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A FRAMEWORK FOR PARTICIPATORY EVALUATION OF PRIMARY
HEALTH CARE PROJECTS IN RURAL AREAS

A Dissertation Presented

by

BERENGERE DE NEGRI

Submitted to the Graduate School
of the University of Massachusetts in partial fulfillment
of the requirement for the degree of

DOCTOR OF EDUCATION

May 1988

School of Education
A FRAMEWORK FOR PARTICIPATORY EVALUATION OF PRIMARY
HEALTH CARE PROJECTS IN RURAL AREAS

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BERENGERE DE NEGRI

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I would like to acknowledge all my teachers who helped me going through my Master in Science and my Doctorate in Education at the University of Massachusetts at Amherst. I am particularly indebted to the chairman of my doctorate dissertation committee, Dr. Robert Miltz and all the members Dr. Peter Pellett and Dr. Hari Swaminathan who helped and provided support all along my research effort. I also want to offer my gratitude to the people of the Center for International Education in which I have felt right at home during these last 4 years.

I would like to thank all the people I contacted through mail survey and direct interview. They contributed greatly to the framework for evaluation of Primary Health Care projects presented in this thesis.

Last but not least, I would like to express my sincere appreciation for the encouragement and every day support given by my husband and the patience of my children when told that the thesis was almost finished...
ABSTRACT

A FRAMEWORK FOR PARTICIPATORY EVALUATION OF PRIMARY HEALTH CARE PROJECTS IN RURAL AREAS

MAY 1988

BERENGERE DE NEGRI, UNIVERSITY OF BRUSSELS

M.S., HOME ECONOMICS/UNIVERSITY OF MASSACHUSETTS

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Directed by: Professor Robert Miltz.

The participatory approach of Primary Health Care (PHC) is certainly a reasonable philosophy to pursue the goal of Health for All in the Year 2000 set at the Alma Ata conference in 1978. But how could this approach be effectively implemented? The numerous PHC projects which have already been carried out do not provide much information on that point because not enough data have been gathered on their implementation. Few evaluations exist and those existing do not shed much light on the reasons of the successes or failures. A more systematic evaluation of PHC projects is necessary in order to build on previous experiences and propose better health projects and programs in the future.

The present research has for overall objective the
development of a framework to systematically evaluate PHC projects or programs. The evaluation is participative and involves a continual monitoring of the activities implemented. The participatory evaluation process is, in this manner, linked to the managerial process. It is also connected with the educational process as the participants are "learning by doing".

A "proposed framework" to evaluate PHC projects was developed from the literature on the subject and submitted to the critics of 120 persons involved in the PHC and related fields through a questionnaire survey. Thirty two responses were used. In addition seven direct interviews related to the evaluation approach were carried out. The reviewers endorsed most of the framework and recommended some change and improvements which were incorporated in a new version called the "revised framework".

The study ends up recommending ways of implementing this framework and of improving it through some participatory research aimed at detailing further the monitoring system proposed.
# TABLE OF CONTENTS

ACKNOWLEDGEMENTS.................................................. iv

ABSTRACT............................................................... v

LIST OF TABLES......................................................... ix

LIST OF FIGURES....................................................... x

Chapter

I. INTRODUCTION..................................................... 1

   Background to the Study........................................ 1
   Statement of the problem........................................ 2
   Statement of purpose............................................ 3
   Rationale and significance of the study....................... 4
   Clarification and delimitations............................... 5
   Assumptions..................................................... 5
   Theoretical rationale.......................................... 5
   Definition of important terms................................. 6
   Limitations of the Study.................................... 8
   Organization.................................................. 10

II. REVIEW OF THE LITERATURE.................................. 11

   Women and Health in Rural Area............................. 11
   Primary Health Care Approach................................ 19
      Primary Health Care (PHC).................................. 20
      Community Participation/Community Involvement......... 22
      Education for Health....................................... 29
   Evaluation of Health Development.......................... 32
      Evaluation.................................................. 32
      Participatory Evaluation.................................. 40
      Previous Experiences in PHC and Participation......... 49

III. THE PROPOSED FRAMEWORK................................. 58

   Development of the Framework................................ 60
      Component 1: A rural, intersectoral and part participative approach.......................... 62
      Component 2: Appraisal and monitoring...................... 64
      Component 3: Decision making................................ 66
# TABLE OF CONTENTS (Continued)

<table>
<thead>
<tr>
<th>Chapter</th>
<th>page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Component 4: Consideration of alternatives</td>
<td>67</td>
</tr>
<tr>
<td>Component 5: Outsider’s evaluation</td>
<td>68</td>
</tr>
<tr>
<td>Component 6: Health indicators</td>
<td>69</td>
</tr>
<tr>
<td>Component 7: Ex-post evaluation</td>
<td>69</td>
</tr>
<tr>
<td>Development of the Questionnaire</td>
<td>70</td>
</tr>
<tr>
<td>Pretesting and selection of the sample</td>
<td>71</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>73</td>
</tr>
</tbody>
</table>

## IV. FINDINGS

<table>
<thead>
<tr>
<th>Collection of Data</th>
<th>76</th>
</tr>
</thead>
<tbody>
<tr>
<td>Questionnaire: Respondent’s description</td>
<td>78</td>
</tr>
<tr>
<td>Statements regarding community participation</td>
<td>82</td>
</tr>
<tr>
<td>Statements regarding evaluation</td>
<td>85</td>
</tr>
<tr>
<td>Statements regarding the proposed framework</td>
<td>89</td>
</tr>
<tr>
<td>Additional findings: Comparative analysis</td>
<td>95</td>
</tr>
<tr>
<td>Synthesis of Comments</td>
<td>97</td>
</tr>
<tr>
<td>Community participation</td>
<td>97</td>
</tr>
<tr>
<td>Evaluation of PHC</td>
<td>98</td>
</tr>
<tr>
<td>Proposed framework</td>
<td>99</td>
</tr>
<tr>
<td>Synthesis of the Interviews</td>
<td>101</td>
</tr>
<tr>
<td>Community participation</td>
<td>102</td>
</tr>
<tr>
<td>Evaluation of PHC</td>
<td>104</td>
</tr>
<tr>
<td>Proposed framework</td>
<td>107</td>
</tr>
</tbody>
</table>

## V. FRAMEWORK REVISED AND RECOMMENDATIONS

<table>
<thead>
<tr>
<th>The Revised Framework</th>
<th>112</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Dynamic of the Framework</td>
<td>117</td>
</tr>
<tr>
<td>Recommendations</td>
<td>120</td>
</tr>
<tr>
<td>Conclusions</td>
<td>125</td>
</tr>
</tbody>
</table>

## APPENDICES

<table>
<thead>
<tr>
<th>A. Cover letter for questionnaire</th>
<th>128</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Postcard reminder</td>
<td>129</td>
</tr>
<tr>
<td>C. Questionnaire</td>
<td>130</td>
</tr>
<tr>
<td>D. Comments from questionnaires</td>
<td>131</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>139</td>
</tr>
</tbody>
</table>

REFERENCES                                                                | 148  |
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Types of evaluation activities and corresponding evaluation issues..........</td>
<td>36</td>
</tr>
<tr>
<td>2.</td>
<td>Tools to measure success through participatory evaluation....................</td>
<td>43</td>
</tr>
<tr>
<td>3.</td>
<td>Summary of the number of questionnaire responses..................................</td>
<td>77</td>
</tr>
<tr>
<td>4.</td>
<td>Respondents' descriptive data.............</td>
<td>79</td>
</tr>
<tr>
<td>5.</td>
<td>Participants’ responses to attitudinal statements regarding community participation of PHC project</td>
<td>83</td>
</tr>
<tr>
<td>6.</td>
<td>Participants’ responses to attitudinal statements regarding evaluation of PHC project</td>
<td>87</td>
</tr>
<tr>
<td>7.</td>
<td>Participants’ responses to attitudinal statements regarding the framework...</td>
<td>91</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>The Primary Health Care Triad</td>
<td>25</td>
</tr>
<tr>
<td>2.</td>
<td>Organigram of the Proposed Framework</td>
<td>63</td>
</tr>
</tbody>
</table>
Chapter I

INTRODUCTION

Background to the Study

Today the quality of life and health status in less developed countries is being recognized as being a priority in the overall development effort. During the International Conference on Primary Health Care (PHC) organized by UNICEF and WHO in Alma-Ata, URSS, in 1978, the concept of PHC was defined and recognized as being an approach to improvement of the health status of everyone, a health status that will permit everyone to lead a socially and economically productive life.

It is realized today that good use of existing knowledge by individuals or communities contribute more in promoting health than generating additional knowledge and technology.

This study will center on integrated rural projects aimed at improving the health status of the population which will participate actively in the development activities. It is felt that it is difficult to implement such projects but their benefits will be long lasting. The focus of our research will be on the implementation - evaluation part of the primary health care component of these projects and the educational implication of participatory evaluation.
Statement of the problem

The Declaration of Alma-Ata designated "education concerning prevailing health problems and the methods of preventing and controlling them" as the first of eight essential activities in PHC. This Declaration mentioned also that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care" (WHO, 1978).

New Approaches to Health Education in PHC were proposed it is essential to review the current approaches to health education in order to identify those that continue to be relevant, to abandon those that are no longer valid, and to develop new approaches which could help in achieving the objectives of health for all through PHC... One major objective is to help individuals and communities becoming self-reliant in dealing with health problems and to raise the effectiveness of the lay contribution to health. (WHO, 1983a, pp. 40-41)

It is within this context that our research in PHC education has been pursued.

To follow the goal of Health for All, and to develop the concept that Rene Dubos, a French eco-biologist, developed "Think globally, act locally", this study will examine how participatory evaluation in PHC rural projects can be an educational and relevant intervention in these activities.
Statement of purpose

If the people can define their health problems, find solutions to them, and be able to evaluate their health activities, they should improve their own health rather than rely on others doing so for them.

With this assertion in mind, the purpose of this study is to look at participatory evaluation as an integral component of any PHC project. It is thought that integrating realistic evaluation criteria defined by the lay persons themselves, will contribute and reinforce the role of health education by (1) promoting individual and community involvement and self-reliance, (2) by paying additional attention to monitoring and evaluation and learning in the process.

The purpose of this study is to propose a framework for better implementation and systematic self-evaluation of PHC projects. The proposed framework uses on a continual basis the main element of PHC philosophy: effective community participation and add to it a new approach of education: a ongoing self-evaluation. The framework proposed will be based on (1) present body of the literature on the subject; (2) past and ongoing field projects experiences and (3) feedback from officers of different organizations familiar with evaluation of health projects.
Rationale and significance of the study

It is now recognized that a community’s values and norms play a vital part in defining a general approach to improve people’s health. The process of socialization is one of the most important mechanism in transmitting certain values and norms from one generation to the next. The emphasis of health education is then placed on social factors associated with health, instead of individual factors associated with health and illness.

According to WHO Global Strategy for Health for All by the Year 2000 (WHO, 1981a), and the WHO Seventh General Programme of Work, (WHO, 1982), it is essential to develop new approaches of health education which could help to achieve the objectives of health for all through PHC.

With the recognition that people are able to think and act constructively in identifying and solving their own problems, the emphasis in health education is shifting from "intervention" to community involvement. (WHO, 1983a).

The rationale for proposing a framework of participatory evaluation of PHC project is based on partial failure of these types of projects and the indication that participation by the people to be helped is found essential in the implementation of such projects.

By presenting a final framework, based on past experiences of PHC projects with community participation,
actual evaluation frameworks and feedback from experts in the field, this study hopes to gather a body of information that could help better implement such projects in the future.

Clarification and delimitations

Assumptions. (1) Political support exists for a participatory approach to health development.

(2) The underlying concept of health education participatory activities is that members of the community involved are able to think together and allow to act constructively in contributing at the identification and solution of their own problems. They have some form of organization before the project starts.

Theoretical rationale

The involvement in rural area and the participation of women are key factors in improving health in developing countries.

Based on new experiences related to health education in PHC, it has been shown that evaluation and people involvement are essential in implementing this type of projects. It is also recognized that it is more urgent to make good use of existing knowledge than to generate additional knowledge and new tools (WHO, 1983a).
Self-evaluation made by the people themselves (participatory evaluation) is seen as an important existing tool to make people know better what the requirements and constraints of their environment are and to integrate this in a strategy for health education.

The purpose of self-evaluation in health development projects is to improve their implementation. Evaluation is perceived as a decision-oriented tool and a necessary part in the learning process.

**Definition of important terms**

(1) Health: is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1954). This statement has been amplified to include the ability to lead a socially and economically productive life.

(2) Primary Health Care (PHC): The term PHC is used to describe many different activities to extend basic health services to unserved populations. It implies a variety of approaches which are categorized as curative, preventive and promotive. The concept of PHC, launched by WHO in 1978 meant "essential health care" that is accessible, affordable and acceptable to everyone in the country.

(3) Health Education (HE): is a continuous process involving community to achieve health goals, here set within
the objectives of PHC. It aims to activities that encourage people to: 1/ want to be healthy; 2/ know how to stay healthy; 3/ do what they can individually and collectively to maintain health; 4/ seek help when needed (WHO, 1983a).

(4) Participation: a process in which a group of people takes action, stimulated by their own thinking and decision-making and over which, they exercise specific controls (Feuerstein, 1980).

(5) Community Involvement: is a process by which partnership is established between government and local communities in planning, implementation and utilization of health activities in order to benefit from increased local self-reliance and social control over the infrastructure and technology of PHC, (Fonaroff, 1983)

(6) Evaluation: is a systematic way of learning from experience and using the lessons learned to improve current activities and promote better planning by careful selection of alternatives for future action (WHO, 1981b).

(7) Participatory Evaluation (PE): is also called self-evaluation. Participation is sought at each stage of the evaluation, not simply at the beginning but also during selection and application of methods for collecting various types of data through to analysis and action based on findings (Feuerstein, 1980). It is an appropriate combination of knowledge and action in which the people are
the real actors (Saint, 1981).

(8) Women in rural areas: Women are the pillar of the family in rural areas. They not only bear, raise and feed the children but often work in agricultural fields and/or in the commerce activities. As such, the woman is the principal but often overlooked actor of health in rural areas of developing countries.

Limitations of the Study

(1) The environment for the framework to be proposed is the rural area which is usually poor and deprived of good infrastructure important in improving health status. The conditions of the people living in this environment will have to be considered realistically, especially their low level of education and low starting health status characterized by malnutrition. This will limit the type of participation that can be expected to evaluate PHC projects.

(2) Because women have such a determinant role in setting the health standard for their family, this approach will assume their heavy participation. Of course this does not preclude the participation of other member of the community, specially their leaders.

(3) As the population in rural areas of developing countries are not homogeneous, this approach will have to be
flexible enough to be applied in these different circumstances. From this point of view, the framework will not be limited by geographical and cultural setting but by the lack of specificity for a particular culture in a given geographical environment.

(4) The evaluation framework will be proposed for the implementation of PHC projects at the local level. This assumption supposes the support at the district and the central levels. This system is limited by the willingness of the higher hierarchy to accept and help the proposed delegation of responsibilities. Evidently the information of the evaluation will be useful for managerial purposes at all three levels.

(5) Various projects can be designed in PHC. We will limit the framework to PHC activities that are more relevant to rural areas but it could be used in more general projects also.

(6) Changes in a health situation are often due to a variety of elements outside the health sector, making evaluation quite difficult. The political and economic situation influencing the project will not be considered as such but only through feedback of the people involved in the implementation and evaluation of the health activity.
Organization

Following this introductory chapter, the study contains four other chapters. Chapter II presents the literature review which is divided into three main parts providing the actual context and bases on which the framework is developed.

Chapter III presents the procedures and research instruments for the development of the framework. A framework for participatory evaluation of PHC projects is proposed which is based on the review of the literature made in Chapter II. The construction of the evaluation framework has been using three main pieces of information: (1) existing evaluation methodologies; (2) PHC project experiences that have stressed community participation and evaluation; (3) a questionnaire sent to officers familiar with PHC evaluation projects and (4) some interviews.

Chapter IV presents the findings of the questionnaire with first, the collection of data, sample description and descriptive analysis of the participants, then the attitudinal statement analysis of the questionnaire. The interviews are summarized in this chapter also.

Chapter V develops the modified framework based on the findings, followed by recommendations and conclusions.

The appendices gather the questionnaire answers.
Chapter II

REVIEW OF THE LITERATURE

The literature review has been made having the development of a framework for evaluating Primary Health Care (PHC) projects in mind. The framework is intended to be used in rural area and for health projects with an active women’s participation especially in the evaluation of the activities undertaken. The review of the literature is consequently subdivided in three areas:

Women and Health Development in Rural Area

Primary Health Care Approach

Evaluation of Health Care Activities.

This review of past and present experiences and research in the above area plus our own experience will provide the basis on which the proposed framework for evaluating PHC projects is established.

Women and Health in Rural Area

If the goal of health for all must be attained, it is recognized that more attention is to be given to women’s health and their roles in health care in the development process.

It is also recognized that the majority of the people in
less developing countries, lives in rural areas, and that women have an active role in that environment. A review of literature on rural development in less developing countries with a special interest on women’s roles and status will be first presented.

In 1976, Burki and Voorhoeve (1977) estimated that the "absolute poor" in LDC’s i.e. those not meeting the basic needs, and excluding China, to be about half of the rural population, or about 650 million, and about one third of the urban population, or about 180 million. For this reason, our focus will be on rural area. This poverty is reflected in poor nutrition, low health standards and inadequate shelter --all affecting the productivity as well as the quality of life of rural populations. Developing countries were once self-sufficient in food. Now they import 10% of their total consumption: 80 million tons of food grains each year (Laidlaw and Laishey, 1980). Around the 1970s, cash cropping for export have led to a decline in food production for local needs.

Knowing that in third world countries, 70 to 90 per cent of the women work in agricultural areas (Boulding, 1980; World Bank, 1980; WHO, 1985a) and that women are the majority of the world’s wood producers (Boserup, 1970), women’s roles and status in rural development should be emphasized.
Many activities traditionally performed by women in developing countries, have been changed. Colonialism and modernization have lowered women's status while raising men's, by imposing new patterns of sex roles in farming and trading (Boserup, 1970).

In traditional rural societies, the family is the unit through which people seek to fulfill their needs and improve their condition. According to the literature, (Boserup, 1970; Pala, 1976; Zeidenstein, 1979), the contributions of rural women to family life go far beyond the provision of the traditional care and feeding of family members. Although the specific tasks performed by women may vary because rural cultures and rural settings differ from one country to another, their activities are often the basis for family survival (Weisblat, 1974; Zeidenstein, 1979).

