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An Evaluation of Work Performed By The American Public Health Association For the Agency for International Development

Contract AID/DSPE-C-0053

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FINAL VERSION

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CONTENTS

Preface. . . . . .

I. Summary and Major Recommendations. . . . . .

II. Contract Components. . . . . .

A) Promotional Information and Education . . . . . .

B) Evaluation and Special Studies . . . . . .

C) Technical Advisory Services . . . . . .

III. General Conclusions . . . . . .

Appendices

A) List of Persons Interviewed

B) Projected and Accomplished Outputs (APHA)

C) Workplan Identified Outputs

D) Additional Information Desired by AID Mission Officers

E) Issues Papers Progress (APHA)

F) Number and Per Cent of Minority, Third World, and Female Consultants (APHA)

G) Growth in Consultant Register of Minorities and Women (APHA)

H) TAS Assignments by Contractual Categories

PREFACE

In September 1979, the Agency for International Development (AID) and the American Public Health Association (APHA) signed a three-year contract for a program of Accelerated Delivery Systems Support (ADSS) under which AID agreed to support and APHA to develop and carry on a series of activities intended to "reinforce and expand Agency capability to exert a leadership and supportive role in the promotion, planning, development and evaluation of affordable health and family planning delivery systems and primary health care in most of the developing countries." Three categories of services were specified: 1) Promotional Information and Education, 2) Evaluation and Special Studies, and 3) Technical Advisory Services (TAS). One purpose of the contract (AID/DSPE-C-0053) was to bring together under a single umbrella arrangement a number of ongoing activities funded under previous contracts between APHA and the Health and Population units of AID.

The contract called for independent evaluations of ADSS activities by outside consultants at eighteen and thirty month intervals. In accordance with this requirement, a five-member Evaluation Team was recruited by AID DS/HEA and DS/POP in June 1981 to review and assess ADSS accomplishments from the start of project activities at the beginning of October 1979 through March 1981. Team members were Barbara Turner, NE/TECH, and Linda Morse, LAC/DR, both of AID/Washington, and three external consultants: Richard Cash, Harvard University School of Public Health and Institute for International Development; Lyle Saunders, independent consultant; and George Cernada, University of Massachusetts Division of Public Health, who was designated as Team Leader.

The scope of work suggested for the team was quite ambitious and, to some extent, impossible to complete, given the time and geographical constraints under which the Team was expected to work. It called for the Team to:

1. Ascertain and appraise performance and to assess problems in the programming and delivery of project outputs by the APHA/ADSS staff.

2. Assess and appraise the impact of the APHA/ADSS project on the "capability of AID to exert a leadership and supportive role in the promotion, planning, development, and evaluation of affordable health and family planning delivery systems and primary health care in developing countries."

3. To determine APHA's efficiency in attaining the second objective given above.

4. To provide recommendations for continuation, replication, and/or modifications in the contractor's scope of work for the remainder of the contract duration.

5. To suggest alternatives that should be considered by AID in relation to the contractor's scope, given the present organizational and health staffing pattern of AID.

6. To comment upon and indicate the need for follow-on activities, and to identify unmet needs related to delivery system support which become evident in the course of the evaluation.

The team met twice briefly in June and July, in Washington, to review each of the three major components of the program and its overall administration and budgeting. Between the two meetings Team members reviewed all materials in draft or final form developed by APHA as part of its contract activity. Presentations of APHA staff were scheduled, and extensive interviews were held by Team members individually and collectively with most members of the ADSS staff and with representatives of AID DSB/ Health and Population units and of the four AID Regional Bureaus. Additionally, several AID Health/Population field officers were interviewed in person or by telephone to seek information about their use of ADSS services and their views of the relation of ADSS activities to Mission information and technical assistance needs. (See Appendix A: List of Persons Interviewed.) Visits were also made by individual team members to a number of international and private health and population agencies in Boston and New York to compare programmatic approaches. A formal presentation of preliminary findings and recommendations was made by the Team on July 2 to elicit feedback from key AID and APHA staff prior to the preparation of a written evaluation report.

A draft report, written by George Cernada and incorporating inputs from all members of the Team, was submitted to AID on August 20. After a review of that draft by AID and APHA, AID requested that a second draft be prepared to revise the order of some of the materials and to update the text to take account of important project events that have occurred since the Team's visit to Washington. This revised version, written by Lyle Saunders, relies heavily on and reproduces verbatim most of the text from Cernada's original, but has been edited and updated to take note of comments and clarifications from APHA and AID, of ADSS accomplishments since July, and of decisions,deriving from recommendations of the earlier version, taken at an October 27, 1981 meeting of the ADSS Advisory Committee.

I

SUMMARY AND MAJOR RECOMMENDATIONS

The Accelerated Delivery Systems Support program (ADSS) includes a series of activities carried on by the American Public Health Association (APHA) under a three year contract with the Agency for International Development (AID) that began in October 1979. This report presents the findings and recommendations of an Evaluation Team that looked at the ADSS program in June and July 1981 in fulfillment of a contractual requirement for a mid-term independent assessment.

A major objective of the program is to reinforce and expand AID's support to and leadership in the expansion and improvement of primary health care in developing countries. In pursuit of this and other objectives, APHA engages in a variety of activities, some of which pre-date the current contract. These service activities can be grouped into three categories: 1) Promotional Information and Education, 2) Evaluation and Special Studies, and 3) Technical Advisory Services (TAS).

A. Promotional information and education: Three types of activity are carried on under this category: the organization and conduct of international conferences and workshops; publication of a quarterly newsletter, Salubritas, and the bi-monthly distribution of a limited number of information packets.

1) Conferences and workshops: Six conferences and six workshops are to be held during the life of the contract. Three regional conferences are to be organized for AID staff, personnel working for AID contractors, and a limited number of health officials of developing countries. A number of circumstances combined to delay these conferences and none was held during the first eighteen months of the contract. But Asian and African conferences were convened in Chiang Mai, Thailand, and Lome, Togo, in November 1981 and preliminary meetings have been held to plan the Latin America/Caribbean conference, scheduled for 1982.

Three international conferences are also to be organized in collaboration with other agencies active in the areas of primary health care and the delivery of health services. One of these, the Third International Conference of the World Federation of Public Health Associations, was held in Calcutta in February 1981 in collaboration with the Federation, WHO, UNICEF, and the Indian Public Health Association. Spanish and English-language versions of a conference on expanded immunizations programs have been held in Quito and Kingston, co-sponsored by WHO and PAHO, and explorations looking toward an African conference in 1982 are going on.

Four workshops have now been held—in Jamaica, St. Lucia, Botswana, and Tunisia. Two others, to be held in Asia according to the contract terms, will be scheduled in 1982.

The conference and workshop components of the ADSS program are thus on schedule.

The Team was not able to assess the quality of any of the workshops or conferences.

Recommendations in regard to conferences and workshops are that:

a) the remaining conferences and workshops specified in the contract be organized and conducted as now planned;

b) APHA (if not already doing so) seek ways to make maximum use of the information and insights generated by the conferences and workshops that have been and will be held;

c) both AID and APHA carefully consider the utility and cost effectiveness of conferences and workshops before building them into a new contract or an extension of the present one.

2) Newsletter: Salubritas, an 8-page, quarterly newsletter, was started in 1977 under an earlier contract with AID. It is published in three languages in an edition of some 16,500 copies and with content strongly oriented to the needs of people working in PHC. It is attractive and readable and appears to be one of the better of its kind. Although global in orientation, its circulation is small and its audience quite limited for a publication that aspires to have an impact in all the regions of the developing world.

The Team's recommendations regarding Salubritas are that:

a) Salubritas continue to be issued through the remainder of the contract period (three issues, according to the schedule);

b) to the extent current funding permits, the subscription list be permitted to expand, with priority given to PHC field workers and appropriate health workers in LDC's.

c) within the next few months, and prior to the visit of the evaluation team that will review the ADSS contract at the end of 30 months, extensive information be compiled about such matters as: 1) reader response to the recent questionnaire sent out to subscribers; 2) unit production costs for each of the three language editions at current printing levels and at several increment levels of, say, 10,000 each; 3) differential costs of present and alternative mailing practices; 4) geographic distribution by language edition; 5) the balance between individual and institutional addresses on the mailing list; 6) the visibility given to AID in the publication; and 7) a categorical breakdown of costs, including administrative and managerial overhead;

d) the 30-month evaluation team be asked to make recommendations about the future of Salubritas under a new or extended contract if either is proposed. One alternative that might be explored is that of substituting for Salubritas a service that would provide news and features about PHC and health care and family

planning delivery systems to existing governmental and private newsletters and periodicals so that these items might reach a larger audience and in a larger number of languages than is possible with the current newsletter format.

3) Informational packets: Distribution of packets began under an earlier contract, and by mid-term of this one 16 sets had been distributed, each containing materials selected by APHA staff and believed to be of importance to the

recipients, who were AID and contractors' staff and selected LDC persons with major responsibilities in PHC. One hundred fifty sets are authorized; some months ago the distribution was restricted to 113, all AID personnel. The number has now been brought back to 150 and packets can be distributed to non-AID persons on request.

Packet distribution is a minor part of the ADSS program, but it takes time and involves costs. At present there is no way of knowing if the materials sent are wanted or read. There is certainly need for information in the field, but the Team is not convinced that the packets are a good way of meeting this need. It, therefore recommends that:

a) as a minimum the proportion of packets going to AID/Washington be substantially reduced;

b) the present format be discontinued and a new system devised that will enable AID field people to select materials they need on PHC from lists sent to them by APHA. A suggestion of how such a system might operate was provided by the Team to personnel of both APHA and AID. (See pages 17 and 18.)

4) Resource Center: A proposal for a Resource Center to serve both the International Health Program of APHA and ADSS was submitted to AID in April 1980. The functions of the Center in regard to ADSS programs are not entirely clear to the Team, although it apparently runs the computer, assembles and mails information packets, and responds to requests for APHA materials. The Team suggests that:

a) the functions of the Resource Center in relation to ADSS activities be clarified, especially in terms of budget costs;

b) the field clientele of ADSS programs, especially members of AID Missions, be informed of any services that may be available to them from the Resource Center and of the means of obtaining them.

