now would be identified as one primarily about change management. With hindsight, the RHSAs may have lacked the full range of skills needed for the complex tasks they faced.

3.3 There were high levels of enthusiasm and widespread participation at the start of this project. Implementation was affected, however, by changes in political leadership which, in the absence of a clear national policy statement or strategy supporting reform, left the project vulnerable at the political level. A comparison of outputs produced against either the original or the revised logical framework indicates that very few targets have been achieved.

3.4 There are a number of reasons for this. The various stakeholders in the Ministries of Health suggested the following reasons:

Management issues
• unclear decision-making mechanisms
• lack of response to request for changes
• lack of bottom-up approach
• local input not fully reflected in decision-making
• limited mechanisms for revisiting ideas
• perception that ideas and agenda were preconceived

Model issues
• perception that model was inflexible to national needs • project did not adequately recognise differences between countries e.g. multi-island versus single island state, existing level of provision; budget deficit or surplus • PMAG mechanism suitable for sharing experiences, less suitable for national decision-making - unclear follow-up mechanisms

Implementation issues
• inadequate audit trail • inadequate monitoring and review mechanisms • insufficient facilitative skills • need for impartial professional support • unclear links to other donor/regional activities (eg PAHO, OECS)

3.5 The project document and logical framework allowed a wide degree of latitude in the way in which the project was to be implemented. At that stage, this appeared an enlightened approach: one that recognised the process nature of the project and the need for different approaches across countries and islands with differing needs. However, in practice it meant that the progress of the project came to depend heavily on the work of the RHSAs, supported by visits from the ISA Project Manager.

3.6 Although a large number of meetings and workshops were held when the project began, (and there were further meetings throughout the duration of the project), feedback from most stakeholders gives an impression of an inflexible project approach, less responsive to stakeholder-input than planned, resulting in a lack of commitment and ownership either of outputs or the wider objectives. This perception, coupled with changing levels of political commitment, had an adverse impact upon project outcomes.

3.7 Early project-related documents do refer to social and economic factors affecting the project, including the problems which typically face micro-states in providing health and other services. This analysis, however, did not extend to the political structures within the Territories, either internally or in their relationships with HMG, (the latter proving to be another key factor influencing this project's outcome).

3.8 Prior to this project, health sector development priorities tended to be identified in terms of infrastructural requirements. One of the positive outcomes of this project has been an

improved recognition within the respective health sectors that more infrastructure and more resources are not enough in and of themselves. The need, for example, for revised management structures, a review of resource allocation, updated legislation, a clear division between public and private provision, and a shift in emphasis away from tertiary care are now recognised and debated issues, even though the evaluators found little tangible evidence of significant progress to date. Widespread disappointment was expressed that more progress on health sector financing was not made, particularly in Anguilla.

3.9 Other external assistance to the BDTs is limited when compared to countries receiving aid according to more accepted criteria. The role of PAHO was supposedly recognised by its position on the PMAG. It is not clear that this involvement allowed PAHO's previous and ongoing contribution to be as fully utilised and integrated within this project as some stakeholders would have liked. Similarly, a USAID-funded ECS Health Services Management Unit involvement was also proposed a number of times by the national stakeholders, but it appears that overtures by the ISA Project Manager did not have any tangible results. Some stakeholders expressed disappointment that PAHO did not play a greater part, given its long history of involvement and its understanding of the issues in the BDTs. If nothing else, it was felt that this would have been useful in bringing an independent external influence to bear on the health sector, to balance what some stakeholders felt was HMG's view, expressed through the ISA.

3.10 Procurement under this project was confined to the activities of the biomedical engineer recruited separately for a specific purpose in 1994. This discrete input is covered under Annex F.

Project inputs

3.11 Appointment procedures were amongst the responsibilities delegated to the ISA by ODA, although the ODA's HPA participated in the selection board for the two long-term RHSA appointments. The evaluators found a lack of consensus between some stakeholders within the governments of the target BDTs and the ISA on the management of the short-term appointments. The former expressed concerns that these appointments had been managed with insufficient reference to them or to ODA. They maintained that they were unaware that they had the option to make proposals for short-term TA. The ISA asserts, however, that all short-term consultancies were undertaken within the framework of the six monthly PMAG meetings, and that all terms of reference and proposed consultants were agreed in-country.

3.12 Training and workshop activities were usually managed at the country level by the RHSA. A significant exception was the Financial Policy Options Workshop held in Anguilla in February 1995 which was ISA-led. Otherwise, workshops were in-country, with needs identified by the RHSA and led by him.

Project outputs

3.13 Outputs identified by the evaluators under this project at the time of their visit were more qualitative than quantitative:

- Changes had been made to the senior management structures in the Ministries of Health although these had not yet been firmly established
- Changes had been made to user fees schedules but collection remained a problem. Some legislative changes had been made
- Reports following short-term inputs may have contributed positively to the discussion/planning process
- There was some evidence of an improved understanding of the need for reform, and of the complexities of the process, particularly within Ministries of Health

3.14 Several external factors adversely affected the progress of this project. These included two hurricanes and an erupting and then rumbling volcano. The gap in activity following these disruptions was felt by some stakeholders to have led to an increased feeling of uncertainty about the HSAP's objectives. Internally, there were national changes of government and changes of HPA within ODA and other staff changes within BDDC/DTRS. Qualitative changes in approach to the health sector are notoriously difficult to define and describe, but the evaluators found what appeared to be an improved understanding amongst many health professionals of the need for change. It is difficult, however, to translate such goodwill into tangible outputs without resources and political will.

3.15 It is possible that the project outputs identified by the evaluators could have been achieved at lower cost. For example, the RHSAs and the short-term consultancy inputs were predominantly sourced from outside the region, although it is not clear whether less costly regional alternatives were available.

3.16 The limited achievement of project outputs makes it difficult to judge whether or not these could have been achieved more efficiently. Successful health sector reform requires not only changes in management structure, legislation and so on, but also a substantive shift in behaviour and attitudes. The evaluators found some limited evidence of shifts in attitude at the operational level and, to a lesser degree, at the political level.

3.17 Experience elsewhere suggests that HSR is a long process and not something which can be achieved in three years from start to finish. As discussed in Chapter 5, the need for a phased approach to health sector reform with clear 'markers' *en route*, rather than a three year 'big bang' approach, is now more widely understood. This applies equally to small and larger countries.

Quality of technical advice

3.18 The RHSAs had a very difficult and complex role to fulfil. This was recognised in the first draft of the Project Memorandum (PM) which noted that *'it is important to avoid a 'roving' Adviser either becoming a pair of hands, or a marginalised 'theoretical planner'.* Both RHSAs were based in the MoH with contact points/co-ordinators in each country. The open-ended nature of the PM placed a heavy responsibility on them in identifying more detailed needs, co-ordinating inputs, and building and maintaining momentum, all with full stakeholder participation. Not surprisingly, this wide brief, which required technical, managerial, dissemination and diplomatic skills, could not be effectively delivered by one person. Given the difficulties they faced, the evaluators felt that the two RHSAs would probably have benefited from a more active ISA management.