Most of women's energies are spent in finding food for survival of their families. In most cases the work of rural women includes childbearing and rearing, household provisioning and management (cooking, cleaning, washing clothes, household repair and manufacture, fuel gathering, and provision of water), as well as income generation through participation in aspects of agricultural production and processing, livestock raising, artisan production, and trade (Zeidenstein, 1979; Pala, 1979).

Women may be producing as much as 50% of the food
production. In some countries and regions the figure is much higher e.g. 60 - 90\% of all agricultural work in Africa. In Bangladesh, 90\% of the female population is engaged in agriculture. In addition, women spend twice as much time in food processing and preparation than in agriculture. Long walk to fetch water and fuel is another overlooked women's activity (Hoskins, 1979; WHO, 1985a).

Strangely however, the history of land policies, from colonial times through development planning and land reform programs, is one of women losing their rights and access to land and its concomitant benefits (Rogers, 1979). With the best land under cultivation for commercial crops, women have to work harder on poorer pieces of land. Land reform, or changes in the land tenure system, as been cited as a priority if the lot of the poorest rural food producers is to be improved (Karl, 1983).

The western model of economic development with its emphasis on cash crops and the use of western agricultural technology, taught only to men, completely overlooked women's key in farming, food processing and production (Boserup, 1970). Special effort to meet the needs of women and the development of appropriate technology depending and local and cultural needs, is seen as one of the most important change to improve the future for rural women and therefore, for the community.
With their double-day of work, women are certainly facing the problem of "lack of time". Do they have time and energy to receive more education, even in a non-formal way? To answer this question, non-formal educational activities addressed to rural women should be approached in such way that any increase of education must come from the "every day life". New ways of education must be found, which "fit" in the day activities (WHO, 1985a; McSweeney & Freedman, 1980). This important fact needs to be taken into consideration in the proposed framework.

Women and health status are strongly related in rural areas. Through their contribution to the health of their families and community, women are central to health and development and they ought to be fully integrated in the "Health-for-All" effort. If they are ignorant, malnourished, or overworked, the health of their families as well as their own will suffer. It is the women who are raising the future generations by ensuring that their children are growing in a safe home environment. They are the ones who are expected to be the first health educators. Women are seen as a key health resource (WHO, 1985a). An annotated bibliography on Women in Health has been done elsewhere (Pizurki, 1982).

Health development is related to the overall economic rural development of a community or region. It has become almost universally accepted that the introduction of modern
health technology to developing countries won't improve the rural and poor populations unless the whole health delivery system and its pattern is altered. (WHO, 1981a) and a multisectoral approach is followed (WHO, 1983, 1984).

Over the past three decades, health care and services have been increasingly defined in terms of medicine and medical care, rather than in terms of those activities and behaviors which actually produce health. Long term investments in public health, such as facing pollution problems, providing better water, sanitation, access to food and vaccination are too often by-passed (Cottingham, 1983).

This concern is not entirely new. Taylor and Hall wrote:

Improved agriculture, by providing more and better food, decreases mortality. Better transportation, by reducing the loss of food and decreasing isolation and ignorance, leads to the same result. Improved housing decreases crowding, and the more favorable home environment reduces the spread of communicable diseases. Improved water supply for agricultural, industrial, or other uses not primarily associated with health also reduces the spread of disease. Basic education increases understanding of personal hygiene and of the causes of disease. Mass media help diffuse knowledge and ideas. (1967, p. 651)

Taylor and Hall' view has been confirmed later by analysis of the facts. The commonly held view among development specialists during the 1950’s and 1960’s that the introduction of Western medical and public health
technologies only were responsible for the precipitous declines in mortality experienced by less developed countries (LDC) has been challenged (Kocher and Cash, 1979). It was also believed that these medical and public health interventions could achieve their dramatic results, the life expectancy in LDC’s increases as much during that period as during an entire century in industrialized countries (Morawetz, 1977), in the absence of substantial social and economic changes.

In Sri Lanka, the malaria eradication program was a success. The death rate fell by about 25% between 1945 and 1946 (Marshall, 1974). Some analysts (Newman, 1965, 1970; Barlow, 1967, 1968) wanted to attribute the bulk of post-war mortality decline and corresponding population growth to that particular health activity. Meegama (1967) shows that the eradication was not the primary cause but was responsible for maybe 25% of the overall mortality decline. The rest was apparently due to improved nutrition, extension of medical services and general improvements in economic conditions. The trend of overall mortality decline in Sri Lanka in fact was shown to have started as early as 1910 (Myrdal, 1968).

A similar experience in Thailand has been reported by Sharpston (1976). McDermott (1972) shows the opposite situation in an American Indian reservation where health
services were introduced but without altering the socio-economic milieu. This intervention had no final health impact after the 5 year project. Kocher and Cash (1979) have for their part stressed the synergism of undertaking several activities, nutrition, water improvement, health education, housing at the same time when trying to create basic needs conditions.

More than three quarter of the "really needy" live in rural areas (Burki and Voorhoeve, 1977) in which women play a predominant role as care, food, water, fuel, education providers (Boserup, 1970; Weisblat, 1974; Pala, 1976; Zeidenstein, 1979; Boulding, 1980; World Bank, 1980; WHO, 1985a).

Given these facts of rural life any evaluation has to consider the participation of women. The framework should be simple to be understood by the participants. There is a need to include flexible components that correspond to the many interrelated areas in which education will have to be provided.

Health interventions per se are not very successful when not integrated with other complementary activities (Taylor and Hall, 1967; Meegama, 1967; McDermott et al., 1972; Sharpston, 1976). These other activities such as agriculture, water sanitation, education and housing, have with health a synergetic effect and the best combination for
the lowest cost has to be sought. The evaluation needs to be intersectoral and to involve the participation of all the persons responsible of the final health impact. As in the case of the rural setting, the framework will have to be flexible enough to accommodate many possible mix of activities needed to bring a successful health education and a mix of participation.

**Primary Health Care Approach**

The link between general development and health status recognized in the beginning of the 70's and just alluded to in the previous section on rural development and health brought about a new concept in health: Primary Health Care (PHC).

This new philosophy requires community participation (CP) or even more than that, it requires community involvement (CI) at all stages in the health planning process. Education is the cornerstone of the implementation of this new strategy. After reviewing succinctly the literature on PHC, we will look more specifically at CI and health education literature.
Primary Health Care (PHC)

At the Alma-Ata conference the PHC concept was formally defined as follows:

Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self reliance and self determination. It forms an integral part both of the country’s health system, of which it is the central junction and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where live and work, and constitutes the first element of a continuing health care process. (WHO, 1978, p. 3)

PHC focuses on the availability of resources such as education, water supply and food supply. Health is an integral part of overall development. It requires much more involvement by people themselves as individuals, families and communities (WHO, 1984).

The PHC strategy requires a change in the health care system from a hospital based system providing relatively sophisticated and costly care to a system meeting the essential needs of the majority (WHO, 1984). The new strategy requires also an intersectoral approach and an approach that involves individual and collective
responsibility for health.

The Alma-Ata conference drew up the following list of essential elements in order to define the minimum services necessary for achieving health for all. These are:

a) education concerning prevailing health problems and the methods of preventing and controlling them;
b) promotion of food supply and proper nutrition;
c) an adequate supply of safe water and basic sanitation;
d) maternal and child health care, including family planning;
e) immunization against the major infectious diseases;
f) prevention and control of locally endemic diseases;
g) appropriate treatment of common diseases and injuries;
h) provision of essential drugs. (WHO, 1978, article VII, item 3)

In real life, these elements cannot be so distinctly separated. As such, the PHC approach may be seen as a set of principles which should guide project design or strategies to achieve better health as opposed to merely planning improvements in health services (Walt and Vaughan, 1982).

The five main components of PHC activities as seen by Walker (1982) are:

(1) peripheral or basic health services and village health worker (VHW) schemes;

(2) intermediate level support to the basic health services and VHW schemes by regional and district services;
(3) intersectional activities particularly with regard to environmental health, nutrition and disease control;

(4) community and individual participation in all aspects of health care, from self-care to involvement in planning and organizing services;

(5) cooperation and coordination with the traditional, private and non-government systems of health care.

The potentials and pitfalls of PHC have been reviewed by Stephens and Kessler (1979). A literature review on PHC has been made by Bossert (1982). By including a review of the meaning of PHC, it is intended to set clearly the context for which the evaluation framework has been developed. A crucial dimension of the PHC philosophy is the participation of the community to which we turn now.

Community Participation/Community Involvement

Although community participation (CP) was already mentioned as an essential component of health promotion in the mid-fifties (WHO, 1954), in 1978, community participation was explicitly defined as:

the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop capacity to contribute to their own and the community’s development. (WHO, 1978, p. 50)

Today, a certain consensus exists on a general working
definition of CP. But before going further, the terms "community" and "participation" must be clarified.

"Community" is seen as a group of people living in the same geographical area with some degree of common interests (PAHO, 1984). Those having a common interest are often different income or family groups. A village is often comprising different sub-committees which are important to distinguish when implementing health programs.

"Participation" of the lay-people is seen as a process where individuals or communities take their own responsibilities for making decisions and carrying out activities. This is what is called "active" participation. White (1982) defines it as "the involvement of local populations in the decision making concerning development projects or in their implementation".

Others define active participation as an educational process which creates awareness, and in which the people themselves try to define their problems, find solution to them, and become active change agents (Bogaert, Bhagat and Bam, 1981; Feuerstein, 1980; Fendall and Tiwari, 1980).

The International Labor Office (ILO), defines participation as:

the collective effort by the people concerned in an organized framework to pool their efforts, and whatever other resources they decide to pool together, to attain objectives set for themselves. (1978, p. 1)
All these definitions have in common that "participation" is perceived as direct involvement of the lay people and not as actions conceived and carried by others, i.e. "passive" participation. In that sense, WHO has preferred the term community involvement over community participation. Their definition corresponds to that adopted by the 33rd World Health Assembly as part of the PHC global strategy for Health for All by the year 2000:

Community involvement is a process by which partnership is established between government and local communities in planning, implementation and utilization of health activities in order to benefit from increased local self-reliance and social control over the infrastructure and technology of primary health care (WHO, 1983b, p.21)

Community involvement is one of these cornerstones of the community based PHC approach called the PHC Triad (figure 1, page 25), (Malher, 1981).

PHC represents the interactive effect of individual, family and other groups in the use of appropriate technology designed to produce specific health benefits jointly with other sectors. It is reinforced by active organization at the village, district and central levels.

Rifkin (1985, 1986) sees CP as the means by which radical health improvements for the majority of the world’s people can be accomplished. CP must be spelled out and "classified" in different areas: breath, mode of action and
Community involvement

Primary health Care

Intersectoral Action

Appropriate Technology

Figure 1. The Primary Health Care Triad


dimensions.

(1) The breath will lead us to these main questions: Who participates? Are women included? Is the most deprived considered in the process?

(2) The mode of action, to these questions: How s/he participates? Which mechanism is used? Who organizes it? Is the community trained? Are the criteria acceptable by s/he?

(3) The dimensions: what kind of participation? Is the community participating in a passive way, receiving only services? Is the participation in all aspects of the program: planning, carrying out activities, taking decision, evaluating?

Even though some common characteristics of community
participation and favorable reasons for its development can be outlined, the degree and perception of participation will always differ according to local beliefs, traditions, taboos. The CP mode of action will also depend on local political conditions.

David Werner (1981) discerned "community-supportive" and "community-oppressive" approaches with regard to community involvement. Susan Rifkin (1981) presented a four-fold typology of approaches in this regard: (1) the public health approach, (2) the health planning approach, (3) the community development approach and (4) the self-care approach. This series reflects a shifting spectrum from "top-down" to bottom-up" approaches.

White (1982) summarizes good reasons for the development of CP, they are:

1. More will be accomplished
2. Services can be provided at lower cost
3. Participation has an intrinsic value for participants
4. Catalyst for further development efforts
5. Participation leads to responsibility
6. Participation guarantees that a felt need is involved
7. Participation ensures are done the right way
8. Use of indigenous knowledge and expertise
9. Freedom from dependence on professionals
10. Conscientization
Martin et al., (1983) recognize that CP

1. promotes social economic development
2. increases self-reliance
3. facilitates behavioral changes
4. contributes unique knowledge resources
5. creates more culturally appropriate services.

The advantages of CP approach have also been given by Mac Lormack as:

(i) A community participation approach is a cost-effective way to extend a health care system to the geographical and social periphery of a country - although it is far from cost-free.

(ii) Communities that begin to understand their health status objectively rather than fatalistically may be moved to take a series of preventive measures.

(iii) Communities that invest labour, time, money and materials in health-promoting activities are more committed to the use and maintenance of the things they produce, such as water supplies.

(iv) Health education is most effective in the context of village activities.

(v) Community health workers, if they are well chosen, have the people’s confidence. They may know the most effective techniques for achieving commitment from their neighbours and, at the very least, are not likely to exploit their neighbours. They come under strong social pressure to help the community carry out its health-promoting activities. However, they must also have dependable supplies and support from the higher levels of the health service. (1983 p. 51)

While these reasons have often been accepted, it is recognized also that many constraints and limitations exist to the implementation of such participation. The major one
is certainly the administrative aspect of the PHC philosophy, which involves a major change in the present health system of most countries. Secondly, community involvement finds its limitations in the level of organization of the community system and its level of education.

To facilitate the contribution of the community in improving health, efforts must therefore begin with a basic understanding of participation, its possible advantages, limitations or constraints based on careful consideration of the political, social and economic environment.

Among the conditions that facilitate effective community participation (PAHO, 1984), are some favorable community characteristics:

1. competent local leadership
2. a certain homogeneity in the community
3. previous experience in participation
4. training and higher level of education
5. strong sense of social cohesion
6. community consciousness of its rights and responsibilities with regard to development.
7. communication and dialogue

A complete literature review on C.I. in PHC have been made in 1983 by Fonaroff in "Community Involvement in Health Systems for PHC" and in 1987 by Oakley "CI for Health
"Development" both for WHO. We will make more references to them as we develop a framework for evaluating PHC projects.

Education for Health

It is not incidental that education was listed as the first element of PHC in the Alma-Ata declaration (WHO, 1978). The WHO Global strategy for "Health for All by the Year 2000" (WHO, 1981a) constantly refers to educational activities as the best way of encouraging people to participate in health care and of making them the true artisans of health and development. The WHO Seventh General Programme of Work stipulates that activities in the field of information and education for health should aim to increase "individual and community capabilities for involvement and self-reliance in health and to promote health behaviour, particularly regarding family health and nutrition, environmental health, healthy life-styles and disease prevention and control" (WHO, 1982).

The PHC revolution gives a de facto important role to health education in promoting individual and community self-reliance and in developing peoples' ability to become full partners in the health development process. Indeed, one major statement in the Declaration referred to above is the affirmation that people not only have the right to participate individually and collectively in the planning
and implementation of health care programs but also a duty to do so (WHO, 1978). The challenge of health education has become to help the people measure up to this task. No longer should the health services filter down through a number of layers to reach the underserved. The people themselves want and need to be the providers and recipients of health education (WHO, 1983a).

The education aspects of PHC should be based on communication and dialogue. Too often, communication has been based on western style and concepts, increasing the interests of the elite, perpetuating the oppression of the poorest (Saint, 1981). Different ways of communication exist, the one linked to participation is what is called the "Liberative communication". According to Paulo Freire (1970), indigenous liberative modes of communication (the original traditional modes of communication) conducts to "cultural action for freedom". It is the expression of people's own desires to share, participate and to become organized.

Having defined a new "health for all" concept (PHC) and having discussed how this concept should be translated in a new type of education characterized by the direct involvement of the people, one is left with the question of what concretly should the roles of health education be. The Director General of WHO has clearly outlined the areas where
new thinking is required:

(1) health education needs to develop new policies in harmony with the principles of PHC and the strategy of health for all by the year 2000;
(2) health education needs to facilitate the development of human resources with the skills to translate social goals into educational objectives for health for all by the year 2000;
(3) health education needs to reflect on the educational and community involvement and self-reliance;
(4) health education needs to strengthen its multisectoral approach and to increase coordination of health education efforts through appropriate technology;
(5) health education must pay greater attention to monitoring and evaluation.
(Malher, 1983, p. 15)

The framework that will be proposed is related to this last point, a very important consideration of the learning process which is to learn from past health activities and failures.

PHC has been defined as a mix of activities of health education, provision of food and water, material and child health care, immunization, treatment of diseases and provision of essential drugs dispensed for the people and by the people (WHO, 1978; Walker, 1982; Walt & Vaughan, 1982; WHO, 1983a). The need of participation of the community and the need to provide a series of health related services, not just one, is stressed.

Education has been cited as the top priority in PHC (WHO, 1978; WHO, 1981a; WHO, 1983a). Active participation is
the *sine qua non* condition for successful education in PHC (ILO, 1978; Bogaert et al., 1981; Feuerstein, 1978, 1981, 1983; Fendall and Tiwari, 1980; Freire, 1970). The new role of education has to be studied and the way to monitor and evaluate education activities in this new context has been important to avoid resources mis-allocation (Malher, 1983).

**Evaluation of Health Development**

Since the 1970’s, there has been greater emphasis on development goals, and on increasing participant involvement and control over development activities. These changes have raised new questions or new perspectives about the effectiveness of what works and what to do.

**Evaluation**

In the context of health development and more particularly of Primary Health Care (PHC), the use of evaluation became somehow confusing. A pressing need to learn more about the process of evaluation that speaks directly to the situation emerged. There is a growing awareness that effective evaluation should replace evaluation coming only at the end of the project and too sophisticated to be interpreted. In other words, the experimental, quantitatively-oriented designs must be
transformed or replaced by small-scale integrated efforts, highly participatory and by internally-organized approaches (ACVAF, 1983).

Evaluation can take several forms and be undertaken for many purposes such as for management and administration, for planning and policy development or to meet fiscal accountability requirements of funding agencies. For all these purposes, the key is to plan and implement an evaluation that is as objective as possible.

The classic approach is to emphasize goals and objectives. Evaluation becomes the process of determining the extent to which the goals and objectives are being attained (Tyler, 1949). For many social scientists, evaluation involves primarily the application of rigorous social science methods to the study of programs (e.g. Bernstein and Freeman 1975; Rossi, Freeman, and Wright, 1979).

Patton (1982), places emphasis on the information needs and interests of specific people, such needs including information relevant to making decisions, judgments, comparisons, or goal attainment assessments.

Another emphasis in evaluation definitions is on the comparative nature of the process: Evaluation is the process of comparing the relative costs and benefits of two or more programs (Alkin & Ellett, forthcoming).
The United Nations, working definition of evaluation is:

a process by which program inputs, activities and results are analyzed and judged against explicity stated norms. The norms may be the stated program objectives, work schedule, budget, etc. (1978, p. 8)

The United Nations (1978) distinguish three types of evaluation, (1) ex-ante (or pre-programme) evaluation; (2) ongoing (or concurrent) evaluation and (3) ex-post evaluation, which is carried out after program implementation. This last one is said summative by contrast to the two first which are called formative.