B. Evaluation and special studies: This component of the ADSS program is to provide regional reports tracking progress toward improved health delivery systems and PHC in AID-assisted countries, state-of-the-art reviews, technical reports and special studies, and summarized information on some 350 projects from a data bank.

1) Tracking reports: Four volumes summarizing the status and progress of AID-assisted projects by region have been completed. A summary volume analyzing problems common to all regions is nearing completion. The Team's recommendations in regard to tracking reports are:

a) that consideration be given to including all AID health projects, and not just PHC projects, in any future reports that might be issued;

b) that, if tracking reports are to be continued, a form should be developed to enable AID field personnel and others to help update them periodically;

c) that the value and utility of the reports, and especially of the analysis section, be assessed by field personnel to determine if they are sufficiently useful to be continued.

d) that consideration be given to sending completed reports to the field on a project by project basis in a loose leaf format to permit cumulation and updating;

e) that consideration be given to using the summary volume of the reports as the basis for a seminar for AID/Washington officials and one or more workshops for national PHC officials to consider the implications of the reports for the organization and management of PHC programs.

2) Global review--Issues Papers: Global reviews of various issues in primary health care are to be produced as a series of chapters, each dealing with a single issue, and all included eventually in a loose leaf binder that would provide a comprehensive coverage of the state-of-the-art. Since the beginning of the project work has begun on ten papers. Two are now published; work is continuing on six others. The potential audience for these works has never been specifically defined and the division of labor between AID and APHA in deciding topics and producing the reviews still requires clarification. With regard to the issues papers the Team recommends that:

a) APHA and AID soon come to an understanding of the exact audiences these papers are intended for;

b) APHA be given more freedom to determine the subject matter of future papers and to move ahead with production;

c) Views of AID Mission personnel about topics, style, and levels of presentation be systematically sought and heeded;

d) quality of the papers in preparation should be reviewed thoroughly and all papers that have not reached first draft stage should be stopped until feedback from completed papers has been received;

e) procedures for selection of principal writers should be reviewed to assure that authors chosen have a record of quality work and international experience in their field of expertise;

f) APHA continue to use all possible means of getting systematic feedback on field needs and reactions to papers distributed.

3) Special studies: APHA is to conduct special studies and/or organize workshops focused on problems of special importance. A study of Growth Monitoring of Pre-School Children has been completed and published in the Issues Papers series. A workshop on Community Participation was organized in Washington in November 1980 and a report was prepared and submitted to AID. The Team's recommendation is that:

a) topics selected for workshops under this component of the ADSS program be as specific as possible so that the information generated has operational value. And, as in the case of Issues Papers, the purpose of activities in this component and the audiences they are intended to benefit need to be more sharply defined.

4) Data bank: A data bank to obtain and store information on some 350 PHC projects is to be established and maintained. The bank now has data on 300 projects, but much of it is not in useful form, the data are now old, and the bank has not been much used. Our recommendation is that:

a) the data bank should be discontinued given its limited utilization. However, if there is a decision to continue it, it should be transformed into a more useful operation with the following changes: 1) data now coded will need to be updated and put into a more usable form; 2) consideration should be given to including data on all AID health projects; 3) the existence of and means of access to the service should be advertised to the international health community; and 4) much expanded funding will be required.

C. Technical advisory services: TAS recruits and provides short-term consultant assistance on request from health and population AID Mission personnel. The service is excellent and is in such demand that it will exceed its contractual obligation well before the contract ends. Recommendations of the Team regarding TAS are that:

a) while progress in adding names of women and minority group members continue to be made, TAS be permitted to abandon the arbitrary goal of 3,000 names in its consultant register;

b) the question of the desirability of a computerized register be reviewed; if the use of a computer is to continue, the form for collecting biographical data should be updated and new coding systems developed. In any case, much of the biographical data in the register should be brought up to date;

c) standards for consultants should be reviewed and, as necessary, revised upwards to assure that those on the roster have the necessary skill and experience levels;

d) a means should be devised to assure that field personnel requesting consultant assistance know about the availability of a wider range of qualified candidates than those known to them personally.

e) consideration be given to seeking funds to permit experiment with the development of a catagory of 'Associate' consultants in order to provide field experience to potential consultants who are otherwise well qualified;

f) Minority Caucuses in APHA membership should be used as a source for identifying minority group members who may be qualified to serve as consultants;

g) explorations be undertaken with AID to seek ways to assure that TAS have more lead time in filling requests for consultants;

h) ways be sought to obtain better evaluations of consultant performance and to use such evaluations in future consultant selections;

i) APHA develop a scope of work format that will enable consultants to know exactly what AID Missions expect of them. Such a format should improve consultant selection as well as the quality of work;

j) consultants be required to leave written summaries of their work when leaving a field assignment;

k) a decision be made soon about the provision of additional funds to permit TAS to continue to meet the demand for consultant help throughout the contract period.

D. General conclusions: The nature of the ADSS contract and the wide range of interests involved in the activities it supports have made for some administrative difficulties and for a lack of clarity at times in regard to the respective roles of APHA and each of the several AID units that have a stake in the ADSS program. Even at this late stage of the contract, there is need for further clarification and better understanding in such areas as, for example, the role of the Advisory Committee or the degree of freedom the APHA staff has for decisions at various stages in the production of Issues Papers. One important action that the Team strongly urges is the inclusion of the APHA director of ADSS as a member of the Advisory Committee.

Relatively little is known with any certainty about the impact of ADSS activities on the field of primary health care or the extent to which those activities contribute toward the objective of enhancing and making more visible AID's capability for leadership in that field. Both organizations need to develop and use more ways of obtaining feedback about ADSS activities as they are perceived in the field and to take that information into account if and when new contractual arrangements are discussed.

PROJECT COMPONENTS

A. PROMOTIONAL INFORMATION AND EDUCATION

Under the terms of the ADSS contract, the priority focus of the information and education activity is to be on primary health care (PHC) broadly defined, and on the low-cost, community-based health delivery systems through which that care is provided. Three mechanisms are specified in the contract as means to inform and educate various audiences: a periodic newsletter, a series of information packets, and a set of international conferences and workshops. (See Appendix B.)

1. Conferences and Workshops

a) Contractual requirements: Six conferences and six workshops are to be planned and convened during the three-year life of the contract. (There is no mention in the contract of an obligation to report on the conferences, but, in the judgment of the Team, this should be an important component of the ADSS informational activity.)

Three conferences--one each year--are to be developed in collaboration with AID and for AID Mission staff and their counterparts. Each is to have a regional focus--Asia, Africa and the Near East, Latin America. The purpose of each should be to help keep AID and AID contractors' field staffs and selected LDC participants abreast of recent developments in PHC.

Three conferences , also at the rate of one a year, are to be developed in collaboration or co-sponsorship with other appropriate international organizations, especially WHO, on a regional basis and with the purpose of helping health leaders in LDC's extend and improve their primary health care programs. Illustrative topics for both types of conference are listed in the contract.

Two workshops each year, organized in collaboration or co-sponsorship with other health organizations, are to be oriented to the interests, problems, or needs of LDC health personnel at intermediate levels.

b) Progress to date: In its provisions for conferences and workshops the current contract continues interests and activities begun and funded under the earlier DEIDS agreement between AID and APHA. In the first half of the ADSS contract period, APHA was active in discussions and the development of conference plans, but, for a variety of reasons, many of them beyond APHA's control, some conferences were delayed. AID Missions were polled early in 1980 to determine their preferences for times, places, topics, and participants, and some preliminary plans were made; but time requirements for planning a conference, conflicting commitments in some of the Regional Bureaus, and restrictions on AID

travel made it necessary to defer AID conferences until at least late in the second year of the contract. During the first year of the contract, considerable work was done in preparation for a proposed AID conference on water and sanitation, but the conference was canceled by AID. At the time of the Team's visits to Washington no AID conferences had been held, but both the African and Asian Bureaus of AID were working with APHA on plans for conferences this fall. These efforts have now resulted in a conference for Asian regional health, nutrition, and population officers held in Chiang Mai, Thailand, November 8-14, 1981, and one concerned with continuing education programs for primary health care convened in Lome, Togo, November 15-20, 1981. A Latin America/Caribbean conference is now proposed for 1982, and an APHA/LAC Bureau meeting to plan it was held on October 7.

The first of the conferences required to be organized in collaboration with other agencies was the long-scheduled Third International Conference of the World Federation of Public Health Associations (WFPHA), held in Calcutta in February, 1981 to consider a world strategy for primary health care. Co-sponsors with WFPHA (for which APHA serves as secretariat) were WHO, UNICEF, and the Indian Public Health Association. In co-sponsorship with WHO and PAHO, APHA has been active in the planning and organization of two related conferences to discuss an expanded program of immunizations, one conducted in Spanish in Quito in May and an English-language counterpart held in Jamaica in August. Explorations are underway with African agencies, looking towards an African conference sometime in 1982.

Two workshops were organized in 1980: one in Botswana in October, co-sponsored by WHO and the Botswana Ministry of Health and dealing with questions of health sector financing; and one in Jamaica in February, concerned with the training of community health workers. A Latin American/Caribbean workshop, organized by UNICEF, PAHO, AID, and the Caribbean Community Secretariat (CARICOM), met in St.Lucia early in June 1981 to review Caribbean regional policy for PHC program development. Interventions for Widespread Coverage was the topic for a workshop organized in collaboration with AID and the Ministry of Health of Tunisia. Originally scheduled to be held in Tunis in June, the workshop was postponed, at the request of the Tunisian Ministry, to late August. The two remaining workshops called for in the contract will be scheduled for sometime in the third year of the contract.

