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AN EVALUATION OF ACTIVITIES
OF THE CENTER FOR DISEASE CONTROL
FAMILY PLANNING EVALUATION DIVISION
(AID/RSSA-PIO/T 932-978-2-3267514)

A Report Prepared By:

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During the Period Of:

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Under The Auspices Of:

AMERICAN PUBLIC HEALTH ASSOCIATION

In Agreement With The:

U. S. AGENCY FOR INTERNATIONAL DEVELOPMENT

AUTHORIZATION:
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AN EVALUATION OF ACTIVITIES
OF THE CENTER FOR DISEASE CONTROL
FAMILY PLANNING EVALUATION DIVISION
(AID/RSSA-PIO/T 932-978-2-3267514)

I. INTRODUCTION

A. Purpose of the Consultation.

The two consultants were selected as a team, working under the auspices of the American Public Health Association, to assist in an evaluation of the Resources Support Service Agreement (RSSA), PIO/T 932-978-2-326514, between the U.S. Agency for International Development, Office of Population (AID/POP), and the Center for Disease Control, Family Planning Evaluation Division (CDC/FPED). CDC is an agency of the Department of Health, Education and Welfare. The scope of work for the consultation assignment included:

1. Review of past and future requirements by AID/POP for CDC/FPED project assistance.
2. Review of CDC/FPED individual trip and summary reports submitted to AID/POP since the inception of the project.
3. Review of past, present and future program activities and direction of CDC/FPED.
4. Assessment of the following elements in one or more of the Latin American countries in which CDC/FPED projects have operated:
 - a) family planning data gathering and verification,
 - b) family planning program enlargement, improvement and policy changes,
 - c) logistics of contraceptive distribution,
 - d) personnel training,
 - e) program categories and/or areas where CDC/FPED efforts could usefully be initiated, increased, decreased or ceased.

The AID/POP expectations were outlined at a briefing held in Washington for the consultants and were stated as follows:

1. Does CDC have the necessary depth of personnel to improve the logistical systems for commodity distribution?
2. Is it feasible to provide short-term technical assistance (3-6 months) to foreign governments that will help generate service and management statistics? Not only are the statistics needed for AID quarterly and annual service statistic reports but--is management making use of the statistics, especially in the better distribution of commodities?
3. What is the possibility of CDC developing a cadre of trainers who could be sent into countries to train incumbent personnel about management and service statistics?
4. Can people be trained in commodity logistics, and could CDC give a course in this?
5. What does CDC think of the demands made upon it by AID?
6. How does CDC compare the long-term vs. the short-term support to USAID Missions and foreign governments?

B. Summary of Activities.

The consultants met on March 29, 1976, for briefing by the AID/POP Family Planning Division staff. Additional briefings were provided by the Deputy Director, AID/POP and members of the AID/POP Latin American Bureau. Prior to this, on March 18, Dr. Wishik received a preliminary briefing at AID/POP and reviewed some of the files relating to the CDC activities.

A site visit was made on March 30 and 31 to the CDC headquarters in Atlanta where the consultants received a general orientation to the CDC and its Bureau of Epidemiology, within which is located the Family Planning Evaluation

Division (FPED), and a more specific orientation to the FPED by its Director. Individual staff members reported on their activities and presented studies in which they had been, or were, involved. The Deputy Director briefed the consultants on FPED activities in the three countries to be visited, future FPED plans were reviewed, and visits were made to the CDC library, the FPED reference collection, and the Office of International Services.

Following the visit to Atlanta, site visits were made to three Central American countries. Dr. Croley went to Guatemala and Dr. Wishik to Panama for two days, and both visited El Salvador. In each country the consultants met with USAID Mission staff and, to the extent possible, with local officials responsible for government and private sector population and family planning activities.

The consultants returned to Washington for a debriefing on April 13. The names and positions of the people with whom the consultants met are provided in Appendix A.

II. PURPOSE OF THE AID/CDC AGREEMENT

According to the Resources Support Services Agreement (RSSA), the objective is: "To provide evaluation information and constructive services directed toward improvement of AID-sponsored family planning programs operating in the lesser developed countries." This is to be done by helping to upgrade data systems, evaluate national programs, conduct follow-up surveys and train developing country personnel.

The AID expectations of the CDC, as expressed at the AID briefing, are as follows:

- a) The RSSA is an enabling agreement which requires AID authorization for specific country activities to be carried out by CDC. However, CDC is encouraged to try to initiate activities rather than just respond to AID requests.
- b) AID would like to learn about any immediate reactions in the form of positive program changes which may promptly follow CDC consultation visits.

- c) Through its support, AID is trying to insure a core staff of people at FPED, but it is not sure that there is enough depth in the present staff. Although there is a small item in the budget for consultation, AID is not interested in CDC relying on outside consultants in lieu of its own regular staff.
- d) AID would like the service statistics improved in the countries which are recipients of AID assistance, but this does not mean imposing a particular system, or a change in system, upon a government as much as helping the government to exploit what it has for prompt implementation and maximum utility.
- e) Although AID is interested in program improvements resulting in increased numbers of contraceptive acceptors and users, it is not expected that CDC's efforts will be directed primarily toward that end. It should focus on improvement in data collection rather than on improvement in methods of program operation.
- f) Although AID has no continuing authority over commodities after they enter the recipient country, AID feels a responsibility to know about the flow of contraceptives from the port of entry to the ultimate consumer. It therefore expects CDC to evaluate this process and contribute toward monitoring and improving it.
- g) AID expects a substantial portion of the RSSA budget to be used to support "research and development" activities, such as: 1) the CDC study on changes in the causes of death of women in Puerto Rico in the years following the introduction of oral contraception, and 2) the assembly of information on thrombo-phlebitis which was used by AID in its discussions with the FDA.

III. CDC/FPED ACTIVITIES

A. Structure And Scope Of Activities.

FPED is located administratively in the CDC Bureau of Epidemiology and is organized into four branches. (See Table of Organization) The Division receives funds from several sources in addition to basic support from its parent organization. Of its annual budget, which is about one million dollars, approximately 25 percent is derived from the AID contract.

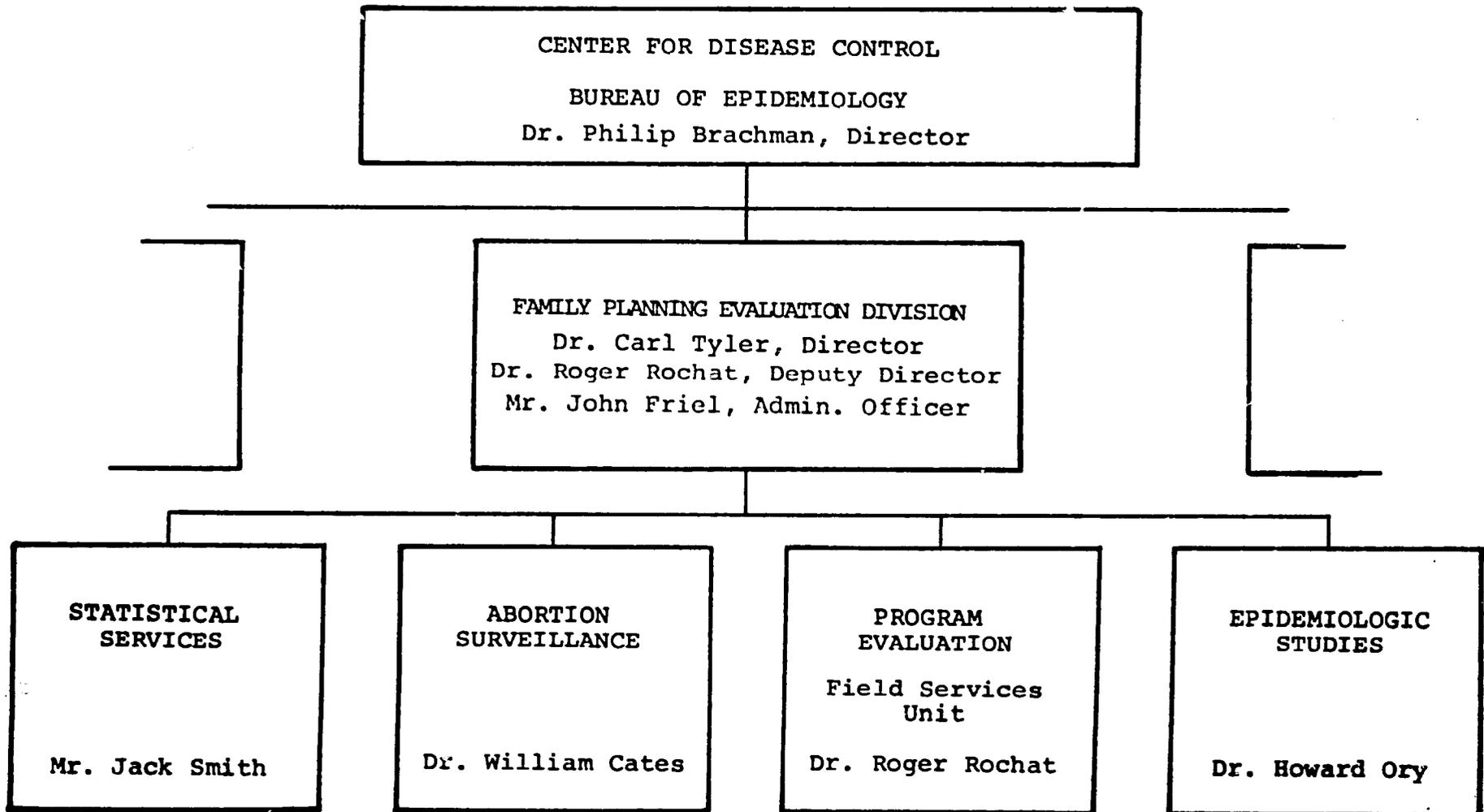
The staff of the Division includes full-time professional persons of a variety of disciplines, of whom 15 derive partial salary support from the contract in differing proportions totalling 70 person-month's per year. (See Appendix B). 28 person-months of the time of seven members of the supportive staff are also funded under the contract. Activities performed under the contract are treated as part of the Division work load and call upon the full resources of the organization, as warranted. This may, at times, involve personnel not funded under the contract, or may require a proportion of a staff member's time in excess of the amount attributed to the contract. It also includes use of the overall resources of CDC outside the Division, such as the Library, possibly translation service, the International Unit, and the products of the Training Division.