Formative evaluation produces information that is fed back during the process of a program in order to improve it. Summative evaluation provides information for a final decision or judgment and looks at the total impact of a program.

Another UN definition of evaluation reported by Ford and Sohm (1982) is "a process which attempts to determine as systematically as possible the relevance, effectiveness and impact of activities in the light of their objectives" Vaughan et al. (1984) went further explaining it in terms of PHC. "Relevance" refers to the appropriateness of the PHC strategies and activities to the political, social, economic, cultural and geographical settings.
"Effectiveness" refers to the extent to which the chosen health interventions can reduce disease. Finally, "impact" refers to the actual improvements that have taken place in the health of the people covered by PHC. The impact evaluation is supposed to show the ultimate improvement that all PHC is aiming for.

In the context of health program evaluation, the definition given by WHO is:

a systematic way of learning from experience and using the lessons learned to improve current activities and promote better planning by careful selection of alternatives for future action. (WHO, 1981b, p. 11)

In the same reference, it is stated that

the purpose of evaluation in health development is to improve health programmes and the services for delivering them and to guide the allocation of human and financial resources in current and future programmes and services.... It is essential to perceive evaluation as a decision-oriented tool, and to link the evaluation process closely with decision-making. (WHO 1981b, p. 11)

Klein et al., (1982) write that "there is a general agreement that evaluations include a planning phase, a program implementation or delivery phase and a phase for the assessment of program impact". This is also shared by UNU (1984). If there are demonstrable program impacts, the issue of program efficiency and the relationship of costs to
measured benefits may be include as a fourth phase of program evaluation (Windsor et al., 1984).

Freeman et al., (1979, p. 20) illustrate these phases in a table (Table 1).

Although a comprehensive evaluation includes all these phases, in practice they are sequential activities which are logically interrelated and which proceed in the order described in the table.

Table 1: Types of evaluation activities and corresponding evaluation issues.

<table>
<thead>
<tr>
<th>Types of Evaluation for evaluation:</th>
<th>Purpose:</th>
<th>Monitoring evaluation</th>
<th>Impact evaluation</th>
<th>Cost-benefit Cost-effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>planning</td>
<td>Designing projects in conformance with intended goals</td>
<td>Testing implementation as corresponding to project design</td>
<td>Testing project effectiveness in reaching project goals</td>
<td>Calculating project economic efficiency</td>
</tr>
</tbody>
</table>

Evaluation 1. Extent of questions: problem
2. Identification of targets
3. Distributional characteristics


note: from "Evaluating Social Projects in Developing Countries" (p.20) by Freeman et al., 1979, Paris, OECD.
As one can appreciate there is considerable variety in the terminology employed in the published literature on program evaluation. Furthermore, the boundaries of the field of evaluation *per se* are not entirely clear which create fundamental disagreements. No sentence-definition of evaluation will satisfy its practice.

To facilitate our purpose of establishing a framework for evaluating PHC education activities, a project context will be used. One can say that a program is comprised by a series of different punctual actions or projects. The project is a well defined action that stands by itself, has its own budget and can be evaluated separately from any other project in a program. The project itself is an analytical tool because it establishes a framework for analyzing information from a wide range of sources (Gittinger, 1982).

There tends to be a natural sequence in the way projects are planned and carried out. Baum (1978) calls it the project cycle and devides it into identification, preparation and analysis, appraisal, implementation, and evaluation. The project cycle has been used for almost a decade by the World Bank, to manage and monitor its investments in agriculture and infrastructure and could be used *mutatis muntandis* for our purpose.

The project cycle is very similar to the managerial
process for national health development as described by WHO (WHO, 1981d) and illustrated by them (WHO, 1981b).

Evaluation in the WHO approach is a component of this managerial process and includes the following components: specify particular subject for evaluation; ensure information support; verify relevance; assess adequacy; review progress; assess efficiency; assess effectiveness and assess impact; draw conclusions and formulate proposal for future action.

Different methodologies for evaluation of programs and national policies have been reviewed for general purpose (UN, 1978) or specifically for the health sector (WHO, 1981b). At a micro-level, the general evaluation method linking project evaluation to the other components of the project cycle (Baum 1978) has been reviewed as well as other project evaluation methodology related specifically to the health sector and more precisely with PHC projects with CP (Rugh, 1986; Werner, 1982; USAID, 1982; Pyle, 1981; Morley & Woodland, 1979). A detail description of these methodologies can be found in the given references.

Too often evaluations have been everything (long, expensive, complicated, inappropriate) but practical and adequate. In the proposed framework for evaluation described in the next chapter, we have tried to avoid this drawback by considering that. Evaluations must focus on practical
problems and feasible solutions imposed by local needs to improve program effectiveness. To this end, we have followed Patton advice:

the practice of evaluation involves the systematic collection of information about the activities, characteristics, and outcomes of programs, personnel, or products for use by specific people to reduce uncertainties, improve effectiveness, and make decisions with regard to what those programs, personnel, or products are doing and affecting. (1982, p. 15)

This definition of evaluation emphasizes:

(1) the systematic collection of information about (2) a broad range of topics (3) for use by specific people (4) for a variety of purposes.

If the standards for practical evaluation are "utility, feasibility, propriety and accuracy" and as Patton goes further by advocating that the evaluators have to be prepared to deal with a lot of different people and situations (situational evaluation), the best type of evaluation should be undertaken by the people themselves. It is through this participatory evaluation process that the health education will be more effective and PHC projects better implemented.
Participatory Evaluation

As it was said earlier PHC was a new health development strategy to bring help to the truly needy by insuring their participation in the process. This has brought about a notion of health education by and for the people. It is then only logical to insure that the evaluation be made in part by these people who are supposed to benefit from PHC activities and in part provide them (WHO, 1983a).

For Feuerstein, the definition of participation is:

> a process in which a group or groups exercise initiative in taking action, stimulated by their own thinking and decision making, and over which they exercise specific controls. (1980, p. 1)

With this definition of participation and with Patton's one of practical evaluation given earlier (p. 35), one can say that participatory evaluation (PE) is seen as a process meant to raise the consciousness of people. As specified by Saint (1981), PE is an appropriate combination of knowledge and action in which the people are real actors.

The responsibility will lie at the local level with those in charge of PHC but evaluation being a component of the managerial process other administration levels (district and central) involved in the implementation of the project need to be included also (WHO, 1981b).

The participatory approaches in learning and evaluation
have stemmed from rather dissatisfying top-down experiences. The International Council for Adult Education has criticized this top-down management practice and proposed alternatives (Hall, 1979). They are not the only ones (Feuerstein, 1980; National Indian Brotherhood, 1979; Crone et al., 1977; Rifkin, 1985).

If it is sensible to say that only by understanding what really happens can one make the necessary judgements about value (Katz, 1978), then participatory evaluation allows the analyst to really evaluate a project. When an outsider evaluates, s/he tries to be objective and collects data to measure things. But measurement is a form of interpretation because what is being measured has in itself a quite important effect on the evaluation (Stromberg, 1977). Furthermore it is often the external evaluator who learns in the process not those who are left to manage the ongoing effort (Taylor and Cuny, 1978). Ruddock (1978) recognizes that the evaluator and his subject inhabit different realities and that it is presumptuous for him alone to determine what is to be investigated.

Unfortunately, complete participation is often not possible and it is more common to find partial participation of various kinds forming a continuum from passive to active participation in the International Labour Office (ILO, 1978) sense of the term.
Different possible stages of participation have been defined by Feuerstein (1980) and will be retained here:

1. The "Study of Specimens" approach.

The participants are expected to play a minimal part in the evaluation. They don't receive any feedback of findings.

2. The "Protection of Minors" Approach.

After partial explanation of project objectives, participants are involved to some evaluation procedures. They receive limited feedback of findings.


Participants collaborate in the initiation of the study and in the selection of objectives and methodology. They participate in analytical exercises and have a part in the utilization of the results, but they are still overreliant on external help if they wish to conduct a future study.

4. The "Full of Active Participation" Approach.

Participants collaborate in the initiation of the study and in the selection of objectives and methodology. Where ongoing evaluation procedures are not already existent, they are built into the project. Participants have priority in decision making regarding implementation and dissemination of findings. Participants may require then minimal help for future evaluation projects.

Once an active or almost active participation is deemed appropriate, one has to investigate its feasibility. The
steps in a feasibility assessment of participation has been well described by Perrett and Lethem (1980) and Martin et al., (1983).

The community participation being seen as necessary and feasible, the objectives of participation have to be clearly defined and some appropriate measures to monitor them set.

Because of the nature of participation, concrete measurable targets may be difficult to establish. If it is possible, many elements not directly measurable may be of equal or more importance. The tools to measure success of the project through participatory evaluation are numerous (ACVAFS, 1983; Rugh, 1986). Some are presented in Table 2.

Table 2: Tools to measure success through participatory evaluation

<table>
<thead>
<tr>
<th>Action cards</th>
<th>Mapping</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analytical Frameworks</td>
<td>Measuring Nutritional Status</td>
</tr>
<tr>
<td>Community Meetings</td>
<td>Arm circumference measurement</td>
</tr>
<tr>
<td>Observation</td>
<td>Health Happenings</td>
</tr>
<tr>
<td>Creative Expression</td>
<td>Photography</td>
</tr>
<tr>
<td>Diaries</td>
<td>Problem Stories</td>
</tr>
<tr>
<td>Farmer’s Own Record</td>
<td>Questionnaire</td>
</tr>
<tr>
<td>Interviewing</td>
<td>Scales</td>
</tr>
<tr>
<td>Investigative Journalism</td>
<td>Unobtrusive Measures</td>
</tr>
<tr>
<td>Road to Health Chart</td>
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</tbody>
</table>


Some criteria are to be kept in mind when deciding which
techniques would be most appropriate to use in evaluating a project. J. Rugh suggests:

1. The technique used should complement the approach and philosophy of the project.
2. Community participants should perceive it to be a way to help them solve their problems, not just information about them gathered by or for outsiders.
3. Those involved in collecting information should understand why it is needed and, as much as possible, be a part of the process of analyzing and utilizing the findings.
4. Match techniques used to the skills and aptitudes of participants.
5. The techniques should not take too much time away from normal responsibilities.
6. It should focus on a minimum number of well-chosen indicators.
7. It should provide timely information needed for decision making.
8. The results should be statistically reliable and, even if not quantitative, objective enough to convince others of their credibility.
9. The sophistication and cost of the technique(s) used should be in keeping with the level of evaluation called for. (Simpler for more routine evaluation; perhaps more complex for occasional major evaluation.)
10. Whatever techniques are used, they should reinforce a feeling of community solidarity, cooperation and involvement. (1986, p.17)

Often a mix of these methods is more appropriate.

Related to the question of what method to use, the actual tendency is to say that there are no logical reasons why qualitative and quantitative approaches cannot be used together (Reichardt and Cook, 1979; Patton, 1982). To the question of what data to collect is the problem of reliability and validity of the data (Stromberg, 1977). The
reliability of a measure is defined by the degree to which similar scores or values would be obtained on this measure in repeated data collection efforts with the same subjects. The validity of a measure is defined by the extent that a test measures what it is intended and presumed to measure. Drake et al., (1983) distinguish data failure between dirty data, inadequate measurement and inadequate data. Cook and Campbell (1979) identify a variety of possible threats to validity in evaluation research: internal validity, statistical conclusion validity, construct validity and external validity. Some of these threats may of course be diminished by a better experimental design but because situations change over time and all the relevant factors for the analysis vary over time this may be a never ending problem.

Quantitative evaluations of the fulfillment of certain PHC objectives exist (Cairncross et al., 1980; Kielmann et al., 1978) often made from a national perspective (Litsios, 1971) or scientific, university perspective (Selwyn, 1978; Kielmann et al., 1978). In the case of the Narangwal project in India, the data gathering and interpretation costed four times more than the PHC activities themselves (Faruque, 1981). When health education aimed just at preventing certain disease, medical models, relating behavior to disease, like in the cases above, are possible but the
built-in evaluation mechanism in such an approach is often too narrowly focused to provide data on the social, economic and cultural factors underlying the behaviour recognized so primordial in PHC education (WHO, 1983a).

Following Patton's ideas (1982), practical and creative data collection consists of using whatever resources are available to do the best job possible. Many contraints exist, resources are always limited which means that data collection will be imperfect. By strategically calculating threats to utility, as well as threats to validity and reliability, it is possible to make practical decisions about the strengths of creative and nonconventional data collection procedures.

Given the relatively high direct and opportunity costs for evaluation, increasing importance is being placed on the utility of "evaluability assessment" prior to embarking on expensive evaluation methods (Wholly et al., 1975).

What is relevant for our purpose is that the information allows the evaluation to be integrated into a managerial process described by WHO (1981d) or the project cycle (Baum, 1978). This will insure participatory evaluation its full importance in the management of the projects.

Jim Rugh (1986) uses different levels of evaluation for different stages in the project cycle to help the process of obtaining information and using it to make an assessment for
decisions.

Decision making is however not the only utility of the evaluation. The cornerstones of the participatory approach are communication and commonality of knowledge and of inquiry that makes it possible for people from different educational levels to work together for the common good of the project. (Swantz, 1975). This approach says Hall (1978) is a dialogue over time, not a static picture from one point in time.

When looking at participatory evaluation in the context of PHC projects, the evaluation is difficult at two levels. First by definition, PHC involves a series of different activities for which the synergism is supposed to successfully bring health development. Second, the fact that the people concerned participate in the evaluation, many different assessments involving different factors and the quality of these factors, will make the data difficult to gather and the quantitative analysis often difficult to make (Vaughan et al., 1984; Kroeger, 1982).

We end this review on P.E. by focusing on its use for evaluating the health education component of PHC. When evaluating the education aspects of PHC, ways must be found of making health education sufficiently specific so implementation of educational activities can be monitored and their effectiveness evaluated. This should permit
decision-makers to allocate money more wisely (WHO, 1983a).

Looking at the five components of PHC activities following Walker (1982) and listed earlier, one may wonder how health education can be specific enough to permit a valid evaluation. To compound the problem, other sectors such as agriculture, water sanitation, industry and literacy programs are often been included in PHC. Furthermore, the evaluation concerns activities implemented not only at the local level but at higher levels also (regional and national (Kroeger, 1982). The PHC involves the participation at all the planning and management steps: formulation of policies and strategies, planning and programming, implementation and monitoring (WHO, 1983a).

It is thus important but difficult to define clearly the scope of the evaluation (Vaughan et al., 1984) even when the objectives of the PHC itself have been set.

In evaluating the contribution of lay persons to health care, criteria defined by the lay persons themselves should be used. But some outsiders may be involved for which the professional values may be different. It will therefore be necessary to devise new methods of evaluation beyond those that have been used so far in health education (WHO, 1983a). Research needed to design these new approaches have been reported in the just mentioned publication (p. 38).

As mentioned before there is a number of evaluation
methods that can be used (ACVAFS, 1983). Others have been described and illustrated by Freeman et al., (1979). What needs to be done is to tailor them to PHC and to make these evaluations participative. Usually the simplest method the best. Some methods such as meetings, discussion, interviews and surveys have been used successfully (Feuerstein, 1980; Kroeger and Franken, 1981; Rugh, 1986). More rigorous methods such experimental design or quasi experimental design are an ideal that we should strive for but which is difficult to realize in PHC evaluation (Drake et al., 1983; Klein et al., 1982). While in evaluation, Campbell and Stanley (1966) favored quantitative methods, Weiss and Rein (1972), Parlett and Hamilton (1976) and Patton (1980) are supportive of qualificative methods. Reichardt and Cook (1979), Gebhart (1980) and Mullen and Iverson (1982) try to reconcile both methods and we will try to do so in our framework.

Previous Experiences in PHC and Participation

Parlato and Favin (1982) reviewed 52 AID funded projects in primary health care, many of which began before Alma-Ata. The diversity and scope of these projects demonstrate the wide range of approaches to PHC. The say that it is still impossible to assess the implications of the approaches, the time frame having been too short so far. However some major
findings about the implementation of these projects and issues raised are summarized in this review:

1. Support services is lacking (communication, transport, supervision) given the wide spread of the activities and the lack of decentralization.

2. Systematic underestimation of costs.

3. Concerning CP the value in improving health is not clear from the projects reviewed. Evidence suggests most ministries of health do not have the ability (financial or organizational) to undertake the dual task of delivering health services and mobilizing communities for more than routine program-support activities. The concept of voluntary participation in government sponsored projects is not widespread in traditional societies. The difficulty of involving communities should not be underestimated. Rural community financing is not always equitable especially when compared to free care in urban area.

4. Community health workers (CHW) are key to efforts to extend services to rural areas. The selection of CHW is made in 75% by the community which of ten have problem in financing them regularly bringing in this case high attrition rate compared with regularly government paid CHW. The experience of the project reviewed shows that communities will pay only for what they perceive as useful: generally drugs and curative care and sometimes for water
and clinic buildings. The credibility of the CHWs is highly dependent on his curative role, preventive health care being a low priority for most poor countries. The CHW’s educational level is low.

All the projects have evaluation components, mostly data on implemented activities (project outputs). Data as service utilization were recorded only for a few projects because the information systems to produce the data are not functioning adequately and because the data available in the fields are always disseminated in project reports. The evaluation data, which indicate the impact of the PHC projects on health status is limited, although most of the projects plan to measure impact. Most of the impact evaluations consist of surveys conducted before and after a project to measure key health indicators. Despite of efforts to simplify them, information systems remain overly complex. Data collection and processing are given low priority.

Project design and management are problematic. Relatively few of the 52 projects were designed based on comprehensive health sector assessment and the country’s political and cultural realities. These kinds of problems arise because host-country participation in the planning and design of projects was minimal. Some project designs include inflated project targets and unrealistic project schedules. Monitoring of projects is sometimes lax in part because
bureaucratic incentives motivate field staff to pay more attention to developing new projects than to monitoring active projects. Project designers do not always incorporate sufficient mechanisms to facilitate the transfer of skills and management capabilities during implementation.

Martin et al. (1983) studied 35 PHC projects funded by governments, USAID, and PVO's. All projects contain some kind of CP in their approach or objectives. They found that 25 percent of the project studied give the community some role in evaluation; an additional 40 percent conduct community surveys with no other role than responding to survey questions, while 35 percent show no evidence of any community input in evaluation. Most information was collected from documents and interviews, and in few cases was also obtained in the field. The question of how CP relates to ultimate health impact was difficult to address since few impact evaluations are available and even fewer analyze the impact of community participation on health status. Nonetheless the authors concluded that the experience of the projects studied yield substantial empirical evidence that CP improves such intermediate measures of health impact as service availability, service utilization, and changes in health behavior.