APHA's role in the conferences and workshops, in addition to planning and organizing activities, includes the recruitment and support of resource people, provision of funds for the travel of LDC participants, provision of literature and films, and dissemination of information about the meetings and their conclusions.

c) Comments and recommendations: At the time of the Team's visits to Washington, late in the second year of the contract period, none of the proposed three conferences for AID regional staffs had been held, and—although some planning was still going on—it was not certain that any would be. Since then the situation has changed dramatically. Asian and African conferences have been held and active planning is going on for a Latin American conference, with good prospects that one will be convened well before the end of the contract term.

With regard to conferences to be undertaken in collaboration with other agencies, excellent progress has been made with the Conference on Primary Health Care: A World Strategy, attended by some 700 participants in Calcutta, and the twin conferences on immunizations held in Ecuador and Jamaica for leaders in the health professions in Latin America and the Caribbean area. WHO was a co-sponsor of the conferences already held and presumably will also co-sponsor the African conference for which preliminary explorations with African agencies have already begun. Prospects are thus good that ADSS will easily fulfill its contractual obligations for this series of conferences.

Workshops also appear to be going well. ADSS is on schedule and has completed its contractual obligations for workshops in Africa and Latin America. Although the contract calls for two workshops in Asia, the Team did not see or hear anything to indicate that, at the time of its visits to Washington, any Asian workshops were being planned. If the contract terms are to be met, the two workshops remaining to be organized during the third year of the contract will have to be held in Asia.

Conferences can be useful, depending on their timeliness, topics, participants, organization, and quality of preparation and follow-up. They are also expensive, time consuming, somewhat unpredictable as to outcomes, and almost impossible to evaluate. The stated purpose of the AID conferences is "to keep AID and the Contractor's staff and LDC participants up-to-date on current developments in the field of primary health care and to provide for exchange of information about lessons learned from AID-assisted country programs and activities." Conferences certainly provide a one-time opportunity for the sharing of information and knowledge among participants, but it is doubtful that they can provide a cost effective way of keeping people current about what is happening in such a diffuse and rapidly changing field as primary health care. The two conferences remaining under the ADSS contract should be convened, but if there is to be an extension of this contract or a new one at its conclusion, both APHA and AID

should carefully consider what they expect to get from future conferences and what they are likely to get, both in relation to costs. Conferences have their uses, but keeping people up-to-date about changes in a developing field is not one of the more appropriate ones.

In terms of helping to plan, organize, and conduct conferences and workshops, the ADSS program is on schedule and will almost certainly fulfill its contractual obligations. One area about which the Team failed to get adequate information is that of what ADSS is doing to follow up conferences and to use the information and insights generated by its conferences for the benefit of people working in the field. The contract did not specify what should be done in this area, but it is an important one and APHA should be (and probably is) appropriately active in it.

The Team had neither the time nor the resources to inquire into the impact of these activities on the field of primary health care or into how they may have affected the image and role of AID in relation to that field. Such assessments require a different mechanism from that of a short-term ad hoc evaluation team. They are likely to be very difficult, but they are also most important, and the Team would recommend that, in another contract or an extension of the present one, AID make provision for assessing some of the effects of some of the conference or workshop activities that may be funded.

The Team's recommendations regarding conferences and workshops are:

1) That the remaining conferences specified in the contract be organized and conducted as now planned.

2) That (if it is not already doing so) APHA find ways to make maximum use of the information and insights generated by the conferences and workshops that have been and will be held.

3) That APHA give more thought and attention to the potential of conferences and workshops as institution building methodologies. Local governmental and non-governmental agencies in LDC's that are concerned with the extension of essential health and family planning services need to be more closely involved in developing appropriate agendas and helping to plan and implement sessions in order to strengthen their capacities for leadership.

4) That both AID and APHA review carefully the utility and cost effectiveness of conferences and workshops before building them into a new contract or an extension of the present one.

2. Newsletter--Salubritas

a) Contractual requirements: The contract calls for a quarterly newsletter to disseminate information about developments in primary health care and serve as a forum for AID and non-AID field personnel. The contract specifies that:

- At least 75 per cent of the copies of each issue should go to individuals or agencies in LDC's active or interested in the delivery of primary health care.

- Publication is to be in English, French, and Spanish.

- The mailing list is to be reviewed annually to assure an appropriate readership.

- Efforts are to be made to avoid duplicating contents of other newsletters.

- Circulation should be around 12,000 copies of each issue.

- Readers should be queried periodically to learn how they view the publication and to obtain suggestions for improvement.

b) Progress to date: Salubritas was started in 1977 under the DEIDS contract with AID. The ADSS contract provides for its continuation, beginning with Vol.3, No.4. In 1979, publication fell behind by two issues, but it has been back on schedule since 1980.

Salubritas is published in three languages, as required by the contract, in a total of 16,539 copies (May 1981), and is sent to 9,029 addresses of which 60 per cent receive the English edition, 14 per cent the French, and 26 per cent the Spanish. To save mailing costs, there has been a successful effort to use bulk mailing wherever possible, and 47 per cent of copies now go out in bulk shipments. The Peace Corps (which receives 800 copies) and the Catholic Relief Services handle the distribution of copies to their overseas field personnel. A recent analysis of the mailing list indicates that 80 per cent of the recipients are in developing countries, and that half of those are either developing country health officials or (the largest category) health field personnel. Twenty-seven per cent of the recipients are in Latin America, 24 per cent in Africa, and 15 per cent in Asia. The actual number of copies reaching these regions is somewhat higher than these figures indicate, since a number of North American agencies receive bulk copies and redistribute them to overseas readers.

An issue of Salubritas is typically eight pages, letter size, with content strongly oriented toward the interests and needs of PHC field personnel. An issue is likely to contain one (mostly) or two brief articles on a health

delivery problem or situation; a section showing how to do simple but important tasks such as write a report or keep records or do an evaluation; notes on recent or current activities or news of the field; a readers' exchange; news of training opportunities, conferences, or other events of interest; and briefly annotated reading suggestions. The writing is simple and clear; the format is attractive; illustrations and color are attractively used. An index of the first four volumes has been prepared and distributed. It indicates coverage of a wide variety of topics of general health interest and reflects the stated intention of the staff to devote proportional attention to the several regions of the developing world. A special effort is made to solicit materials from readers, and there is a standing offer to pay US$25 for each field originated article used and $10 for items used as briefer notes or news. A reader survey questionnaire was scheduled to go out with the July 1981 issue. The Team has no information about the questionnaire or any responses that may have been received.

c) Comments and recommendations: Newsletters serve a useful, if limited, purpose, and Salubritas appears to be one of the better of its kind. It is attractive and readable; its content and style are such as to interest PHC administrators and, especially, front line field workers; it can help keep AID Mission staffs informed about what is going on in their region and the world (although not fully or especially well since copies are published only four times a year and each is necessarily brief); its multiple languages make it useful beyond the English-speaking regions; and it is innovative with such measures as the "how to. . ." series and its attempts to develop a two-way interaction with its audience so that it becomes, in part, a periodical by as well as for its readers. It deals with a wide range of topics (as revealed by the index to the first four volumes), and it seeks to attain broad geographic as well as substantive coverage.

The orientation of Salubritas, like that of ADSS in general, is global. The intended audience is PHC workers everywhere. But a circulation of 16.5 thousand, more than half of which go to institutions and individuals who are not PHC workers or administrators and 20 per cent of which go to developed country addresses, can provide only the thinnest coverage of developing country PHC workers. It is plausible that the maximum effect of a copy of Salubritas is achieved when it is in the hands of a field level PHC worker, and the minimum effect when it goes to a developed country institution. If this is

so, the distribution list is unbalanced somewhat in an unfavorable direction.

There is no realistic probability that Salubritas can ever be produced and and distributed in sufficient quantity to meet the needs of a majority of PHC workers in LDC's. But the present volume seems more modest than it need be, and not only increased coverage but perhaps also some economies of scale might result from an expanded production. The publication of 16.5 thousand copies in three languages means two translations and three separate press runs each with a different make-up. It also means very small editions in each language. Since the translation and make-up costs are likely to be the same for any number of copies, it is likely that the per copy cost could be brought down significantly if the production were substantially increased.

Much more detailed information about unit costs and the mailing list in each of the three languages than was available to the Team during its visits to Washington is needed before any sound judgments can be made about the publication. The Team, therefore, recommends:

1) That Salubritas continue to be issued through the remainder of the current contract period (three issues according to the schedule).

2) That within the next few months, and prior to the visit of the Evaluation Team that will review the ADSS contract at the end of thirty months, extensive information be compiled about such matters as: a) reader response to the recent questionnaire that was sent out; b) unit production costs for each of the three language editions at current printing levels and at several increment levels of, say, 10,000 copies each; c) costs of present and alternative mailing practices; d) geographic distribution by language edition; e) the balance between institutional and personal addresses on the mailing list; f) the visibility given to AID in the publication; and g) a categorical breakdown of costs, including administrative and managerial overhead.

3) That this, and such additional information as may be requested, be made available to the 30-month Evaluation Team and that it be asked to make recommendations about the future of Salubritas under a new contract or an extension of the present one if either is proposed.

4) That, to the extent that funding under the current contract permits, the subscription list of Salubritas be permitted to expand, with priority given to PHC field workers and appropriate health officials in LDC's.

3. Informational packets

a) Contractual requirements: Informational packets are intended to provide current and vital information or technical data relating to primary health care and affordable health delivery systems to AID staff, AID contractors' personnel, and a few LDC persons who have major responsibilities for developing or implementing PHC programs. A maximum of 150 packets is authorized, and the activity is to be coordinated with other appropriate health organizations, both to seek input materials and to avoid duplication of effort. The contract also calls for a follow-up system to assess the usefulness and relevance of packet materials to the recipients.

b) Progress to date: Major responsibility for the packets rests with the IPH Resource Center. As of March 1981, sixteen packets had been distributed (including seven under a previous contract) with information on 21 topics in a variety of formats including an atlas, bibliographies, monographs, reprints, journals, books, charts, and reports. A subject index for the first thirteen packets was prepared and distributed. There is no consistent pattern or theme for the packets unless it be that of PHC itself. A given packet may contain several items on a single broad topic or several that have no particular relationship to each other. A questionnaire seeking recipients' views about the materials received was sent with packet No.14 (October 1980), but no tabulations of the returns were made available to the Team.