Activities of the Division are of the following types:

1. Conducting epidemiologic studies (e.g. abortion surveillance).
2. Giving technical assistance in the U.S. and abroad (e.g. developing a data system on the distribution of contraceptive supplies).
3. Training of personnel (e.g. organizing a special week of training in Atlanta for a group from Panama).
4. Dissemination of information (e.g. presentation of scientific reports at meetings, publication and

Table 1.

Condensed Table Of Organization



distribution of study reports, submitting to AID and USAID Missions interpretive analyses of country data).

The AID contract, in addition to generally strengthening the Division's work, contributes particularly to its foreign technical assistance activities, which may take one or more of the following forms:

1. Development of family planning program service data systems.
 - a) Logistics systems for supply distribution.
 - b) Records and reports systems for clinical and educational family planning services.
2. Evaluation of specific elements of family planning services.
 - a) Design or conduct of evaluations.
 - b) Design or conduct of community surveys.
 - c) Analysis and interpretation of already collected data.
3. Demographic analyses.
 - a) Census and other data sources.
 - b) Population projections for program target setting and planning.

B. Quantitative Analysis Of International Travel.

CDC provided a "Summary of International Travel, FPED Staff" (see Appendix C) covering the period January 1973-March 1976. An analysis of this document reveals that nineteen countries were visited on thirty-nine occasions for a total of 488 person-days. (The actual number of trips made from Atlanta would be less than thirty-nine, as two or more countries often were visited on one trip.) Twenty-four of the visits were made by a single consultant, fourteen were made by a pair of consultants, and on one occasion there was a team of three. Ten different people

went on these visits, but one person was on twenty-two of the thirty-nine. About two-thirds of the time was spent in Latin America and one-third in Asia. Three countries in Africa were visited on one 22-day trip. CDC staff spent an average of 12.5 days per month on these visits, with a mean of 12.5 person-days per visit and a mean of 25.7 person-days in each country.

In addition to traveling to provide advice to USAID Mission staff and nationals in the developing countries, CDC staff traveled to a number of other countries to attend conferences, present papers, lead seminars and workshops, etc. Each of these trips was made by one person. Six different people spent eighty-two person-days on fourteen trips for these purposes.

C. Content Analysis Of International Travel.

CDC staff members consulted on a wide variety of topics during the thirty-nine months covered by their report. There may be some overlap in the items listed below, but the list provides a good picture of the range of activities.

1. Continuous motivation systems.
2. Establishing, evaluating and improving family planning record systems.
3. Contraceptive continuation studies.
4. Data analysis.
5. Demographic and family planning surveys.
6. Population projections and demographic target setting.
7. Family planning program evaluation.
8. Demographic impact of fertility control policies and fertility practices.
9. Abortion studies.
10. Evaluation of training of family planning professionals.

11. Contraceptive supply systems.
12. Cervical cancer screening.
13. Censuses.

IV. REACTIONS OF RECIPIENTS OF CDC SERVICES

A. AID/Washington.

Following are some of the comments expressed by AID/POP staff at the time of the briefing:

1. As the quarterly and annual AID reports of service statistics now cover a larger number of countries than at the beginning of the AID/CDC agreement, it is assumed that CDC is at least partially responsible for this.
2. The CDC trip reports have been quite useful in revealing much more about the programs than statistics alone can do. For example:
 - a) Characteristics of acceptors and factors associated with differential continuation rates among population sub-groups.
 - b) An independent judgment of the validity and reliability of service statistics in given countries.
3. CDC representatives have been helpful in bringing about better governmental understanding and cooperation in submitting data for quarterly and annual reports to AID.

B. AID/Missions In The Three Countries Visited.

The USAID Mission staff had very high praise for CDC personnel and the backstopping they provided. The CDC staff who provided consultation and assistance were described as "universally excellent" people who were "dynamic, responsive, technically competent, and culturally attuned." Among the several specific ways in which they were helpful,

that were mentioned, are the following:

1. Willing to spend as much time as the task required rather than limiting a visit to a fixed number of days.
2. Rapid provision of written reports and recommendations.
3. Frank and open discussions.
4. Speak the language and know the culture.
5. Willing to process data in Atlanta when there is a local computer breakdown or other need.
6. As outsiders, they are able and willing to say things to nationals (diplomatically) that USAID Mission staff are unable to say, or have said so often it is embarrassing to say them again.
7. In order to make CDC backstopping "perfect", one USAID Population Officer recommended that the CDC employ a full-time translator and obtain AID funds to be used for training of evaluation and demographic personnel in Atlanta.

C. Representatives Of Governmental And Private Family Planning Organizations.

Host country representatives also spoke highly of the CDC consultants. The head of the private association in Guatemala was not well acquainted with CDC staff, but was requesting their assistance in designing and evaluating his expanded program. According to the former USAID Population Officer, two of the CDC consultants were the only consultants to be allowed out in the field on their own.

The chief of the Department of Studies and Evaluation of the private family planning association in El Salvador said the CDC consultant had been valuable in helping them to develop the Second National Fertility Study and in designing a simple and brief interview schedule which got at what they wanted to know. Personnel of the El Salvador Ministry of Planning who did not know this consultant, but

who knew of him from other Salvadoreños are planning to request that he return to help them in a top level review of population policy.

In Panama, governmental program officials seemed to have little familiarity with CDC consultants, but personnel in the statistical units reacted favorably to having met them.

The evaluation team consultant who went to Guatemala did not meet with any of the governmental officials who had contact with the CDC consultants because of the current cool relations between the USAID Mission and the Ministry of Health. He was, however, informed that they would be negative toward the CDC because the data processing systems revealed the inadequacies of the program. The director of the private organization was critical of the system because it was "very complicated and expensive." This was in reference to the thirty-two items for which information was obtained and the \$40,000 which AID budgeted annually for Ministry of Health staff salaries, computer time, programming, forms, etc.

V. CDC/FPED REACTIONS TO AID RSSA

The FPED is satisfied with the contract in general, and with the level of funding and personnel support. Appreciable expansion or reduction of staff is not sought. The Director is pleased that he has achieved polyvalent depth with two or more persons in each of the relevant subspecialties, especially medicine, statistics, demography and logistics. The staff is rather fully occupied, with some latitude for greater participation among the new, younger members. Significant expansion of training responsibility would require commensurate staff strengthening.

With approximately half of its funds coming from the regular CDC budget, FPED is about at the ceiling of desirable "soft money" support. The chief of the Bureau of Epidemiology indicated that he too feels that the Division is at an appropriate level of size and activity. He would try his very best to maintain this level if outside support were unfortunately reduced.

With respect to travel abroad, FPED prefers short visits rather than extended ones. Short visiting has been the past pattern, with the one exception of a recent 45-day assignment of a consultant in Bangladesh to work through the complex logistics of a supply distribution system, and to help develop a procedures manual for that program. It is not deemed feasible for FPED staff members to be away from their homes and families for several months at a time. In addition, the needed breathing time or "simmering process" during the evolution of program designs usually finds advantages in intermittent return visits with shorter stays each time. If the occasion arose, long-term placement of an advisor in a country for two years would be considered, although recruitment would not be easy.

FPED believes that they could be more contributory if they had greater access to countries. Under the present system, invitations do not generate themselves easily, whether for CDC or other technical assistance. Certainly, after first clearances of particular staff members for given countries, subsequent direct exchange between CDC and individual USAID Missions should be the usual method.

FPED is especially interested in the epidemiology of abortion and contraception. They would like to do more studies on side effects and would maintain relevant staff competence toward that end.

VI. ASSESSMENT OF CDC/FPED PERFORMANCE

FPED staff have made country visits on an average of once a month. This is a commendable achievement in staff allocation, especially in view of the necessity of waiting for specific invitations before visiting. An average of 150 person-days per year have been spent in the countries thus visited, with additional time in preparation and follow-up work at the Atlanta headquarters.

The length of each visit varies from a single day upward, with an average of about 12 days. Two weeks of the type of intensive effort that is expended by the FPED staff, backed up by CDC's resources, is a long enough period to accomplish a reasonable bite-size task. Stays measured

in days or weeks have conferred better cost benefit than would consultation visits measured in months. For certain tasks, such as the establishment of a complete record and report system, the longer period that is required can be and has been met through serial visits with intervening correspondence when there is a responsible local counterpart.

