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EVALUATION OF HEALTH-RELATED PROGRAMMES IN AFRICA: A VISION FOR 2020

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## EVALUATION OF HEALTH-RELATED PROGRAMMES IN AFRICA: A VISION FOR 2020

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### ABSTRACT

**Background:** Whereas systematic evaluation practice is over five decades old in economically developed continents (DCs), that culture has not yet taken root in Africa.

**Objective(s):** To provide an overview of the current situation of health-related evaluation in the African Region; to envision an appropriate evaluation framework for the next two decades; and to provide overviews of what formative (FE) and summative (SE) evaluations are and how they could be conducted.

**Design:** Descriptive study.

**Setting:** Health policies and plans evaluation in the WHO African Region.

**Subjects or participants:** WHO Country Representatives for 25 African Countries.

**Interventions:** Non-intervention descriptive study.

**Main outcome measures:** Availability and quality of long-term health plan (LTHP), health policy (HP), strategic plan (SP), operational plan (OP), and an evaluation culture.

**Results:** The study found that: 88%, 8%, 36%, 28% and 48% of the countries in the Region do not have LTHP, HP, SP, OP and evaluation culture. A conceptual evaluation framework, tools for formative and summative evaluations are proposed.

**Conclusion:** It is envisioned that all partners for health development in Africa will cooperate with individual countries to develop (or strengthen) LTHPs, HPs, SPs, and Ministries of Health OPs (national, provincial and district level); and to make complementary investments in building technical and administrative capacity for evaluating implementation of District Operational Plans (DOPs).

### INTRODUCTION

Whereas systematic evaluation practice is over five decades old in economically developed continents (DCs)(1), that culture has not yet taken root in Africa. This is rather unfortunate, since, given its dwindling resource base, there is greater need for resilient and cost-effective performance in Africa than in the DCs. In the next two decades, we envision that evaluation in health care will be a major health policy driving force for a number of reasons. Firstly, since the cold war between the East and the West ended, the total number of grants and soft loans to African Governments and Ministries of Health have tended to decrease, and thus, there is need to optimise the returns from the available resources. Secondly, there is enormous pressure (and it will continue

growing) from multilateral donors for health priorities to be set with reference to outcomes, using economic analysis and measurement of achievement. Thirdly, on the face of growing democratisation in Africa, the next two decades will witness growing pressure from the public on governments and ministries of health to be more accountable and transparent in their spending for health-related activities, and hence, the need for developing sound evaluation systems. Fourthly, in view of the above mentioned challenges, both African Governments and Ministries of Health have a formidable task of reforming the organisation and management of health services and health care financing in a way that helps in pursuit of improved cost-effective public health interventions, efficiency, equity, and quality. Lastly, the evaluation of public health care spending will increasingly be viewed as

a moral obligation, an indispensable managerial approach, and a key element for decision-making towards the achievement of health outcomes.

This paper attempts to address the following questions: (i) What is the current situation of health policies and plans evaluation in the African Region? (ii) What is the appropriate evaluation framework for the next two decades? (iii) What are formative (FE) and summative (SE) evaluations, and how could they be carried out?

**OVERVIEW OF THE CURRENT SITUATION OF EVALUATION IN THE REGION**

*Fools you are to say you learn by experience.*

*I prefer to profit by others' mistakes and avoid the price of my own.*

Otto Von Bismark-Schonhausen, 1815-1898

*Bismark, The Man and the Stateman, 1898*

The main obstacles encountered (Table 1) in Africa in relation to evaluation include: lack of long-term health plans (LTHP); either non-existent or inadequately formulated health policies (HP); either non-existent or inadequately developed (poorly conceptualised and executed) strategic plans (SPs); where SPs exist they rarely impact the day-to-day decisions made in the Ministries of Health - partly because they are often filed away until a revision is mandated by the preparation of the next period's plans; almost singular lack of OPs that operationalise SPs; non-inclusion of evaluation plans in the planning process (and when included they are often to satisfy donor conditionalities); implementation of programmes without policies (or adequately formulated policies) to guide them; lack of evaluation culture; lack of budgets for evaluation; lack of trained manpower in evaluation and the relevant hard/soft ware; lack of standardised tools for evaluation; lack of common understanding of what evaluation entails; lack of culturally acceptable and methodologically sound health index that combines both effects of intervention on quality and quantity of life(2,3,4); multiplicity of factors that confound health impact; and absence of a universally accepted conceptual framework in health within which to undertake evaluation. So far health care programme evaluators have gone about their business as though evaluation occurs in a vacuum, Bryce *et al* (5). The following section argues that evaluation does not take place in a vacuum; and instead, it is part and parcel of the planning (including policy and strategic planning) and implementation processes.