Packets, according to an early cost estimate, average about $5 each for materials, exclusive of APHA costs for procuring and packaging them, with an additional $1.25 for mailing. An examination of materials cost estimates for several individual packets indicated a cost range of $0.58 to $9.36, with most running in or near the $2.00 to $2.50 range.

The ADSS Advisory Committee, at its December 1980 meeting, suggested that the distribution list be reviewed and updated to assure that the packets were going to an appropriate audience. It also suggested that APHA explore the possibility of making paid subscriptions available as a means of satisfying the two or three requests for packets APHA said it averages each week.

Although the contract calls for some packets to go to a small, carefully chosen list of LDC people responsible for PHC programs, all packets being distributed at the time of the Team's visits to APHA were going to AID personnel or offices, in accordance with instructions received by APHA from AID. Up to 150 packets are authorized for each mailing, but, following a review of the distribution list in August 1980, the distribution was reduced from 150 to

113 packets. Of the 113 packets mailed in March 1981, 63 went to AID offices or personnel overseas and 50 to AID/Washington. A breakdown of the distribution of packets Nos. 14 and 15 shows that 64 went to AID Missions; 29 to the Bureau for Development Support; 15 to Regional Bureaus; 6 to the Bureau for Program and Policy Coordination; and 2 to the Bureau for Private and Development Coordination. A recent communication from APHA reports that the number of packets has been increased to 150 and that, on request, packets are distributed to non-AID personnel.

c) Comments and recommendations: It is difficult to see much justification for the informational packet project as it now operates. The volume is too small to have any important impact, and the mailing list is too heavily weighted with office addresses and individuals who could have easy access to the materials through other and less expensive means. There can be no certainty that any of the items included in the packets will be of interest to a substantial proportion of the recipients. (Discussion with ten former or present AID field staff indicated that from none to no more than half the packet materials received were read.) And, given the complexity and variety of the PHC field, it is doubtful if the small number of items distributed can give even a minimal sampling of the range of issues or problems involved in designing, operating, and evaluating PHC programs.

With regard to the informational packets the Team agrees that there is a need for information in the field and that the types of materials distributed in the packets can, if properly distributed to people who want and can use them, be of considerable value. Its recommendations are:

1) That, as a minimum, the proportion of packets going to AID/Washington be substantially reduced and the proportion going to field Missions or selected LDC personnel be correspondingly increased.

2) That, as a means of assuring that materials go to those who want them, consideration be given to experimenting with other ways of providing valuable and usable materials. One procedure suggested by the team would have APHA prepare periodically a brief list of materials that it considers outstanding, relevant to field needs, likely to be of more than transient interest, and that it is prepared to distribute. The list need not be long, perhaps eight to ten items, and should include an annotation of each item and an indication of its cost. The lists should be sent to a set of potential recipients of materials including appropriate field mission personnel, a very limited number of individuals at AID/Washington for whom such materials are known to be relevant, and as many LDC public health personnel (recommended perhaps by AID Mission members) as resources permit. Recipients should be notified that each may, in the course of a

year receive materials requested from the list up to a value of X dollars, with X being a function of the relationship between the size of the funds available and the number of recipients. Several restrictions should be imposed: for example, that all materials requested be relevant to PHC problems and issues (the list will have only such materials, but the procedure should be flexible enough to permit an occasional request for unlisted materials if the Resource Center can supply them)and that only single copies can be sent. Such an arrangement would permit a certain amount of self selection among the recipients since some are likely to request little or nothing, and this can be used as a basis for occasionally culling the list to assure that the service is going only to those who want it and can use it. Something like this, or some other procedure based on the premise that people in the field are the best judge of what they need and want to read, should be tested--perhaps concurrently with continued packet mailings--over the next few months to provide information useful in guiding decisions that will need to be made if an extended or new contract is under consideration.

3) That, if the recipient survey conducted in connection with packet No. 14 was not analyzed and reported or did not provide sufficient information to assess the value of the packet service, APHA take steps to obtain information about how those who currently receive the packets use and value the materials received.

4. Resource Center:

a) Contractual requirements: No mention of a Resource Center seems to have been made in the ADSS contract, but provision for such a Center was included in the earlier DEIDS contract and costs for establishing one were incurred as early as 1976.

A modified version of the document on technical considerations and costs for ADSS, submitted to AID in September 1979, describes a position of Documentation Coordinator to be in charge of obtaining and cataloguing information on PHC to be used as a basis for materials for informational packets to AID field staff and some non-AID individuals and institutions in the developing world, and to assist consultants, the Special Studies unit, other APHA staff, and individuals and institutions working in the PHC field. In April 1980, a separate proposal describing the organization and functions of an IHP Resource Center was submitted to AID. As described in that proposal, the Center was mainly to be a resource for International Health Program activities, but was also expected to perform services for the ADSS program, including the storage and retrieval of computer data, assembling and mailing the information packets, and responding to requests for

monographs and Salubritas.

b) Progress to date: The first ADSS semi-annual report (October 1,1979--March 31, 1980) lists a Resource Center Manager among the ADSS staff and reviews some of the Center's activities, such as cataloguing reports on technical assistance assignments, preparing specialized bibliographies, compiling and maintaining a mailing list of some 1700 names for distributing various APHA/IHP publications, and mailing information packets. No further information about the Center, other than that relating to the mailing of information packets, is given in the two subsequent semi-annual reports seen by the Evaluation Team.

c) Comments and recommendations: The Team toured some facilities and met several staff members connected with the Resource Center but came away with very little understanding of the range of functions the Center performs in and for the ADSS program. It would appear that the Center has the equipment, materials, and staff to perform a number of valuable services for clientele of the ADSS programs, but it seems unlikely that many outside of Washington know what those services are or how they might be obtained. The Team recommends:

1/) That the functions of the Resource Center in relation to ADSS activities be clarified, especially in terms of budget allocations.

2/) That the field clientele of ADSS programs, especially members of AID Missions, be informed of any services that may be available to them from the Resource Center and of the means for obtaining them.

B. EVALUATION AND SPECIAL STUDIES

As illustrated in Appendix C, there are differences between the original contractual requirements and the later approved workplans. Under the terms of the ADSS contract, APHA was to provide overall tracking of progress being made towards improved and extended health delivery systems and PHC programs in AID-assisted countries. Tracking reports were to identify methods being used, approaches that are succeeding, and constraints present and to suggest possible solutions and alternative approaches to problems. In addition, there was to be some effort to synthesize progress being made in extending health services throughout the world.

A data bank was to be established to abstract, store, and permit ready retrieval of information on primary health care programs in LDCs. A minimum of 350 projects, to be selected by APHA and including non-AID-supported projects, was specified.

By March 1 of each contract year, a global state-of-the-art review was to be published. In addition to synthesizing major developments, the reviews were to include chapters dealing with matters of special concern to AID health personnel. Seventeen possible chapter topics, relating to primary health care, were specified in the contract. A format for these reviews was to be developed by APHA for approval by the DS/HEA Project Officer.

In the process of gathering information on PHC, APHA was authorized to engage a total of 54 person months of short-term consultant experts during the life of the contract to discuss and advise on PHC issues, with their contributions to be incorporated in published materials distributed to AID Mission health personnel.

The range of outputs called for in the contract includes:

1) Regional tracking reports.

2) Annual state-of-the art reviews, in English, in editions of 3,000 copies.

3) Technical reports, in English editions of 2,000 copies, summarizing special studies and the findings and conclusions of consultant experts.

4) Annual reports summarizing progress, constraints, suggested changes, and areas for problem oriented research for AID-assisted projects, with 100 copies to go to AID.

5) Two workshops a year to bring together highly qualified experts to focus on vital aspects of primary health care and health service delivery.

6) Expansion of the data bank from the original 180 PHC/HDS projects to a minimum of 350 projects.

In accordance with contract wording, these suggested outputs were redefined to become--as listed in the ADSS semi-annual report for the period ending March 31, 1981--four programmatic areas under the Evaluation and Special Studies Section: tracking reports, global review-issues papers, special studies, and data bank. Each of these is reviewed below.

1. Tracking Reports

a) Contractual requirements (revised): Progress toward improving and extending health delivery and primary health care systems in AID-assisted countries was to be tracked and reported. The tracking reports are intended for use as reference documents, with summary descriptions of all active AID primary health care projects, and as analytical documents to trace progress made by projects and examine common project problems.

b) Progress to date: Five volumes, tracking the progress of AID-funded PHC projects, have been drafted. They cover, respectively, Asia, Latin America and the Caribbean, Africa, the Near East, and a Summary Analysis of Problems Common to AID Primary Health Care Delivery Experience in All Four Regions. At the time of the Team's visits to Washington all were in draft form and had been sent to the field for feedback comments, but none was in final form. The four regional volumes have now been completed and distributed.

c) Comments and recommendations: It is likely that much of the information contained in the tracking reports is outdated as an inevitable result of delays inherent in the processes of field observation, project reporting, synthesizing data, and printing the documents. Whether this rather cumbersome process is the best approach to providing tracking information that can be devised is a problem that should be considered by the ADSS staff and the Advisory Committee if contract renewal or extension appears likely.

The Team's recommendations relating to tracking reports are:

1) That consideration be given to including all AID health projects in future tracking reports. Usually more limited in scope than PHC projects, other health projects can offer important lessons. What is being learned from immunization or malaria control projects, for example, can be valuable for primary health care, and individuals using tracking reports can benefit if such projects are included.

2) Information on single country or regional projects can be valuable to contractors who are implementing many of the AID projects. Consideration should be given to informing them of project activities and accomplishments by giving them access to the tracking reports. (APHA has indicated that this will be done.) Consultants going to the field for APHA or a contractor should

also see the appropriate regional tracking report and the summary document.