3.19 In theory, the use of short-term consultancy inputs to provide the range of expertise needed in the project should have helped. In practice, a number of the short-term consultants were less than fully informed, lacked sufficient relevant experience, were inadequately guided, and produced reports and advice which were simply shelved.

3.20 The RHSAs also became involved in ongoing operational and political issues, as might be expected given their ready access to senior civil servants and politicians and the open-ended nature of the HSR project. This resulted in a perception amongst some staff further down the hierarchy that the objectivity of the technical advice provided had been undermined to some extent. In addition, turnover in the HPA post, imperfect communications with BDDC/DTRS, and the lack of clarity concerning the PMAG's role, meant that other sources of technical advice or guidance to supplement the core input, were less readily available than had been envisaged.

Monitoring

3.21 The biannual PMAG meetings, chaired by the HPA, were intended to be a key component of the monitoring system. PAHO was included in the PMAG, together with representatives of all of the target BDT governments, BDDC/DTRS and the ISA. In practice, this was a somewhat unwieldy group with broad but rather vague responsibilities. In practice, too much of the Group's efforts were concentrated on progress reporting, and too little on providing effective quality control. By the time of the mid term review (MTR), certain positions had become entrenched and the PMAG became a vehicle for curtailing the project's scope. In the evaluators' view, key issues were not openly and frankly explored by ODA at the MTR, because of the presence of senior officials of the BDT governments, and were instead addressed in the margins.

3.22 Ongoing monitoring was undertaken by the ISA project manager and by BDDC/DTRS and the HPA. However, their visits were not co-ordinated and there does not appear to have

been full agreement between them on benchmarks for monitoring progress, or on the prioritisation of objectives. This resulted in a measure of institutional friction which hindered clear assessment of progress and the identification of necessary changes .

3.23 In-country, the monitoring process was perceived by some stakeholders as somewhat of a burden, involving numerous visits, and an apparent lack of clarity about who was reporting to whom and against what criteria. Agreements reached or reports back to senior management did not always reach those charged with implementing reform. The lack of clarity about the role of the RHSA was an important factor here.

Other influences

3.24 External circumstances (e.g. the volcanic eruption and hurricanes), and changes in the scope of the project decided upon at the MTR, affected the project's outcome. Given the range of problems encountered by the project both internally and externally, it was somewhat difficult for the evaluators to distinguish between cause and effect. For example, some health professionals in Montserrat suggested that the project had run into serious problems prior to the volcanic eruption.

Management

3.25 BDT governments played a limited role in managing the project, both internally and in relation to other stakeholders. The lack of clear lines of authority hindered any desire on their part to be more active. Furthermore, internal institutional and political considerations across government affected support for e.g. a revised management structure, changes in legislation or increases in funding to the health sector by whatever means.

3.26 The evaluators believe that project progress was hindered by the fact that no single accountable officer was appointed within HMG for this project. The HPA was London- based, the Programme Manager and Officer sat in DTRS and professional advisers (notably institutional development and economic) sat in BDDC. There were thus a number of different sources of opinion and advice. As noted in paragraphs 64-6, the ISA management of UK inputs was not entirely satisfactory. Clearer management responsibility might have facilitated more effective quality control of inputs and allowed problems to be sorted out before they became serious.

3.27 PMAG reports were issued after each meeting but it is unclear how much follow-up actually occurred as a result of these reports. The meetings appear to have served a useful 'report back' mechanism allowing each country to report on and compare progress. As many as three representatives from each country or organisation attended, increasing costs and multiplying

numbers, making it an even more disparate group. The PMAG notes produced are simply summary minutes of the meeting. Clear objective setting for the next six months was meant to form part of the Agenda and papers

4

EFFECTIVENESS & IMPACT

4.1 The stated objectives were only very partially achieved, with varying success across countries. The substantive elements of the work done by the ISA are difficult to identify. The scope of the project was reduced at the MTR, when the original fifth objective was dropped and the logframe rewritten with a restatement of objectives. Neither change assisted those stakeholders not present at the MTR to understand the project's objectives or to promote project ownership. The project cycle management terminology used by ODA also changed during the course of the project.

4.2 Many health professionals expressed to the evaluators a sense of disappointment that, although some progress had been made as a result of the project, this was only a beginning and more could and should have been achieved. A new management structure had been put in place, albeit perceived by some as top heavy, but there was no clear idea what the BDT governments intended to do about the middle management level. While there had been changes in structure and in job titles, and, in some cases, changes in personnel, some stakeholders felt that this had not been accompanied by any substantial change in function, or, most importantly, in levels of autonomy and responsibility.

4.3 The very limited involvement of the Personnel and Finance Departments in the project and the failure to take into account the implications of the restructuring of the MoH (usually one of the largest Ministries and with one of the biggest budgets) across the wider public service, were factors contributing to the only partial success of the original first immediate objective, which was *'to develop and implement improved management structures and policies'*.

4.4 The original second immediate objective was *'to develop and implement improved planning approaches and systems'*. This was intimately related to the previous objective, and it is not surprising that the outputs were affected accordingly. The evaluation team were referred to a discussion/forward strategy document 'A healthier future for BVI'. This identifies the lack of clear health policies or plans and the need for a clear planning process. As with the other Territories, however, the issue of management structures took precedence over this need and

progress in this area was negligible. It appears that the other three target BDTs also produced strategic planning documents but these were not made available to the evaluation team or mentioned by stakeholders in-country.

4.5 The wider political and fiscal ramifications also needed to be more closely considered. For example, in order to meet the original third immediate objective, *'to develop and implement improved health sector financing strategies'* there needed to be a political will to levy or increase charges at the point of delivery. In small islands with tiny constituencies, this might make fiscal sense but was clearly difficult politically. Ministries of Health already absorbed between 16-18% of the recurrent budget in the BDTs, and moves to improve financing strategies need to be viewed in this light. This objective was further complicated by potential links with ongoing or proposed Public Sector Development (PSD) programmes. Such programmes, often driven by fiscal necessity, tended to be seen as externally inspired (ie by HMG), and could be politically risky. One interesting unplanned outcome from the HSAP project has been the perception now in some Territories that HSAP thinking has benefited the approach to PSD, acting as a prototype for the approach to improved efficiency and effectiveness in the public service. The PSD programmes beginning at the same time as this project if anything encountered even more resistance to change at both political and operational levels. Although outputs identified under the original fourth objective are not immediately impressive, the project did appear to increase interest in health financing issues in a number of BDTs.

4.6 At the time of the MTR, the original fifth objective, *'to improve the quality of care produced by the health sector'* was removed. In any case at that stage little input could have been made towards meeting this objective. There was some limited short term consultancy work, with mixed results. Health sector professionals expressed the view to the evaluators that the project appeared to have had no positive impact on service delivery either in terms of quantity or quality.

Ownership

4.7 Actual ownership of the outputs in-country appears somewhat fragile. The evaluators found that changes in senior management structures were still not firmly established and middle managements were often ill-informed and confused. An improved understanding of the complexities of health sector reform is widespread, along with the perception that further assistance is required to take this forward.