CP is not a panacea however, and is not feasible in certain circumstances. In general, CP requires an investment
of substantial personnel time for motivation training and monitoring. Four of the most common limitations or risks are: absolve the government of responsibility, threaten political authorities, support local elites and cause desillusion of community members when objectives are not quickly attained.

PAHO (1984) reviewed 16 case studies in the Americas to investigate what kind and how much CP has occurred in health, why CP has occurred or failed to occur, and how CP has helped improve services, coverage and health conditions. Specific conclusions (18) were derived from this study:

1. An official policy supporting community participation (CP) is a factor only insofar as it is implemented and policy and health system structure are congruent.
2. Flexibility in the health system is necessary to allow scope for local decision making and to enable the system to adapt to varying local conditions. No single approach is appropriate to all circumstances.
3. Training in CP for health personnel is important to help change negative attitudes and to enable staff to work more effectively with the community.
4. Service deficiencies and delays in carrying out health programs lead to loss of community confidence and interest and thus discourage CP.
5. Traditional health education approaches have not been effective in motivating CP. Health education should emphasize participation in solving health problems and should itself be participatory.
6. The higher degree of participation noted in the urban cases indicates the need to give more consideration to urban health programs and demonstrates that CP is neither limited to nor more likely to occur in rural areas.
7. This same phenomenon (the surprisingly high rate of urban CP) also highlights the importance of assessing local conditions. Social, political, economic, cultural, and physical characteristics have a significant effect on CP; the health system must be able to adapt its approach accordingly.

8. Communities are neither homogeneous nor monolithic - they are composed of disparate groups with different interests and problems. In order to encourage all community members to participate, the health system must know who participate and how much and how often, and it must take specific measures to incorporate groups that might not otherwise be reached, e.g., women, the elderly, adolescents, minorities. Women's participation is particularly important in health programs especially in planning.

9. A history of CP in solving community problems in any sectoral area encourages CP in health, but cooperation in building facilities alone is not sufficient to engender continued participation.

10. Communities in which health is felt as a priority need are more likely to participate actively in health programs.

11. Active participation requires a formal mechanism for continuing group participation, such as a community health committee (CHC), preferably organized by the community itself.

12. Training community members in how to organize, work in groups, and plan and manage activities increases the effectiveness of participation and of the mechanism established.

13. The areas of planning/decision making most closely associated with active community involvement are determining needs and helping develop solutions. Needs are best determined through discussion with the community rather than formal surveys.

14. Programs that give the community a role in managing activities and resources are more likely to achieve active, continuing CP than those that expect the community only to provide resources and disseminate information.

15. Community involvement is enhanced when community health workers (CHWs) are primarily responsible to the community and identified with it, rather than identified with the health
16. Evaluation has been largely neglected. Regular systematic monitoring and evaluation in which the community participates jointly is essential if the community is to be involved in planning.

17. The evidence suggests that there is more active involvement in other types of community development activities than in health. This appears to be due primarily to barriers to participation within the health systems rather than to community factors.

18. While there was little evidence of intersectoral coordination, it seems clear that greater coordination is necessary to adequately meet community needs. It appears that a coordinated, integrated approach is more effective in relating to communities, which tend to see problems in a more global way.

(PAHO, pp. 27-28, 1984)

Rifkin (1984) reviewed numerous experiences in Maternal Child Health/Family Planning (MCH/FP) programs in order to identify the factors and conditions which create effective CP. The material has been collected from publications and files of numerous international agencies but few documents tend to analyze problems and failure in the program. Thus it was not possible to find answers to question about the process of community decision making, cost-effectiveness of the community approach and the possibility of replication. More effort is recommended to be channeled in evaluation and monitoring of these projects and programs.

Bichmann (1985) relates a PHC project started in Benin in 1968 and which was evaluated with a people participation approach. Three categories of problems are reported: the
resources and logistic of the program; operation and process affecting the functioning of services; and finally the perceived needs and politics which affect activity priorities.

Finally WHO reviewed the community involvement for health development or (CIH) in 9 countries at an interregional meeting at Briony, Yugoslavia 9-14 June 1985 (WHO, 1985b). The meeting identified and reviewed seven critical themes for both their conceptual and operational aspects. In terms of the definition of CIH, the report stresses the difficulty of a single definition of CIH and explores the range of interpretations to be found in practice. Focus is then placed on the "community" in CIH and the report outlines the more important dimensions of the building up of community involvement with emphasis upon the need to thoroughly research and understand community based concepts and practices of health care. The analysis of support mechanisms for CIH details the critical issues of this important theme and stressed the difficulties of implementing CIH with such support. Similarly the report underlines the importance of preparation for CIH and the need to build this preparation into the more formal educational aspects of health care training. The examination of CIH methodology presents some provocative suggestions for the kinds of methodological changes that might be required.
in health care practice if CIH is to be successfully implemented. The two final themes of monitoring and evaluation and research into CIH are dealt with more briefly in the report, reflecting the fact that to date we are still at the stage of developing the concept and, therefore, in a position where much has yet to be done to develop our understanding of how we might monitor and evaluate CIH (WHO, 1983b).
Chapter III

THE PROPOSED FRAMEWORK

Within the Primary Health Care (PHC) philosophy of improving health status for everyone, new approaches in health education, shifting from "intervention" to community involvement have been recognized as necessary to achieve the goal "Health for All by the Year 2000".

Community participation (CP) in PHC projects is accepted today as being an indispensable element for better implementation of PHC projects by encouraging self-reliance and "empowering" the people concerned. But how could these projects be better implemented and evaluated? The lack of systematic and comparable evaluation has not prove the distinct advantage of these PHC projects. Better and consistent evaluation would be helpful to judge and improve this approach.

The overall study objective is to propose a systematic self-evaluation and decision making framework which at the same time, implement, manage and evaluate PHC projects. Here the application of the framework will only concern the rural area in which women have an important role to play. However the scope of the framework is wide enough to accommodate other circumstances as well. Such framework is seen as an educational tool: the community is learning by doing. It is
also seen as a management tool.

To attain this overall objective the following steps have been followed:

1. Review the literature pertaining to health in rural development, Primary Health Care, Community Participation, Health Education, Evaluation, and Participatory Evaluation.

2. Synthetize information on past and ongoing PHC projects especially those which have set a useful evaluation system based on wide community participation.

3. Propose an initial monitoring and evaluation framework based on (1) and (2), and on our own personal experiences.

4. Submit this initial framework together with a structured questionnaire to officers of different organizations familiar with evaluation of health projects for comments and future inputs to the evaluation framework.

5. Propose an improved framework based on the information gathered in (4).

6. Clarify the limitations of the approach and suggest recommendation for its application.

The first two steps in the methodology to develop the framework of evaluation have been covered in the literature review of the preceding chapter. Based on this review and our own experience, we will now develop our proposed framework together with a questionnaire to test its adequacy
by professionals with experiences in the implementation of PHC with important CP. In chapter IV we will report on the results of the questionnaire. In the last chapter, we will propose the revised framework while at the same time, specify some of the mechanics of this evaluation framework based on the comments received. Limitations and use of the framework for evaluating PHC projects will be discussed in the last chapter also.

Development of the Framework

The review of the literature and projects experiences in health care has shown that the implementation of PHC projects should:
- be intersectoral
- benefit from the participation of the people involved
- be linked to the health service by a CHW preferably from the community
- be carefully appraised
- monitor cost overrun
- be evaluated by the participants themselves even if with outside help
- involve the participants in the decision-making process
- be monitored on a permanent basis
- include an important education component built in all the activities
-be evaluated for their overall health impact on the community

-include as a last step a complete ex-post analysis of the actions undertaken during the project.

These factors conditioning the successful implementation of PHC projects are in no way exhaustive but appears to be crucial points that require the attention of project appraisers and managers.

While the framework is confined to the micro aspects of PHC philosophy, it needs to be pointed out that it addresses indirectly the macro-planning aspects of PHC also. The framework that will be proposed now for PHC projects can be aggregated for different projects comprising a program. The national budgetary allocation as well as its monitoring can be organized along the lines that will now be proposed for individual PHC implementation. The advantage of this link of the micro and macro aspects of PHC planning is that it permits to attain a right equilibrium of top-down and bottom-up planning or what participants at a UNICEF regional planning termed upward planning and downward support.

Upward planning and downward support is an ideal difficult to achieve... technical guidance and logistic support are inputs from above, peripheral levels must balance these inputs by taking initiatives in identifying needs, proposing possible strategies to fulfill the needs and taking part in carrying out these strategies. A reality in many development
programmes has been downward planning and implementation with little upward support. PHC is designed to counter such reality and community participation is the main-stay of its success. (UNICEF/EAPRO, 1981, p. 35-36).

The framework for implementing/evaluating PHC projects with CI includes seven components which group the important factors just listed. These seven components encompass ten different actions or steps numbered on the organigram of the proposed framework in figure 2, (page 63).

Component 1: A rural, intersectoral and participative approach.

Health development in a rural area needs to be pursued in an holistic way including all the sectors susceptible to bring an improvement in health status: agriculture, water, education, nutrition, or other relevant sectors depending upon the circumstances in which the PHC project is implemented. The emphasis should be put on linking-up community level health workers with the activities of the other sectors mentioned (Oakley 1987). For this reason we choose the term Community Facilitator (CF) instead of Community Health Worker (CHW) to express this intersectoral approach but also to emphasize the fact that the community itself is in charge and the CF is there to help but not to substitute in the implementation of the project activities. The CF is seen as an educator of the community to improve
Figure 2: Organigram of the Proposed Framework
the efficiency in the involvement process (WHO, 1984). This intersectoral approach lays on a coordination of various agencies at the district and local levels that are not always easy to obtain (WHO/UNICEF 1980 and UNICEF/WHO 1980). At a community level this integration should be easier but a problem may arise in defining the community. It needs to be a group as homogeneous as possible. The more homogeneous the community the better the integration of the sectors will be as the trade offs between sectors are easier to make.

The figure of the proposed framework represents this rural intersectoral approach by its overall context line "Socio-politico-economic-rural environment". The intersectoral approach appears also in the monitoring of inputs, costs and satisfaction (actions 2, 3, and 4) explained in the second component.

**Component 2: Appraisal and monitoring**

The appraisal of the health project is crucial especially for PHC with an important community involvement component. The activities need to be organized in advance at the most detailed possible level in order to prepare a realistic budget for the project or program. A scheduling of inputs and outputs and their prices need to be forecasted. This appraisal (action 1) will be important for the evaluation process since it will be the standard against which the actual project/program outcomes will be compared.
Unless this standard is properly established, the comparison will not be meaningful.

The community, or representative committee, together with the CF will closely monitor the inputs, outputs and prices (action 2) over time to see if the activities proceed along the line set by the appraisal. Output prices may not exist or be relevant for the community purposes but the responsables and the CF will be able to assess readily the sentiments of the beneficiaries regarding the services delivered by the health project (action 4). Having an handle on inputs and prices, hence, the costs of the project and on the other side an appreciation of the project services rendered, an informal comparison of benefits and costs can be made.

Often the measurement of community' satisfaction vis-a-vis the PHC project will not be collected through surveys on a regular basis but often in the middle life or at the end of the project life. (see component 5). In this case, a simple comparison costs-outputs may suffice for the regular monitoring, i.e. a cost-effectiveness measure (action 3). Meanwhile the satisfaction-dissatisfaction with the project outputs that transpire from the people comments and reaction can be included informaly in the decision-making process to which we now turn.

A word of caution before we proceed is in order. The
exercise suggested in this component is not made for its own sake, for bureaucratic purposes or in the aim of measuring a precise cost-effectiveness ratio. The exercise should be useful because it forces to follow diligently the activities of the project in order to gain some crucial insight into its usefulness and organization. The process we are force to go through should be most helpful in managing carefully the project in order to insure its future sustainability.

Component 3: Decision making

The above information will now be used by the community and the CF to reflect on the present situation and decide on the next course of actions in order to secure the best possible implementation plan for the project. These decisions will have to be made on a permanent basis, the frequency being related to the type of projects and the surrounding socio-politico-economic environment. The reflection (action 5a) in front of the comparison of costs-outputs with the level of satisfaction will help the decision making process (action 5b) that concretize in specific actions (action 5c) inducing feedbacks to each project sector as we will explain in the next component of the framework.

It is worth mentioning here that the continual monitoring cycle comprising cost-(dis)satisfaction-reflection-decision-action constitutes an ongoing evaluation
process by the people themselves which indeed is well in the
philosophy on participatory evaluation (action 5) described
in the literature and epitomized in Feuerstein' (1986) new
book "Partners in Evaluation".

**Component 4: Consideration of alternatives**

At each loop of the monitoring cycle described in the
above component, three different decisions/actions can be
chosen:

- to continue or alter slightly the project as set in the
  appraisal throught feedback 1 (action 6)
- to alter or drop some parts of the project, and so
  reappraise the project through feedback 2 in the framework
  (action 7)
- or to discontinue the project, at least in its present
  form, so that there is no feedback possible if it is judged
dissatisfying i.e. cost-ineffective or with no health impact
  (action 8).

The impact of health may be difficult to make
objectively and over a period of time because of the mix of
factors influencing health status of a community. Another
framework component will refer to this aspect in a moment.

While the framework so far has included the community
itself and the CF only, it is necessary to broad the scope
of the review for the agencies sponsoring the project.
Component 5: Outsider’s evaluation

The appraisal and the monitoring will need the involvement of outsiders to set a system which will benefit from other experiences and the higher commitment from the project sponsors e.g. the health or other sector national agency, some internal donors or a mix of these two.

The external evaluation is usually carried out at the beginning of the project, the appraisal phase, in order to insure initial funding. In the middle and at the end of the project the sponsors carry an impact analysis based on the information provided by the monitoring and maybe collect some supplementary information more related to the final effect of the PHC activities on the beneficiaries and the overall community. Self evidently, the project participants are key partners in this evaluation together with the outsiders. The literature abounds on the best mix of methods to use to measure impacts. Whatever method is used, the qualitative unstructured interview approach will have to play an important function if the impact assessment has to be insightful and helpful to improve management.

Note that outsiders can help also during the routine monitoring. They should be involve when major decisions are called for such as a major redirection of the activities or the abandonment of the project all together.
Component 6: Health indicators

Whatever the objectives of the PHC project are, one of the overall aim of the health related activities is to improve the health status of the project participants and the country in which the project takes place. Impartial measurements made over the life of the project, such as anthropometric measurements should be helpful to complement the information provided by the monitoring of the daily activities and the mid-term and final evaluation discussed in the last framework component.

Here again the anthropometric techniques have been well developed for this purpose and although we did not review them in the literature review, an useful overview of such techniques are available in Morley & Woodland, 1979; WHO, 1979, 1981c, 1983c; 1986; Chen and Bush, 1975; W. Keller, in Klein, 1982; UNU, 1984.

Component 7: Ex-post evaluation

A final evaluation at the end of the project or a follow-up, sometimes years after the outside (foreign or national) help ends, will use the full information provided by the successive monitoring cycles, the mid-term evaluation or any other non-final evaluations and the overall health impact indicators. The ex-post evaluation will serve eventually to insure a second phase to the project and especially to better appraise future similar projects. The
literature has stressed that this information is surely lacking for PHC projects with CI. The exercise has managerial implications also, it will inform the managers of future similar projects and alert them of some implementation problems and how to solve them.

The seven components of the proposed framework to evaluate participatively PHC projects have been described separately for expository purpose only. We want to stress the holistic approach of the framework and the arrows linking the components and actions as shown in figure 2, (page 63). Continuous arrows show the concatenation of automatic steps to be carried out in the evaluation process while the feedbacks are represented in dotted lines.

Development of the Questionnaire

The framework for evaluation just developed is essentially our thesis i.e. how we see an effective way to evaluate participative PHC projects based on the literature, other people experiences and our own. The framework stresses the managerial implication of the evaluation process and the participative approach required. This is our thesis.

We now need to validate this approach. It was done by structuring a questionnaire along the lines described in the framework and three open-ended questions. In addition, we included two sets of general statements and questions
related to the nature of community participation in PHC projects and the evaluation processes in general. These two sets of information are indirectly linked with the framework. In order to identify the respondents who were chosen for their experiences in PHC projects and programs, a series of personal data were requested also. In addition to the questionnaire, certain interviews were made along the line of the questionnaire but in an unstructured format.

In final analysis the framework proposed and the critics offered will be used to assess the feasibility of the evaluation approach developed and to improve upon its initial design.

Now the pretesting and selection of the sample will be briefly discussed before explaining the content of the questionnaire.

Pretesting and selection of the sample

In December 1986, the researcher constructed three sets of statements related to the concepts of community participation and evaluation to validate a proposed framework. The pilot test questionnaire was sent to 6 experts in the field of health education, public health, water supply sanitation and evaluation. Each expert had considerable PHC development experience. Five pilot test questionnaires were returned which helped the researcher to:

1. develop a questionnaire component on the background
of respondents which was judged necessary for the interpretation of the information gathered.

2. clarify and restrict the number of statements regarding community participation, evaluation and the proposed framework. We did not have enough respondents in the pretest however to run an item analysis whose purpose would have been to select from a pool of statements the ones that most effectively show support or rejection of community participation and participatory evaluation.

3. Add to each part of the questionnaire open-ended comments for additional and better interpretations of the concepts and the improvement of the framework.

4. Check on some possible correlations for future statistical analysis of the survey.

Anonymity of respondents was provided, although identification of respondent was prefered by the researcher for better interpretation. Final choice was left to the respondents who could destroy a number on the questionnaire.

The questionnaire in its final form has been sent to one hundred twenty three persons working for Private Voluntary Organizations (PVO’s), academic institutions and international organizations. They have been selected because of their high qualification in the field of evaluation and PHC activities. This selection has been possible thanks to personal contact, the literature, and recommendations given
by the dissertation committee.

A package consisting of the following items was mailed to each person living in the USA on March 12, 1987 and on March 17, 1987 to each person living in Europe or Africa.

1. A cover letter of introduction and description of the study, asking for completion of the enclosed questionnaire (Appendix A). Note that the first paragraph of this cover letter was personal to the sender, depending on his/her background and expertise.

2. A four part questionnaire which we will describe in a moment.

3. A self-addressed return envelope for returning completed questionnaires anonymously if desired.

At the end of April 1986, a postcard reminder (Appendix B) was forwarded to the persons whose questionnaires had not been returned.

**Questionnaire**

The presentation of the questionnaire in its entirety is given in Appendix C.

The first part (A) of the questionnaire related to the respondents characteristics: (1) sex, (2) age, (3) education, (4) main and secondary fields of interest, (5) present responsibilities and (6) past experiences.

It was thought that characteristics 3-6 could be related
somewhat with the respondents' view on community participation (CP) in PHC and evaluation as well as they stance vis-a-vis the framework.