3) If tracking reports are to be continued, a form should be developed to enable AID field personnel and those of contractors to help update them at regular intervals. Forms should be periodically supplied to project personnel and be so designed as to assure both uniformity and completeness.

4) The checklist at the end of each report does not seem to have much value to AID staff. The Team sees no reason to include this in the report, unless it serves a useful purpose for APHA.

5) The value and utility of the analysis section should be assessed by field personnel to determine if it is sufficiently useful to justify the time and space it requires.

6) A way to expedite getting tracking reports to the field might be to have them done initially on a project or country basis rather than regionally and send them to the field on a project by project basis as they are completed. Thus data on some projects could be put to use while the total regional set was being assembled. Use of a loose leaf format would permit easy updating as new information became available on particular projects.

7) Consideration should be given to the possibility of using the summary volume of the tracking reports as the basis for an APHA-organized workshop where the national PHC officials in a region could meet and discuss how PHC programs might better be organized and managed.

8) Similarly, a seminar based on the summary volume might be organized for appropriate AID/Washington personnel to consider the implications of the report for future field projects.

2. Global Review--Issue Papers:

a) Contractual requirements (revised): The contract requires that APHA prepare and publish global reviews of the state-of-the-art of primary health care. The reviews are intended to provide information useful for choosing among policy options or improving skills for designing and implementing national primary health care programs. The reviews are to be produced as individual chapters, each dealing with a single topic, with all eventually to be included in a loose leaf binder, so that,at the end of the ADSS project, recipients would have on hand a comprehensive review of primary health care issues organized under appropriate chapter headings and arranged for easy reference. The audience for the reviews is viewed as individuals responsible, at sub-national, national, or international levels, for translating policy into actions, including those working with or for multinational and bilateral

organizations, private and voluntary organizations, and foundations.

b) Progress to date: Health personnel of AID Missions were polled to obtain their views about the relative importance of items on a list of review topics originally suggested in the ADSS contract. On the basis of their responses, topics were ranked in order of their perceived importance. A nine-stage guide for development of chapters was agreed upon (Appendix E) qualified writers were sought, outlines were developed, and, over time, eight topics had reached various stages of preparation. Ten topics and their stage of development midway through the contract period are listed in Appendix E. At the time of the Team's visits to Washington, no chapter had been completed, but since then two papers have been published, one on immunizations and one on growth monitoring. There appears to be still some uncertainty about the target audiences, some of the remaining topics, and the degree of independence APHA has for choosing topics and authors. These and related problems concerning the issues papers were discussed at the October 27, 1981 meeting of the Advisory Committee for ADSS and the need to begin to clarify and resolve them accepted.

c) Comments and recommendations: A great deal remains to be done on the iseues papers before the contractual obligations can be fulfilled. A significant amount of work has been done on only eight topics; at least fifteen were envisioned for the life of the contract. An essential step is for better clarification of the roles of APHA and AID in deciding topics and producing the papers,and the first of the Team's recommendations are concerned with this issue.

1) APHA and AID together must come to an understanding of the exact audiences these papers are designed for, and APHA should then begin to develop an appropriate mailing list. The mailing list of PIP could be a valuable resource in this effort.

2) APHA should be given more freedom to determine the subject matter of the issues papers and special studies and greater independence in the selection of authors. It should have full responsibility for the final product and be judged on its quality. The respective roles of APHA and AID in the selection of topics, content, and format need to be clarified. An ideal arrangement,perhaps, would be to formalize AID's technical inputs in the very early stages and to give full responsibility for all later stages to APHA. Manuscript review should

be limited to not more than four reviewers and a definite time frame for the review process adhered to.

3) Advice from Mission personnel about future topics should be systematically elicited and listened to. Their views about format, style, and level of presentation should also be obtained and taken into account, although final decisions should be made by APHA.

4) The present status and quality of papers, in whatever form they are presently in, should be carefully reviewed. It may be that work on some should be discontinued if the quality is judged not to be up to desired standards. (It is far better to have a smaller number of well conceived and well written papers than a larger number of lower quality.) The team strongly recommends that all papers for which a full draft has not been completed be stopped so that the ADSS staff can devote its full time and attention to getting the first four chapters finished and into the field for reaction. Feedback on these should be sought and reviewed before further work on other papers is resumed.

5) The procedures for selection of principal writers should be reviewed and redesigned to assure that only persons with a record of quality work and extensive international experience in a field of their expertise be appointed. Geographic location should not be an important consideration in selecting writers.

6) Before writing begins a detailed outline should be prepared in close collaboration with APHA staff and with approval from an appropriate office or person in AID. Attention to and agreement about details at the planning stage will help to prevent problems at later stages of the work.

7) Population Information Reports may provide a useful model in terms of organization of materials, style, and format. It is recommended that they be kept in mind when new papers are being planned.

8) It is vital that APHA continue to use all possible channels to get systematic feedback on field needs and reactions to early Issues Papers. APHA staff members and consultants who visit field sites should be asked routinely to obtain from AID health personnel answers to specific questions about past papers and suggestions for future topics.

3. Special Studies.

a) Contractual requirements (revised): The contract specifies that APHA conduct special studies and/or organize workshops focussed on topics and problems considered to be of special importance. Such studies and workshops are to be designed to provide to AID personnel timely responses to concerns

about critical issues in primary health care that might surface during the preparation of Issues Papers.

b) Progress to date: At the time the Team visited Washington, one special study, "Growth Monitoring of Preschool Children: Practical Considerations for Primary Health Care Projects", had been completed in close consultation with members of AID's Near East Bureau. A report was nearly ready for publication and distribution. (This has now been published as one of the Issues Papers.)

One workshop, on Community Participation, was held in Washington in November 1980 with 24 experienced researchers, professional people, and agency administrators participating. A report of the workshop was prepared and submitted to AID.

It is likely that the regular workshops scheduled under the Information and Education program of ADSS contribute to the purposes of the special studies and workshops program, but the Team has no specific information on how any of these may have been used.

c) Comments and recommendations:

1) It is recommended that topics selected for workshops be as specific as possible so that the information generated has operational value. They should also be specifically related to proposed Issues Papers or special studies so that they may be useful either in initiating discussion and exploring ideas for the Papers or in bringing experts together to review a Paper.

4. Data Bank:

a) Contractual requirements (revised): The contract provides that a data bank, to store information about primary health care programs in developing countries, be established and maintained. A pre-existing quantity of data about 180 projects is to be expanded to a minimum of 350 projects.

b) Progress to date: Following an announcement in Salubritas soliciting information about projects that might be included in a data bank, some 600 health projects requested that they be sent questionnaires for recording data on their organization and activities. A form was sent to all those requesting it, and, during the spring and summer of 1979, 120 forms were returned. These data, together with those of the original 180 projects, which had been on IBM cards, were entered into the computer in the pre-coded form of the questionnaire. There has been no updating of the information on the original 180 projects nor any follow-up on the data in the 120 additional projects.

c) Comments and recommendations: As the data bank is now constituted it is of limited value. Information on the projects is so coded that a print out is not very useful; data are no longer timely, since the information

sembled in mid-1979; few potential users of the information have been informed about the availability of the data bank; and the 120 additional responses are not a valid sample of the universe from which they were drawn. At the same time, the data bank offers a potential for providing, in easily accessible form, a great deal of information of interest to individuals and organizations. Given the above, the following recommendations are made:

1) The data bank as currently designed and operated should be abandoned. No new non-AID-funded projects should be added to the 120 now in the data bank until better determination can be made as to how this information will be coded or used in the future.

2) To date the data bank has been little used. The cost implications of expanding it must be carefully weighed against the potential usefulness before any decision is made to expand. In the months remaining in the contract period, AID and APHA should study the feasibility of transforming the data bank into a new project that would constantly imput and retrieve information about AID (and other) PHC projects and provide informative summaries of project activities. This would require updating and re-coding information on the 300 projects now in the bank, a systematic arrangement for routinely acquiring and adding new information on other projects, and, of course, additional funding.

3) If a data bank is to be continued the following will need to be done:

a) A follow-up questionnaire should be sent to the original 180 projects to determine their current status and progress since the original data were collected.

b) Consideration should be given to abstracting and coding information from AID health projects in the Tracking Reports and non-AID projects from the data bank and elsewhere in such form that short resumes of the projects could be readily extracted.

c) If a new data bank is developed or the present one continues, its existence and access must be advertised to the international health community, and APHA should develop a fee system through which the bank services could be made available to non-AID individuals and organizations.

C. TECHNICAL ADVISORY SERVICES (TAS)

The Technical Advisory Service, like some of the other components of ADSS, was operating long before the current contract became effective. The purpose of the TAS component is to enable APHA to provide "short-term, rapidly responding technical advisory services to AID/Washington, AID Missions and regional programs, and governmental and non-governmental organizations in developing countries as requested through the Regional Bureaus and the DSB of AID in a wide range of activities aimed at the extension of essential health and family planning services."

a) Contractual requirements: The contract provides for 360 person months (20 work days per month) of technical advisory services, the development and maintenance of an up-to-date register of 3,000 qualified consultants; and special attention to including in the register and using qualified women and members of minority groups.

TAS consultants are to be used to:

1) assist AID Missions in assessing the opportunity, advisability, and feasibility of initiating new HDS, PHC, POP/FP, or water supply and sanitation (WS&S)assistance projects;

2) help governments of LDC's assess their existing health and family planning delivery systems and provide guidance toward restructuring existing systems to extend PHC to unserved areas;

3) evaluate ongoing AID-supported projects and activities related to HDS, POP/FP, WS&S, and PHC;

4) provide expertise in specialized aspects of PHC, HDS, POP/FP, and WS&S development and implementation activities;

5) provide guidance in solving unanticipated problems that emerge during the implementation phase of PHC,HDS, POP/FP, and WS&S projects.

Some 29 types of technical assistance capability in areas of public health and family planning are listed as likely to be required (for example, "developing research topics and procedures", "development of rural and urban water supply", or "process evaluation and assessment").