Cost effectiveness

4.8 The overall model of the project - two advisers based in the region (one shared between three countries), plus short term inputs, ISA support and PMAG guidance - should have been a cost-effective approach. As discussed in paragraph 61, it might have been possible to deliver some of these inputs at a lower cost. However, a more detailed assessment of the cost effectiveness or otherwise of this project is complicated by the fact that the authorising department, DTRS, only ever used one MIS code. Thus expenditure can be broken down annually and quarterly, sometimes by TC or not, or sometimes by country, but otherwise information is scattered across files in Barbados and London in a haphazard manner. This situation exemplifies one of the problems with this project, namely the multiplicity of participants but an absence of clear delineation of responsibility.

4.9 The incomplete attention to costs by DTRS/BDDC might suggest that they regarded responsibility in this area as delegated to HPD or to the ISA. In practice, the ISA submitted invoices to DTRS which were paid once approved by the HPA, based in London. Occupants of this post, (five in the course of the project,) had less day-to-day experience of the project than advisers and programme staff in Bridgetown. In-country, many health staff believed, incorrectly, that the RHSA had delegated authority (particularly with reference to short term inputs) from the ISA.

Constraints

4.10 The process nature of the project, the then novel approach of contracting out management to a third party; and the differences of opinion and approach of the London and Bridgetown offices of ODA, created a dissipation of responsibility in inverse proportion to the amount of paper generated in commenting on project progress. Many players had opinions but it was never clear who carried overall responsibility. There was much internal criticism of the project and, immediately prior to the MTR, Bridgetown proposed, tentatively, that it should be shut down. A cautionary minute from ODA's contracts department pointing out that this might lead to legal difficulties caused the proposal to be abandoned. At the MTR, the internal criticism was articulated, through the PMAG, but still only tentatively, by suggesting a reduction in the project's scope. In-country, changing levels of political commitment, confusion about the project's objectives, and an undue reliance on the RHSA for information and inputs, further adversely affected the project's impact.

5

SUSTAINABILITY & REPLICABILITY

5.1 The issue of sustainability is important in assessing the impact of any project, particularly one aimed at achieving institutional change, but it has proved especially difficult to evaluate in this project, given the aid relationship between the BDTs and HMG. In other situations, there may be a withdrawal of, or a decline in donor assistance, or at least the threat of it. In the case of the BDTs, there appeared to be an expectation that health sector support would continue at roughly similar levels, because of their special status, with or without reform.

5.2 Further, the paradox of the sustainability question for aid to the BDTs is apparent when one considers that whilst there is no clear plan for continued support in the institutional development of the health sector, there are plans for still more investment in the hospital and other health infrastructure in all the territories. The CPPs for the three countries which had them made no explicit attempt to link capital and recurrent health budgets. The incentives to the countries therefore appeared somewhat perverse. While it was clear that the individual BDTs needed to have some strategy to move forward, DTRS/BDDC also needed to re-evaluate their own economic and development strategies for the health sector, in line with their overall country strategies.

5.3 The fact that the scope of the project appears, with hindsight, to have been over-ambitious, is largely due to this lack of clarity, on the part of the BDT governments and HMG, about the incentives which are needed to promote sustainable institutional change in the health sector. The impact of certain types of health infrastructure development, particularly hospital-related, on recurrent expenditure, was a further factor.

Replicability

5.4 While not directly replicable, the experience of the project is valuable in a number of ways:

- influencing the design of HSR Programmes and initiatives globally;

- providing lessons on donor behaviour - the project raised a range of questions about roles and relationships, which are important internally for HMG and externally with the BDTs; and
- future work in the BDTs as they continue to advance some of the institutional objectives of HSAP, particularly in the light of the impending and continuing planned investment in health sector infrastructure by HMG and the CBDT government themselves.

Objectives and ownership

5.5 The objectives for the individual countries which were included in the Project Memorandum lacked either a strategy or an appropriate policy framework for implementation. The initiative also had some undocumented 'global' sub-objectives, related to the fact that the participants were all BDTs.

5.6 Based on their reviews of the project and discussion with the players, the evaluators identified some of these sub-objectives as follows (in no order of priority):

- Provide cost effective technical support for the HSR process in each country
- Explore the applicability of the UK health reforms in the CBDT context
- Decrease dependency on HPD for operational level technical input
- Decrease dependency on HMG for financing capital investment in health
- Control recurrent expenditure in health, introduce financial discipline
- Provide regional health sector development advice to DTRS/BDDC.

5.7 The nature of these global objectives were that:

- they tended to be 'owned' by HMG, split between HPD and DTRS/BDDC;
- they were more political in nature and based on improving various aspects of the relationship between the territories and HMG.

5.8 It seems to have been almost expected by the BDTs that such 'unwritten' objectives existed, and much of the suspicion about the overarching intention of this project appeared related to speculation of what these global objectives were. Thus, the lack of clarity about perceived "spoken and unspoken agendas" had an important impact on the behaviour of the various stakeholders. This problem needs to be addressed explicitly in any future initiatives of this kind.

5.9 HSR is different from traditional health service strengthening projects in that it involves fundamental institutional change with respect to roles and relationships. In many respects, many of the players involved in HSR may be neither comfortable nor supportive of it - even though they may see it as necessary. Many view HSR as a technical issue, particularly those within Ministries of Health. The key lesson of our experience of HSR, and, indeed, reform within other sectors elsewhere, is that without consistent political support above and outside the technical level - which, in the BDT context, includes HMG - no real and sustainable change will take place.

5.10 There is also need to recognise that HSR is not a quick-fix short term input. HSR requires long term strategies which are best viewed as elements of rolling programmes of development. HMG needs to make these development objectives explicit and to ensure that there is a common understanding of these objectives both within and between HMG and the BDTs. Increased transparency in internal decision making on the HMG's part would help considerably.

5.11 The issue of ownership needs also to be explicitly addressed. The evaluators found that neither the governments of the BDTs nor any of the parts of HMG involved considered themselves to be the owner of the HSAP Project. A clear need was identified for more meaningful participation in project identification, design and implementation by both the BDTs and the relevant parts of DFID.

5.12 While most donors are striving to build aid relationships based on partnership, project logical frameworks and memoranda are often still very much generated by the donor or its agents without active client participation. Logframes can be a powerful tool to promote clear objectives and client ownership, provided they result from a genuinely participatory process, but their full potential is often not realised.

5.13 The HSAP project was ultimately over-ambitious not only because its purpose was ill-defined but because the assumptions underpinning the project were unrealistic. In particular, there appears to have been a significant lack of understanding of, and political commitment to, HSR in the BDTs. One option, given the complexities of reform, might have been to extend the project's duration to allow extra time for the process aspects of building commitment to work. A more convincing option would have been to break the programme up into distinct phases with clear milestones for moving on from phase to phase. These milestones would have had to be country-specific and supported by clear policy development to ensure both political and technical commitment.