The second part (B) presents two sets of statements relating to CP in PHC and the evaluation of PHC projects. For each statement, the respondent was asked to select one of 5 choices: Strongly agree (SA); Agree (A); Undecided (U); Disagree (D); or Strongly Disagree (SD).

The third part (C) of the questionnaire offers one to three statements per action such as recognized in the development of the framework to see to what extent the respondents agree with a particular point of the evaluation framework. The scale of agreement is the same as in part B of the questionnaire.

Together with the statements, a figure of the framework and a description of the 7 components and ten actions were given. Each statement corresponds to an action number put in parenthesis so that the respondents can appreciate the context under which the statement had to be interpreted.

For both part B and C, the following analyses will be made:

1. A frequency distribution of total attitude scores;
2. Descriptive statistics on total attitude scores (mean, standard deviation, number of respondents);
3. At the item level, distribution of scores; mean and
standard deviation of scores; correlation of total scores between certain variables (CP, E, PE and the framework);

4. Correlation among some groups of respondent.

The last part of the questionnaire (D) are open-ended questions related to the proposed framework to invite their opinion concerning the level of community participation and the type of monitoring/evaluation proposed in the framework.

The respondents are also asked to identify the weaknesses and strengths of the methodology proposed in the evaluation framework and to suggest improvements.

A questionnaire has been developed to validate or improve a framework proposed to better evaluate PHC project implemented with community participation. The results of this questionnaire and a summary of the comments made on the framework will be presented in the next chapter "Findings". Conclusions will then be made with some recommendations in the last chapter.
Chapter IV

FINDINGS

The main purpose in developing an initial framework to evaluate PHC projects was to solicit feedback through a questionnaire from persons familiar with this subject and having field experience in order to improve it.

In the first part of this chapter we will look at the collection of data and the descriptive statistics for the four parts of the questionnaire regarding respectively the respondents characteristics, community participation, evaluation and the framework. Further analyses looking for relationships between different information will then be presented. Finally, comments on the open-ended questions and interviews will be summarized.

Collection of data

A total of 123 questionnaires were mailed in March 1987 to persons thought to be familiar with the subject of community participation, evaluation and Primary Health Care of rural projects. In April 1987 a postcard reminder was forwarded to the persons whose questionnaire had not been returned. The responses received and used, the number of incomplete responses and no-responses are summarized in table 3, page 77.
Table 3: Summary of the number of questionnaire responses

<table>
<thead>
<tr>
<th>Questionnaires</th>
<th>number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total sent</td>
<td>123</td>
<td>100.0</td>
</tr>
<tr>
<td>returned - usable</td>
<td>32</td>
<td>26.0</td>
</tr>
<tr>
<td>returned - incomplete</td>
<td>2</td>
<td>1.6</td>
</tr>
<tr>
<td>respondent not found</td>
<td>11</td>
<td>8.9</td>
</tr>
<tr>
<td>respondent not appropriate</td>
<td>12</td>
<td>9.8</td>
</tr>
<tr>
<td>sent to committee</td>
<td>3</td>
<td>2.4</td>
</tr>
<tr>
<td>no reply</td>
<td>63</td>
<td>51.2</td>
</tr>
</tbody>
</table>

Grand total: 123 100.0

Eleven questionnaires were returned as the potential respondents were not found at the given address.

Twelve blank questionnaires were returned with a letter explaining that the respondent did not feel comfortable enough to complete the questionnaire. Two of these twelve sent additional materials related to the field of study which were useful for the development of the framework.

Sixty three questionnaires never came back nor received any reply.

Thirty four questionnaires were returned but two of
these were incomplete and could not be use in the study.

Three questionnaires were sent to the members of the thesis committee for informative purposes.

For the purpose of this study, 32 questionnaires will be analyzed, which constituted 26% of the total number of questionnaires sent.

**Questionnaire: Respondents’ description**

Thirty two respondents answered most of the questions. The following table (table 4, page 79) presents the respondents’ descriptive data. The majority (25 respondents or 81%) are male. Most, 78% of them, are in the mid-fourthies (15) and fifties (10); 7 respondents are between 30-39 age old and none are younger than 30. An equal number of respondents (14) have a doctorate and a master (43.8% and 43.8%), and the rest (4) has a bachelor or engineer diploma.

Their principal fields of study are public health or medecine (15 respondents) followed by sociology/anthropology (5), agriculture (4), education (2) and other (5), where one is in public work; one in political science; one in material development for rural community development projects; one in management skills training and the last one in administration. The respondent’s present responsibilities have been categorized in: Director (mostly desk work)(21.9%); Executive Officer or Consultant (40.6%);
Table 4: Respondents’ descriptive data

<table>
<thead>
<tr>
<th>Demographic variable</th>
<th>number</th>
<th>Absolute frequency</th>
<th>Adjusted frequency %</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )= No. of category</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Sex (2)</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>25</td>
<td>80.6</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>6</td>
<td>19.4</td>
<td></td>
</tr>
<tr>
<td>2. Age (4)</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>30-39</td>
<td>7</td>
<td>21.9</td>
<td></td>
</tr>
<tr>
<td>40-49</td>
<td>15</td>
<td>46.9</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>10</td>
<td>31.3</td>
<td></td>
</tr>
<tr>
<td>3. Highest Educational degree (5)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Doctorate</td>
<td>14</td>
<td>43.8</td>
<td></td>
</tr>
<tr>
<td>Master</td>
<td>14</td>
<td>43.8</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
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<td></td>
</tr>
<tr>
<td>Bachelor</td>
<td>3</td>
<td>9.4</td>
<td></td>
</tr>
<tr>
<td>Less than bachelor</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>4. Field of work (7)</td>
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<td></td>
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<td>Agriculture</td>
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<td>12.5</td>
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</tr>
<tr>
<td>Economics</td>
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<td>0</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>2</td>
<td>6.3</td>
<td></td>
</tr>
<tr>
<td>Food/Nut.</td>
<td>1</td>
<td>3.1</td>
<td></td>
</tr>
<tr>
<td>Public Health/med.</td>
<td>15</td>
<td>46.9</td>
<td></td>
</tr>
<tr>
<td>Sociol/Anthropol.</td>
<td>5</td>
<td>15.6</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
<td>15.6</td>
<td></td>
</tr>
<tr>
<td>5. Actual position (5)</td>
<td>32</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director</td>
<td>7</td>
<td>21.9</td>
<td></td>
</tr>
<tr>
<td>Executif/consultant</td>
<td>13</td>
<td>40.6</td>
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<tr>
<td>Chief/Coordinator</td>
<td>4</td>
<td>12.5</td>
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</tr>
<tr>
<td>Academic</td>
<td>2</td>
<td>6.3</td>
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<tr>
<td>Other</td>
<td>6</td>
<td>18.8</td>
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continued next page
Table 4: continued

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<tr>
<th>Demographic variable</th>
<th>number</th>
<th>Absolute frequency</th>
<th>Adjusted frequency %</th>
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<tbody>
<tr>
<td>6. Institution (6)</td>
<td></td>
<td></td>
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<tr>
<td>PVOs</td>
<td>13</td>
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<td>International</td>
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<td>3.2</td>
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<td>Academic</td>
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<td>12.9</td>
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<td>WHO</td>
<td>10</td>
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<td>Governmental</td>
<td>0</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td></td>
<td>9.7</td>
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<tr>
<td>7. Experience in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>evaluation (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>high 50% of time</td>
<td>7</td>
<td></td>
<td>23.3</td>
</tr>
<tr>
<td>low 50% of time</td>
<td>23</td>
<td></td>
<td>76.7</td>
</tr>
<tr>
<td>Importance given in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluation (3)</td>
<td>25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Should do more</td>
<td>21</td>
<td></td>
<td>84.0</td>
</tr>
<tr>
<td>Should do less</td>
<td>2</td>
<td></td>
<td>8.0</td>
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<tr>
<td>not applicable (N.A.)</td>
<td>2</td>
<td></td>
<td>8.0</td>
</tr>
<tr>
<td>8. Experience in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third World country (3)</td>
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<td></td>
<td></td>
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<tr>
<td>High (more than 5 y.)</td>
<td>25</td>
<td></td>
<td>83.3</td>
</tr>
<tr>
<td>moderate (1 to 5 y.)</td>
<td>4</td>
<td></td>
<td>13.3</td>
</tr>
<tr>
<td>low (less than 1 y)</td>
<td>1</td>
<td></td>
<td>3.3</td>
</tr>
<tr>
<td>9. Experience in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHC (2)</td>
<td>29</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26</td>
<td></td>
<td>89.7</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td></td>
<td>10.3</td>
</tr>
<tr>
<td>10 PHC experience in % (3)</td>
<td>23</td>
<td></td>
<td></td>
</tr>
<tr>
<td>more than 75%</td>
<td>11</td>
<td></td>
<td>47.8</td>
</tr>
<tr>
<td>35% to 75%</td>
<td>5</td>
<td></td>
<td>21.7</td>
</tr>
<tr>
<td>less than 35%</td>
<td>7</td>
<td></td>
<td>30.4</td>
</tr>
</tbody>
</table>
program Coordinator (mostly field work) (12.5%); Academicians (6.3%) and others (18.8%) where one is an administrator; one is housewife; one does mainly research in epidemiology of disaster; the others did not specify.

The institution they work for were mostly PVOs (13) and WHO (10) but also academician (4), international organization (1) and others (3).

As far as the respondents familiarity with evaluation of PHC per se, one fourth of them (23.%) spend more than 50% of their time dealing striclly with evaluation related activities. Most of the others (77%) are linked somewhat with evaluation but it never reached 50% of their time. Of all the respondents who responded to the previous question, i.e. time spent on evaluation, 84%, or 21 respondents, thought that they should spend more time on evaluation than the exact amount they reported for that previous question. Two (8%) said they should spend less time.

Most respondents (83%) spent more than 5 years working in developing countries, 14% less than 5 years but more than one year, and only one respondent spent less than one year in developing countries. During these years, 90% were involved in some ways with PHC. Half of the respondents deal for more than 75% of their time with PHC activities, 22% deal between 35% and 75% of their time with PHC while 30% of the respondents deal only in less than 35% of their time.
with these types of activities.

The respondent's description just outlined shows that they were well chosen to respond to the questionnaire concerning the framework because they have experiences in evaluation, PHC and overseas. The respondents came from different fields but 50% of them were directly related to the health field while the other half were related to fields related to PHC. The background of the respondents will be related later with their average agreement with the statements on community participation (CP), evaluation, participatory evaluation (PE) and the framework.

Statements regarding community participation

Twelve statements were developed to reflect the understanding of CP and its role. Table 5 (page 83) presents the descriptive statistics for each statement. The exact repartition of the number of answers among the 5 agreement classes are given in table 5 also.

For discussion of response frequencies, the response of "strongly agree" and "agree" are referred to as agree, and "strongly disagree" and "disagree" as disagree.

The majority of the respondents (91%, 97% and 94%) agreed that CP should take place in all stages of the project cycle (statements 1 to 3) and that CP is essential (94%), leads to self-reliance (88%), leads to a more
Table 5: Participants' responses to attitudinal statements regarding community participation of PHC project

<table>
<thead>
<tr>
<th>Statements</th>
<th>Absolute &amp; percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SA</td>
</tr>
<tr>
<td>1. CP is where the community as a whole takes active part in the design of a project</td>
<td>14 15 1 2 0 32</td>
</tr>
<tr>
<td></td>
<td>(43.8) (46.9) (3.1) (6.3)</td>
</tr>
<tr>
<td>2. CP is where the community as a whole takes active part in the implementation of a project</td>
<td>16 15 1 0 0 32</td>
</tr>
<tr>
<td></td>
<td>(50) (46.9) (3.1)</td>
</tr>
<tr>
<td>3. CP is only effective when the community shares in the decision making process</td>
<td>19 11 1 1 0 32</td>
</tr>
<tr>
<td></td>
<td>(59.4) (34.4) (3.1) (3.1)</td>
</tr>
<tr>
<td>4. CP is essential for PHC activities</td>
<td>15 15 2 0 0 32</td>
</tr>
<tr>
<td></td>
<td>(46.9) (46.9) (6.3)</td>
</tr>
<tr>
<td>5. Women are the most important participants in PHC projects</td>
<td>8 12 6 6 0 32</td>
</tr>
<tr>
<td></td>
<td>(25) (37.5) (18.8) (18.8)</td>
</tr>
<tr>
<td>6. Effective CP is impracticable at present</td>
<td>0 2 5 16 9 32</td>
</tr>
<tr>
<td></td>
<td>(6.3) (15.6) (50) (28.1)</td>
</tr>
<tr>
<td>7. CP leads to self-reliance</td>
<td>13 15 2 2 0 32</td>
</tr>
<tr>
<td></td>
<td>(40.6) (46.9) (6.3) (6.3)</td>
</tr>
<tr>
<td>8. CP is a threat to the efficient operation of a PHC project</td>
<td>0 1 1 19 11 32</td>
</tr>
<tr>
<td></td>
<td>(3.1) (3.1) (59.4) (34.4)</td>
</tr>
<tr>
<td>9. CP increases costs</td>
<td>0 5 7 10 10 32</td>
</tr>
<tr>
<td></td>
<td>(15.6) (21.9) (31.3) (31.3)</td>
</tr>
<tr>
<td>10. CP leads to a more motivated community</td>
<td>17 13 2 0 0 32</td>
</tr>
<tr>
<td></td>
<td>(53.1) (40.6) (6.3)</td>
</tr>
<tr>
<td>11. CP ensures that PHC meets the people's needs</td>
<td>10 16 3 3 0 32</td>
</tr>
<tr>
<td></td>
<td>(31.3) (50) (9.4) (9.4)</td>
</tr>
</tbody>
</table>

continued next page
Table 5: continued

<table>
<thead>
<tr>
<th>Statements</th>
<th>Absolute &amp; percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SA A U D SD n X SDev</td>
</tr>
<tr>
<td>12. CP requires that members of the immediate community be trained as community worker or &quot;facilitator&quot; (CF)</td>
<td></td>
</tr>
</tbody>
</table>

motivated community (94%) and ensures that projects meet the people’s needs (81%), (statements 4, 7, 10, 11).

Concerning the statement (statement 5) that women are (or should be) the most important participants in PHC projects, 63% of the respondents agreed. The others often mentioned that women are as important as men.

Most (78%) disagreed that effective CP is impracticable (statement 6); 16% were undecided, mentioning that it depends on the situation. and 6% agreed.

Almost all (94%) disagreed that CP is a threat to the efficient operation of a project. The person who agreed outlined his/her philosophy by mentioning that CP can raise unrealistic expectations in community minds that they will control at a level not possible in light of agency funding constraints. One participant questioned mark the word "efficient" leaving this statement as "undecided".
Concerning the cost increase of involving the community (statement 9), 63% disagreed, 16% agreed and 22% were undecided reflecting that it depends on the situation, as commented by the interviewees or on the forms.

Most (78%) agreed that CP requires that members of the community be trained as community worker or "facilitator" (CF), (statement 12); 3 persons (9.4%) disagreed and 4 (12.5%) were undecided, one mentioning that the statement was ambiguous.

For further analysis, responses to the statements were assigned a numerical value (strongly agree = 5 to strongly disagree = 1). After reversing the score for the item on statements 6 and 8 which were expecting negative answers, the scores were added and averaged to yield a mean attitude score for each subject. The average score for the 32 questionnaires regarding community participation, was 4.04, with a range of 3.33 to 4.58, reflecting the overall attitude of respondents that community participation is essential in the development of PHC project. Table 5 (page 83) presents also the means and standard deviations for each statement regarding community participation.

Statements regarding evaluation

A similar analysis regarding the statements related with evaluation of PHC projects is made and reported here.
Twelve attitudinal statements were developed to reflect the roles given to evaluation activities and/or to reveal attitude towards participatory evaluation. Table 6 (page 87) presents the exact repartition of the answers among the 5 agreement scale and the percentage of subjects who agreed or disagreed with each statement.

For discussion of response frequencies, the response of "strongly agree" and "agree" are referred to as agree, and "strongly disagree" and "disagree" as disagree.

The high percentage of respondents agreeing with statements 1, 2, and 3 (78%, 94%, 88% respectively) shows that they see evaluation playing several roles not just one function.

The diversity of responses regarding statement 4, 48% agreed, 36% disagreed, 16% undecided, showed that sometimes (or too often, as mentioned by one respondent) continued funding is the purpose of the evaluation.

Practically all (97%) agreed that evaluation is an on-going process (statement 5); only one person remained undecided.

The responses to statement 6 that cost-effectiveness should be an important evaluation concern showed that 72% agreed, 13% disagreed and 16% remained undecided. Four respondents (13%) who disagreed or were undecided were WHO officers who could explain themselves during the interviews.
Table 6: Participants' responses to attitudinal statements regarding evaluation of PHC project.

<table>
<thead>
<tr>
<th>Statements</th>
<th>Absolute &amp; percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SA  A  U  D  SD  n  x  SDev</td>
</tr>
<tr>
<td>1. The purpose in evaluating PHC projects is to assess the final impact of the project on overall community's health</td>
<td>8  17  2  5  0  32  3.875  .976</td>
</tr>
<tr>
<td></td>
<td>(25) (53.1) (6.3) (15.6)</td>
</tr>
<tr>
<td>2. The purpose of evaluation is to improve project management</td>
<td>9  21  1  1  0  32  4.188  .644</td>
</tr>
<tr>
<td></td>
<td>(28.1) (65.6) (3.1) (3.1)</td>
</tr>
<tr>
<td>3. The purpose of evaluation is to measure project expected outputs</td>
<td>6  22  0  4  0  32  3.938  .840</td>
</tr>
<tr>
<td></td>
<td>(18.8) (68.8) (12.5)</td>
</tr>
<tr>
<td>4. The purpose of PHC project evaluation is to ensure continued funding</td>
<td>0  15  5  9  2  32  3.065  1.031</td>
</tr>
<tr>
<td></td>
<td>(48.4) (16.1) (29) (6.5)</td>
</tr>
<tr>
<td>5. Evaluation of PHC projects is an on-going process</td>
<td>15  16  1  0  0  32  4.438  .564</td>
</tr>
<tr>
<td></td>
<td>(46.9) (50) (3.1)</td>
</tr>
<tr>
<td>6. An important evaluation concern should be cost-effectiveness</td>
<td>3  20  5  4  0  32  3.688  .821</td>
</tr>
<tr>
<td></td>
<td>(9.4) (62.5) (15.6) (12.5)</td>
</tr>
<tr>
<td>7. Only outsiders can evaluate PHC projects objectively</td>
<td>1  1  3  14  13  32  4.156  .954</td>
</tr>
<tr>
<td></td>
<td>(3.1) (3.1) (9.4) (43.8) (40.6)</td>
</tr>
<tr>
<td>8. Local community should participate in the on-going evaluation process (PE)</td>
<td>15  17  0  0  0  32  4.469  .507</td>
</tr>
<tr>
<td></td>
<td>(46.9) (53.1)</td>
</tr>
<tr>
<td>9. Participatory evaluation (PE) is an educational tool</td>
<td>15  16  1  0  0  32  4.438  .564</td>
</tr>
<tr>
<td></td>
<td>(46.9) (50) (3.1)</td>
</tr>
<tr>
<td>10. PE reinforces the &quot;learning by doing&quot; process</td>
<td>15  14  3  0  0  32  4.375  .660</td>
</tr>
<tr>
<td></td>
<td>(46.9) (43.8) (9.4)</td>
</tr>
</tbody>
</table>

continued next page
Table 6: continued

<table>
<thead>
<tr>
<th>Statements</th>
<th>Absolute &amp; percent (%)</th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
<th>n</th>
<th>X</th>
<th>SDev</th>
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</thead>
<tbody>
<tr>
<td>11. PE is a tool to monitor the population satisfaction with the PHC project activities</td>
<td>11 19 2 0 0 32 4.281 .581</td>
<td>(34.4) (59.4) (6.3)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. PE is too cumbersome to be part of the project' evaluation system</td>
<td>0 3 4 11 14 32 4.125 .976</td>
<td>(3.1) (12.4) (34.3) (43.8)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regarding participatory evaluation (PE), everybody agreed (100%) that local community should participate in the on-going evaluation process (statements 8). Almost all (97%) see PE as an educational tool, while only one person (3%) remained undecided (statement 9). Furthermore, a high percentage (91%) of the respondents agreed that participatory evaluation reinforces the "learning process" (statement 10), where 9% of the participants remained undecided without giving any explanation.