TAS is the one component of ADSS that is well ahead of schedule, an accomplishment that reflects both a considerable demand from AID Missions for this service and the fact that the service has a long history at APHA. No person in AID to whom the Team spoke disagreed with the notion that the consultant service is the contract component AID field personnel most favor.

And feedback from the Missions served has been equally favorable. The major concern expressed by both the DS/POP/FPSD project component manager and the DS/HEA project manager has been that AID not lose this flexibility to obtain short-term consultants easily and on short notice when necessary.

b) Progress to date: In the first half of the contract period, TAS has accomplished the following:

- As of March 31, 1981, 308.5 person months of consultant services had been provided, of which 268.7 were from the contract and 39.8 funded from other sources. Of the total time, 40 per cent of the consultations were for health matters, 60 per cent for population.

- At the end of April 1981, 281.4 person months--78 per cent of the 360 allocated in the contract budget--had been expended. Indications are that TAS will over-run its contract budget well before the end of the contract period and the service will either have to be cut back or new funds provided.

- In the 20 months from October 1979 through May 1981, some 271 requests for consultants were filled, 160 for population assignments and 111 for health. About three-quarters of the consultants recruited were requested by name by AID personnel. This has important implications, both for APHA implementation of consultant recruitment and for quality control, which are discussed below.

- Active recruitment has brought the consultant register up from 1,300 names in October 1979 to 2,400 of the targeted 3,000 qualified consultants.

- Both registration and use of women and minorities are increasing. Seventy-eight (29 per cent)of the 271 consultants recruited through May were female; 13 (5 per cent) were members of minority groups, and 24 (9 per cent) were from developing countries. Of the 160 recruited for population assignments, 33 per cent were female, 6 per cent minority group members; the proportions of the 111 with health assignments were 23 per cent female and 3 per cent minority. (See Appendix F)

- Of all consultants listed in the registry, 38 per cent are female and 28 minority group members, as compared with 30 per cent and 20 per cent, respectively, on October 1,1979. However, the ratio of actual use to registration is much lower for minorities than for females. (For a breakdown of registration by minority group see Appendix G.)

- In terms of the five types of assignment categories identified in the contract, the largest proportion (36 per cent) of the assignments were

classified by APHA staff as falling into the evaluation category; only 7 per cent were classified as working to solve unanticipated problems. (A breakdown of the distribution of assignments by category is provided in Appendix H.)

The Team did not try to categorize assgnments by the 29 types of TAS listed in the contract because of problems of overlapping and the lack of discrete categories. Such a breakdown does, however, deserve future attention in terms of planning, as our recommendations will indicate.

Comments and recommendations: It was not possible for the Team to determine the extent to which TAS fills country needs or is being provided to "governmental and non-governmental organizations in developing countries" as the contract specifies. Such an assessment was beyond its resources.

The performance of APHA seems good in most of the areas specified in the contract, although processes of selecting and evaluating the performance of consultants are not as satisfactory as they might be.

The strength of TAS lies in its flexibility and its capacity to respond rapidly to requests, attributes that are highly important in the context in which TAS operates. Appreciation of the quality of service provided is high, as revealed by feedback from a recent APHA survey and by comments from current and former AID field personnel to whom the Team was able to talk in Washington. However, there remain aspects of the operation that could be improved, and these are the subject of the Team's recommendations.

1) Consultant registry: While the objective of listing the most highly qualified people--including women and minority group members--on the register is desirable and should be pursued vigorously, the setting of a quota of 3,000 names to be achieved by the end of the contract period serves no useful purpose and, in fact, can result in wasted effort from recruiting and listing individuals who are less than fully qualified. How large the list of potential consultants should be is best determined by how many highly qualified persons with appropriate skills and experience can be identified, not by an arbitrarily chosen number. The Team, therefore, recommends that the numerical target be abandoned, and that APHA continue its efforts to identify potential consultants--especially women and minority group members--in sufficient numbers to meet all predictable demands.

2) Computerizing consultant rosters: There was question among some Team members about the value of a computerized roster. Only a small number of consultants are requested at any one time, and about 70 per cent of these are being requested by name by AID Missions with apparently no reference to the roster. There were also questions about whether appropriate persons could be identified with present coding categories. It is worth noting that larger agencies, such

as UNDP, handle more than twice as many requests per year, keep a roster of some 3,500 consultants, and have not felt the need to computerize.

If computerization is to continue, the questionnaire used to collect biographical data should be updated to reflect current PHC experience and needs; data coding systems developed at other agencies should be reviewed and a system developed that would include levels of language ability and skills or areas of expertise more relevant to PHC; and biographies in the file, many of which are now outdated, should be periodically updated.

3) Analysis of consultant requests: Assignments to date should be analyzed in light of the 29 functional types mentioned in the contract to help focus the search for additional qualified consultants with a sufficient range of skills and experience to meet future demands for both frequently requested combinations of skills and experience (e.g., French-speaking public health physicians) and those that are only rarely required.

4) Consultant qualifications: Standards for consultants should be reviewed and, as necessary, revised upward. APHA is considering two levels of consultants: those with a minimum of five years experience in their field plus two years experience in LDC's, and those without this experience. By way of comparison, it can be noted that UNDP requires 10-12 years of international experience for a consultant to be listed in their registry. Occasionally, APHA has sent out as consultants persons who are looking at a situation in terms of a possible future assignment by AID; at other times persons who lack appropriate credentials for a particular assignment (e.g., individual health education or aspects of training) have been recruited; and, in some instances, consultants have been called upon to do a variety of tasks that would seem to require a number of specialized skills. As a minimum, the Team would like to see uniform minimum training and experience standards adopted to require several years of experience abroad and at least five years of other experience.

5) Selection process: With more than 70 per cent of the consultants being specified by name in requests, room for improving the selection process is limited. As a minimum, APHA should seek a way to make AID Mission staff aware of what is available in the way of expertise. It seems clear that some field personnel specify a particular person because they do not know who else is available, not always because they want only that one person. Some systematic way of bringing a short list of names and qualifications quickly to field personnel requesting consultant help might open up possibilities for a larger proportion of selections being made from among consultants not previously known to someone in AID.

6) Consultant associates: One of the essentials for a consultant appointment is overseas experience. But it is very difficult for young people who are otherwise qualified to get such experience. One proposal for solving this difficulty and beginning to build a cadre of young people on the consultant registry is that of establishing a category of "associates" composed of individuals who would not qualify for solo consulting jobs, but who might be useful members of a team and thus acquire overseas experience credentials. It is likely that a number of well-trained young people would be willing to serve as associate consultants for expenses only; but the difficulty remains: how to find funds for those expenses. One solution might be to seek a grant from one of the private foundations, emphasizing benefits to young females and minority group members. This idea was suggested to APHA staff by the Team and was considered worth exploring. The Team, therefore, recommends that APHA seek a source of funding for a trial of the associate idea. If the present ADSS contract could support a modest trial, it would be a valuable contribution.

7) Minority recruitment: ~~One way to recruit~~ more actively for minority members might be through the Minority Caucuses existing in APHA. The Team recommends that this avenue be actively explored and used.

8) Source of consultant requests: The team suggests that APHA, with AID, make an effort to ascertain what proportion of the requests for consultants are meeting the needs of governmental and non-governmental organizations in developing countries as specified in the contract.

9) Timing of requests: One of the major advantages of this contract is the TAS ability to provide consultants within a short lead time. This is fortunate since some 37 per cent of health assignment requests have given only two weeks notice. Since more than a third of the requests are for evaluations that are generally written into projects at the beginning and can be foreseen long in advance, a longer lead time on many requests should be possible. If a way could be found to induce AID field personnel to give TAS more lead time (with exceptions as necessary) the likelihood of recruiting the most qualified consultants might be considerably increased. The Team recommends that this issue be explored with AID.

10) Consultant performance evaluation: This is an area that needs improvement. The present evaluation process consists of questionnaires sent to AID/Washington, Missions, APHA, and the consultants (who chronically record dissatisfaction with debriefing sessions and strong feelings that there was not sufficient time to complete the scope of work.) The questionnaires focus

in a general way on how well the consultant carried out the assignment and how he or she performed in the field. The return rate has been variable: 35 per cent from consultants, 64 per cent from AID/Washington, and 82 per cent from Missions. The checklists are informative to some extent (85 per cent of returns by Mission personnel rated consultants' performance in getting the job done at 1 or 2 on a five-point scale, Excellent to Unsatisfactory), but they do not provide for a measure of programmatic outcome. One solution might be specific questions related to specific work results based on the original or revised scope of work.

It is not clear that APHA routinely uses evaluation data in making future consultant selections. There is need for TAS to set up a system for correlating consultant performance with levels of experience and training, both to assess the relationship of experience and training to subsequent performance and to provide AID with an account of past experience and performance when consultant selections are being considered.

11) Scope of work: The Team strongly recommends that some model 'Scopes of Work' be developed that illustrate how to specify just what kind of job is required, what skills and experience are needed, and what outcomes are expected. Some of the cabled scopes of work that come in say so little that it is difficult to know exactly what needs to be done and what skills are required to do it. A few model scope of work examples distributed to Mission personnel might help to bring about an improvement in requests from the field that would enable TAS to recommend with more assurance exactly the right consultant for the job to be done. More comprehensive scope of work statements would also contribute toward better evaluations.

12) Final report: Most consultants do not leave a written summary of their work with the Mission when they depart. Since final reports are a long time in reaching the field (three months to more than a year, field staff say), such a summary would seem to have value, particularly if it is to be shared with local counterparts. APHA and AID should make the writing of such a summary a formal requirement. There should also be a firm deadline for receipt of the final report and a procedure agreed upon for getting it to the field as rapidly as possible.

13) Funding: A joint APHA/AID decision needs to be made soon as to whether TAS can exceed its budget during the final months of the third contract year, with additional funds coming from within the current contract budget (if savings from other components make that possible) or from other AID sources, or whether the service will have to be curtailed. If the latter, some criteria for deciding priorities among requests in a period of diminished funds will have to be adopted.