5.14 While the evaluators would argue that a "blueprint" approach to HSR project design should be avoided, it is possible to speculate about the form such a phased approach might take. Annex H provides a sample logframe for the design phase of a Health Sector Development Programme which has as its purpose the development and approval of strategies for

strengthening Health Sector Management and Financing. The duration of such a design phase would be around 12-18 months and at its end, the country specific strategies would need to be backed up, at the highest level of political commitment, by joint BDT and HMG policy support. In order to develop these strategies for reform, specific outputs of the design phase would include development and approval of:

- new management structures and functions
- strategies and costing of implementing new management systems
- management development programme
- a national health services plan
- strategy for health financing
- a costed Communications programme.

Roles and relationships

5.15 Reform implies some fundamental shifting of roles and functions and, in a break with the past, the development of new skills and relationships. This step has proved the most difficult in many countries implementing, or attempting to implement, reform - because the inertia and power of the existing structures to undermine any new capacity is often underestimated.

5.16 In support of real change, therefore, it is important in the design and early implementation phases to be clear about roles and functions, so as to remove ambiguity and improve the transparency and effectiveness of decision-making. This clarity is also essential for effective monitoring and review mechanisms.

5.17 Many of the difficulties that HSAP encountered resulted from the lack of clarity of its roles and functions. Decision-making about the application of project resources was unsystematic, and led to confusion. Where roles were left undefined, past rules and experiences were assumed. Much of the feedback within the BDTs and DTRS/BDDC was concerned with what the respective ISA and HPD roles should have been. Much of the feedback from the ISA was about what HMG and the BDTs should have done. The evaluators found it difficult to make a judgement about where the balance lies in all of this.

5.18 As described in Chapter 4, the uncertainty of the project stakeholders (namely DTRS, HPD and the BDTs) about their responsibilities, meant that the ISA was given a greater level of autonomy and responsibility than, perhaps, it had the capacity to manage or, in fairness, should have been expected to take on.

5.19 Table 5.1 suggests a possible model for implementation. It attempts to map out appropriate relationships between the various stakeholders, based on a partnership approach between country and funding agency. It therefore assumes that the country will have a fair degree of control over the programme resources programme and full responsibility for the programme's implementation.

5.20 The following are brief summaries of these relationships:

- HMG as the financing and development agency should work to encourage country ownership of the HSR process. It can appoint the ISA and should ensure that there are appropriate joint country performance review mechanisms of the ISA. As much decision-making as possible should be devolved to the regional level which should ensure that the appropriate policy context is developed and in place to support HSR.
- the ISA should work to support the country in the implementation of the programme by providing jointly identified resources which have been approved by the country. The ISA should avoid assuming ownership of the programme and be as process-oriented as possible within the available time frame. The ISA will be accountable both to Regional Programme Manager and to the Permanent Secretary of the MoH
- the MoH will be the owner of the project and be responsible for timely decision making and the establishment of appropriate linkages within the Government.

Table 5.2 sets out the roles and responsibilities of these three main groups at progressive stages of the project.

Figure 5.1 Model of Implementation for DT HSAP

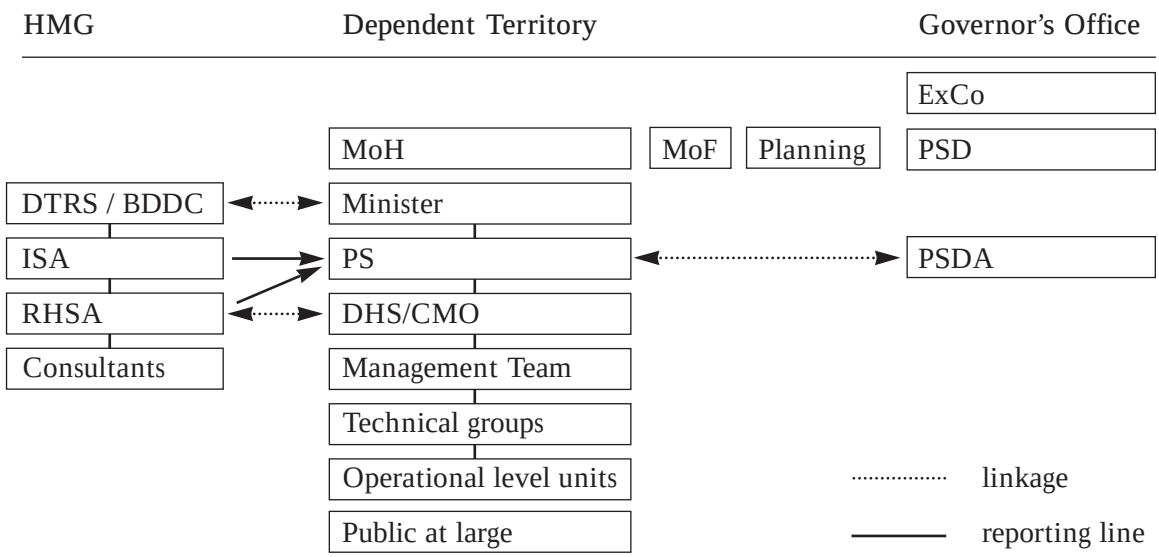

Table 5.2 Roles and Responsibilities for different stakeholders

HMG Team	ISA Team	Ministry of Health Team
Support needed internally for the Programme Manager eg. BDDC, HPD, Governor	Support needed internally for the RHSA eg. Project Manager, Consultants	Support needed internally for the Project Manager e.g. MoF, Planning, PSD
Ensure that monitoring and evaluation mechanisms are appropriate	Design and implement the monitoring and evaluation mechanisms	Design and implement the monitoring and evaluation mechanisms
Ensure compatibility of projects with BDDC country strategy	Ensure that the programme and country projects are executed within the stated objectives	Implement the project in keeping with project objectives
Ensure that the workplans are executed within stated resources	Manage the technical support that is required to implement the projects & workplans	Develop and implement the workplans and the mechanisms to manage the involvement of the various stakeholders
Ensure that HMG's administrative requirements are being met	Provide the administrative support necessary for efficient implementation of ISA input	Provide the necessary administrative support in country
Influence the political and decision making process needed to implement the project	Provide technical support to DFID and Ministry on critical dependencies for HSR	Manage the political and decision making process needed to implement the project

Monitoring and project management

5.21 In projects of this type, rolling monthly workplans should be jointly planned, and the nature and timing of inputs should be agreed with the key stakeholder, in this case the MoH. Monitoring and review mechanisms should aim to be as prospective as possible in order to avoid slippage of time lines and to optimise the use of the available programme resources. This is of particular significance in process-oriented consultancy work. The role of DTRS/BDDC in the monitoring and evaluation process should have focused at output-to-purpose level, and on supporting BDT governments in assessing the quality of the ISA performance. Responsibility for routine monitoring at activities-to-outputs level should have been left with the BDTs.

5.22 The PMAG appears to have had limited usefulness in terms of decision-making and

monitoring at the activity level, and its contribution to the progress of HSR in any of the BDTs is uncertain. In theory, however, a PMAG-type institution is a potentially important vehicle for linking regional activity and resources, for promoting the sharing of learning and for the more effective and efficient use of programme resources.