The quality of FPED consultant work is quite high, with outstanding competence in statistical tabulation, analysis and interpretation of survey data. The staff are very effective in paraphrasing study findings into forms which illuminate those aspects that deserve highlighting. Nevertheless, it is our impression that this important contribution is not as strong with respect to directing data analysis toward implications for program change that are clear to the usual program administrators and decision makers. It is conceded, for example, that information on differential contraceptive continuation rates according to type of residence--metropolitan, urban, rural--gives general clues for program emphasis. Ranking of rates of identified geographic areas would be more useful in allocation of supervisory observation time and support. Life table attrition findings for one, two and three year periods are helpful in sharpening estimates of prevalence of contraceptive practice, however, attention is too often diverted from the need to correct obvious gross service deficiencies which discourage women from returning to a clinic after the first unhappy visit. It should be made clear that this is not to decry the excellent research counseling given by FPED. But it is more than an academic suggestion to hope that the design of field studies might have a dual objective, often with little additional investment.

FPED advisors take one extremely useful approach. They keep pushing for measurement and reporting on the prevalence of contraceptive practice in addition to the incidence of new acceptors. Toward that end, they have helped in the design of simple and relatively inexpensive mini surveys. This laudable effort would be complemented and balanced by advising on minor additions to service record systems to permit reporting on unduplicated count of numbers of different clients served during the year rather than the universal reports on numbers of visits.

FPED consultants have done a number of useful country exercises whereby population projections have been used in target setting and program planning. It is hoped that through exposure to the process and intimate collaboration in it, country personnel will become proficient enough to do such studies on their own in the future.

It so happened that two of the three countries visited by the evaluation consultants, Guatemala and Panama, had the relatively unusual feature of computerized program record and report systems. The Guatemala system is not functioning, for a number of reasons implied elsewhere in this report. The program never reached the volume for which the system was created. The Panama system, established under guidance from CELADE, and not subject to modification by FPED visitors to that country, is producing data quite promptly. For other than routine analyses, however, statisticians in the Ministry of Health do manual tabulations because the computer tapes are not accessible to answer special questions. Much of the content of the printouts is simple marginals on information readily available in the local clinics where the data originates. FPED might participate in an intensive AID sponsored assessment of computerized family planning service data systems, including the burden imposed upon local clinic and community workers in filling numerous forms at the expense of service time.

A staff member of FPED had just returned with a draft of a new procedure manual for the processing of contraceptive commodities in Bangladesh. This had been developed jointly with the responsible government official and a UNICEF commodities expert. The manual is excellently organized to cover stock, inventory, and distribution recording in detail at levels comparable to national, regional, district and local geographic units. However, it is our opinion that the system is formidable and burdensome to the point of inevitable collapse. One can understand the necessity of monitoring the dynamics and status of commodities flow and storage. This should not be confused, however, with requirements for maintaining 100 percent records and central reporting on individual transactions for identified consumers. It is perhaps no more reasonable to require full notation each time a man and wife obtain three condoms than it is if they are purchasing soap. A manufacturer can sell quite a bit of toothpaste and keep track of its distribution

accomplish

prohl

without identifying the ultimate purchasers. It should be sufficient to do periodic spot checking of distributors' ledger books. It is just as easy to falsify transmitted reports as those locally recorded. It is strongly recommended that the pilot phase of use of the new method in Bangladesh be thoroughly and objectively monitored and evaluated before deciding on national implementation.

Rec

VII. RECOMMENDATIONS

A. The consultants, as a result of their own observations and from the reactions expressed by recipients of FPED services, were impressed with the quality and quantity of FPED activities and the contribution they have made. It is strongly recommended that AID continue to support the program.

B. It is recommended that the role of CDC in other countries be more broadly defined than it was at the AID/POP briefing. This recommendation is based on the following:

1. CDC can offer much more.
2. USAID Missions want much more.
3. The narrowly defined role limits assistance to be provided to nationals and makes it difficult for them to understand why they cannot have the kind of assistance they want.
4. The same individuals are involved in program and trend data, both at the administrative and local service levels.

C. It is recommended that because of its special knowledge, interest and language skills that the majority of the FPED international assistance be directed toward, but not limited to, Latin America. This would capitalize upon the multiplier effect through an increased opportunity for exchange and application of results from one country to another within this large region.

D. It is recommended that CDC be cautious in developing data processing, logistical, or other systems that are too

complex for the situation in which they are to be used, or which are too expensive to be maintained after the withdrawal of foreign assistance. It may be timely for AID to sponsor a review of this question by a group of experts.

E. It is recommended that FPED increase the utilization of consultant teams to strengthen the program development and administration components of the consultations, particularly when common sources of data are to be used for different purposes.

F. Relative to abortion, it is recommended that:

1. The results of the FPED abortion surveillance study should be published in English, French and Spanish and distributed to the full membership of FIGO (International Federation of Obstetricians and Gynecologists) as well as to other appropriate individuals and agencies in different parts of the world. An increase in AID financial support may be necessary to cover printing and distribution costs.
2. FPED develop guidelines, procedures and criteria to be used by review committees on preventable mortality associated with abortion as a step toward reducing the incidence of such deaths in the future. This would be similar in importance to the review procedures that were developed and used in reducing maternal mortality.
3. The FPED develop procedures for standardizing methods of assessing the impact of abortion related mortality on total maternal mortality. This would be useful because abortion mortality data do not logically fall within data that pertain to numbers of live births.
4. That FPED continue in its efforts to develop methods for estimating the number of non-hospital abortions from the number of hospital abortions in different situations.
5. That FPED attempt to develop syndrome descriptions to assist in identifying and distinguishing unreported induced abortions from spontaneous abortions.

G. Relative to training, it is recommended that:

1. FPED provide tutorials in Atlanta for a few carefully selected Latin Americans to learn specific skills needed on actual tasks in their respective programs. However, it is not recommended that FPED develop regular training courses for Latin Americans in Atlanta, but that they collaborate with Latin Americans and personnel of technical assistance agencies and academic institutions in providing training in Latin America when and where it is needed.
2. CDC place greater emphasis on the development of local competence in data analysis by focusing on at least one key individual in each organization counseled.

H. It is recommended that FPED adopt follow-up procedures which will increase the feedback it receives from its reports and recommendations; such as by inquiry to USAID Missions concerning routing and use of the reports.

I. It is recommended that AID give thought to ways of increasing the awareness of USAID Missions of the possible contributions of FPED. For example, by a strategic distribution to Missions and governments of some of the FPED interpretive reports to illustrate the type of consultation FPED could provide. Attendance of CDC staff at meetings of USAID Mission Population Officers would be another way of facilitating this recommendation.

J. It is recommended that FPED staff continue to attend scientific and professional meetings, not only for their own professional development, but as a means of strategic dissemination of the evaluative and data analysis methods which arise from their consultation work under the contract.

APPENDIX

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APPENDIX A

PERSONS CONTACTED

WASHINGTON

Dr. Harold Pedersen; Chief, PHA/POP/FPSD
Dr. Joseph Loudis; Project Monitor, FPSD
Mr. Harry Harris; Program Officer, FPSD
Dr. Andrew Wylie; Population Manpower Development Officer
Mr. Charles Johnson; Chief, Latin America Division, POP
Mr. Vernon Scott; Deputy Chief, LA Division, POP
Mr. Robert Grant; Chief, NESA Division, POP
Dr. William Boynton; Deputy Director, Office of Population
Dr. Malcolm H. Merrill; Director, Division of International
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Mr. Howard Hough; Project Coordinator, Division of
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Dr. Carl Tyler; Director, Family Planning Evaluation
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Mr. Jack Graves; Program Analyst, FPED
Dr. John Anderson; Demographer, FPED
Dr. Howard Ory; Chief, Epidemiologic Studies Branch, FPED
Dr. Joel Greenspan; Medical Officer, Epidemiologic Studies
Branch, FPED
Dr. David Grimes; Abortion Surveillance Branch, FPED
Dr. Philip Brachman; Director, Bureau of Epidemiology
Dr. William Cates; Acting Chief, Abortion Surveillance Branch
Mr. Jack Smith; Chief, Statistical Services Branch
Mrs. Mary Alice Mills; Chief Librarian, CDC
Ms. Doris Ingle; Staff Assistant, Office of International
Services

GUATEMALA

Mr. John Paul James; Population Officer, USAID
Dr. E. Croft Long; Medical Advisor, USAID

Mrs. Cynthia Burski Braaton; Former Population Officer, USAID
Dr. Roberto Santiso; Executive Director, APROFAM (IPPF
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PANAMA

USAID Mission:

Dr. Felix Hurtado; Chief, Division of Health and Population
Mr. John Rogers; Assistant Chief, Division of Health and
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Sr. Guillermo Vasconez; Assistant to Chief, Division of
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Sra. Angela de Mata; Assistant to Chief, Division of Health
and Population
Mr. Herbert Caubill; Environmental Engineer, AID Division
of Health and Population
Dr. Harold Rice; Nutrition

Ministry of Health:

Dr. Julio Sandoval; Vice-Minister of Health
Dr. Vasquez; MCH/FP
Lic. Raul M. Batista E.; Chief, Dept. of Stat. & Electronic
Computing
Lic. Frederico Guerra; Office of Population Studies
Dr. Ernesto Rothery; Director, Metropolitan Health Region
Dr. Rafael Anguizola; Chief, Maternal Sub-Program, MCH
Sra. Doris Robles; Nurse, Nuevo Veranillo Clinic
Sra. Gloria de la Cruz; Secretary, Nuevo Veranillo Clinic
Dr. Juan Mas; Director, Nuevo San Juan Health Center, Colon
Dr. Hugo Spadafora F.; Director, Integrated Health System,
Colon
Dr. Walter Lawson; Med. Dir. Sabanitas Integrated Med. Center,
Colon
Dr. Hugo Viejas; PAHO Consultant
Dr. Paul Penna; Rural Health Development, Gov't of Panama
Lic. Bolivar I. Castro; Chief, Dept. of Statistics, Colon
Province
Sra. Graciela de Playa; Exec. Director APLAFA (IPPF
affiliate)
Sr. Victorina Canton; Information & Education, APLAFA

EL SALVADOR

USAID Mission:

Mr. Sam Taylor; Chief, Division of Health and Population
Mr. Bob Haladay; Division of Health and Population
Mr. Roberto Chavez; Division of Health and Population

Other:

Lic. Ricardo Castaneda Rugamos; ADS (IPPF affiliate)
Dra. Aparicio; Director, MCH
Dr. Jose Raul Moran; Sub-Director, MCH

| | | | | |
|--|-----------------|---|-----------------------------|--|
| 1. APPROPRIATION NO. 72- 11X1024 | | RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND DEPARTMENT OF HEALTH, EDUCATION AND WELFARE Center for Disease Control | ORIGINAL AMEND NO 4 | |
| 2. ALLOTMENT NO. 424-32-099-00-81-61 | | | 8. RSSA NO. HEW/CDC 6-74 | |
| 3. PIOT NO. 932-978-2-3267514 | | | 6. FISCAL YEAR FY 76 | |
| 7. CURRENT FISCAL YEAR FUNDING | PREVIOUS AMOUNT | CHANGE | AMOUNT TO DATE \$293,190 | |
| 8. AUTHORITY GENERAL AGREEMENT BETWEEN A.I.D. AND THE AGENCY NAMED ABOVE, DATED March 3, 1966 | | | | |
| 9. PURPOSE Management and Consultant Services for Family Planning Services Evaluation | | | | |
| 10. SERVICES TO BE PERFORMED | | | | |

Summary and Purpose

Since program initiation in February 1974, 19 trips have been made to nine different LDCs mainly in connection with a variety of international workshops and conferences. LDC data systems have been upgraded, national programs evaluated, follow-up surveys undertaken and trained LDC personnel are scheduled to receive six weeks logistic field experience in the Philippines and Bangladesh.

The purpose of this amendment is to continue these activities for another fiscal year.

I. Objective

To provide evaluative information and constructive services directed toward improvement of AID-sponsored family planning programs operating in the lesser developed countries

(Continued)

| | | |
|---|--|---|
| 11. LIAISON OFFICES | | |
| A. PARTICIPATING AGENCY LIAISON OFFICE Dr. Roger W. Rochat | B. A.I.D. TECHNICAL OFFICE Family Planning Services Division PHA/POP | C. A.I.D. BUDGETARY AND ADMIN. OFFICE CM/PAS <i>J. Auer</i> |

12. TERMINATION. UNLESS OTHERWISE INDICATED IN THE RSSA, THIS AGREEMENT WILL CONTINUE IN FORCE, AND SERVICES WILL CONTINUE TO BE RENDERED UNTIL THE AGREEMENT, OR ANY PART THEREOF, IS TERMINATED AFTER 90-DAY NOTICE BY EITHER PARTY.

| | |
|--|---|
| 13. SIGNATURES | |
| <i>[Signature]</i> NAME: S. Paul Ehrlich, Jr., M.D. TITLE: Director, OIH OFFICE: Office of International Health AGENCY: DHEW/Public Health Service DATE: February 4, 1976 | <i>[Signature]</i> NAME: Edward Rawson TITLE: Chief, Participating Agency Staff OFFICE: Office of Contract Management AGENCY: Agency for International Development DATE: NOV 11 1975 |

14. ATTACHMENTS, WHEN ATTACHED, THESE APPENDICES ARE CONSIDERED PART OF THE RSSA AGREEMENT

APPENDIX A BUDGET AGREEMENT
 APPENDIX B RSSA CONTINUATION SHEET

DHEW/PHS/OIH:MACodding
DHEW/PHS/CDC:Carl Tyler *CT*

APPENDIX A

BUDGET AGREEMENT

1 of 2

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
 THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
 DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
 Center for Disease Control

ORIGINAL AMEND 3
 NO.

RSSA NO.
 HEW/CDC 6-74

FISCAL YEAR
 1976

1. BUDGET BY OBJECT CLASS.

THE AMOUNT BUDGETED FOR ANY OBJECT CLASS SHALL NOT BE EXCEEDED BY MORE THAN 15 PERCENT UNLESS THERE HAS BEEN PRIOR APPROVAL BY A.I.D.

2. STAFFING (OBJECT CLASSES 11 AND 12) - DETAILS

| OBJ. CLASS | DESCRIPTION | AMOUNT | TITLE/NAME | GRADE (GS) | MAN-MONTHS | SALARY | BENEFITS | TOTAL |
|------------|--|-----------------------|-------------------------------|------------|------------|--------|----------|--------|
| | | | Chief Medical Off., Kochat | 15/10 | 6 | 17,870 | 1,660 | 19,530 |
| | | | Suprv. Med. Off., Tyler | 06/VII | 3 | 10,019 | 931 | 10,950 |
| 11 | PERSONAL COMPENSATION | 165,499 | Asst. Proj. Director, Morris | 14/4 | 6 | 13,967 | 1,297 | 15,264 |
| | | | Chief, Stat., Services, Smith | 14/2 | 2 | 4,374 | 406 | 4,780 |
| 12 | BENEFITS (AT 8.5 PERCENT) | 15,374 | Medical Off., Heiby | 13/10 | 10 | 23,424 | 2,176 | 25,600 |
| | | | Public Health Analyst, vacant | 12/4 | 7 | 11,760 | 1,092 | 12,852 |
| 21 | TRAVEL AND TRANSPORTATION OF PERSONS (EXPLAIN BELOW) | 32,323 | Nurse, Epidemeologist, Rooks | 12/4 | 2 | 3,360 | 312 | 3,672 |
| | | | Public Health Admin., Graves | 12/10 | 6 | 11,913 | 1,107 | 13,020 |
| 23 | RENT, COMMUNICATIONS, AND UTILITIES | 5,779 | Progs. Spec., Hill | 13/1 | 6 | 10,838 | 1,006 | 11,838 |
| | | | Demographer, Anderson | 11/2 | 5 | 6,615 | 615 | 7,230 |
| 24 | PRINTING AND REPRODUCTION (EXPLAIN BELOW) | 1,000 | Math/Statistician, Conn | 9/2 | 2 | 2,196 | 204 | 2,400 |
| | | | Statistician, Schultz | 0-3 | 2 | 2,326 | 216 | 2,542 |
| 25 | OTHER SERVICES (SPECIFY BELOW) | 22,000 | Visiting Scientist, Monreal | VS-01 | (11)6 | 12,578 | 1,168 | 13,746 |
| | | | Info. Specialist, Taxman | 5/1 | 6 | 4,222 | 392 | 4,614 |
| 26 | SUPPLIES AND MATERIALS | 976 | Div. Management Off., Friel | 13/3 | 1 | 1,925 | 179 | 2,104 |
| | | | Stat. Clerk, Rhodenhiser | 7/4 | 3 | 2,871 | 267 | 3,138 |
| 31 | EQUIPMENT (EXPLAIN BELOW) | 1,375 | Mg. Card Operator, Barnes | 5/1 | 4 | 2,815 | 261 | 3,076 |
| | | 48,865 | Stat. Secretary, Fitch | 5/1 | 2 | 1,407 | 131 | 1,538 |
| | | | Clerk Typist, James | 4/1 | 6 | 3,761 | 349 | 4,110 |
| | | | Secretary, Kurtz | 5/1 | 6 | 4,222 | 392 | 4,614 |
| | TOTAL | Rd. \$293,190 293,191 | | | | | | |

3. EXPLANATION OF OBJECT CLASSES AND SPECIAL PROVISIONS

- 11.&12. Includes additional 5% to offset Federal Pay raise effective Oct. 1975.
- 21. Includes: \$30,060 International Travel plus per diem costs-visits by senior staff to: Panama, Columbia, Philippines, Bolivia, Paraguay, Brazil, Bangladesh, Nicaragua, Canada, Mexico, Peru, El Salvador, Costa Rica & Chile (approx \$5,692 Domestic Travel: approx. 28 trips between Atlanta and AID/W for trip meetings, 308 person days)
- 24. Covers printing of reports required under the terms of the BSSA based on 857 pages @ 7¢ a page.
- 25. Covers the following costs:
 - 2 in-country surveys at \$6,000 each \$12,000
 - 2 " workshops at \$ 3000 each 6,000
 - 20 days consultant services at \$100 a day 2,000
 - Curriculum Development 2,000

166,618

| | | |
|--|--|--|
| <p>APPENDIX B RSSA CONTINUATION SHEET Page 1 of 3</p> | <p>RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND DEPARTMENT OF HEALTH, EDUCATION AND WELFARE Center for Disease Control</p> | <p><input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> AMEND 3 NO. NO. RSSA NO. HEW/CDC 6-74 FISCAL YEAR 1976</p> |
|--|--|--|

II. Scope of Work

A. General

The Center for Disease Control will provide service statistics concerning family planning programs suitable for study and strategy development. As problem areas are identified and a practible remedial approach recognized, on-site technical assistance will be furnished and presented to appropriate host country personnel as feasible. AID will be provided with technical reports detailing program needs and the nature of existing problems as developed through diagnostic studies and the scope of technical assistance provided.