**Table 1**

*Summary of the results from the quick 1999 survey of the existence of policies and plans in Ministries of Health in African Countries*

Planning Document	Yes	No	Respondents' Rating of The Formulation		
			A	B	C
LTHP	12%	88%	0%	67%	33%
HP	92%	8%	19%	38%	43%
SP	64%	36%	42%	29%	29%
POA	72%	28%	8%	38%	54%
Adequacy of POA	72%	18%			
Formative and Summative Evaluation					
Culture	52%	48%	20%	10%	70%

*Note:* Twenty five WHO Country Representatives from various African countries responded.

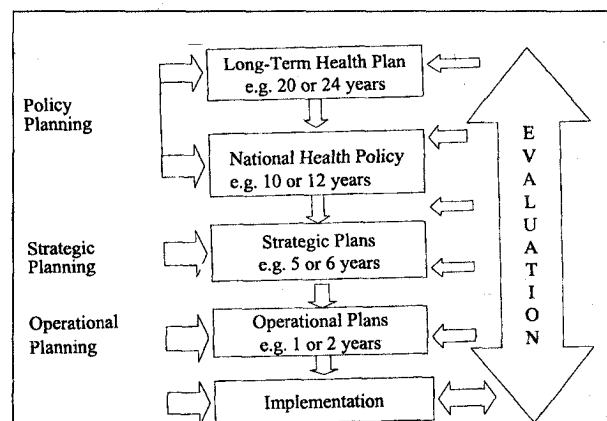
*Key:* A Excellent  
 B Satisfactory  
 C Needs improvement

**A CONCEPTUAL EVALUATION FRAMEWORK**

We envision that in the next two decades all the countries in Africa will have an appropriate evaluation framework consisting of adequately formulated LTHP, HP, SPs, and OPs (Figure 1). The OPs will implement the SPs.

**Figure 1**

*Health-related evaluation framework*



Generally, planning is what we need to do before taking actions. It is the process of establishing objectives and choosing the most cost-effective means for achieving these objectives prior to taking action.

LTHP imply projection of current mortality and morbidity profile (by cause) into the long-term with a view to foreseeing relevant interventions for attenuating suffering and prevent premature deaths in, targeted

communities. Thus, LTHP will provide a long-term vision for improving the health of communities.

HP is a set of statements and decisions defining priorities and main directions for attaining a health goal(6). So, it reflects the national health needs and also includes the selection of national health priorities. It is elaborated within the framework of the national Constitution. So, HP will provide an expression of political commitment for implementing the LTHP.

A health strategy is a broad line of action adopted to give effect to an HP. Strategic planning is the process by which the guiding members (e.g. Minister of Health, Permanent Secretary, Director of Medical Services, Departmental Heads, Provincial plus District Health Heads) of MOH and all the other stakeholders envision the nation's health future and develop the necessary procedures and operations to achieve that future. The SP sets the macro programmatic directions and financial resources associated with each of them. In an SP, targets and results to be achieved in the SP period, which are consistent with the national health priorities, are stipulated. SPs constitutes a secondary step towards implementing the LTHP and HP.

Each OP should contain the following planning elements: priorities, objectives, targets, expected results, activities, resources (i.e. cost distributed by activities and expected results), monitoring and evaluation plan (consisting of responsibilities, monitoring indicators, evaluation indicators, data sources - for verifying indicators, and periodicity).

## FE OBJECTIVES AND FRAMEWORK

### *Working Definition*

The ensuing proposals presupposes existence of rolling national and districts OPs. FE is a continuous follow-up of on-going operational activities, milestones achieved, expected results realized, the use of budget, staff time and other resources, that enables the program managers to take corrective action promptly in response to changing circumstances.