Cross-cutting issues

5.23 Typically for projects of its time, the appraisal and design of HSAP did not explicitly address poverty, gender or environmental considerations, and the project's impact in these areas is therefore difficult to identify. If we were re-casting the logframe now, we would highlight the link between the development of effective and efficient health systems and poverty reduction: better management of available resources can facilitate increased access to health services by poor groups, and consequently to improved health status. This broader objective can be regarded as implicit at goal level in the logical framework.

Sustainability

5.24 The sustainability issues could be addressed to a large extent by ensuring increased national ownership and control over resources in an HSR Programme that is developed as a rolling programme of development. HMG must be able to commit to the HSR Programme on a longer term basis, the form and content to be negotiated. Without this, it is difficult to see how these difficult issues of reorganisation will be addressed.

5.25 Other important issues include:

- linking HSR and PSD in terms of timing and resources
- linking HSR and the macro-economic policy framework (including through the Country Strategy process)
- exploring more regionally focused activity rather than linking with other BDT programmes to ensure better complementarity with relevant Regional developments eg. OECS Drug Procurement Programme (as Anguilla was encouraged to do), PAHO Telemedicine Project
- exploring more regionally based technical cooperation support e.g. PAHO, UWI.

The evaluators acknowledge that the ISA did explore the latter two points, but with no discernible results.

Impact

5.26 Given the delays in implementation and the only partial achievement of the project objectives, it would appear at first sight that the impact of this project has been minimal. However, the impact of institutional reform cannot always be predicted through application of simple linear cause and effect logic. Institutional and organisational reform is about breaking the reinforcing cycle of the existing paradigms - the effects of small change could be exponential.

5.27 Examples of some of these small changes identified by the evaluation include:

- a better understanding of the complexities of HSR in both the BDTs and HMG (territory specific context);
- an expressed need for a communication programme, a more bottom-up approach, and involvement of the public;
- an acknowledgement that better linkages are needed with PSR and that PSR has and will benefit from the project;
- some improvements in the management capacity to lead HSR.

5.28 The evaluators believe that, despite this particular project's apparent lack of achievement, further involvement by DFID in this key area should not be ruled out. Any such further involvement, however, should learn from the experience of HSAP, as set out in this evaluation.

TERMS OF REFERENCE ANNEX A

EVALUATION OF BRITISH DEPENDENT TERRITORIES (BDT) HEALTH SECTOR ADJUSTMENT PROJECT

The wider objective (goal) of this ODA project was to 'improve the health status of populations in the Dependent Territories'.

The immediate objective (purpose) was to 'improve the efficiency and effectiveness of health care delivery'.[2]

OBJECTIVES OF THE EVALUATION

The evaluation will:

- Assess the extent to which the ODA project was consistent with the priorities and policies of the target group, recipient institutions and government, and donors.
- Consider the coherence and realism of project design and appraisal.
- Determine whether the most cost efficient and effective approach was adopted.
- Assess the overall institutional, social, health and economic impact and sustainability of the project and establish whether the stated objectives were achieved.
- Make a judgement on success in particular whether the costs are justified by the benefits that have accrued from the project activities.
- Contribute appropriate lessons and conclusions to assist with the development of an Evaluation Department synthesis study on health management strengthening and system reform. Particular focus will be on identifying critical success factors in the design, application and impact of the attempted health reforms.
- new organisation and management including the creation of independent health authorities;
- health financing: the consideration of alternative health financing options including the revision of user fees and the introduction of national health insurance schemes;
- planning and priority setting including the development of strategic frameworks, information systems and managing the relationship between private and public health care.

[2] These are the revised objectives. The original goal was 'To optimise health outcomes', and purpose 'To develop and implement improved management structures and policies including revised planning approaches and systems, revised financing strategies and to improve the overall quality of care'.

SPECIFIC REQUIREMENTS

The evaluators should produce a report according to the standard format specified by Evaluation Department and within the time norms for report completion. Specific recommendations should be separate to the report. A two page Evaluation Summary (EVSUM) should also be produced.

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

Examine:

- how the project was identified as a priority area for ODA funding;
- the relevance to the BDT developmental priorities;

B. Design and Appraisal

1. Assess whether or not the ODA project was adequately designed and appraised with respect to institutional, economic, social and gender considerations and within the individual BDT contexts. To what extent was stakeholder involvement in this process secured.

2. Consider whether the health reforms pursued were appropriate given the desired institutional and behaviour changes identified. What alternative options for achieving the same aims were considered?

3. Examine the realism of project objectives given the resources (time and financial inputs) devoted to the project. Examine the developmental and management link between the project and other related programmes of support, such as the public service development programmes.

4. Consider whether the balance between short and long term consultancy inputs was appropriate.

5. Examine the developmental and management link between the project and other related programmes of support, such as the public service development programmes.

C. Efficiency

1. Consider whether inputs (ODA and BDT) were adequate to achieve the desired outputs.

2. Assess whether implementation targets were met and whether targets fully reflected potential for achievement. Identify the main reasons for under-achievement.

3. Consider the process by which the project was implemented and the extent to which this ensured key constituent (stakeholder) participation in, commitment to, and ownership of the outputs and objectives of the project.

4. Examine whether adequate account was taken of:

- the socio-political structures and economic circumstances of the individual BDTs;
- BDT's health sector development priorities;
- other external assistance.

5. Examine the effectiveness of procurement procedures in providing the right equipment on time and with value for money.

6. Assess the effectiveness of the appointment procedures for project technical assistance (long term advisers and short term consultants), and the identification of training and workshop activities.

7. Assess the efficiency with which the outputs were achieved: could more have been achieved in the time or could the outputs have been achieved faster and/or at less cost?

8. Examine the quality of the technical advice provided and technical solutions recommended.

Monitoring

9. The evaluators will:

Assess how effective was the monitoring system in informing both ODA and BDT Governments of project progress and appraise how monitoring information was utilised including feedback from ODA on project progress.

Establish how flexibly the project responded to any significant changes in project conditions.

Management

10. Consider the role played by the BDT Governments in managing the project.

11. Assess the quality of management of UK inputs by the implementing support agency and the project monitoring and advisory group.

D. Effectiveness and Impact

1. Examine the extent to which the project has achieved its stated objectives and identify the most important factors explaining success or failure.

2. Assess the impact (intended and unintended) of the project in the four BDTs with particular reference to:

- the quality and appropriateness of project inputs;
- the contribution made to the efficient, effective, and equitable deployment and use of resources in the health sector;
- the impact on target groups.
- ODA's three cross cutting issues: environment, poverty and gender.

The evaluators will consider the impact of the key individual health reforms attempted, specifically: new organisation and management structures, health financing and planning and priority setting.

3. Identify the extent of actual ownership of the outputs by the key constituents (stakeholders) and its resulting influence on the achievement of objectives and impact.

4. Consider whether the project design was the most cost effective method of achieving the objectives and impact. Given the desired outcomes were there alternative ways of achieving them which might have been most cost effective.

5. Assess whether impacts can be attributed to the ODA project.

6. 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.