B. Overseas Visits and Surveys

CDC will arrange to visit at least 15 countries during FY 1976. During these visits they will conduct in-country surveys to determine levels of contraceptive prevalence. Up to four surveys may be requested during FY 76. Assistance will be given in the production of service statistics information related to logistical problems and in the collection of data on the use of contraceptives: acceptors, number of clinics, number of personnel, and other service statistics required for reporting purposes. CDC will assure that the required data are assembled and transmitted to AID/W in accordance with the required schedule. In addition, a compilation of information on contraceptive commodities will be made in terms of volumes received in the systems and dispensed. Surplus stock or bottlenecks in the system, or supply deficiencies should be reported so that corrective action can be taken.

A minimum of 300 days overseas support is programed.

Follow-up visits will be arranged as needed.

C. Quarterly Planning and Review

CDC key personnel shall meet quarterly with AID/W staff to discuss priorities, strengths and deficiencies of their family planning program data/submissions and decide which countries should be visited. Activities of the previous quarter will be reviewed and plans laid for the next quarter.

D. Workshops and Conferences

Workshops are arranged as needed, either in-country or regionally for program personnel on recording contraceptive data, dispersing contraceptive commodities, good logistic practice, and various other aspects of family planning evaluation. AID will arrange short-term visits to CDC/Atlanta for host country and mission family planning program personnel with special program evaluative skills.

APPENDIX A

BUDGET AGREEMENT

2 of 2

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Center for Disease Control

ORIGINAL AMEND NO.

RESA NO.
HEW/CDC 6-74

FISCAL YEAR
1975

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2. STAFFING (OBJECT CLASSES 11 AND 12) - DETAILS

| OBJ. CLASS | DESCRIPTION | AMOUNT | TITLE/NAME | GRADE (GS) | MAN-MONTHS | SALARY | BENEFITS | TOTAL |
|------------|--|--------|---|------------|------------|--------|----------|---------|
| | | | | | | | | |
| 11 | PERSONAL COMPENSATION | | Secretary, Johnson Secretary, Knighton | 5/1 | 6 | 4,222 | 392 | 4,614 |
| 12 | BENEFITS (AT _____ PERCENT) | | | 6/7 | 1 | 941 | 87 | 1,028 |
| 21 | TRAVEL AND TRANSPORTATION OF PERSONS (EXPLAIN BELOW) | | | | | | + 5% | 172,260 |
| 23 | RENT, COMMUNICATIONS, AND UTILITIES | | | | | | | 8,613 |
| 24 | PRINTING AND REPRODUCTION (EXPLAIN BELOW) | | | | | | | 180,873 |
| 25 | OTHER SERVICES (SPECIFY BELOW) | | | | | | | |
| 26 | SUPPLIES AND MATERIALS | | | | | | | |
| 31 | EQUIPMENT (EXPLAIN BELOW) | | | | | | | |
| | TOTAL | | | | | | | |

3. EXPLANATION OF OBJECT CLASSES AND SPECIAL PROVISIONS

| | | |
|---|--|---|
| <p>APPENDIX B RSSA CONTINUATION SHEET Page 2 of 3</p> | <p>RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND DEPARTMENT OF HEALTH, EDUCATION AND WELFARE Center for Disease Control</p> | <p><input type="checkbox"/> ORIGINAL NO. <input checked="" type="checkbox"/> AMEND 3 NO. RSSA NO. HEN/CDC 6-74 FISCAL YEAR 1976</p> |
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CDC attendance at international family planning conferences is encouraged, especially meetings concerned with improving program management and expediting contraceptive coverage to target groups.

E. Special Provisions

1. Utilization of up to 30 days of consultant services may be requested under this amendment.

2. CDC will be expected to be flexible in responding to AID's needs from the points of view of geographic area, timeliness, specific focus of interest and language capability.

III. Reports Required

A. A comprehensive annual report detailing accomplishments of the preceding 12 months. This report should point out steps needed to improve service statistic and logistic data collection and improve program coverage and effectiveness (20 copies to AID/W).

B. Reports will be made periodically on evaluations of program. Efforts to correct problems and changes in corrective strategy will be documented.

C. A brief report on each overseas trip within 30 days after completion.

D. An activities report shall be submitted to AID/W in September 1975 and every six months thereafter. This retrospective report should account for person days, identified by type of activity, specific country involved and category of employee (5 copies to PHA/POP and 3 copies to PHA/PRS).

A copy of all reports required under this RSSA will be provided for the Program Review Staff PHA/POP and CM/PAS.

IV. Other Provisions

A. At least two professionals should be fluent in Spanish.

B. All international travel must be approved by CM/PAS in AID prior to departure.

C. CDC will participate with PHA/POP and PRS in a formal review to assess project effectiveness and program evaluation.

D. No funds under this RSSA will be used to promote or encourage abortions.

APPENDIX B
RSSA CONTINUATION
SHEET
Page 3 of 3

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Center for Disease Control

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| <input type="checkbox"/> ORIGINAL | <input checked="" type="checkbox"/> AMEND 3 |
| RSSA NO. | |
| HEW/CDC 6-74 | |
| FISCAL YEAR | |
| 1976 | |

V. Liaison

Unless otherwise designated by AID, the country family planning administrator will serve as the cooperating country liaison official.

The mission population officer (or Public Health Officer) will serve as the AID liaison official.

VI. Equipment Purchases

AID will receive a credit upon termination of this project of any equipment paid for by AID on the basis of depreciated value or the equipment may otherwise be disposed of as agreed by AID.

1. SUMMARY OF INTERNATIONAL TRAVEL, FPED STAFF
January 1973 - March 1976

(* = not paid for by AID)

1973

Asia

January 22-30: Pakistan (Darney)--Sialkat
Continuous Motivation System

January 31-February 6: Thailand (Darney)--National Record
System, WHO IUD Continuation Study,
WHO Clinical Evaluation of Fertility
Regulating Agents, McCormick Hospital
(Depo-provera)

July 17-July 23: Thailand (Darney)--ECAFE/USOM--Family Planning
Record Systems; Chiang Mai (Depo-provera)

July 25-August 4: Indonesia (Darney)--USAID, BKKBN, IBRD--
Record Systems; Clinic Site Visits

Latin America

March 8-10: Mexico (Darney, Morris)--PAHO Population Studies
Foundation

March 11-16 Guatemala (Darney, Morris)

March 17: El Salvador (CARS) (Darney, Morris)--Family Planning
Record Systems (Mexico-FEPAC, Guatemala-NFPP,
El Salvador-ISSS; Guatemala-Study of duplicate counts
in record system)

March 26-April 5: Venezuela (Morris)--1) AVPF (record system),
2) WHO Chagas Disease Vector Research Planning
Meeting

December 10-11: El Salvador (Morris)--INCAE, MOH--Management
Seminar, Data Analysis

12-13: Nicaragua--ISSS, CARS--Disease Demography Survey

Other

August 27-9/1: Liege, Belgium (Darney)--IUSSP

September 10-12: London, England (Darney)--Multiple Consultations--
BODA, IPPF, LSHTM

SUMMARY OF INTERNATIONAL TRAVEL (contd.)

1974

Africa

*December 11-15: Cairo, Egypt (Tyler)--International Conference on Intrauterine Contraception--presented paper, "Morbidity and Mortality Associated with Use of Intrauterine Devices in the United States"

Asia

August 10-25: Philippines (Rochat)--1) Service Statistics System Transfer, 2) Evaluate Overcount of Acceptors, 3) Site visit Iglesia ni Cristo Mobile Family Planning Clinics

September 21-October 6: Hawaii (Rochat)--AID Asian Population Officers Meeting
Korea (Rochat)--Costs of IUDS vs. Pills

November 11-23: Philippines (Rochat, Smith, Huber-AID)--Evaluate Iglesia ni Cristo

Latin America

April 25-May 8: Guatemala (Rochat, Morris)--NFPP evaluation; 1973 Annual Report; Estimate duplicate counts; Estimated completeness of reporting and pill continuation from one clinic

June 16-18: Monterrey, Mexico (Morris)-- U.S.-Mexico Border Public Health Association Meeting--presented paper, "Family Planning Services in the United States, 1967-1973"; Obtained data for AID/W on Mexico family planning services

June 9-14: Nicaragua (Morris)--Demographic goal setting, analyze family planning service statistics, review ADN Survey; Estimates of abortions

SUMMARY OF INTERNATIONAL TRAVEL (contd.)