In regards to PE as being a tool to monitor the population satisfaction, 94% agreed, where 6% remained undecided.

Two respondents (6%) agreed that only outsiders can evaluate PHC projects objectively, 85% disagreed, and 9%
remained undecided (statement 7).

Finally, 78% disagreed that PE is too cumbersome to be part of the project evaluation system, 9% agreed, and 12% remained undecided.

Table 6, (page 87) shows the means and standard deviations of the statements regarding evaluation. Responses to the statements were assigned a numerical value (strongly agree = 5 to strongly disagree = 1). After reversing the score for the item on statements 7 and 12 which were expecting negative answers, the scores were added and averaged to yield a mean attitude score for each subject. The average score for the 32 questionnaires regarding evaluation, was 4.07, with a range of 3.41 to 4.75. This overall high mean score reflects that evaluation is a very useful process having several purposes.

Looking more closely at the attitude towards participatory evaluation, the statements 8–12 were added to pull out the general attitude of the respondents. An average score was calculated for the 32 questionnaires giving a mean of 4.34 with a standard deviation of 0.578 reflecting the overall positive attitude towards PE.

**Statements regarding the proposed framework**

We report now the responses to the statements regarding the proposed framework. Eighteen attitudinal statements were
developed to reflect the agreement or disagreement of respondents towards each step of the proposed framework.

Table 7 (page 91) presents the descriptive statistics for each statement. The exact repartition of the number of answers among the 5 agreement classes are also given.

For discussion of response frequencies, and as explained previously, the response of "strongly agree" and "agree" are referred to as agree, and "strongly disagree" and "disagree" as disagree.

Regarding the first component of the framework outlined in the questionnaire (statements 1, 2, and 3) specifying that the project is implemented in a rural ecological environment of a given-socio-politico-economic structure, that the sectors of a project are interrelated, and that these sectors should share, on a continual basis, progresses or difficulties encountered, 84%, 90% and 81% agreed, while 13%, 3%, 13% remained undecided, and only two persons (6%) disagreed. These three statements added together give a 85% favorable rating for this type of PHC project implementation.

For the statements 5, 6, and 7, where the inputs, costs and outputs should be assessed and provided by the community, 71% of the respondents agreed, 7% disagreed while 22% remained undecided.

Half (53%) agreed that adequate training of the
Table 7: Participants' responses to attitudinal statements regarding the framework

<table>
<thead>
<tr>
<th>Statements</th>
<th>Absolute &amp; percent (%)</th>
<th>n</th>
<th>X</th>
<th>SDev</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rural PHC activities are components of an integrated rural project</td>
<td>5 21 4 1 0</td>
<td>31</td>
<td>3.968 .657</td>
<td></td>
</tr>
<tr>
<td>2. These PHC components are all interrelated</td>
<td>6 22 1 2 0</td>
<td>31</td>
<td>4.032 .706</td>
<td></td>
</tr>
<tr>
<td>3. These components should share on a continual basis, progresses made or</td>
<td>5 16 4 2 0</td>
<td>31</td>
<td>4.032 .836</td>
<td></td>
</tr>
<tr>
<td>difficulties encountered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Adequate training of the community should be provided mainly by community</td>
<td>7 10 10 5 0</td>
<td>32</td>
<td>3.594 1.012</td>
<td></td>
</tr>
<tr>
<td>facilitator(s) (CF)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Inputs information of a PHC project should be provided by the local community</td>
<td>10 12 7 3 0</td>
<td>32</td>
<td>3.906 .963</td>
<td></td>
</tr>
<tr>
<td>and CF</td>
<td>(31.3) (31.3) (31.3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and CF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Costs of inputs should be assessed by the community</td>
<td>5 17 7 3 0</td>
<td>32</td>
<td>3.750 .342</td>
<td></td>
</tr>
<tr>
<td>and CF</td>
<td>(15.6) (53.1) (21.9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Outputs information should be provided by community</td>
<td>6 18 7 1 0</td>
<td>32</td>
<td>3.906 .734</td>
<td></td>
</tr>
<tr>
<td>and CF</td>
<td>(18.8) (56.3) (21.9)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Cost-effectiveness is essential in a PHC project evaluation</td>
<td>4 12 10 6 0</td>
<td>32</td>
<td>3.438 .948</td>
<td></td>
</tr>
<tr>
<td>9. Community and CF can value in terms of satisfaction</td>
<td>7 16 2 6 0</td>
<td>31</td>
<td>3.774 1.023</td>
<td></td>
</tr>
<tr>
<td>dissatisfaction the project outputs</td>
<td>(22.5) (51.6) (6.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

continued next page
Table 7: continued

<table>
<thead>
<tr>
<th>Statements</th>
<th>Absolute &amp; percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. The continual monitoring cycle (cost-(dis)satisfaction-reflection-decision-action) constitutes an effective on-going participatory evaluation process (PE)</td>
<td>7 17 7 1 0 32 3.938 .759</td>
</tr>
<tr>
<td>11. This participatory evaluation (PE) will improve the PHC project implementation</td>
<td>9 19 3 1 0 32 4.125 .707</td>
</tr>
<tr>
<td>12. The feedback mechanism in the framework helps to take better management decisions</td>
<td>8 18 5 1 0 32 4.031 .740</td>
</tr>
<tr>
<td>13. The feedback mechanism in the framework is an effective education tool</td>
<td>8 18 5 0 1 32 4.0 .842</td>
</tr>
<tr>
<td>14. Outsiders should review the evaluation procedure on a periodic basis</td>
<td>5 14 12 1 0 32 3.719 .772</td>
</tr>
<tr>
<td>15. Outsiders should be brought in the evaluation when major changes are needed</td>
<td>3 11 11 7 0 32 3.313 .931</td>
</tr>
<tr>
<td>16. A health indicator is important to assess the overall PHC project impact</td>
<td>8 14 7 2 0 31 3.903 .870</td>
</tr>
</tbody>
</table>

continued next page
Table 7: continued

<table>
<thead>
<tr>
<th>Statements</th>
<th>Absolute &amp; percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SA  A  U  D  SD  n  X  SDev</td>
</tr>
<tr>
<td>17. Standard of child growth is a good tool to measure overall PHC project impact</td>
<td>4  14  14  0  0  32 3.688  .593</td>
</tr>
<tr>
<td>18. The information provided through this framework could improve the appraisal of future PHC projects</td>
<td>3  22  6  1  0  32 3.844  .628</td>
</tr>
</tbody>
</table>

community should be provided mainly by community facilitator (statement 4), 16% disagreed and 31% remained undecided.

Cost-effectiveness analysis was seen as essential in a PHC project by 51% of the respondents, 30% remained undecided and 19% disagreed. On the other hand, the expression of satis-dissatisfaction of the community was agreed on by 74%, disagreed by 19% and 7% remaining undecided.

The proposed monitoring cycle seen as on-going participatory evaluation process was accepted by 75% of the respondents and not accepted by only one respondent (3%) while 22% stay undecided.

The majority of the respondents (88%) agreed that such
process (PE) would improve project implementation. Only 1 person disagreed and 3 (9%) remained undecided.

Most (81%) shared that the feedback mechanism in the framework was an effective educational tool and that it would help to take better management decisions. Only one person (3%) disagreed with these two statements while 16% remained undecided.

The high percentage of undecided (36%) towards the role of the outsiders reflects that it all depends on the situation as mentioned twice in the questionnaire by respondent. Only one person disagreed that outsiders should review the evaluation procedure on a periodic basis, 59% agreed while 38% remained undecided. More people (22%) disagreed that outsiders should be brought only when major changes are needed, while 44% agreed and 34% remained undecided.

Regarding the health indicator importance to assess the overall PHC project impact, 69% agreed, 22% remained undecided and 6% disagreed with that assertion. More people remained undecided (44%) for the chosen of standard of child growth as the specific tool of measurement, 56% agreed.

Finally, the information provided through this framework was seen as useful for future similar project appraisal by 78%, 19% were undecided and only one person (3%) disagreed.

Overall score regarding the statements related with the
different components of the framework give a mean score of 3.9 with a range of 3.11 and 4.94 reflecting that the majority of the people do agree with the theoretical framework proposed.

Additional findings: Comparative analysis

Data were further analyzed to examine relationships between variables. Spearman coefficients and t-tests were used. A probability of $P < 0.05$ was chosen as the level of significance.

1. There was a significant correlation between overall attitude toward CP and PE and the framework (Spearman’s $r = 0.273$, $p = 0.02$).

2. Groups were formed between respondents.

(a) People with overall high mean score toward CP and PE were compared to respondents with lower mean to see if there was any significant difference in their attitude toward the framework.

(b) WHO respondents and PVOs respondents were compared for their attitude toward CP, PE and the framework. No significant differences in their attitude were found.

(c) Respondents with high percentage of time spent in evaluation were compared to respondents with low percentage of time spent in evaluation to look for significant difference in their attitude towards PE and the framework.
No significance was found but the number of respondents per group was low for statistical significance: 7 persons for one group, 22 for the other.

(d) Respondents with high experience in PHC projects (>75%) vs. respondents with low PHC experience (<30%) were compared to see if one group was more in favor of the framework than the other. No significant differences were found.

Even though the researcher recognizes that all conclusions can not be made by these 5 point Likert-scale statements, additional analysis of part D of the questionnaire, shows that the overall attitude toward the level of involvement of the community is quite positive: 29 persons were in favor (97%), with 1 person disagreeing and three did not answer directly the question, but explained that the level of community involvement remains unclear to them to agree or disagree.

Regarding the support given to the type of monitoring/evaluation proposed in the framework, of the 28 persons answering, 25 agreed (89%), and 3 disagreed (11%). This section of the questionnaire received additional open-ended comments which will be reviewed next. Synthesis of the taped interviews will be presented at the end of this chapter.
Synthesis of Comments

Each of the different parts of the questionnaire comprised at least one open-ended question aimed at qualifying the preceding statements or giving the chance to the respondents for exposing their own philosophy about the subjects of inquiry. All the comments as written in the questionnaire can be found in appendix D.

Community participation

A series of comments stress the fact that the external environment, formal health sector as well as the national policies, and the internal village organization needed to be propitious to CP before the start of the project. At the village level, the social structure of the community has to be taken into consideration so that the poor benefits also. If the village is not organized for this involvement, it becomes the first task of the project. The community needs to get motivated, this requires time. Only then can they take the responsibility of undertaking a series of activities to improve their health. Only through participation can sustainability and so success of the project be insured. Participation cannot be imposed.

One respondent cautions against unrealistic expectations. Once confronted with reality the initial enthusiasm can fade quickly. Another recommends to use time
efficiently in order to diminish people opportunity costs. Indeed most participants will have to forgo the output of some other activities from which they are diverted by the project.

Community participation means being given responsibility to plan and implement the project, ideally with the power of reallocating resources during the project.

Participation of the community has not been used enough to collect data, evaluate satisfaction and assess the usefulness and problems of health projects.

Evaluation of PHC

Different respondents made the distinction between an on-going monitoring process and evaluation. They stress that the former is more important and see it as a management tool. An evaluation will eventually summarize the successive monitoring report, and to be useful should be shared with the people involved especially if the evaluation has been made by outsiders. They see evaluation in this sense as a managerial tool, a way to improve decision making.

For the managerial tool to be helpful, the evaluation should stay a tool not an end in itself. The project needs to be flexible to readjust to the monitoring and evaluation results.

The evaluation needs to involve the project
participants.

Only they can tell us how well the project meets their expectations and how it could do that better in the future.

To evaluate participatory projects, one needs to be able to measure the level of participation to relate it to a measure of success. To measure accomplishment of the health related activities, different measures techniques are available for different situations. Informal, unstructured approach "look and listen survey" can often be more useful than a correct statistical survey of some outputs. Whatever methods are used, the evaluation and monitoring of these activities will take time and money and these expenses need to be budgeted in the project.

Proposed framework

Concerning the participation aspects of the model, 97% agree with the level of community involvement requested by the framework. Yet some people point out that it is not clear from the schema how people have been involved in the design of the project. There is a need to show that people need to be involved in the PHC appraisal stage at least as much as during the implementation. It is only if community feels that it is its project that they will be interested in making it succeed. A problem with involving the community in the appraisal is the heterogeneity of the village which
comprises different income and family groups with divergent interest. This is a problem in the implementation also.

There is also a concern on how the people will actually participate. Reservations are expressed on the capability of the community to implement such complex PHC projects and the time availability of its people to do so.

With regard to the evaluation procedure most (89%) agree on the principle on which the framework is built even if all the information concerning the dynamic could not be made explicit in the short summary given in the questionnaire. The link between the internal evaluations process and the outside, national government and donors concern, is not clear. Community involvement in the evaluation is said to be essential. Participatory evaluation is appropriate.

The last question of part D on the strength and weakness of framework and how it can be improved reveals that most agree with the framework from a theoretical point of view but do not see precisely how this will be applied easily in practice. On the other hand, a well known practitioner and author of articles and books on the subject, qualified the framework as "on target".

Concerns about the absence of participation at the design level has already be mentioned. People challenge the cost-effectiveness concept as obstructing other measure of achievement such as the performance/non-performance of
tasks, the percentage of the population served, the non-monetary costs, the nature of constraints and the performance of the community facilitator. One doubted that anthropometric measurements were valuable measures of impact.

Some find the framework too simplistic, linear, technical and making many assumptions. The framework appears to some as inviting a top-down approach instead of a good mix of bottom-up top-down.

While we recognize many of these comments on the framework limitations justified, we have been constrained by the conciseness of the questionnaire and have tried to depict a framework broad enough so that it can fit most PHC situation in rural areas. The dynamic under which the evaluation framework should be implemented will be made more explicit later.

Synthesis of the Interviews

The interviews were unstructured but the conversation was guided somewhat by the questionnaire that we just finished analyzing. In one or two instances, it followed the questionnaire rather closely. We will highlight the important points made by the interviewees regarding CP, evaluation and the framework proposed. The retranscription of the interviews can be obtained from the Center of International Education, University of Massachusetts at
Amherst.

A preliminary remark made by one of the interviewee is worth mentioning at the beginning of these interviews review. It concerns the meaning of the key words used in this inquiry: PHC, PE and evaluation. While the statements and the framework itself help defining these terms for our purpose, it is possible that different people interpret most of the statements, purposely general, in the lights of the respondents' own meaning. This could in part explain the very high level of acceptance of our evaluation framework by the respondents and interviewees.

Community participation

Participation is recognized as important but happens rarely in the field at least as far as decision and allocation of resources are concerned. Yet the people are the ones who know what they need and it is a prerequisite of a project success to have the potential beneficiaries themselves establishing their own priorities. Involvement needs not to be always at the community level, it is sometimes more effective at the district level. A well organized health district can be an essential back-up for many successful community participations projects in a region. What is important is to have a framework to monitor them along a relatively similar approach in order to permit
a meaningful comparison of experiences. In this regard the proposed framework is helpful.

For participation to become real more delegation of responsibility than what occurs now is needed. However for political or professional reasons, the technicians and administrators often do not want to relinquish too much authority in order to maintain control. Real participation is attained when communities are really empowered to take their future into their hands.

Participation goes beyond improving the efficiency and effectiveness of PHC projects, it aims at empowering people to take action on their own behalf. A useful participation model is one that will provide the communities with the information necessary to make the right decision about what to undertaken and how.

In developed countries people make their discontent heard through political channels that are well established at the local, regional and national level. This is participation. Feedback from the people bad and good, needs to be expressed and a mechanism put in place to take actions in consequence. While community involvement is fine, it is often difficult to have people agreeing on priorities. In that sense a smaller unit is helpful in implementing PHC: the family and with priority the mother. She is the one who has the most direct impact on the health status of the
family.

While participation is a laudable goal, it often connotes a philosophy of self-reliance which if taken literally is unrealistic as a base for a new health philosophy. Citizens of developed countries are totally dependent on each other for everything. Participation philosophy is sometimes used as a nice way out or as a way to relinquish government responsibility. Let’s not forget that people at the limit of survival will have few spare time after taking care of the essential. There is no time for discussing and getting involved in preventive medicine in such cases. Often health will be a distant priority for communities, way after agriculture, water, road, and curative medicine.

Community participation has been a useful concept to remember the formal sector of the people reality and to improve health status of more people. But the problem that the framework addresses is how to do it? Different levels of participation exist. Which one is best for a particular community is the relevant question.

**Evaluation of PHC**

The concept of evaluation is primordial to the correct implementation of PHC projects. Participation is essential in the evaluation exercise because the beneficiaries alone
are in a position to tell you if they get their money worth. Sometimes the people cannot see any differences when some in fact exist. In this case the help of an outsider to measure some impacts can be useful for the community to perceive the real benefits of the project.

Evaluation is useful only when it relates to the management of the project and so its monitoring. Project evaluation occurs usually at the end of the project and now often in the mid-term in order to serve a purpose in redirecting management actions. While the evaluation is directly benefiting the PHC participants, it is requested by the formal health sector and the external donors to ensure that funds are spent on the right activities and with some favorable outcomes. The evaluation needs to be multipurpose.