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

1. Comment on, and assess the effectiveness of, the strategies adopted to ensure that project outcomes will be sustained beyond the provision of ODA and other donor involvement.

2. Consider whether the activities, outputs and impact could be reproduced in other places or circumstances.

F. Methodology

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. Suggested evaluation indicators will be shared with key project stakeholders. The methodology will include a combination of the following:

a. desk reviews of available reports;

b. questionnaires sent to, and semi-structured interviews with, key stakeholders;

c. field visits to the four BDTs;

d. discussions with project implementers, managers, and participants.

Evaluation Department

25 February 1997

ITINERARY, MARCH-JUNE 1997 ANNEX B

24-28th March	Barbados
14-25th April	London, of which 16-18 at Keele
5-7th May	BVI
8-10th May	Montserrat
11-15th May	Anguilla
19-21st May	TCI

PEOPLE CONSULTED ANNEX C

Bridgetown

DTRS

Alan Huckle	Head
Frank Black	Deputy Head
Doug Williams	Programme Officer
Carol Cullen	Programme Officer
Sandra Harewood	Programme Assistant

BDDC

Brian Thomson	Head
William Kingsmill	Senior Economic Adviser
Rod Evans	Senior Institutional Development Adviser
Bill Baker	Senior Institutional Development Adviser

PAHO

Karen Sealey	Caribbean Programme Coordinator

London

DfID

HPD

David Nabarro	Head
Jane Pepperall	HAPAE & HSR Adviser
Jessica Patton	Health Economist
Phil Mason	Programme Manager
Tim Martineau	Health Adviser

Nick Dyer	Economic Adviser, Evaluation Department
Mukesh Kapila	Senior Advisor, Emergency Aid Department
Charles Clift	Senior Economic Adviser (ex BDDC)
Bob Smith	Programme Manager (ex BDDC)
Andrew Cassells	Consultant adviser

Keele

Centre for Health Planning & Management

Ken Lee	Director
Calum Paton	Professor
Michael Rigby	Project Manager
David Wildman	RHSA, TCI
Ruth Roberts	Short term consultant

Anguilla

Edison Baird	Minister of Social Services
Sinclair Buchanan	Permanent Secretary, Ministry of Social Services
Stanley Mussington	P.A.S. Health
Dr Brett Hodge	SMO/Acting DHS
Yvonne Ray	Principal Nursing Officer
John Fabien	Primary Health Care Coordinator
Foster Rogers	Deputy Primary Health Care Coordinator
Marvella Richardson	Public Health Sister
Stephenson Rogers	Chief Environmental Health Inspector
Patricia Baird	Senior Health Educator
Vernice Battick	Nutritionist
Prasad Gonovarum	Senior Dental Surgeon
Thelma Lee	Health Services Administrator
Irma Carty	Acting Matron
Alma Hughes	Inservice Coordinator
Robert Harris	Acting Governor
Stevenson Sarjeant	PSR Coordinator
Julian Harrigan	PS Public Administration
Ralph Hodge	Director of Finance
Carl Harrigan	Deputy Director of Finance

BVI

Hon. Ralph O'Neal	Chief Minister

Hon. Eileen Parsons	Minister of Health
Theodore Fahie	Permanent Secretary, MoH
Dr Irad Potter	Director of Health Services, DoH
Vessalie Mathavious	Asst. Director of Health Services, DoH
Winifred Charles	Hospital General Manager
Dr Francis Longsworth	Director of Primary Health Care, DoH
Tanya Parkins	Physiotherapist
Rawle Hannibal	Senior Radiographer
Ethel Spann	Hospital Nursing Director
Irene Allen	Laboratory Director
Ivy George	Health Educator
Grace Ann Creque	Administrative Officer, DoH
Cecilia Stoutt	Health Information Officer
Dawn Lenard	Nutritionist
Aubrey George	Chief Environmental Health Officer
Wisteria Donovan	Administrative Officer, Hospital
Phyllis Smith	Medical Records
Gracia Wheatley	Pharmacy
Ritalia O'Neal	Administrative Officer, Hospital
Lily May	Accounts Officer, Hospital
Althea Kellman	Nurse, Community Services
Alred Frett	Former Minister of Health
Elvin Stoutt	Permanent Secretary, MoC&W, former Project Coordinator, MoH
Glenroy Forbes	Financial Secretary
Otto O'Neal	Head, Development Planning Unit
David MacKilligin	Governor
Elton Georges	Deputy Governor
Magdaline Rhymer	Chief Personnel Officer

Alan McNaught	Former Regional Health Sector Advisor
Montserrat	
John Skerritt	Permanent Secretary, MoH
Dr Ronnie Cooper	Ag. Director of Health Services, MoH
Dr Vernon Buffong	Government Dental Surgeon (former HSAP Project Coordinator and PS MoH)
Sr Valerie Lewis	Ag Health Services Manager/Sister Tutor Training Department
Sr Viola Harley	Administrative Sister, PNO Hospital Nursing Services
Sr Sarah Ryner	Administrative Sister, Community Nursing Services
Major Joseph Lynch	Chief Environmental Health Officer
C.T. John	Financial Secretary
Angela Greenaway	Head, Development Planning Unit
Frank Black	Head, Aid Management Office
Graham Carrington	Health Field Manager
TCI	
Marilyn Forbes	Permanent Secretary, MoH
Gloyd Lewis	Permanent Secretary, Natural Resources; Former Permanent Secretary, MoH
Dr Hugh Malcolm	Chief Medical Officer, MoH
Dr Leo Astwood	Chief Dental Officer
Mary Forbes	Chief Nursing Officer
Monica Wilson	Primary Health Care Manager
Joseph Williams	Chief Environmental Health Officer
Neville Adams	Ag. Permanent Secretary, MoF

Roger Cousins	Chief Secretary
Cynthia Astwood	Chief Secretary Designate
Kingsley Been	Establishments Secretary
John Kelly	Governor

BIBLIOGRAPHY ANNEX D

Title	Author	Date
CBDTs HSD in Small Island States - Cayman Declaration	BDTs MoH	91/9
Third Annual Conference of BDTs Health Ministers - Declaration of Providenciales	BDTs MoH	92/9
Medium Term Plan for the prevention and contol of HIV/AIDS/STDs	BDTs MoH Anguilla	92/2
Primary Health Care Approach Anguilla	BDTs MoH Anguilla	96/6
Introducing Health Insurance in Vietnam	Ensor T	95
Introducing Health Insurance	Ensor T	97
Macro issues in the development of health insurance: world experiences and lessons for transitional Asia	Ensor T	97
ODA Health and Population Sector Review (Summary): Anguilla	Keele	89
ODA Health and Population Sector Review (Summary): BVI	Keele	89
ODA Health and Population Sector Review (Summary): Montserrat	Keele	89
ODA Health and Population Sector Review (Summary): TCI	Keele	89
Draft Project Memorandum HSAP	Keele	92/10
RHSA and PM CVs, ToRs	Keele	93
Keele Proposal for HSAP	Keele	93/3/17
Overview and updated situation analyses, MTR	Keele	95/2
Proposal for restructuring and extending the second stage of the Project	Keele	95/6
Interim End of Project Report	Keele	96/12
Project Manager's report on forward activities 6-9/96	Keele	96/8
Biomedical Engineering Review of CBDTs 1994-1995	Keele	96/9
Overall End of Project Review	Keele	97/3
Anguilla End of Project Review	Keele	97/3
BVI End of Project Review	Keele	97/3
Montserrat End of Project Review	Keele	97/3
TCI End of Project Review	Keele	97/3
Biomedical Engineer End of Project Review	Keele	97/3

