I read with interest Ms Sue Nancholas’ paper on the LogFrame. I found it informative, clear and correct. However, I believe that, as presented, it may shortchange the method for those who do not know it by overly emphasizing the final product, or worse, give the careless reader the impression that filling a matrix takes care of business. In this sense, I would like to add some complementary comments.

The LogFrame matrix as such summarizes what is basically a very interactive process to ensure that: a) those problems posed are, at least on paper, solved, and b) the solutions actually solved the problems posed and not others. This may sound obvious but our experience with the introduction of objective-oriented planning (or the project approach, or ZOPP or many other names) in the countries covered by the Pan American Health Organization is that it is quite frequent to find projects that pose problems but do not solve them, and, worse, may solve others. For example, a project aiming at ‘reduction of maternal mortality’ may end up buying computers for the central statistical unit. Surely there is a relation between those two, but they are definitely not identical.

The LogFrame indeed helps to at least highlight these inconsistencies. But we believe that the reader should understand that, as indicated in the article, the matrix is the result of a highly interactive – and very valuable – process, but that the foundations of the process are two: the problem tree and the stakeholder analysis. Based on practical experience, we believe it is better that the design group agree on these two and only later on the matrix. Since they are only briefly mentioned in the article, I will try to point out some important factors here, concentrating only on the tree for brevity.

The problem tree is a hierarchical ordering of the causality of the problem to be tackled. It forces the designers to spell out the main problem. For example, a goal such as ‘poor conditions of health attention’ needs to be translated into operational definitions such as ‘length of queue’, ‘percentage of care’, ‘users satisfaction’ and others. In other words, evidence-based data. Many formulations of public health concerns may not hold much water under this criterion.

Second, causality needs to be determined, in what usually consists in a mixture of ‘technical’ and ‘social’ reviews which are interdisciplinary by definition, to the chagrin of some health specialists, who may find it unpalatable that ‘amateurs’ enter their turf. Why is this? Because if one could tackle the main problems directly one would do it and this exercise would not be needed. But while we cannot reduce the incidence of AIDS directly, we can educate the public about its perils, assuming ignorance is a cause. And we do know how to educate, hence that will be our intervention. But we want to be able to measure the value of the intervention, not on the educational process as such, but on the reduction of AIDS incidence. Thus the effectiveness of one intervention (or tree branch) or another one can be compared.

Obviously there is an infinitely large problem tree, which has at its top human happiness, and branches with the many concerns of human endeavours, such as health, education, culture, income, etc. We normally work with a small subset of this tree. In any event, the tree used for analysis will have many levels down as the respective explanations for problems are developed. Which leads us to the third point that we think needs to be elaborated: implicitly or explicitly the four levels in the matrix are taken from this problem tree. It is neither a direct nor a desirable exercise to jump directly into the four levels of the matrix.

The selection of which of the many levels of the tree correspond to the four specific levels of the project we want to deal with is not arbitrary but has to do with our managerial power. For the Prime Minister something like ‘improving health of the population’ may be adequate as a goal. For the person in charge of a vaccination campaign, on the other hand, reaching 100,000 children may be the appropriate one. Notice that this goal is several levels under in the Minister’s matrix, which is part of the same tree as the vaccine person. His/her goal, however, may be an activity cluster or even further down in the Minister matrix. This points to the fact that deciding at what level one is in condition to intervene (and hence establishing goals) is as tricky a decision as the technical definition of the problem, but one that is seldom emphasized enough, and results in very frustrated designers.

I trust that these observations, based on years of training health specialists in the techniques, will complement the article by explaining further the intellectual and group implications of the methodology that need to be understood by users to avoid the feeling of yet another formal requirement on the users of health systems. We welcome the opening of exchanges in this line of planning in the journal. As Ms Nancholas very well notes, it is becoming a crucial tool for resource mobilization in health.

Correspondence: Hernán Rosenberg, Sr. External Relations Officer, DEC, Pan American Health Organization, 525 23 St. NW, Washington, DC, USA. Email: rosenbeh@paho.org