June 23-26: Guatemala (Morris, Anderson)--Demographic goal setting, population projections, fertility analysis

September 8-14: Guatemala (Morris, Rochat)--Record System.
See also June 23-26 report

September 26: Mexico (Rochat, Morris)--SSA and FEPAC Record Systems

October 2-11: Nicaragua (Morris, Monreal, Heiby)--See June 9-14 report

September 8-14: Guatemala (Rochat, Morris)--NFPP Record System

October 13-19: El Salvador (Morris, Monreal)--1) Contraceptive continuation rates, 2) Demographic impact of family planning program, 3) Abortion data

Other

*December 8-11, 15-18: London, England (Tyler)--IPPF, University of London, WHO officials--presented seminar to IPPF staff on morbidity and mortality associated with the IUD in the USA.

SUMMARY OF INTERNATIONAL TRAVEL (contd.)

1975

Africa

November 22-December 13: Kenya, Ghana, Nigeria (Rooks)--AHTIP evaluation

Asia

May 26-June 6: Philippines (Graves)--Contraceptive supply system, Department of Health

June 9-20: Bangladesh (Rochat, Graves)--1) Contraceptive supply system, 2) Service statistics, 3) Abortion mortality

June 21-25: Thailand (Rochat)--MOPH--Program evaluation

June 26-28: Singapore (Rochat)--Interview Dr. Mark Cheng; Consulted on abortion counseling, and received fertility changes 1969-74; Discussed possible collaborative projects in abortion epidemiology and impact of fertility control policies and practices of fertility.

Latin America

January 13-23: Panama (Morris, Scott-AID)--MOH-FP evaluation

February 11-13: Guatemala (Morris)--1974 Annual service statistics, Depo-provera continuation study

February 14-March 1: El Salvador (Morris)--1) Initiate study of contraceptive continuation rates, 2) Cervical cancer screening, 3) National Fertility Survey

April 13-19: El Salvador (Morris)--1) Review contraceptive continuation study field work, 2) Mini-KAP fertility study

SUMMARY OF INTERNATIONAL TRAVEL (contd.)

- June 2-3:** El Salvador (Morris, Heiby)--1) 1974 Service statistics,
2) NLFS fertility questions
- June 4-7:** Panama (Morris Heiby)--1) 1974 Service statistics,
2) Quarterly contraceptive supplies report
- June 8-14:** Colombia (Morris, Heiby)--1) Evaluate service
statistics, 2) 1973 Census, 3) National Fertility
Survey
- June 15-21:** Chile (Morris, Heiby)--Evaluate service statistics
- June 19-July 2:** Mexico (Jones)--Attend International Women's
Year Tribune
- September 11-19:** Paraguay (Morris)
20-26: Bolivia (Morris)
- October 26-November 3:** Guatemala (Anderson)--Population
estimates, program targets
- November 10-15:** El Salvador (Morris)--1) Attended Latin
American Population Officers Conference and
presented paper, "Impact of Family Planning
Programs on Health, 2) NLFS fertility analysis,
3) Contraceptive continuation rate study
- December 7-12:** Colombia (Rochat)--1) Participate in PAHO-
sponsored Latin American Seminar on Statistics,
2) Presented 3 papers: "Fertility Control and
Family Planning in the United States", "Prevalence
of Cervical Cancer Screening in the U.S.A.: 1970"
and "Cervical Cancer Screening: The Effect
of Infrequently Occurring Disease on the
Accuracy of Diagnosis

Other

- *May 22-24:** Geneva, Switzerland (Slaughter)--Presented papers
on prostaglandin research, Task Force Meeting on
the Use of Prostaglandins for the Regulation of
Fertility
- *May 26-30:** Florence, Italy (Slaughter)--International
Conference on Prostaglandins

SUMMARY OF INTERNATIONAL TRAVEL (contd.)

June 19-20: London, England (Rooks)--IPPF, UCMS, DHSS

June 21-27: Lousanne, Switzerland (Rooks)--Attend International Confederation of Midwives

June 26: Geneva, Switzerland (Rooks)--WHO

September 8-12: Washington, DC (Rochat)--Participated in PAHO Workshop "Family Planning Statistical Systems in Latin America"

October 27-31: Washington, DC (Smith)--Participated in WHO-sponsored "Establishment of an International Statistics System on Maternal and Child Health Care Services and Family Planning Activities"

***December 21-June 6, 1976: Japan (Slaughter)--Presented paper on Prostaglandin Research**

SUMMARY OF INTERNATIONAL TRAVEL (contd.)

1976: January - March

Africa:

January 30-February 5: Tunisia (Tyler)--Attended Third International Conference on Voluntary Sterilization

Asia

February 6-March 21: Bangladesh (Graves)--Contraceptive supply system; devise system, draft manual

Latin America

January 12-27: Honduras (Heiby, Morris/Lorimer, Cooper, White-ISPCC)--1) Analysis of 1974-74 acceptor data and record system, 2) Evaluate rural penetration program, 3) Program targets

March 15-April 2: Nicaragua (Monteith, Heiby)--1) Evaluate service statistics, 2) Evaluate new Rural Community Health Project, 3) Evaluate contraceptive logistics system

March 22-26: El Salvador (Morris)--Work with Salvador Demographic Association in writing first draft of paper on contraceptive use (prevalence) and fertility based on 1975 National Fertility Survey

Other

February 5-7: Geneva, Switzerland (Tyler)--Confer with WHO Reproductive Unit on epidemiology of abortion and infertility, and on family planning program evaluation techniques

February 7-10: London, England (Tyler)--IPPF, Discuss collaborative project on IUD insertion policies

SUMMARY OF
 QUANTITATIVE ANALYSIS OF INTERNATIONAL CONSULTING
 FPED STAFF January 1973-March 1976

| <u>COUNTRIES</u> | <u>NUMBER OF VISITS</u> | <u>DAYS DURATION OF EACH VISIT</u> | <u>TOTAL NUMBER OF PERSON-DAYS</u> |
|------------------|-------------------------|------------------------------------|------------------------------------|
| Bolivia | 1 | 7 | 7 |
| Chile | 1 | 7 (2)* | 14 |
| Colombia | 1 | 7 (2) | 14 |
| El Salvador | 6 | 7 (2)/16/7/2(2)/6/5 | 52 |
| Guatemala | 6 | 6 (2)/14(2)/9/4(2)/7(2)/3 | 74 |
| Honduras | 1 | 16 (2) | 32 |
| Mexico | 2 | 3 (2)/1(2) | 8 |
| Nicaragua | 4 | 2/6/10(3)/19(2) | 76 |
| Panama | 2 | 11/4(2) | 19 |
| Paraguay | 1 | 9 | 9 |
| Venezuela | 1 | 11 | 11 |
| Bangladesh | 2 | 12/45 | 57 |
| Indonesia | 1 | 11 | 11 |
| Pakistan | 1 | 9 | 9 |
| Philippines | 3 | 16/13 (2)/12 | 54 |
| Thailand | 3 | 7/7/5 | 19 |
| Ghana | 1 | } 22 | } 22 |
| Kenya | 1 | | |
| Nigeria | 1 | | |
| TOTAL | 39 | | 488 |

--- RECAP ---

| | |
|--|------|
| Number of countries visited | 19 |
| Number of visits | 39 |
| Number of Person-Days | 488 |
| Mean Number of person-days per visit | 12.5 |
| Mean Number of person-days per country | 25.7 |
| Mean Number of person-days per month | 12.5 |

*Numbers appearing in parenthesis refer to number of consultants on visit.

VISITS BY FPED CONSULTANTS
BY CONSULTANT AND YEAR*

| <u>CONSULTANT</u> | <u>YEAR</u> | | | | <u>TOTAL</u> |
|------------------------------------|-------------|-------------|-------------|---------------|--------------|
| | <u>1973</u> | <u>1974</u> | <u>1975</u> | <u>1976**</u> | |
| Darney | 6 | 0 | 0 | 0 | 6 |
| Rochat | 0 | 5 | 2 | 0 | 7 |
| Smith | 0 | 1 | 0 | 0 | 1 |
| Graves | 0 | 0 | 2 | 1 | 3 |
| Morris | 3 | 7 | 10 | 2 | 22 |
| Anderson | 0 | 1 | 1 | 0 | 2 |
| Monreal | 0 | 2 | 0 | 0 | 2 |
| Heiby | 0 | 1 | 4 | 2 | 7 |
| Monteith | 0 | 0 | 0 | 1 | 1 |
| Rooks | 0 | 0 | 3 | 0 | 3 |
| <hr/> | | | | | |
| TOTAL CONSULTATIONS | 9 | 17 | 22 | 6 | 54 |
| TOTAL NO. DIFFERENT CONSULTANTS | 2 | 6 | 6 | 4 | 10 |

* A consultation is one visit by one consultant to one country. However, a consultant often visited more than one country on a trip and on one occasion a team of three went together; on 14 occasions a team of two; and on 24 occasions a single consultant.

** Three months only.

GUATEMALA

A. INTERVIEW WITH MR. JOHN PAUL JAMES, POPULATION OFFICER

The data processing system was in operation from January 1971 to December 31, 1975, but the data for the last half of 1975 have not been processed as yet because of lack of funds and lack of computer time. However, the cards have been punched for the first four months of this time period and there is hope that the remainder will be punched by the end of May.