A. GENERAL CONCLUSIONS

The ADSS contract, in large part, represents a fusion of selected program components from two previous AID/APHA collaborations: Development and Evaluation of Integrated Delivery Systems (DEIDS) and Population Consultation and Technical Services (CATAS). It thus provides a vehicle for serving three distinct sets of interests--those of the Population and Health personnel of AID and those of APHA--and for continuing activities that had begun under bilateral arrangements between APHA and AID's population staff and APHA and AID's health staff some years earlier. Actually the situation is even more complicated than the tri-partite range of interests would suggest since, within AID, Regional Bureaus and Mission personnel concerned variously with family planning and health objectives are involved and within APHA there are sub-units with vested interests in activities long established before the contract began.

Although from a bureaucreatic point of view the contract represents something of a marriage of convenience, it also contributes to administrative problems that, in some instances, have hampered the work of the program. Both AID/Population and AID/Health make independent administrative interventions into the program from time to time and there is an Advisory Committee whose membership has not been stable and whose functions have never been clearly defined or explicitly stated. In its dealings with APHA in relation to this contract, AID seems not to speak with a single voice, and this has caused some confusion and some problems of administration and performance in APHA.

The contract gives a great deal of flexibility to APHA in designing and carrying out the various project components, but also permits AID to be free to intervene from time to time to assure that its organizational needs and purposes, as well as those of of APHA, are being served. To some extent flexibility on both sides is desirable and useful, but in the absence of clear guidelines about who is responsible for what it can lead to program uncertainties and deficiencies such as a lack of clear definition of audiences for some project components, and a delay in some project outputs as, for example, the issues papers.

To maximize the ADSS program's effectiveness in the remaining months of the contract, AID and APHA need to clarify their respective roles in such areas as administrative policy, technical monitoring, and production and to develop a single channel for formal communication about the contract and its implementation. Informal communications about ADSS activities should, of course, continue, both within and between the two organizations. The role of the Advisory Committee

should be clarified and its scope explicitly defined. APHA's director for ADSS should become a member. Both organizations also need to develop a systematic way of eliciting feedback from the target audiences of the several project components. Some small efforts have been made by APHA for some of its activities (e.g., Salubritas) but, with the possible exception of feedback from AID Mission personnel about the value of TAS, relatively little is known about the impact of ADSS activities on the field of primary health care or of the extent to which those activities may be enhancing AID's leadership capability in that field. That some progress toward some of these ends may be expected soon is indicated in a decision made at the October 27 meeting of the Advisory Committee that a work plan for the remaining months of the program should be developed, with concurrence of the Committee and the AID project director, and put into immediate effect. Important aspects of the new plan are to be improved definitions of target audiences and messages and clarification of each organization's role and responsibilities in ADSS decision making procedures.

From a process perspective, APHA appears to have done well in its performance under the ADSS contract. Conferences and workshops are on schedule; Salubritas and information packets are going out regularly; TAS is performing in a satisfactory manner. Tracking Reports and Issues Papers have been delayed--not entirely through fault of the APHA staff--and are now beginning to appear, but with little time left for feedback on quality or appropriateness. If these activities are to be continued under an extended or new contract, it is clear that there will need to be adjustments made in the light of experience to date, and an assessment made of the extent to which the activities, as carried out, have contributed toward attainment of the objectives of the current contract or are likely to contribute new aims emerging from changing conditions.

Appendices : A-H

List of Persons Interviewed

APHA

S. Kessler, Director, International Health Programs
A. Gerald, Program Manager
S. Olds, Chief, Technical Advisory Services
B. Karlin, Manager, Technical Advisory Services
P. Burgess, Chief, Evaluation & Special Studies
W. Stinson, Analyst, Evaluation & Special Studies
A. Brasfield, Conference Manager, Information Services
I. Selden, Editor (Salubritas - Inf)
S. Mowatt, Fiscal Manager (Adm)
J. Aung, Registry Coordinator (TA)
M. Favin, Research Associate (ESS)
W. H. McBeath, Executive Director

USAID

C. Pease, DS/HEA
D. Ferguson, DS/HEA
G. Curlin, ASIA/TR
R. Haladay, DS/POP
B. Turner, NE/TECH
J. Sheppard, AFR/DR
H. Pedersen, DS/POP
L. Morse, LAC/DR
A. Tinker, DS/HEA
G. DeLuca, USAID, Liberia; AFR/DR
C. Mantione USAID/Liberia/Pakistan/LAC/DR
J. Riggs-Perla, USAID, Swaziland/AFR/DR
T. Tiffany, USAID, Jamaica
M. Laskin, Regional Development Office/Caribbean
J. Russell, USAID, Haiti
J. Massey, USAID, Honduras
J. LeSzar, USAID, India
L. Lion, USAID, Guyana

Persons Interviewed (Continued)

Educational Development Center (Boston)

C. Meyers
I. Fajardo

John Snow Inc. (Boston)

B. Hirschorn

Management Sciences for Health(Boston)

J. Montague
P. Rousselle

The Population Council (NYC)

S. Robbins
E. Churchill
V. Slade
G. Brown
J. Bausch
J. Frank
H. Hoogenboom*

UNDP (NYC)

S. Kurobe

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* Presently with Association for Voluntary Sterilization

PROJECTED AND ACCOMPLISHED OUTPUTS

ADSS

October 1, 1979 - May 31, 1981

Source: APHA

Promotional Information and Education

PROJECTED AND ACCOMPLISHED OUTPUTS

Contract #AID/DSPE-C-0053

ADSS

Information Packets

		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	NOTES
Contract language:														
6 per year	Year 1:	●		●		●		●		●		●		#8-#13
	Year 2:	●		●		●		●		o		o		#14-#17
	Year 3:	o		o		o		o		o		o		

o planned
● accomplished

5/31/81

20 months into contract

PROJECTED AND ACCOMPLISHED OUTPUTS

Contract #AID/DSPE-C-0053

ADSS

Salubritas Newsletter

		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept	NOTES
Contract language:														
4 per year	Year 1:	●			●			●			●			Vol. 4
	Year 2:	●			●			●			o			Vol. 5
	Year 3:	o			o			o			o			

o planned

● accomplished

5/31/81

20 months into contract

PROJECTED AND ACCOMPLISHED OUTPUTS

Contract #AID/DSPE-C-0053

ADSS

Conferences

Output	Quantity		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
In collaboration with AID	1 per year	Year 1:		o[1] Water and Sanitation										
		Year 2:	Asia Region: Administrative and management reforms for PHC; manpower training & utilization issues; infectious disease control											
		Year 3:		o	o Africa Region: Water and sanitation; PHC and community participation; training of non-professionals; oral rehydration				o LAC Region: Administrative and management reforms; national health information systems; community participation; water and sanitation in PHC programs					

o planned

● accomplished

5/31/81

20 months into contract

[1] Prepared, but cancelled by AID

PROJECTED AND ACCOMPLISHED OUTPUTS

Contract #AID/DSPE-C-0053

ADSS

Conferences

Output	Quantity		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
In collaboration with other donors	1 per year	Year 1:												
				With WHO & UNICEF in Calcutta: PHC Implementation			●							
		Year 2:								● With PAHO in Quito: EPI (Spanish)			o With PAHO in Kingston: EPI (English)	
		Year 3:			o With WHO & SHDS in Abidjan: Management									

o planned

● accomplished

5/31/81

20 months into contract

PROJECTED AND ACCOMPLISHED OUTPUTS

Contract #AID/DSPE-C-0053

ADSS

Conferences

Output	Quantity		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Workshops	2 per year	Year 1:					● LAC: CHWs (with WHO)							
		Year 2:	● Africa: Financing (with WHO)							LAC: PHC strategies (with CARICOM) ●				Near East: PHC interventions o
		Year 3:			o Asia: PHC interventions for field workers								o Asia: MCH -- Role of nutrition and family planning	

o planned

● accomplished

5/31/81

20 months into contract

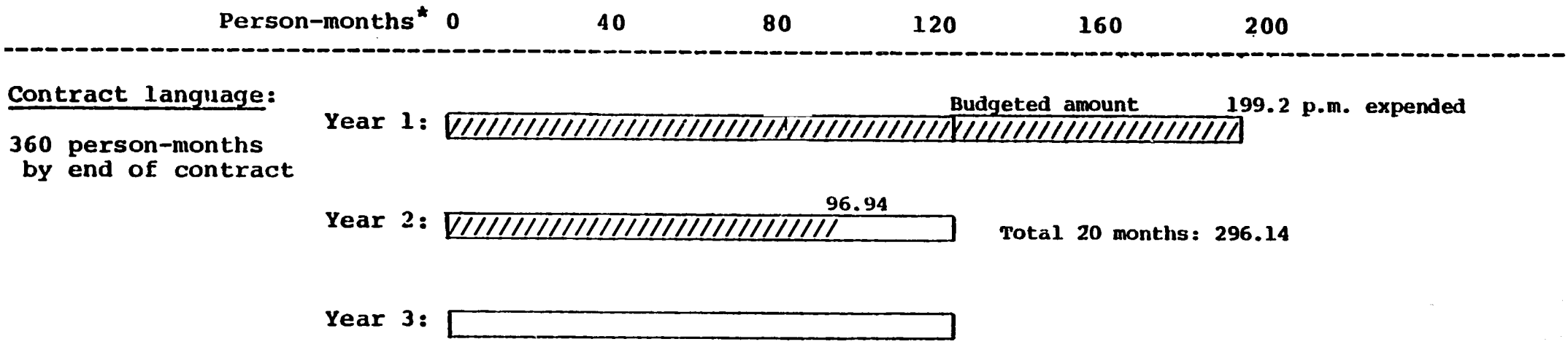
Technical Advisory Services

PROJECTED AND ACCOMPLISHED OUTPUTS

Contract #AID/DSPE-C-0053

ADSS

Technical Advisory Services



person-months expended

* figures not absolute

5/31/81

20 months into contract

Evaluation and Special Studies

PROJECTED AND ACCOMPLISHED OUTPUTS

Contract #AID/DSPE-C-0053

ADSS

Tracking of Aid-Assisted Projects

Output	Quantity		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
racking Report	Initial five-volume report plus two annual updates	Year 1:												● Asia
		Year 2:	● LAC	● Africa	● Near East				Analytical		● Summary			o Update
		Year 3:												o Update