For an evaluation to be credible, the objectives behind the undertaken actions need to be clearly spelled out and the indicators of success stipulated in measurable terms. Objectives set in economic terms are not always valid especially in health policy. What is the value of good health and happiness? Yet some standards of inputs per unit of outputs needed to be developed with time and experiences. Often numerous indicators collected through scientific methodologies are costly and rarely give you some information than you did not know already. An internal, informal system may go a long way in explaining satisfaction
with some PHC activities. When objectives and indicators exist we have to be sure that they are relevant, for comparing achievement with false or unrealistic objectives do not help the evaluation.

Evaluating projects with participation is difficult because the level of participation is difficult to measure in the first place. If a relationship between success and participation is sought, such measurement of participation is important. But even if a measurement scale could be adopted, great variability could still be found for the exact same type of PHC project having the same "level" of participation simply because of the difference in the personality of the CF for example or the village health committee or one of its member. To that extent comparability of PHC with CI may be difficult and the evaluation of such projects uneasy. Yet, if the exercise of monitoring inputs and outputs is done properly, this process should have a positive managerial impact which is one important aim of the whole evaluation approach.

Evaluation is discerned from monitoring. But even the term evaluation can be dissociated in short and long terms while the short-term impact is often an important information requested by the donors and external agents, the long term impact is really what should concern the communities the most. Measure of overall impact and study
tempting to quantify this should be helpful for all the parties involved. Outside help is appropriate for such study.

A good criterion to evaluate is often the sustainability of the PHC project after the first important investments have been made and only some of the recurrents costs are provided (subsidy). A better criterion could be the facility that the community has acquired to start on their own some activities related to the health of their people or family. The ability to replicate a PHC activity or project is a measure of its success.

Proposed framework

All the interviewees agreed on the concepts beyond the framework and its perceived utility but insisted that the real challenge would be to make it work in practice. Different application can be made of the framework. What is important in following this approach will be to insure maximum flexibility in its implementation according to the monitoring-evaluation findings.

The intersectoral approach in monitoring PHC project is relevant but may cause an inordinate effort of coordination between agencies at the national and district levels and between people at the village level. This is not to say that the approach is not correct but just that the implementation
will not be simple. As continual sharing of the PHC monitoring information may be difficult, some intermediary evaluation with outsiders (district, national, expatriate) having a specific objective in mind can be helpful to foster coordination of activities at the village level, as well as at the district level. All this coordination assumes of course that a political consensus exists at all administrative levels to delegate responsibility to the people supposed to benefit from the PHC activities.

Participation is essential and to involve the community together with the CF to monitor input outputs and (dis)satisfaction is relevant but outside help may be needed to insure a certain standardization in the data recording in order to improve comparability. The participation in defining satisfaction with the project activities is a must, if the cost-effectiveness measure has to be weighted against something. It is also useful in determining what the project outputs really are.

Much discussion revolves around the cost-effectiveness measure that many found limited in its usefulness. Affordability is mentioned as a better term for the community to judge on the level of health care they need. How much time and effort can we direct toward an abstract concept of improving health? Can we afford it? The idea of affordability is of course linked with the level of outside
help. If the project activities are paid by national or foreign outsiders, it does not cost anything to the community and whatever actions are undertaken may be cost-effective for them as long as the external support exists. Once the project is terminated, however, all activities will cease and the project will fail in as much as project sustainability is a measure of its success. It is thus important that the cost-effectiveness includes all costs, including opportunity costs and that the recurrent costs be quantified, at the beginning probably with help of the CF and someone at the district level, as precisely as possible so that the project management can be planned when external support diminishes after a certain point in time and the exact amount of subsidy calculated for the long run. Communities will usually favor a PHC project with substantial capital investment and low maintenance cost over low investment but high maintenance costs to facilitate sustainability of the activities from their own point of view. This is why appropriate technology is not always popular with communities. If high maintenance costs are required they may not agree on the project which often in this case will be imposed on them. This is a sure source of project failure in the long run. In the cost-effectiveness the empowerment of the people is not factored in this ratio and yet is an important element in favoring the PHC.
philosophy.

Most agree that the management undertaken by the community along the line sketched in the framework would be helpful to better implement such projects but many insist in having continued outsiders assistance in the technical, managerial and financial aspects of health care. Empowerment by the local community cannot mean relinquishing responsibility at the central level. A simultaneous upward and downward planning mechanism should be set up where the district would play a crucial role. For that reason one interviewee objects to the project context adopted for this evaluation framework and would instead prefer a programatic approach. A program could still be sustainable even if some projects fail. Self-reliance is utopic but some level of it may be necessary especially in the first stage of health development. Overall the role of community outsiders should impact the whole evaluation framework. Yet outsiders are not always more objective in evaluation. They have their own bias and mind set to start with. The long-term health impact of a particular project or program needs to be assessed in the most objective way. Anthropometric measurements can be as simple as a children arm circumference measure. In the long run this indicator, or another anthropometric measurement, should show the final impact of a series of health care activities. Doubts were emitted on the
usefulness of these indicators to assess overall PHC activities impact especially as related to improve health organization and the level of self-reliance attained. Yet this indicator has the great advantage of cutting across sectors and to establish an objective measurement of impacts.
Chapter V

FRAMEWORK REVISED AND RECOMMENDATIONS

The proposed framework described in chapter 3 resulted from a review of past experiences and the literature on Primary Health Care, Community Participation and Evaluation. Based on our knowledge, the best possible approach to evaluate PHC project with the participation of the beneficiaries was succinctly summarized with the accompanying schema of the framework and sent for review by persons working in these aspects of health care. Their responses to the framework for evaluating PHC projects were summarized in chapter IV. We want now to review our initial framework in light of the comments received and to describe the conditions under which this evaluation methodology should be used and how it can be implemented. Finally we will offer some recommendations for making the framework functional and improving it over time.

The Revised Framework

While the respondents and interviewees have overwhelmingly endorsed the initially proposed framework, they have suggested various ways in which it can be improved:
The socio-politico-economic-rural environment is not something imposed upon and estranged to the community but it is an environment with which the community should interact and receive help from. The political and economic conditions should be propitious to a smooth project implementation through real participation at all level of the project cycle. This should take place at the appraisal, reappraisal, management and evaluation stages of the project.

Clearly the formal health sector should have a more important role to play than the initial framework was suggesting. It requires that the National Health System really strengthens Primary Health Care (PHC) at the district level, while giving some autonomy at the local level. It would be inefficient from society’s point of view if each community had to reach self-reliancy and decide on all actions from their own point of view only without being helped by the District and National levels.

The integration of all the community sectors which impact on health status should to some extent be formalized at the village level (and for a program a the district level). This is important to create interaction between the different sectors and to avoid duplication of actions.

The appraisal and reappraisal should explicitly show the participation of the community whose people are the only
one in position to set priorities for themselves even if outside help is useful at this stage also.

-The decision-making process mechanism has to be specified as much as possible from the outset of the project and will vary from project to project, community to community, depending on their level of education. As education is part of the project, the community should over time have a greater role in decision-making as they become more knowledgable of the alternatives offered to them.

-Inputs and costs should distinguish both the contribution of the communities and outsiders and both initial and recurrent costs.

-Output measures and the expression of (dis)satisfaction are given by the community preferably during informal meetings but can be improved by outside participation also.

-Cost-effectiveness should be calculated from different points of view: community, district, national, donor, and should focus on recurrent costs crucial for the sustainability of the activities.

-The information derived from the continual monitoring of one village activities should be used for better management of the project itself but this experience should not be lost for other to use also. This flow of information
has to reach the outside through a Management Information System (MIS) that should stay very simple and be recorded for future reference by the district.

-The level of participation has to be measured in some ways so that the experiences and costs, and the satisfaction measures can be related to a participation model as well defined as possible in which the characters of the community and CF should be well described.

While many of these suggestions should be incorporated in the implementation of the framework, it is not possible to depict all these suggestions on a schema. We have altered the framework somewhat to reflect these changes that could be readily reflected in a new and more explicit framework. Changes have been made in figure 3, (page 116).

-One change indicates that the community is now an integral part of the appraisal, monitoring and evaluation process together with the outsiders, at the district, national and international levels.

-A MIS will receive data from the project management in charge of coordinating the multi-sectoral PHC project, data which are further processed at the district level before to be sent to national headquarters and maybe some donor agencies. A project is seen as part of a wider program.
Figure 3: Revised Schema of the Evaluation Framework
Each sector is managed by an ad hoc committee: health, agriculture, water and other with the help of a CF if one is available. If not the CF will be made available to the management (coordination) unit which will coordinate all those sectors for which a committee may or may not exist or eventually in the process of being created.

The remaining parts of the schema stay the same except to accommodate for the above changes.

The Dynamic of the Framework

Here it will be attempted to describe the functioning of the evaluation schema as it evolves through time.

-Given the national health objectives of a nation and its executive agency, a certain budget is allocated to different programs comprising different projects. One program tries to implement the PHC philosophy and decides to invest in the health component of an integrated rural project or in the integrated rural project itself at least as the coordinator.

-A community is approached, the possibility of a project mentioned and priorities of activities solicited from the potential beneficiaries. The organization of the community is studied as well as the different groups comprising the village. The delegation of responsibilities is explained and
the salary of a CF will be made available to, among other things, maintain a monitoring system together with the community in order to assess the sustainability of the project with minimum external support once the project stops.

-A scheduling of activities following the community’s priorities and given the donor’s constraints are established with the corresponding detailed budget. This appraisal will be the point of comparison of the inputs and costs monitored at the beginning of the project. Deep discrepancies may cause a reappraisal of the same activities or the initiation of a new one. This new reappraisal will then serve as point of comparison for future monitoring until this reappraisal is eventually again changed.

-Once the critical implementation plan established, the management unit headed by a community facilitator (CF) will coordinate the multi-sectoral activities and will be recording the data collected by the different sectoral committees themselves helped eventually by another CF.

-The measures of outputs and (dis)satisfaction are difficult and need the active participation of the beneficiaries. Personal talks or informal meetings more than formal surveys would be helpful in that regard. Outsiders could help in more formal procedures if necessary.
- The records on inputs, time and costs could be weighted by the community vis-a-vis the perceived benefits. This reflection brings a decision followed by an action to continue, reappraise the project or to stop it.

- After a series of monitoring cycles, and the collection of impact measures such as the anthropometric measurements proposed, a quarter, mid- or three-quarter time evaluation can be made using all the above informations. The worst case scenario would be the abandonment of the project. Otherwise the project would be changed following the wishes of the participants in consensus with outsiders and/or along more cost-effective line. Overall the community will be learning by doing. At the end of the project an ex-post analysis will be carried out and improve the appraisal of similar PHC in the future.

The dynamic of the project evaluation following the framework proposed can apply as well for a group of projects or a program. The information gathered by each project is entered in a data base aggregated by district and eventually for the nation. An overall cost for the progress achieved will be sanctioned by a policy decision to stop or proceed with a particular program or better the policy beyond that program. The difficulty in this case will be to have an appreciation for the overall sense of satisfaction derived by the beneficiaries. While this may be possible at a
village level it is difficult to assess on a national level. The impact assessment at the national level will have to be made using the individual project anthropometric measurements or other measures will have to be gathered through a national survey. National statistics may not be developed enough at least at the beginning of the program to give a short run assessment of health impact. The final decision may be political.

An hypothetical application of the framework and its dynamic is available upon request at the Center of International Education, University of Massachusetts at Amherst.

**Recommendations**

PHC is mostly a philosophy at this time even if different programs and projects have already be designed and implemented along these lines. But history of project monitoring and evaluation are surely lacking. The difficulty in obtaining reports on past PHC projects with important community involvement for our research reflects the difficulty in standardizing the evaluation because of the diversity of projects undertaken under the banner of PHC, CP and participative evaluation.

We found then necessary to propose a framework for evaluation which would be general but useful enough to
organize the evaluation of such projects along some common lines. This type of evaluation is seen as an integral part of the project managerial process also. It is not only an ex-post evaluation.

There is no doubt that it is only through the experiences learned from past projects and programs that we will be able to improve in its implementation the philosophy of "health for all by the year 2000". The process of education is to learn from our own mistakes. To perfect this process we have to carefully record these errors as well as the successes of past PHC project experiences.

In following the proposed framework, different points have to be remembered for using this tool for PHC evaluation effectively.

-Health improvement can only come through broad-based changes, coming from different sectors. This broader approach sees the improvement of the health sector coming from people' wider cooperation, inviting intersectoral activities and not merely a health development activity often not perceived necessary by the community.

-There exist as many PHC projects as there are communities and groups within that community involved in these activities. No two projects are the same. The evaluation framework which is general enough can be used
with great flexibility depending not only on the community characteristics but also its regional and national environment and the particular objectives the project is trying to achieve.

- The community needs to have been involved in the implementation of the project for the project to be sustainable and for the interest in the activities to be maintained so that participation will not eroded during the life of the project or after the outside help stops. The interest and need of monitoring should be felt by the people who initially plan the implementation of these PHC activities.

- Community values have to be approached through dialogue and shared commun actions. To assess what a community wants, what its felt needs or felt problems are, community meetings structured or unstructured, seem to be the most appropriate tool to assess value and (dis)satisfaction. Community meetings provide a forum for either new issues, a presentation of evaluation findings, a discussion of perceived problems and for decision making or plan of actions. They have the major advantages of being open to all interested community members. One of their dangers though, could be that they are "manipulated" by some powerful community members not sharing the benefits of the entire community or the group involved in the project. Along
with the community meetings, other "data collection" tools can be used to analyze people's satisfaction-dissatisfaction which can be presented to the community meetings. They are for example: interviews, people's own record, diaries, mapping reflecting specific aspects of the community. These tools will probably reflect the community's values better than anything an outsider could do even with sophisticated data collection. However, it is not to say that more formal impact studies carried out with outside help could not be relevant in some occasions.

- Flexibility is needed in the establishment of the ledger for recording inputs, costs and outputs. The ledger may just be a diary recording expenses and input used in a chronological order or may be classified by sector, type of inputs and costs and outputs which are summarized per period by the participants themselves. In this regard the district will have to help the villages in organizing a reporting system as standardized as possible.

- Having planned the activities and understood the recording system proposed, it is important that the community be educated in making decisions during the implementation of the project. This entire process of appraisal, recording, deciding and managing the project is an educational tool. The community is learning by doing.
This learning by doing process must come from performing the daily project activities and carefully recording their outcomes to understand their significance. Health education can in addition be an activity in itself but needs to be integrated with the other project components.

-The final evaluation is the last step of the participatory approach of PHC proposed in the framework. The future of the community health will depend on future allocation of time and resources to a series a multisectoral activities that all should be integrated to help in improving the health status of the community. The final evaluation based on a continuous monitoring put in place by the participants as suggested in this framework should be seen as an educational tool which will convince them on the necessity of undertaking and perpetuating these PHC activities in the future or not. It will also encourage other communities to undertake similar projects to improve their own well-being if these projects have been evaluated as helpful by those who participate in these projects.

-While the all framework process stresses participation as a means toward some autonomy in managing the community own affairs, the all process of PHC should be initiated and organized by the formal health sector which in the end is the one responsible for the overall health status of the country’s citizens. The participation of outsiders at all
level of the framework will be required to some extent depending on the circumstances.

- The profile of the participants and their precise activities have not been specified to maintain the evaluation approach flexibility. It is foreseen that the family and the woman in the family are important partners in the all effort geared toward health improvements. This was stressed in the outset of the study but was not made specific in the framework. However it should always be present to the persons attempting to follow such an evaluation approach in practice.

Conclusions

Our overall objective has been to propose an evaluation approach of PHC projects in which the beneficiaries themselves take part and sanction the activities which were designed to improve their health status.

Although we recognize that much has to be done at the organizational level, - and a key issue here is the political will, - the proposed framework offers a systematic way of self monitoring and self evaluating actions undertaken at local level.

By incorporating health development in a broad sense, community’s values will be better respected. It is common to
see that health services are not supported in the same way that other sectors. Often people give priority to other activities than to the improvement of health or the delivery of health services per se. Their chosen priorities should be seen as a positive step toward the improvement of a better health status for their community. This liberty of choice and decision make them more enthusiastic in undertaking activities which certainly, if well implemented, should in the long run improve their health.

Only through careful monitoring of these projects will we be in a position to judge on their usefulness and limitations.

While the evaluation approach suggested to learn more about past and ongoing PHC projects is a modest attempt to contribute to a more realistic discussion on the implementation of the PHC philosophy, it is hoped that it will focus attention on the need for more careful evaluation of these projects in the future.

More participatory research is needed to improve upon this framework and spread the information derived from their uses to all health administrators and educators in order to improve the efficiency and effectiveness of these types of project in the future. This participatory research should focus on simpler, better and more effective way to record activities in order to monitor them closely and improve
decision during the projects life and hopefully thereafter.

It is only with diligent recording of past experiences that we will be in a position to request continual and increased funding for these PHC activities. By organizing this recording with the potential beneficiaries themselves we will educate them along the way and hopefully make them taking initiatives that will improve their health and happiness.
APPENDICES
APPENDIX A: Cover letter for questionnaire

March 1987

Dear

Given your familiarity with health development projects, your response to the enclosed questionnaire will be particularly important for the success of this research.

Few evaluations of Primary Health Care (PHC) projects with an important community participation component are available today. These evaluations are crucial however to better manage and appraise PHC projects now and in the future, and to assess their impact.

This research has been initiated to study how community participation and self-evaluation procedures could be incorporated systematically into the evaluations of these PHC projects.

A framework for evaluating, in rural areas, participatory PHC projects which incorporates a self-evaluation mechanism is summarized here and submitted to your review. To facilitate this review process, a questionnaire is attached. It is divided into four sections:

- Part A identifies the respondents’ background;
- Part B attempts to obtain the respondents’ view concerning the importance of participation and evaluation to implement successfully PHC projects;
- Part C asks for a critical review of the framework;
- Part D ends with some open-ended questions related to the improvement of the framework.

Your input in each question or statement is crucial for the success of this study. It should not take you too long. Only aggregate results will be published to preserve anonymity. Please find enclosed a self-return envelope for your convenience.

We thank you in advance for your kind cooperation.

Sincerely,

B. de Negri
APPENDIX B: Postcard reminder

April 1987

Dear.....

About a month ago, you received a questionnaire concerning a framework to evaluate Primary Health Care (PHC) projects involving important community participation.

Because the time constraint put upon us, we would appreciate you returning the questionnaire dully filled at your earlier convenience. If you sent it back already, please disregard this notice.

Thank you in advance for your comprehension.

Sincerely,

B. de Negri
APPENDIC C: Questionnaire

The following questionnaire is an example of what was sent to the population.
QUESTIONNAIRE

PART A  BACKGROUND

Please answer all of the following questions by placing an X next to your response or by filling in the appropriate box.