From now on presence of computers may not be the problem. There are two IBM 370's in the country - one with Empresa Electrica Company and one with the Ministry of Defense (MOD). In addition there now is a private computer company (owned, at least in part by Mr. James Westrick) and Mr. James has suggested contracting with it. However, he thinks there will continue to be a problem with programmers and operators. Once a program is written, which is a very slow process, programmers often refuse to work unless paid more money. In one case the program was destroyed by the programmer because his demands for more money were not met.

One of the main advantages of the data processing system developed with the Center for Disease Control (CDC) assistance was that it furnished more accurate data concerning the activity of the Ministry of Health (MOH) family planning program. Mrs. Cynthia Burski Braaton, the previous Population Officer, and Dr. E. Croft Long, the Medical Advisor, were able to take the computer results directly to the Minister of Health and each time this resulted in some program improvement.

Because of the inadequacies of the program and other reasons, AID reduced support to the program by 40% beginning in January 1975. A meeting Mr. James and Dr. Long had with the Minister of Health in July 1975 resulted in the Minister requesting that AID terminate its support to the family planning program. This was done but two months later the Minister of Health called Mr. James to his office and asked

him, in cooperation with a very competent Guatemalan, to prepare a new program within two weeks. It took very hard work to complete such a task within two weeks but it was done and what Mr. James describes as a "marvelous" program was submitted to the Minister. The urgency in the request for the program design was not reflected in the slowness of the official response. When received, the request was for \$300,000 (almost twice the previous AID allocation) which AID did not agree to fund. There is still no agreement between AID and the Government for family planning support. Twenty-five thousand dollars of the previous AID support was for MOH staff salaries and \$15,000 for computer time, programming, and forms. Now that there is no AID support the thirty-two items on which data were obtained have been reduced to two: (1) new acceptors; and (2) continuing users. Neither of these reveals the type of contraceptives used.

Officials are desirous of knowing the status of the program as of January 1976 to use as a baseline (but apparently it will be limited to the two items). This requires data processing. Assistance is being asked of APROFAM. The family planning program is being expanded from 142 clinics to all 608 clinics. APROFAM will have supervisory control of family planning activities in all of them; will work through the twenty-two area health chiefs; and will deal directly with the clinic directors. The latter is particularly significant because about 300 of the new clinics will be staffed with just one person, the nurse-midwife, who Mr. James thinks may be more sympathetic toward family planning than some other health personnel. This program will begin in the first department on May 1 and APROFAM wants someone from CDC by April 19 to help them in planning it. Mr. James was going to request this as soon as he had a chance to talk to Mr. Westrick, which was to be on April 5. ✓

By July 1 APROFAM will have control of family planning in all clinics. About 1,000,000 cycles of pills arrived at the time of the earthquake and another half million were on hand. About 3.7 million condoms are available. APROFAM is recruiting supervisory personnel and is employing a high level pharmaceutical company official to take direction of the program. APROFAM will have \$40,000 from IPPF for a media program. Mr. James thinks that a private association

is in a better position to provide an effective media program because its message does not get lost in the larger health message promulgated by the Government and because political sensitivities provide less restraint.

This year (calendar 1976) APROFAM is receiving \$230,000 from AID. One hundred and fifty-three thousand dollars is for salaries and \$77,000 for operating expenses. Combining salaries and operating expenses \$87,000 is allocated for salaries for follow-up personnel. AID is not providing support for evaluation because IPPF is supporting the small evaluation unit out of the \$244,000 it is providing for contraceptive supplies and local costs.

The Director of APROFAM would like technical assistance from CDC, as the IPPF consultant from London probably will not be able to make more than one trip per year. More specifically he would like CDC to:

1. Train the staff of the evaluation unit to deal with increased demands that may be made upon them.
2. Develop indirect measures of the flow of contraceptives and the number of acceptors.
3. Develop a logistics system.

The IE&C Office of APROFAM, with the assistance of Dr. Donald Bogue's staff will evaluate the media program. The evaluation unit will be involved in this. The increased expectations for the evaluation unit may require additional staff with implications for additional training by CDC.

Mr. James said that the CDC could help this year and next in the evaluation of:

1. The MOH family planning program.
2. The APROFAM clinic operation and its community based distribution projects.
3. The family planning program of the Ministry of Defense for which AID expects to allocate \$16,000. This, of necessity, will have to be indirect - probably limited to recording contraceptive distribution.

In the discussion of the CDC's past assistance, Mr. James had high praise for the staff members he has dealt with, describing them as dynamic, responsive, technically competent and culturally attuned. When he arrived in Guatemala he would not have been able to assess what the clinics were doing without the results of the system the CDC staff had developed. He has been impressed with the speed with which they have responded to requests. And as examples, he mentioned Dr. John Anderson's visit in October-November 1975 and the times that CDC has processed data in Atlanta when the local computer system broke down.

He said that the data processing system has been costly for the Mission (\$25,000 for MOH salaries and \$15,000 for computer time, programming and forms) and questioned the value of producing follow-up sheets for the women who did not return to clinics. If AID had agreed to continue to finance the system the follow-up sheets would have been omitted anyway. He thought that Mr. Leo Morris of the CDC agreed with him about this.

In response to a question about the necessity of a computer system, Mr. James said that a hand tabulation or sorting system might have been better as the program stabilized at 18-20,000 new acceptors per year, but that he had the benefit of hindsight. Given the early assumptions of large volume, a computer system was a necessity. He also mentioned that switching from one computer to another had created problems and delays. Five different computers were used!

The expansion of the program to more than 600 clinics makes the role of evaluating logistics of increasing importance. The long involvement of CDC in the Guatemalan program plus the positive attitude the Director of APROFAM has toward the CDC staff makes the CDC a logical choice to assist in this role whenever outside consultation is required.

Now that AID provides no direct assistance to the Government for family planning and as the contraceptives it provides are given via a third party, it has very little leverage for obtaining service statistics from the Government. Even if the Government does release the limited data it plans to obtain it will be of little value, as pill users are not differentiated from IUD or condom users. Only a

yearly sample survey would provide the data needed. If this is done there will still be the need for the computer but no interest in this direction is evident.

If a population policy is developed or if the Government puts a substantial sum into family planning and reorganizes the program, Mr. James thinks that assistance for data processing will be sought from the UNFPA.

It is estimated that about two million cycles of pills are needed per year to supply 10% of the women in the fertile age group (150,000). However, 10% is a very optimistic figure, considering past performance.

In addition to the \$34,000 to be raised locally, the IPPF has allocated the following to APROFAM:

| | |
|---------------------------|----------|
| Evaluation unit | \$18,000 |
| Community distribution | \$14,000 |
| Medical and clinics | \$86,000 |
| Education and information | \$33,000 |
| Social Service | \$ 8,000 |
| Administration | \$51,000 |

The E&I budget is for family life seminars for secondary school students and out of school adults, whereas the same item in the AID budget is for mass media.

Mr. James sees the new organization of the family planning program as a unique opportunity for the private association. In the past it has been limited mainly to running a few clinics and a training program. Although it will continue to train, it now will be responsible for mass media and all of the clinic family planning activities, and it may be asked to evaluate the program. How well it plays this new role may establish a new pattern of government-private cooperation. As consultation has been requested from CDC, and as its consultants are well acquainted with the Guatemala program, it may be in a position to make a significant contribution to the success of the program.

B. INTERVIEW WITH DR. E. CROFT LONG, MEDICAL ADVISOR

The Population Officer reports to Dr. Long but as population is not Dr. Long's only responsibility he said that he does not have the detailed knowledge of the program that the Population Officer has. Therefore, the discussion centered on his reaction to CDC support.

He said he had known Dr. Rochat and Mr. Morris for a long time and described them, as well as all other CDC consultants he had known within and outside of the population field, as "uniformly excellent" and for whom he had a "universally high regard". In reference to Mr. Morris and Dr. Rochat he said they "have good input, speak Spanish, relate well, don't try to take over, and are respected and liked on the Guatemalan side." He pointed out that the demise of the data system had nothing to do with the CDC.

C. INTERVIEW WITH MRS. CYNTHIA BURSKI BRAATON, (FORMER POPULATION OFFICER)

Mrs. Braaton just happened to be visiting the AID Office the day the consultant was there. Because she only had about fifteen minutes available the emphasis of the discussion was on her reaction to the CDC support.

She echoed Mr. James' reaction by describing the CDC support as "excellent". By telephoning Atlanta she could get the person she wanted when she needed him and the consultants were willing to spend as much time as necessary to complete the task at hand. Because of the rapport that was established, it was possible to be very frank and open in the discussions. The fact that the same consultants returned contributed to this and whenever there was a changeover of consultants there was enough overlap for the new consultant to become thoroughly acquainted with the program.

Mrs. Braaton said she found repeated visits by the same CDC consultant helpful, as the consultant would leave a set of recommendations which she could refer to in anticipation of the next visit as pressure on local people to take action or risk embarrassment. CDC consultants, as compared to others, were very good about getting something in writing to her in a very short time.