### *Objectives of FE*

The aim of FE is to assess the progress made by DHMTs in implementing planned activities (in relation to the rate at which the resources are being used) and realization of expected results at the end of each year of the OP. The objectives of FE for each OP are:

- to monitor the progress made in implementing of planned activities and achieving expected results; and
- to identify the factors that inhibit the implementation of planned activities and realization of the expected results with a view to tackling them speedily.

### *How FE Could be Conducted*

The tool presented below contains FE Forms 1, 2 plus 3 and instructions on how to complete them. To assess the

degree of the implementation of planned activities, the OP Manager could, using *FE FORM 1*:

- list in *column A* the activities planned for the reporting period.
- assess in *column B* the level of implementation of the planned activities by placing a tick [✓] under either "1= fully implemented", "2=partially implemented", or "not implemented".
- code indicate in *column C* whether each activity was: 1 = fully implemented at exactly the allocated budget, 2 = fully implemented at less than the allocated budget, 3 = fully implemented at more than the value of allocated budget, 4 = partially implemented although the whole budget was spent, 5 = partially implemented although some of the allocated budget was not spent, 6 = partially implemented although the allocated budget was exceeded, 7 = not implemented although the whole budget was spent, 8 = not implemented although some of the allocated budget was spent, 9 = not implemented and none of the allocated budget was spent, 10 = other (specify).
- explain in *column D* the reasons for either partial-implementation or non-implementation (where applicable) of planned activities.

To assess the degree to which the expected results are being achieved, the OP Manager could, using *FE FORM 2*:

- list in *column A* the expected results for the reporting period.
- assess in *column B* the degree of achievement of the expected results by placing a tick [✓] under either "1=fully achieved", "2=partially achieved", or "3=not achieved".
- code indicate in *column C* whether each expected result was: 1 = fully achieved at exactly the allocated budget, 2 = fully achieved at less than the allocated budget, 3 = fully achieved at more than the value of allocated budget, 4 = partially achieved although the whole budget was spent, 5 = partially achieved although some of the allocated budget was not spent, 6 = partially achieved although the allocated budget was exceeded, 7 = not achieved although the whole budget was spent, 8 = not achieved although some of the allocated budget was spent, 9 = not achieved and none of the allocated budget was spent, 10 = other (specify).
- state in *column D* any relevant comments you may have regarding the level of achievement.

Finally, regarding the reprogramming, for the following year of the planned activities not implemented during the year under evaluation, the OP Manager could, using *FE FORM 3*:

- list in *column A* the activities planned for the year under evaluation but were not implemented, and thus, need to be reprogrammed for next year.
- provide in *column B* the estimated cost of implementing the reprogrammed activities.
- give an indication in *column C* whether the funds for

implementing reprogrammed activities will still be available next year.

## SUMMATIVE EVALUATION (SE)

### Working Definition

SE is a systematic and critical analysis of the relevance, adequacy, progress, efficiency, effectiveness, impact / effect and acceptance of an OP. Thus, it is a systematic way of learning from experience and using the lessons learned to promote better planning and better use of resources in subsequent OP periods to reach the targets. The planning elements to be subjected to SE would include objectives, targets and expected results.

SE could involve the following seven stages:

- Assessment of Relevance of the planning elements (i.e. objectives, targets and expected results) to the national health priorities as stipulated in LTHP, HP and SPs.
- Assessment of Adequacy - evaluate the extent to which sufficient attention was paid to the formulation of the OP objectives, targets, expected results, activities, resources and evaluation indicators. At issue are whether the different elements are well linked and whether budgeted resources are adequate to achieve the expected results.
- Assessment of Effectiveness - to assess the degree of achievement of objectives, targets and expected results as expressed in the OP.
- Assessment of Efficiency - an examination of the results achieved in relation to the resources used to implement OPs. At issue is the extent to which the available resources were optimally used.
- Assessment of Quality - extent to which a result meets technical standards and clients expectations.
- Assessment of Acceptability - the extent of appreciation of OP results by the beneficiaries.
- Assessment of Impact - the total, direct and indirect, effects on health status and socio-economic development of the target population(s).