List of consultancies completed	Keele	97/4
Proposals for restructuring the organisation and management of TCIs Health Services	Keele	
Health Sector Education and Training Review	Keele, Edmonston	94/11
Staff/Consumer Assessment of Health care -Pt1	Keele, Hamer	96/9
Staff/Consumer Assessment of Health care - Final Report	Keele, Hamer	96/9
Financial Analysis Report, Montserrat	Keele, Hoare	95/1
Report on the Financial Policy Options Workshop	Keele, Lee	95/3/14
Health Information Strategy Needs Analysis, BVI	Keele, Plymouth	95/2
Health Information Strategy Needs Analysis, TCI	Keele, Plymouth	95/2
A Framework for Quality	Keele, Roberts	94/8
Enriching the Prime Years	Keele, Roberts	94/8
ODA Contract Document, Pilot II, Caribbean	ODA	92/7/22
Project Memorandum CBDTs HSAP	ODA	93/3
ODA Contract Document, HSAP	ODA	93/7/26
Report of the MTR 3/6-21 1995	ODA	95/3
MTR Notes (internal ODA)	ODA Cassels A	95
ODA Support for HSR in the CBDTs	ODA Cassels A	95/7
CBDTs HSAP Consultancy Report	ODA Cassels, A	94/10
CPP Extracts Anguilla	ODA DTRS	96
CPP Extracts Montserrat	ODA DTRS	96
CPP Extracts TCI	ODA DTRS	96
Comments HCF in Anguilla, Lee Report	ODA DTRS Clift	94/12
ODA Evaluation Studies, guidelines for evaluators	ODA EVD	94/8
Final ToRs EVD CBDTs HSAP	ODA EVD	97/2/26
Revised Project History	ODA EVDT	97/3/30
Model Logframe 2	ODA EVDT	97/4/25
A guide to appraisal, design, monitoring and impact assessment of Health and Population Projects	ODA HPD	96/8
Back to office report 31/3-14/4	ODA Martineau T.	97/4/18
Health System strengthening and HSR: An overview of ODA's involvement	ODA Nabarro D	96/11
Judgements about the potential for a sector wide approach to Health Dev	ODA Nabarro D	97/4

Fiji Health Planning Project evaluation report	ODA Pepperall J.	95/9
Early experience of the Health Planning Unit in Fiji (article for PHD)	ODA Pepperall J.	97/2
Draft HSR Synthesis	ODA Pepperall J.	97/3/3
Public Sector Development Programme in TCI	ODA PSD Ambury M	95/10/17
PAHO Special Meeting on HSR, HSR and Monitoring in the CBDTs	ODA Sergeant C, McNaught A	95/9

CORE CHRONOLOGY ANNEX E

1989	Keele field visits to all four DTs.
1990	`Keele Reports` for all four DTs. Health & Population sector reviews. Also a 5th report on future health sector needs across all 4 DTs.
September 1991	Second meeting of BDT Health Ministers and officials. Cayman Declaration.
November 1991	First draft Project Memorandum. Two year duration.
1992	Pilot phase in Anguilla - further discussion and workshops
September 1992	Third meeting of BDT Health Ministers and officials. Declaration of Providenciales
October 1992	Keele up date to 1990 reports. Draft Project Memorandum for HSAP from Keele.
December 1992	Redraft of PM by the then HPA, Mukesh Kapila.
October 1993	Official start of the project. Budget L890 000 over 3 years Keele appointed the Implementation Support Agency (ISA) without competition.
April 1994	PMAG meeting No. 1, TCI
October 1994	PMAG meeting No. 2, BVI
March 1995	Mid term review (MTR), BVI, Anguilla, TCI, Montserrat
March 1995	PMAG meeting No. 3, Barbados immediately after MTR.
June(?) 1995	RHSA transfers from Montserrat to BVI.
July 1995	Volcano erupts on Montserrat
Summer 1995	Hurricane Luis hits Anguilla and BVI
Summer 1995	Hurricane Marilyn hits Anguilla and BVI
September 1995	PMAG meeting No.4, Bermuda

June 1996	PMAG meeting No. 5, Anguilla (Last meeting)
March 1997	Evaluation begins
April 1997	Keele submits final reports

BIOMEDICAL ENGINEERING INPUT ANNEX F

Biomedical engineer

This was a supplementary input to the HSAP prompted by the need for technical expertise to commission biomedical equipment for the new Glendon Hospital in Montserrat. It was not integral to the objectives of HSAP, rather it was an additional input which it was found convenient to 'bolt-on' to the ongoing HSAP project.

The ISA supplied two biomedical engineers to do an initial one-week review in Montserrat in October 1994. In November 1994 one full time biomedical engineer arrived for a two year contract based in Montserrat but with a roving brief to cover the other three countries.

The initial workplan was severely disrupted by the eruption of the Montserrat Soufriere Hills volcano on 18th July 1995. The new hospital was finished in February 1996 and mothballed in early April 1996. The hospital was relocated to St John's school in the north of the island and a large percentage of the new equipment was put into storage for commissioning at some later date.

Review were undertaken in the other three countries and recommendations made. Some action was taken following these visits, although staff changes affected progress.

ORIGINAL AND REVISED PROJECT FRAMEWORKS ANNEX G

PROJECT TITLE: BDTS HEALTH SECTOR ADJUSTMENT PROJECT
PERIOD OF ODA FUNDING: FY 1993/94 TO FY 1995/96
BRIEF DESCRIPTION: Technical Assistance to improve the management, planning, financing of, and quality of care provided by health services in Anguilla, BVI, Montserrat, TCI
DATE FRAMEWORK PREPARED: 21 December 1992
TOTAL ODA FUNDING: £0.890 MILLION