o planned

● accomplished

5/31/81

20 months into contract

PROJECTED AND ACCOMPLISHED OUTPUTS

Contract #AID/DSPE-C-0053

ADSS

"Global Review" Issues Papers

Output	Quantity		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
Issues Papers	Not stipulated	Year 1:							Simplified Information Systems				CHW Functions	
		Year 2:					Overview	Immunization			Local Financing	Training CHWs		Comm. P
														Health Communications in PHC
								Motivation and Incentives for PHC Workers						
		Year 3:				Supervision of CHWs			Referral Systems & PHC		Logistics & Supply of Commodities			Water & Sanitation Part of PHC

o planned

● accomplished

5/31/81

20 months into contract

PROJECTED AND ACCOMPLISHED OUTPUTS

Contract #AID/DSPE-C-0053

ADSS

Special Studies and Workshops

utput	Quantity		Oct	Nov	Dec	Jan	Feb	March	April	May	June	July	Aug	Sept
ecial Studies Workshops	Not stipulated	Year 1:												
									Report AID Africa Health Officers Conference					
		Year 2:	Comm. Part. Workshop											
								Methodology for Assessing Comm. Part.			Weighing Practices and Weight Charts			
		Year 3:												
					Resource Generation for PHC					Lessons from Small-Scale PHC Programs for Expanded or National Level Programs				

o planned

● accomplished

5/31/81

20 months into contract

Additional Sources/Information Desirable Under ADDS or from AID*

1. Information on U.S. and Third Country training programs, both degree and non-degree.
2. Inventories and copies of training materials used in AID and non-AID programs, especially for community-level health workers.
3. Inventories and copies of audio-visual materials used in health education programs.
4. More "how to" operational papers, e.g., responses to disasters, cold chain, vector control.
5. Reference materials and journal subscriptions.
6. More opportunities to communicate with other AID officers, e.g., observation, study tours similar to those funded for host country nationals.
7. Opportunities for continuing education and training.

* Compiled from interviews with ten USAID staff having recent Mission health officer field experience: July 1981, Washington, D.C.

ISSUES PAPERS PROGRESS

Nine stages of development guide the preparation of the issues papers:

1. identification of topic
2. development of outline
3. selection of specialist
4. technical working session
5. data collection and analysis
6. completion of first draft
7. internal review and revision
8. external technical review and revision
9. delivery to AID for distribution

Status of ten chapters in the global review as of March 31, 1981:

Chapter	Title	Stage of Development
I	Overview of Progress in Primary Health Care Movement	9
II	Immunizations in Primary Health Care	9
III	Local Financing in Primary Health Care	8
IV	Community Participation in Primary Health Care	5
V	Simplified Health Information Systems in Primary Health Care	6
VI	Community Health Workers Functions in Primary Health Care	5
VII	Training of Communit Health Workers in Primary Health Care	6
VIII	Trends and Alternatives in National Health Financing	on hold
IX	Health Communications in Primary Health Care	6
X	Supervision of Community Health Workers in Primary Health Care	on hold

Number and Percentage of Minority, Third World & Female Consultants
10/1/79 - 5/31/81

		AID Selected				APHA Selected				Total
		Population		Health		Population		Health		
		Number	%	Number	%	Number	%	Number	%	
Total Consultants	-	95		90		65		21		271
Females	-	15	16%	20	22%	37	57%	6	29%	78 (29
Minority	-	2	2%	3	3%	8	12%	0	0%	13(5
Third World	-	7	7%	4	4%	12	19%	1	5%	24(9

APHA was asked to select only 2 teams of three or more for health assignments. (For each of these assignments we had approximately one week's notice before team was in the field. APHA was asked to select 11 teams of three or more for population assignments.

Minority and female composition of these teams are:

		Population	Health
Minority Members	-	4 Teams	0 Teams
Third World "	-	6 "	1 Teams
Female "	-	11 "	2 Teams

Growth in Representation in Consultant Registry of Minorities and Women

	Number of Registrants as of 10/1/79			Number of New Registrants as of 03/16/81		
	Female	Male	Total	Female	Male	Total
American Indian	4	2	6	-	3	3
Asian or Pacific Islander	11	42	53	21	53	74
Black/not Hispanic	44	76	120	51	97	148
Hispanic	16	54	70	27	47	74
White/not Hispanic	285	697	982	305	465	770
Not Identified	23	40	63	0	4	4
Total	383	911	1294	404*	669	1073

Total registrants 10/1/79	1294
New registrants 3/31/81	1073
Total in registry	2367

* Since inception of the ADSS contract (10/1/79), the percentage of registrants that are female has increased from 30% to 38%; the percentage of registrants that are minorities has risen from 20% to 28%.

TA Assignments by Contractual Categories

10/1/79 - 5/31/81

The contract specifies that technical advisory services will be used to:

(1) assist AID missions in assessing the opportunity, advisability and feasibility of initiating new HDS, PHC, POP/FP or water supply and sanitation (WS&S) assistance projects,

(2) help governments of LDCs assess their existing health and family planning delivery systems and provide guidance towards restructuring the existing systems aimed at the extension PHC to unserved areas,

(3) evaluate ongoing AID supported projects and activities related to HDS, POP/FP, WS&S and PHC,

(4) provide expertise in specialized aspects of PHC, HDS, POP/FP and WS&S development and implementation activities,

(5) provide guidance in solving unanticipated problems that emerge during the implementation phase of PHC, HDS, POP/FP and WS&S projects.

Each assignment has been classified by only one category although many could have been classified by two categories.

Category	Population	Health	Total
(1)	18	15	33
(2)	15	12	27
(3)	38	24	62
(4)	20	18	38
(5)	7	5	12
TOTAL:	98	74	172

CONTRACT IDENTIFIED OUTPUTS

Promotional Info & Ed

Info Packets
- AID Staff and Contractors
- 100 - 150 individuals in LDCs
- 6 per year (300 circulation each)
- Evaluation system

Newsletter
- Quarterly, 12 issues, 3 languages (12,000 copies each issue)
- 75% to personnel in LDCs
- Formal Assessment
- Effort not to duplicate other newsletters

Conferences & Workshops
- With AID: 1 per year (total of 3)
- With other donors: 1 per year (total of 3)
- Workshops: 2 a year (total of 6)

Evaluation & Special Studies

Annual Review "State-of-the Art" by March of each year - 3000 copies
- Format required by AID within 3 mos

Technical Reports - (2000 copies each) summarizing special studies

WORKPLAN IDENTIFIED OUTPUTS

I. Promotional Info & Ed

A. Info Packets
- Same as Contract

B. Newsletter
- Same as Contract

C. Conferences & Workshops
- With AID: 3 - 1 in Asia, 1 in Africa & NE, 1 in LA
- With other donors: 3 - 1 Africa, 1 Asia, 1 LA
- Workshops: 2 each Africa, Asia & LA

II. Evaluation & Special Studies

A. Global Review containing:
- 2 special modules for overall review of "State-of the Art" (over life of contract)
- 4 - 6 Chapters (Issues papers) by 9/80
- 9 - 10 Issues papers each remaining contract year
- Consultants to assist in development

B. Special Studies
- 1 by 3/81
- 1 by 9/81

OUTPUTS COMPLETED 7/1/81

Appendix 3

I. Promotional Info & Ed

A. Info Packets
- 16 packets to 113 AID personnel (63 field/
- None to NON-AID LDC personnel
- None to Contractors
- Evaluation questionnaire in packet 14

B. Newsletter
- 6 issues
- 16,539 copies each issue in 3 languages
- 85% to LDCs
- Reader Survey in Vol 5, No. 3 (only one to
- 80 Newsletters received and reviewed by APH

C. Conferences & Workshops
- None with AID held - One being considered for Asia and one for Africa - Fall 81
- Other donors: 2 held, 1 in Africa being exp
- Workshops: 3 held; 1 committed for Aug. 81

II. Evaluation & Special Studies

A. Global Review Issues Paper: 10 topics selecte 8 papers in process; none published

B. Special Studies & Related Workshops:
2 workshops held
1 special study underway (due for publication Aug 81)
1 special study under discussion

C. Annual Reports summarizing progress (AID Projects and others) 100 copies

D. Workshops (2 per year)
- Focused on vital aspects of PHC

E. Data Bank extended from 180 to 350 projects

F. To Accomplish A - E: (1) Track progress of projects, (2) Utilize up to 18 person months of consultants/year (54 pm total)

III. TA Services

- 360 person months of TA services
- Register of 3000 qualified consultants
- Evidence of positive effort to maximize inclusion & utilization of minority groups

C. Tracking Reports
- 4 regional descriptive volumes by 3/81
- 1 analytic volume by 3/81

D. Workshops
- 1 by 9/81
- 2 by 9/82

E. Data Bank - extended to 350 projects
- Records of AID use to be maintained

F. Resource Center to be established

III. TA Services

- Same as contract, plus:
- Program to inform PVOs of Technical Services available
- Associates program to be implemented
- MIS for recruitment activities

C. Tracking Reports - 5 drafts volumes to AID for review, none finalized

D. Data Bank
- 120 projects in computer retrieval form
- 180 projects (data from 1976) not in computer
- Shortened questionnaire designed to update an computerize original 180 projects

F. Resource Center
- Manager hired and assisting project related activities, i.e., consultant briefings, packe bibliographies, etc.

III. TA Services

- 314 person months utilized by 5/1/81
- 2,447 consultants in registry of which 417 femal (increased 30% to 37% from beginning of contract and 326 minority (increased from 20% to 28%)