1. **SEX:** M [ ] F [X]  
2. **AGE:** 20-29 [ ] 30-39 [ ] 40-49 [ ] >50 [ ]

3. **HIGHEST Educational degree:**
   - Doctorate [ ]
   - Master [ ]
   - Other [ ]
   - Bachelor [ ]
   - Less than bachelor [ ]

4. Please indicate your three most important fields of work.
   (*1* being the most important, *3* the least important).
   - Agriculture: [ ]
   - Economics: [ ]
   - Education: [ ]
   - Food/Nutrition: [ ]
   - Public Health/Medicine: [ ]
   - Sociology/Anthropology: [ ]
   - Other: [ ]

5. Describe your present responsibilities?

   Institution: ____________________________  No. of years: [ ]

   Percentage of time you actually spend in evaluation activities: ....%
   Percentage of time you think ought to be spent in evaluation activities: ....%

6. Number of years of activities in third world countries: [ ]
   For the last ten years specify the country and institution you worked for.
   For short terms give the number of months.

<table>
<thead>
<tr>
<th>No. of Years</th>
<th>Country</th>
<th>Institution</th>
<th>Was PHC included?</th>
<th>If yes, what % of time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
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</table>
PART B  VIEW ON COMMUNITY PARTICIPATION AND EVALUATION

In this section of the questionnaire, please indicate the extent to which you "agree" or "disagree" with a set of statements related to community participation and evaluation of PHC projects. Indicate your response (\%\ ) to each statement by selecting one of the five choices: Strongly Agree (SA); Agree (A); Undecided (U); Disagree (D); Strongly Disagree (SD).

a/ Statements regarding Community Participation (CP) of PHC project

<table>
<thead>
<tr>
<th></th>
<th>SA</th>
<th>A</th>
<th>U</th>
<th>D</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CP is where the community as a whole takes active part in the design of a project.</td>
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<tr>
<td>2. CP is where the community as a whole takes active part in the implementation of a project.</td>
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<tr>
<td>3. CP is only effective when the community shares in the decision making process.</td>
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<td>4. CP is essential for PHC activities.</td>
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<td>5. Women are the most important participants in PHC projects.</td>
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<tr>
<td>6. Effective CP is impracticable at present.</td>
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<td>7. CP leads to self-reliance.</td>
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<tr>
<td>8. CP is a threat to the efficient operation of a PHC project.</td>
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<tr>
<td>9. CP increases costs.</td>
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<td>10. CP leads to a more motivated community.</td>
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<tr>
<td>11. CP ensures that PHC meets the people's needs.</td>
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<tr>
<td>12. CP requires that members of the immediate community be trained as community worker or &quot;facilitator&quot; (CF).</td>
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</tr>
</tbody>
</table>

Please outline your own philosophy about community participation and the most required elements for its success.

133
b/ Statements regarding evaluation of PHC projects.

1. The purpose in evaluating PHC projects is to assess the final impact of the project on overall community's health.
2. The purpose of evaluation is to improve project management.
3. The purpose of evaluation is to measure project expected outputs.
4. The purpose of PHC project evaluation is to ensure continued funding.
5. Evaluation of PHC projects is an on-going process.
6. An important evaluation concern should be cost-effectiveness.
7. Only outsiders can evaluate PHC projects objectively.
8. Local community should participate in the on-going evaluation process (=participatory evaluation).
9. Participatory evaluation (PE) is an educational tool.
10. PE reinforces the "learning by doing" process.
11. PE is a tool to monitor the population satisfaction with the PHC project activities.
12. PE is too cumbersome to be part of the project evaluation system.

Please outline your own philosophy about effective evaluation of PHC projects.
PART C THE PROPOSED FRAMEWORK.

In this section, a framework for evaluating Primary Health Care (PHC) projects requiring community participation (CP) and participatory evaluation (PE) is presented. Please read the explanations about the framework together with the detachable schema on p. 7 before answering the statements on p. 5. (The numbers in parenthesis relate the following explanations of the framework with the schema on p. 7 and the critical statements (p.5)).

The framework is purposely general and flexible to accommodate a wide range of rural environments in which PHC projects could be implemented.

The proposed framework.

- The project is implemented in a rural ecological environment of a given socio-politico-economic structure and comprises different components (e.g. health, agriculture, water sanitation) (1).

- Each project component has its inputs, outputs and costs appraised and later monitored by the community with the help of a community worker or "facilitator" (CF) who is a trained person able to work with and guide the community (2). Together they calculate the cost-effectiveness of that component (3). They express also their satisfaction-disatisfaction with the specific project component activities through a qualitative evaluation method, (e.g. community meeting, interview) (4).

- The above informations (2,3,4) feed a permanent process of reflection, decision and action by the community. The reflection (5a) in front of the comparison costs-outputs-satisfaction helps the decision making process (5b) that concretizes in specific actions (5c) inducing feedbacks to each project component. This continual monitoring cycle (cost-(dis)satisfaction-reflection-decision-action) constitutes an on-going evaluation process by the people themselves (participatory evaluation (P.E.) (5).

- At each monitoring cycle, three different decisions and actions can be chosen:
  - to continue or alter slightly project component(s) (6);
  - to alter or drop some project component(s) and so reappraising the project (7)
  - to discontinue the project if it is judged dissatisfying i.e. cost-ineffective or with no health impact (8)

The periodicity of the monitoring cycles will depend on the type of project and the conditions in which it is implemented.

The health education in PHC is insured through the continual feedback mechanism built in the framework. The community is learning by doing. The experiences from the project successes and failures contribute to the community education in PHC.

- Outsiders should not be precluded from this process but incorporated to bring additional perspectives and help final decisions (9).

- Concurrently with this monitoring, an overall measure of health impact could also be collected to evaluate the whole project impact and the fulfillment of its intended general objective of improving health status. We choose anthropometric measurements, i.e. standard of child growth for this purpose (10).

- A final or follow up evaluation at the end of the project will use the full information provided by both the successive monitoring cycles and the overall impact measurements. This information will serve to better appraise future similar projects.
Statements regarding the framework

1. Rural PHC activities are components of an integrated rural project (1) ........................................................................

2. These PHC components are all interrelated. ..........................................................................................................

3. These components should share, on a continual basis, progress made or difficulties encountered. .............................

4. Adequate training of the community should be provided mainly by community facilitator(s) (CF) (2). ............................

5. Inputs information of a PHC project should be provided by the local community and CF. ............................................

6. Costs of inputs should be assessed by the community and CF. ....................................................................................

7. Outputs information should be provided by community and CF. ....................................................................................

8. Cost-effectiveness is essential in a PHC project evaluation (3) ..............................................................................

9. Community and CF can value in terms of satisfaction-dissatisfaction the project outputs (4). .................................

10. The continual monitoring cycle (cost-(dis)satisfaction-reflection-decision-action) constitutes an effective on-going participatory evaluation process (PE) (5). .................................................................

11. This participatory evaluation (PE) will improve the PHC project implementation ..........................................................

12. The feedback mechanism in the framework helps to take better management decisions (6, 7, 8) .....................................

13. The feedback mechanism in the framework is an effective education tool .................................................................

14. Outsiders should review the evaluation procedure on a periodic basis (9). .................................................................

15. Outsiders should be brought in the evaluation when major changes are needed .........................................................

16. A health indicator is important to assess the overall PHC project impact (10) ..............................................................

17. Standard of child growth is a good tool to measure overall PHC project impact ..........................................................

18. The information provided through this framework could improve the appraisal of future PHC projects ..........................

136
PART D  OPEN-ENDED QUESTIONS REGARDING THE PROPOSED FRAMEWORK.

1/ Do you support the level of community participation in the evaluation framework?  Yes___  No____.  Explain

2/ Do you support the type of monitoring/evaluation proposed in the framework? Yes___  No____.  Explain

3/ -What do you feel are the weaknesses, strengths?  
-What improvement do you suggest?

Please indicate below the name and address of persons to whom this questionnaire could be sent.

We thank you for your time.

No.__ If you desire complete anonymity, please remove this number.
SIMPLIFIED SCHEMA OF A FRAMEWORK FOR PARTICIPATORY EVALUATION OF PRIMARY HEALTH CARE PROJECTS

Socio-politico-Economic-rural-environment

Initial Project Appraisal (1)

Reappraisal

Other components

Water-sanitation Component

Agriculture Component

Health Component

CF: Community participation

REFLECTION (5a)

EVALUATION (5)

DECISION (5b)

ACTION (5c)

Impact evaluation (Anthropometric measurements) (10)

Outsiders (9)

(7) change

no

satisfaction

yes

continue (6)

cost-effect. (3)

comm.sat-dis (4)

inputs

costs

outputs

inputs

costs

outputs

inputs

costs

outputs

inputs

costs

outputs

(2)

(2)

(2)

(2)

(3)

(3)

(3)

(3)

(4)

(4)

(4)

(4)

138
APPENDIX  D: Comments from questionnaires

The following comments have been grouped by topic. They are all retranscribed from the questionnaires received.

Outline own philosophy about COMMUNITY PARTICIPATION and the most required elements for its success. (Part B, a/)

---CP is common sense, but depends on willingness of developing countries to take health seriously. It involves participation of community, perceived and actual need, agreed upon decision, community involvement in implementation and evaluation and redesign, based on community’s behavior.

---While people’s participation is key to PHC, it can only happen when the government makes the necessary changes to make this possible. Handling over power and funds to the people may not always be easy. PHC cannot be considered in isolation. Unless PHC is part of development people will be less interested to participate. It would be best to encourage CP in selected communities to demonstrate outcomes so as to convince administration.

---The staff of an implementing agency have to really believe that community members are capable of exercising leadership, and be willing to relinquish some of their "professionals", seeing themselves more as trainers than renderers of services to "patients".

---A community has conflicts of interest: rich/poor and divisions within poor. This must be taken into account and priority given to participation of poorest.
  -Trust of villagers/villagers trust program
  -Willingness to listen to villagers needs in broadest sense.

---Participation is that set of activities whereby people in a locality organize around a need, decide how to go for this need, assemble necessary resources and do something together to meet that need. Then they either go on to something else or hire someone to continue the job.
There are many different forms of CP. One neglected area is the involvement of local people in data gathering. CP should not be designed in such a way that it costs a lot of valuable, irreplacable TIME.

CP is very important in a project. It is a tool to educate people so that they understand and know the project. It is through participation that people can find out about the community, preferences, taboos. The acceptance of a project by the community underlines its success.

I was fortunate to have the experience of spending eleven years working in a variety of projects in the SAME location (Chimaltenango Department of Guatemala) and was able to observe the long-range affect of different approaches on the ultimate success of projects. This "concientizacion" taught me (slowly but surely) that the only projects that function successfully are those that grow out of felt community needs and are conducted from start to finish with full community participation.

Initiative, resources and responsibilities (IRR) must come primarily from the community and be kept in balance with IRR from an outside group or institute.

PHC should "start where they are AT!! In other words, ESTABLISHMENT, participation in what the community itself is doing (EP).

The two most critically missing elements are:
- a proper balance between "things" and "people"
- an honest PACE, i.e. the people's pace.

1. Supporting Organization must allow for the time involved to engage in CP.

2. CP can raise unrealistic expectations in community minds that they will control at a level not possible in light of agency funding constraints.

3. CP is a good source of information about projects and an essential part of project acceptance.
Community participation is essential for the success of a PHC programme but it is not something you can impose, you just initiate it. Whether the community will respond or not depend on several factors you must assess before launching your programme.

---read article in Health Forum 1987.

---Crucial but difficult. Much good care can be done without it but true development only occurs with CP.

Outline your own philosophy about EFFECTIVE EVALUATION (Part B, b/)

--- One question is missing regarding evaluation of PHC projects: The purpose is to obtain full participation of community. How to measure?

---Projects of something that is USEFUL, somethings that works and used, whatever facilities have been used.

---Important to distinguish monitoring, an on-going process, from evaluation, a periodic process. Former is much more important than the latter. Assessment of performance is more important, at community level, than assessment of impact.

---1. The community and professionals must first set their values right about evaluation. They must see it as a means of improving inputs and not as a means of finding fault.

2. A framework and mechanism for evaluation needs to be part of the project (including funds)

3. Flexibility to make changes in project activities.

---See my book on this very topic.

Self-evaluation: Ideas for Participatory Evaluation of Rural Community Development project published by World Neighbors.
---See Helping Health Workers Learn

---If the people of the community "own" the project - They can tell how well the project meets THEIR expectations.

They can ask -what did we want to do?
what actually happened?
why?
what did we learn from this?
what do we do next?

Outside help is often useful in helping people design their evaluations.

---It is usually impossible to measure "effects on overall health" Evaluation should focus more on "process" and implementation.

Evaluation should be planned and budgetted, from the beginning.
Evaluation should have both "outside" and "inside" components.

---The evaluation of a project gives a feedback for improvement and shows the weaknesses of the so called project.

---My experience is limited but I believe that a combination of techniques and tools can be used to satisfy institution, provide useful information for the on-going management of a project, and stimulate community involvement/commitment as part of a long-term "conscientization" process. In other words, the evaluation tool should be suited to the objectives, a variety of techniques can be used to satisfy more than one objective each. The objectives and results should ALWAYS be shared with those who participate in implementing the evaluation and with the community.

---Subjective approaches ("look and listen survey") can still be "effective" in a functional sense, even though not "statistically significant". Ordinary citizens must feel that they are team members (to some degree) in the exercise. Africa has been overly exploited by "PhD cultures" who swoop in, gobble up data (and our time) and fly off leaving
NOTHING in reciprocity. They are as bad as donor agency career - trach "carpet-baggers".

---Evaluation is essentially a tool for learning how to make better future decisions.

   Evaluation should supply management with useful information.

   Evaluation should involve indicators that are meaningful to participants as well as to the project technicians.

---Evaluation in a PHC project is a tool, it should never became the aim of the project. It is important but it must remain as a service to the project.

Comments on the PROPOSED FRAMEWORK (Part C)

---Main remark: the community does not have a say on resources.

---No comments except that birth weight is a better tool to measure overall PHC project impact (better than standard of child growth).

---For several statements: "should be" instead of "are"

---regarding the proposed framework: cost-effectiveness:
   Who pays?.

---Comments on "the Proposed Framework"

2nd. point: ...guide the community... =difficult. Communities are not homogeneous nor do they have time for detail.

3rd. point: ...by the community...= CFs, not whole community
6th. point: ...anthropometric measurements: growth may be better, reference child.
OPEN-ENDED QUESTIONS REGARDING FRAMEWORK (Part D)

1/ the level of COMMUNITY PARTICIPATION

--- It remains unclear

--- Yes, Framework does not indicate WHO is responsible for initiation and continuance of the activity. WHO is community

--- No, too much, too costly of time.

--- It is through CP in the evaluation that changes can be made and find out if the community accepts the project.

--- In principle I agree, however in my experience communities are not homogeneous. They are made up of conflicting factions who will try to use the program to their advantage. Most families do not have large blocks of time to devote to analysis in any case.

--- Yes, If approached in a way that allows then to express their true feelings & ideas, community input is invaluable for assessing PHC or any other type of CD project.

--- I can’t tell what it is.

--- Yes, if it can be clarified EXACTLY HOW the community will actually participate, decide, act, etc...

--- Yes. But it must be very FLEXIBLE.

--- Yes. Community yes, but no community will be able to participate at this level

2/ the type of MONITORING/EVALUATION proposed in framework

--- Input - output model gets complicated
   Must have simple CE measures.
---seems like common sense.

---No, too much focus on "costs"
   - its hard to define. Anthropometric measurements too narrow.

---Lots of organizations dump money into programs and don’t follow up the results. It is good to monitor a project to improve others.

---Yes, but with CF doing the detail work and reflexion and "the community" given opportunities to react through meetings and especially interviews conducted by other than CF’s (See #4)

---Perhaps. I don’t fully understand the question or the model, but I support the component of CP as ESSENTIAL.

---I don’t see a connection between the model and a reality involving politics economics and communication cross culturally where all play important roles in PHC projects.

---Simplify language for local participants.

---monitoring techniques are UNCLEAR in the framework but the evaluator schema is excellent.

---Some remark as above the community will by-pass the "facilitator" or who ever else, if she thinks she is becoming more and more a case for study and controls...

---No. Impossible to implement.

3/ WEAKNESSES/STRENGTHS/IMPROVEMENTS

---In general, I see no point in construction, diagram, to describe the obvious. This does not seem to add anything to an already overly theoretical subject. CP is painfully, simple, it needs DOING, not describing. This study will not
change anything. No idea, it's being done.

---The framework looks solid, but doing what is indicated may pose different problems with different communities in different settings.

---On target!

---Need to explore ways to make sure community members participate effectively and are not merely manipulated.

---Must recognize external requirements and interests of donor agencies. "satisfaction" is a very elusive subjective measure - satisfied with what?

---Focus on COSTS is here very OVER stressed. Other questions are:
  2. % of population served.
  3. non-monetary costs
  4. nature of constraints/facilitators.

---I also have some question about mounting an anthropometric survey (this, if done well, is expensive and difficult). Could we think of another indicator.

---To assess the strenghts and weaknesses I would need to have some idea of the methodology proposed for carrying out the process of community evaluation. The "reflection--decision--action sequence is an excellent theoretical framework but HOW will it be implemented?

---Much too neat & linear. Fails to mention a relational context. May be too top-downistic when actually put into practice.

---Until PHC is more objectively defined (and differentiated from traditional care) these questions cannot be objectively answered. Community - based Health care changes just do not happen in the "clickety-click" measurable act THAT askable,
THAT answerable or THAT analysable. What you have offered is not wrong. But it needs a much stronger clarification and elucidation of the "bottom up" component.

---relationship between Ministry of Health (MOH) & Community.

---1. Initial Project Appraisal needs to be related to CP. As it is, it seems to be divorced from community input.

    2. I don't see at the input stage how the cultural and socio/psychological variable is incorporated. It looks like a situation where only technique is emphasized.

---1. Show SPECIFICITY of monitoring; & show the PROCESS through which the community gains greater participation in decision-making OVER TIME (not a static process).

    2. What will be done with the cost effectiveness data? HOW will actual changes take place based on that data?

---Ideally CP + PE should be + can be supported. The problem is making it happen in the field.

---There is no indication whether there has been CP in the design + implementation stages of the PHC projects. What was level of CP in needs assessment?

---weaknesses: multiple assumptions; verifiable indicators.

---Strenghts: good theoretical framework.
    Weakness: where has it been implemented?

---Expects too much time, understanding on part of community. It won't work on my communities.
REFERENCES


Crone, Catherine D. et al. (1977, October) Special Issue on Evaluation, World Education Reports, No. 15.