### Objectives of SE

The purpose of SE would be to assess the level (or degree) of success achieved (including the explanatory factors) with a view to improving programme design in subsequent OP periods. The specific objectives would be:

- a. to assess the level of **achievement** of objectives, targets and results;
- b. to analyse the **relevance** of OPs to national and district health priorities;
- c. to assess the **technical quality** of the results;
- d. to do a retrospective analysis of **adequacy** of planning elements and organizational mechanisms;
- e. to assess the **utilization** of results by health programmes, clients and other relevant partners;
- f. to assess the **efficiency** with which objectives, targets and expected results are realized; and
- g. to provide insights for better planning in future.

### How SE Could be Conducted

SE could be conducted using SE Forms 1, 2 and 3 presented below. To assess the degree of achievement and relevance of OP objectives, the Programme Manager could, using **SE FORM 1**:

- list in **column A** the objectives for the OP period.
- assess in **column B** the level of achievement of each objective by placing a tick [✓] under either "1 = fully achieved", "2 = partially achieved", or "3 = not achieved".
- assess in **column C** the relevance of each objective to the national health priorities by placing a tick [✓] under either "1 = totally relevant", "2 = partially relevant", or "3 = not relevant".
- assess in **column D** the relevance of each objective to the district health priorities by placing a tick [✓] under either "1 = totally relevant", "2 = partially relevant", or "3 = not relevant".

To assess the degree of achievement and relevance of OP targets, the Programme Manager could, using **SE FORM 2**:

- list in **column A** the targets for the OP period.
- assess in **column B** the level of achievement of each target by placing a tick [✓] under either "1 = fully achieved", "2 = partially achieved", or "3 = not achieved".
- assess in **column C** the relevance of each target to the OP objectives by placing a tick [✓] under either "1 = totally relevant", "2 = partially relevant", or "3 = not relevant".
- assess in **column D** the relevance of each target to the national health priorities by placing a tick [✓] under either "1 = totally relevant", "2 = partially relevant", or "3 = not relevant".

To assess the degree of achievement, technical quality, relevance, adequacy and utilization of OP expected results, the Programme Manager could, using **SE FORM 3**:

- list in **column A** the expected results for the OP period.
- assess in **column B** the level of achievement of the result by placing a tick [✓] under either "1 = fully achieved", "2 = partially achieved", or "3 = not achieved".
- assess in **column C** the technical quality of the result by placing a tick [✓] under either "1 = excellent", "2 = satisfactory", or "3 = poor".
- assess in **column D** the relevance of the result to the targets stated in the OP by placing a tick [✓] under either "1 = totally relevant", "2 = partially relevant", or "3 = not relevant".
- assess in **column E** the adequacy of formulation of the expected results by placing a tick [✓] under either "1 = perfectly adequate", "2 = partially adequate", or "3 = not inadequate".

To assess the degree of efficiency, the Programme Manager could, using **SE FORM 4**:

- list in **column A** the expected results for the biennium.

- assess in **column B** the level of achievement of each expected result by placing tick [✓] under either “fully achieved”, “partially achieved”, or “not achieved”.
- list in **column C** the budget allocated to each result.
- list in **column D** the actual expenditure of money on each result.
- indicate in **column E** the cost variation, i.e. C minus D. If negative, please put the figure in brackets.
- and codes in the last row, analyse in **column F** the relationship between the consumption of allocated budgetary resources and the level of achievement of each expected result.
- in **column G**, give a few general comments, if relevant.

### THE EVALUATION PROCESS

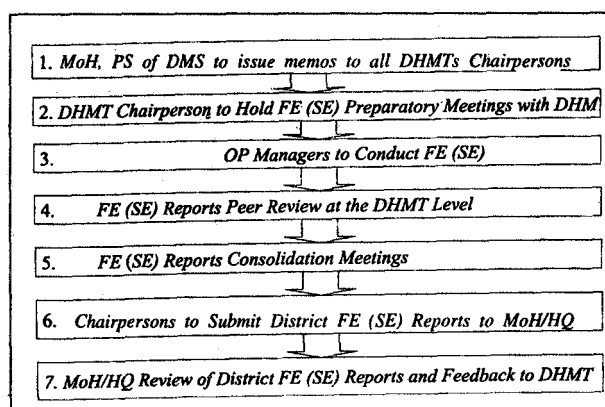
We envision that both FE and SE would entail the process summarized in Figure 2. It consists of seven steps.