The Guatemalans reacted very positively toward Dr. Rochat and Mr. Morris. As with many governments, the Guatemalan government is reluctant to let consultants see anything other than the showpiece clinics, etc., but because of the confidence they had in Mr. Morris and Dr. Rochat they were the first consultants allowed into the field. She said that the combination of statistical and medical competence worked out quite well. By rendering assistance on non-family planning matters of concern to the Guatemalans, they received cooperation that other consultants did not obtain. Also their detailed specific recommendations facilitated action and follow-up. General recommendations may sound nice but it is difficult to know when and whether they have been acted upon.

One approach of the CDC consultants which Mrs. Braaton found particularly useful was that they took key Guatemalan staff to Atlanta to show them how something should be done and then let them return to Guatemala to work out how to apply in their own setting what they had learned. After a suitable period of time, the consultants returned to help in dealing with problems the Guatemalans encountered and to help them improve their program.

Mrs. Braaton's comments covered a period of about four years. Originally the visits were financed from Mission funds and later by the AID-CDC agreement.

D. INTERVIEW WITH DR. ROBERTO SANTISO, EXECUTIVE DIRECTOR, APROFAM

Dr. Santiso was very pleasant but wasn't too sure why he was being interviewed because he said he didn't know very much about CDC (which was confirmed in a later conversation with Mr. James). However, he did talk about what APROFAM would like CDC to do in the near future.

He said that, with the expansion of the program and with the anticipated increased volume in distribution of contraceptives, "logistics was the next work in Guatemala". He sees what is needed as analogous to what businesses require for the establishment and control of channels of distribution and product flow and would like CDC to assist in developing this.

He also wants CDC to help in developing cost-benefit studies so there will be an objective assessment of program effectiveness.

Reestablishment of the data processing system has low priority for Dr. Santiso. He regards it as "very complicated and expensive" although he did expand on the two items that Mr. James mentioned, listing seven items that will be recorded:

1. New acceptors
2. Continuing users
3. Reentry of former users
4. Closed cases
5. Age
6. Parity
7. Ethnic group

A simpler system, but with the necessary data, is needed and he said Mr. Morris had agreed to help with this. When talking about the computer he went across his office to the print-out sheets and said that the people "in the country" never see the results and implied that better feedback to clinic staff was needed.

APPENDIX E

PANAMA

In February 1976, AID Mission received a cable from Washington asking for quarterly FP data. This was passed along to the MOH, after which the National Committee on Vital Statistics became interested and asked for assistance in three data areas--fertility, demography, and registration of vital events. They would like to have training given at the Provincial level. The need is for better data collection; local processing can be done, if data are obtained. AID Mission has invited Dr. James Brackett's office to send an advisor in April or May 1976.

The quarterly FP data have been reported more fully and promptly since the visit of CDC consultant. The consultant's trip report to Mission was forwarded to and discussed with the MOH by AID Mission, but no health personnel interviewed could recall seeing any such reports.

A group of five persons from MOH spent a week in training at CDC in Atlanta. Discussions continue on plans for a course on epidemiology to be given by CDC in Panama. Health officials are eager for more training from CDC.

FP program data are processed by computer through a system developed by CELADE. At visits to several health centers, it was possible to observe in detail the work required at the peripheral data source to furnish information for the computerized system. In some clinics, there actually are full-time secretaries, a luxury which hardly lends itself to generalization. Registration cards on new cases and daily summary sheets have to be hand copied line by line for every revisit of every client. A medical orientation seems to dominate decisions on record and report forms. For example, a huge sheet reports countless details on each client visit, organized according to the physicians on the cases. Physicians, nurses, secretaries and auxiliaries participate in completing record forms. Much of the information is recorded in direct numbered code, which is notoriously open to error, but seemed to offer no difficulty among the persons interviewed.

The centers visited are greatly overstaffed and exorbitantly expensive for the apparent work load. Categories of personnel include physicians, nurses, auxiliary nurses, social worker, health educator, and secretary, etc. Auxiliaries receive four months training. There are plenty of candidates, but high turnover because they leave for better paying private jobs after their training and experience. Therefore, secretaries are easier to obtain and keep, but their pay is low and skills limited, often not even able to type. Yet, they are the primary source of centrally reported data.

Each clinic is reported to receive a monthly service analysis report from the computer printout, but no example of it could be found when asked. Interpretive analysis for use by each Regional director in administration and supervision is not done, although supervisors sometimes telephone the statistical office for information prior to making field visits. Data sent to Districts furnish percent of targets achieved, but there is no evidence that a catchment population base is defined for each service unit or used in assessment of comparative accomplishment.

Most of the collected information does not seem to be used. Except for data on caseload prevalence, totals could be obtained more simply. Statisticians are doing a number of special studies manually because the data in the computer cannot be obtained for other than the routine runs. Computer printouts on clients who miss appointments are sent to local clinics. Follow-up is supposed to be done to obtain reasons for dropout; these reasons too will be entered in the computer for later analysis. Little community outreach is done, although paper plans call for it. The professional persons in charge of the clinics did not have any idea of the catchment area or population assigned to their service.

Statistical analyses of contributing factors and tabulations are done nationally, but not by geographic areas, with corresponding limited utility. Central statistical office does analyses which it deems useful rather than responding to administrators' interests and questions. The statistical office states that service data are much more realistic than formerly, but feels that there is not enough of a bridge between statisticians and program administrators.

A survey of fertility and family planning practices has been done and evaluation of the FP program is planned. A study of discontinuation and a community survey are planned in conjunction with the Population Council and with UNPPA funding.

A most interesting and important development in Panama is the integration of the MOH and Social Security Health Services. The latter has been almost entirely curative, the former partially preventive. Many problems exist in such an ambitious effort at integration, including record systems, personnel policies, use of facilities, budgets, etc. Six of the nine regions of the country have already been integrated.

This has tremendous implications for most of the Latin American countries which tend to have two classes of public health care. The CDC consultant's trip reports referred to the difficulty of obtaining FP data on Social Security clients, but did not touch upon this highly significant opportunity to plan and assess a dual agency integrated record and report system and program evaluation.

APLAFA (IPPF Affiliate voluntary association). In 1973, AID made a grant to APLAFA via the Ministry of Planning, bypassing the Ministry of Health. Prior to the usual evaluation of this grant, AID Mission wrote to the Minister of Health (MOH) who indicated that evaluation of APLAFA program was not necessary, since the clinic activities would be discontinued. Present AID contracts with APLAFA are scheduled to run until December 1976 and June 1977. Relationships between the MOH and APLAFA are very strained at present.

EL SALVADOR

USAID Mission staffs have very high praise for CDC work whose trip reports are described as excellent and useful. They translate data into more meaningful form; they point out data errors and furnish helpful highlights. CDC consultants are good at saying things to local officials that Mission might not be able to or had said too many times. For example, the program record forms included as one of the reasons for client dropout "absence". Discussion of this with the CDC consultant led to decision to do the continuation study.

It has been useful for CDC to send copies of trip reports to area Bureaus in Washington. Mission tries to abstract and translate the reports for forwarding to appropriate local officials. At times, CDC has done the translation. Mission recommends that AID fund a full-time Spanish translator because of the high benefit therefrom. Mission welcomes more frequent CDC consultant visits and sees a broader role for CDC than logistics and supply data.

For the recent contraceptive prevalence study, CDC helped train interviewers and absorbed the costs of their work. This was advanced by Mission as an example of flexibility achieved by merging available Mission and CDC contract resources to meet specific situations. The CDC consultants worked long hours into the evening each day helping to get the material into form for immediate reporting of results. This was greatly appreciated by local officials. It was the culmination of earlier contributions in study design, sampling, advising on tabulation and analysis, verification and tabulation in Atlanta of locally punched cards, among other activities. Personnel trained for the Continuation Study were coopted to help on the Prevalence Study.

Local officials and Mission are interested in an annual repetition of a mini-survey to measure trends in relation to the baseline established by the recently completed study. CDC advisor recommended a two-year interval. The shorter

interval is favored for strategic and public relations reasons.

There is much interest in developing an educational campaign in support of a community based distribution program. Few leads for the direction to be taken in such an educational effort emerged from the recent studies. Similarly, it is desirable that the serial surveys be modified to furnish more useful program implications in addition to primarily demographic data.

Mission appreciated the usefulness for program planning of CDC population projections related to program targets. CDC is planning to collaborate with other international technical assistance agencies to help the MOH set up a service data system. Mission has done some of its own estimations of cost benefit from births averted by programs in the country.

The Continuation Study followed traditional lines. A cohort of clients admitted during 1971 and 1972 in five of the 160 clinics were studied with respect to contraception behavior up to the cutoff date of February 1, 1975. Forty-seven percent of the sample could not be contacted. Of the remainder, forty percent who had discontinued, did so because they were dissatisfied with the clinic service. This was a dramatic finding but would need much elaboration of detail to be very useful in program modification.

About three years ago, the MOH liberalized its service policies so as to permit giving three pill cycles at a time and obviating need for a monthly visit, requiring only an annual medical examination rather than one at every visit and permitting rural health aides and malaria volunteers to distribute contraceptive re-supplies. These were important departures from previous rigid policies and deserve evaluation to demonstrate the advantages, so as to obtain fuller acceptance in El Salvadore (some clinics still adhere to former procedures) and to use in other Central American countries with similar attitudes and practices. The program in El Salvador still retains the ceiling on number of consultations that may be scheduled for the physicians.