PROJECT STRUCTURE	INDICATORS OF ACHIEVEMENT/OUTCOME	ASSESSMENT OF OUTCOME	ASSUMPTIONS, RISKS AND CONDITIONS
WIDER OBJECTIVE: 1. To optimise health outcomes arising from the Improved organisation and financing of health services.	1.1 Mortality and morbidity from marker conditions such as diabetes, hypertension, maternal and child health, surgery complications. 1.2 Clients' satisfaction improved	1.1 Clinical audit system; official statistics; statistics from MIS; 1.2 Qualitative and quantitative public surveys; 1.1-1.2 Mid-term and Final Review; Annual State of Health Reports	Improved management of health services will lead to better health outcomes.
IMMEDIATE OBJECTIVES 2.To develop and Implement Improved management structures and policies.	2.1 New management structures in position eg Anguilla Health Authority; 2.2 New supervisory procedures accepted; 2.3 Revised Human Resource Development policy promulgated; 2.4 Functioning Management Information System; 2.5 Explicit policy towards and role for private sector.	2.1-2.5 six monthly mid-term and final reviews - data from MIS	2.1-2.5 - continued political institutional and professional cooperation with change process; - availability of staff for training and development.
3.To develop and Implement improved planning approaches and systems.	3.1Consultative planning system functioning; 3.2 Realistic quantified two-year operational plans produced.	3.1-3.2 - six monthly, mid-term and final reviews - operational plans accepted by Ministry of Finance	3.1-3.2 - availability of information on costs and services (MIS) - cooperation of Ministry of Finance.
4.To develop and implement improved health sector financing strategies	4.1 New financing system in position such as health insurance/user charges where appropriate, with target income from each source.	4.1 - outturn reports from Ministry of Health/Ministry of Finance - six-monthly, mid-term and final project reviews	4.1 Support from Ministry of Finance and legislative changes where required.
5.To improve quality of care produced by health sector.	5.1 Protocols for clinical management of ten common, major conditions seen in - or out-patients. 5.2 Clinical audit system in place. 5.3 Inventory of health and safety risks in medical establishments, with action plans to deal with them. 5.4 Annual public 'State of Health' reports published.	5.1-5.4 official statistics from MIS - Annual 'State of Health' Reports - six-monthly, mid-term and final project reviews	5.1-5.4 - Cooperation of health care professionals.

INPUTS	£k
Health Sector Development Advisers	360
Additional short-term specialists	70
Training	90
Equipment and misC resources	90
Mid-Term Reviews	10
Implementation support agency - support costs	150
Travel/subsistence costs for HSDAs, Project Monitoring/Advisory Group and ISA	120
TOTAL	£890,000
(at December 1992 prices)	

MTR LOGFRAME

OBJECTIVES	MEASURABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
GOAL			
1. Improved health status of population in DTs	1.1 Mortality and morbidity statistics. 1.2 Prevalence of marker conditions such as diabetes, obesity, AIDS, hypertension.	1.1 Official statistics, surveys, information systems	
PURPOSE			
1. Efficiency and effectiveness of health care delivery improved.	1.1 Indicators of service performance, output and quality measured against total and unit cost of delivery.	1.1 Ministry of Health statistics.	1.1 Strategy for improvements in efficiency and effectiveness targeted on key causes of low health status. Government committed to project purpose
OUTPUTS			
1. Improved management and organisation structures developed and implemented.	1.1 New structures approved by EXCO. 1.2 New structure implemented. 1.3 Lines of responsibility and delegation clarified. 1.4 Management skills and capacity upgraded. 1.5 Collaboration with private sector improved. 1.6 Greater financial autonomy and delegation for health sector managers.	1.1 Project management reports. ODA/BDDC/DTRS monitoring	1.1 Governments and current health sector managers want to change current methods of management. 1.2 Improved structures lead to better management. 1.3 Adequate managerial potential exists in health sector. 1.4 Government able to delegate adequate financial and management powers to health sector managers.
2. Planning systems improved and strategic plans agreed.	2.1 Capacity for strategic planning created. 2.2 Strategic framework for health sector development approved by EXCO.	2.1 As 1.1	2.1 Human resources to undertake planning can be made available. 2.2 Governments recognise necessity of taking strategic decisions to improve resource allocation, policies and efficiency
3. More resources raised more efficiently outside the government budget.	3.1 User charges, better related to costs, revised and new schedule implemented. 3.2 National health insurance scheme devised and ready for implementation. 3.3 Private sector charged economic cost for use of public sector facilities, staff and consumables.	3.1 Printed charge schedules, revenue from charges. 3.2 Viable proposal in place. 3.3 New policy implemented, revenue collected.	3.1 Governments willing to increase charges and collection systems also improved. 3.2 Governments willing to introduce health insurance schemes. Project provides appropriate support and can mobilise suitable expertise. Data available or collectible to model financial viability of scheme. Schemes consistent with project purpose.

DRAFT MODEL HSR PROJECT FRAMEWORK ANNEX H

Project Name: BDT's Model Health Sector Development Programme, Design Phase 12-18 months
Country: Anguilla, BVI, Montserrat, TCI
Date of Preparation: April 1997
Design Team: HSAP EvD Team
Latest Date of Revision: Evaluation 6/97

Narrative Summary	OVIs	MoV	Assumptions
Goal: Improved efficiency, effectiveness and equity of health services.			
Purpose: Strategies for strengthening Health Sector Management and Financing capacity approved.	1. Policy framework approved by ExCo by xx for development of health sector over the next 5 years 2. Implementation plan for providing quality and cost effective health services approved by ExCo by xx.	ExCo meeting minutes	1. DTRS and DT Governments to agree to support strategies with resources made available through the CPP
Outputs: 1 National Health Plan (NDP) developed and approved. 2 New organisational roles and structures to implement NHP designed and approved. 3 Strategies for introducting new management systems (financial, HR, health information & quality of care) developed and approved. 4 Appropriate management skill sets identified. 5 Health financing strategy developed and approved. 6 Communications/Change programme outlined and approved	1. Essential range of services defined and costed by xx. 2. National Health Plan for rational provision of essential range developed by xx. 3. Options for new management structures presented to ExCo by xx and approved by yy. (PSD). 1. High priority management systems specified by xx 1. Rolling management development strategy designed by xx. 1. Draft strategy submitted to ExCo by xx and approved by yy. 1. Plan to support change process and improve public awareness approved by xx.	National Health Plan ExCo options paper IS Strategy paper Management Development strategy Health Financing paper Communication Strategy	1. DT Personnel remain available for the duration of the project 2. DT Governments supportive of goals of PSD. 3. Stable economic conditions. 4. DTRS maintains appropriate level of inputs.

Narrative Summary	OVIs	MoV	Assumptions
Activities: 1.1 Establish Interministerial Project Steering Committee 1.2 Analyse health situation, including status and service issues. 1.3 Develop strategic intent for Health sector (public and private). 1.4 Agree essential range of services to be provided nationally. 1.5. Develop National Health Plan. 2.1 Undertake Efficiency Review of roles and functions of the different l evels of the public sector, (joint PSD). 2.2 Undertake review of health relevant legislation. (joint PSD) 2.3 Develop options for new management structures for implementing National Health Plan. 3.1 Complete management systems audit. 3.2 Agree information strategy in line with overall sector strategies. 3.3 Complete specifications for first year implementation. 4.1 Undertake a management training needs analysis. 4.2 Identify national and regional capacity for management development. 4.3 Development management development strategy and outline programme. 5.1 Complete analysis of total health sector financing patterns. 5.2 Cost essential range of services. 5.3 Develop and agree options for user charges and exemption mechanisms policy. 5.4 Complete feasibility study for health insurance and review options. 6.1 Develop context sensitive process and change management tools. 6.2 Develop and cost communication programme for HSR.			

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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