**Step 1: Minister of Health (MoH), Permanent Secretary (PS) or Director of Medical Services (DMS) to issue memos to all District Health Management Teams (DHMTs) Chairpersons**

The purpose of the memo would be to circulate the agenda for the FE and SE preparatory meetings. It is vital for guidelines to be sent from a very senior office within the Ministry of Health to underscore the importance of evaluation.

**Figure 2**

*Evaluation process*



**Step 2: DHMT Chairperson to hold FE and SE Preparatory meetings with DHMT**

The preparatory meeting, consisting of all OP managers in the District, will be chaired by a DHMT Chairperson. The objectives of the meeting would be to:

- discuss the objectives of FE and SE;
- confirm information to be used;
- review the sources of monitoring data;
- divide internal responsibilities for the FE and SE exercises;
- take the participants through the FE and SE frameworks; and
- draft a schedule of activities related to FE and SE.

**Step 3: Conduct the FE and SE**

The OP Managers of various OPs at the DHMT will conduct FE and SE using *FE Forms 1, 2 and 3, and SE Forms 1, 2, 3 and 4*. Each Manager would be expected to write up a short report (e.g. 300 words) with completed forms annexed to it.

**Step 4: Peer Review at the DHMT Level**

Each DHMT would hold a meeting to critically and systematically review FE and SE reports for OP. In the course of the meeting the OP Managers could be called upon to provide evidence for the assessment made. The meeting ought to make appropriate recommendations for improving the implementation of the remaining planned activities.

**Step 5: FE and SE Reports Consolidation Meetings**

The DHMT Chairperson can consolidate the FE and SE reports for the district. For example, if a district has got 10 integrated programs OPs, the narrative part of the district FE (or SE) report should not be more than 3000 words. Completed FE and SE Forms for all OPs should be annexed to the report.

**Step 6: Chair Persons to Submit District FE and SE Report to the Ministry of Health (MoH) Headquarters (HQ)**

The Ministry of Health Headquarters (MoH/HQ) has to establish deadlines for submission of district FE and SE Reports to MoH/HQ.

**Step 7: MoH/HQ Review of District FE and SE Reports and Feedback to DHMT Chair**

To accord the FE and SE processes the importance that they deserve, the district reports should be channeled through either the MoH, PS or DMS. In addition, the feedback to the DHMT Chairpersons should follow the same channel.

### CONCLUSION

At the DHMTs level, we envision that:

- evaluation will be conducted within the conceptual frameworks proposed in this paper;
- there will be dramatic growth in commitment at all levels to a “culture of evaluation” (in other words evaluation will become a part of the managerial culture);
- training will take place to ensure informed management practices (in planning, implementation and evaluation);
- appropriate and adequate public resources will be allocated for planning and evaluation activities;
- the decisions of policy makers in developing/revising policy, setting priorities, establishing new programmatic areas of work or reforming existing ones, reforming health systems organisational structures and management styles would increasingly

depend on evaluations;

- planning and evaluation will be based on broad integrated programs as opposed to narrow disease specific vertical programs;
- cost-effectiveness and efficiency evaluations will be the norm rather than an exception;
- planning and evaluation will be on the basis of the managerial process for national health development starting at district health system level; and
- result-oriented health-related management approach would flourish across all countries in Africa.

In conclusion, evaluation is a necessary but not sufficient condition for achievement of national health missions and goals. We envision that all partners for health development in Africa will cooperate with individual countries to develop (or strengthen) LTHPs, HPs, SPs, and Ministries of Health OPs (national, provincial and district level); make complementary investments in building technical and administrative capacity for evaluating implementation of DOPs; provide support for planning, monitoring and evaluating the national health policies and plans. There ought to be a genuine desire to work together with countries to build national evaluation capacity. Although it was never our intention to propose a completely new way of doing things, to make a significant improvement in the health status of the citizens of Africa, we need to critically and systematically scrutinise whether people are getting optimal health returns from the health sector investments. That calls for a rapid growth in evaluation culture. For such a culture to take root in Africa, Ministers of Health, Permanent Secretaries and Directors of Medical Services ought to be intimately involved in the formative and summative evaluation of DOPs. They can delegate tasks related to evaluation to the relevant technocrats, but not the ultimate responsibility. Nevertheless, we would not

be shocked if this proposal is not welcomed by those who profit from the status quo. Our hope is that this work will enlighten decision-makers and stimulate critical debate for further action.

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