PDAAN 349
ISN-31942

EVALUATION OF COLUMBIA UNIVERSITY'S OPERATIONS RESEARCH FOR FAMILY PLANNING PROGRAMS COOPERATIVE AGREEMENT

A Report Prepared By:
STANLEY SCHEYER, M.D.
GEORGE CERNADA, Dr. P.H.
MIRIAM LABBOK, M.D.
JACK GANLEY

During The Period:
APRIL 18 - MAY 11, 1983

Supported By The:
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT
(ADSS) AID/DSPE - C - 0053

AUTHORIZATION:
Ltr. AID/DS/POP: 8/23/83
Assgn. No. 582188

TABLE OF CONTENTS

		Page
PREFACE		v
ABBREVIATIONS		vii
I.	INTRODUCTION	1
II.	PROGRAM POLICIES, GOALS AND OBJECTIVES	5
	Specific Activities	5
III.	THE OVERALL PROGRAM	9
	Goals and Objectives of the Cooperative Agreement	9
	Compatibility of CPFH's Direction with AID Trends	11
	Major Conclusions and Recommendations	11
IV.	PROJECT SELECTION, DEVELOPMENT, OPERATION AND EVALUATION	13
	Project Selection and Identification	13
	Project Development	14
	Project Operations and Management	15
	Research	16
	Dissemination of Information, Feedback, Replication	19
V.	TECHNICAL ASSISTANCE	23
VI.	LIBRARY/INFORMATION CLEARINGHOUSE	27
	Conclusions	27
	Recommendations	27
VII.	ORGANIZATION, OPERATIONS AND MANAGEMENT OF THE CENTER	31
	Organization and Structure	31
	Direction	31
	Center Management and Administration	32
	Staffing	32
	Headquarters and Field Communication	34

APPENDICES

Appendix A	Scope of Work for the Evaluation of the Cooperative Agreement
Appendix B	Background on Scope of Work
Appendix C	Site Visit Reports
Appendix D	CPFH Decision Making Process
Appendix E	Project Development Matrix
Appendix F	Population, Contraceptives, and Service Coverage Matrix
Appendix G	Field Workers Training and Supervision Matrix
Appendix H	Evaluation Matrix
Appendix I	Major Findings & Dissemination Matrix
Appendix J	Operations Research Design - Nigeria
Appendix K	Modified Inventory Format
Appendix L	Letter from John Ganley
Appendix M	Cable on Evaluation of Columbia University Assistance to Thailand
Appendix N	Country Expenditures
Appendix O	Suggested Future Research Areas

Preface

This is a report of the formative evaluation of the Family Planning Operations Research Cooperative agreement between AID/ST/POP and Columbia University Center for Population and Family Health (CPFH) conducted by APHA during April 18 to May 11. The evaluation team worked together with the staff of CPFH and AID/ST/POP in a highly positive and constructive manner. Many of the ideas and recommendations outlined in the report were suggested by the Center and the evaluation process served as a catalyst for action.

The Center has carried out and in many instances exceeded the tasks and expectations outlined in the 1979 cooperative agreement. As a result, most of the recommendations in the report focus on the future. These recommendations are being discussed with CPFH and it is the evaluators' understanding that there are no basic disagreements. In many instances the team outlined activities or shifts in emphasis for the Center which will require a clearer future mandate from AID. Although these changes could begin under the current agreement, future agreements must be more specific about priorities and the deployment of resources.

The team's overall evaluation of the Center's activities was very positive. The intent of the evaluation was to constructively identify areas where the program could improve its operations or shift its emphasis and resources toward more timely or higher priority activities. Of major significance were team recommendations that the project should place greater emphasis on the documentation and dissemination of its overall experience to date. The team also recommended a greater degree of definition and standardization in the Center's processes for carrying out its activities.

The team concluded that AID should continue to support the CPFH. The ideas and recommendations outlined in the report are designed to further strengthen the program.

ABBREVIATIONS

CPFH	Center for Population and Family Health
FP	Family Planning
ICARP	International Committee for Applied Research on Population
IEC	Information, Education, and Communication
IPAVS	International Project-Association for Voluntary Sterilization
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KAP	Knowledge, attitude, practices
LDC	Less developed countries
OR	Operations research
ORT	Oral Rehydration Therapy
POPINFORM	Multicenter computerized population information system
POPLINE	Multicenter computerized population information system
TA	Technical Assistance

INTRODUCTION

The intent of the APHA evaluation team's scope of work was to assess the Columbia University Center for Population and Family Health Operations Research Program. Specifically, the team focused on the program's progress in achieving the goals and objectives of the Center's cooperative agreement with AID ST/POP. The agreement (AID/DSPE-CA-0043) was signed in 1979 and the Center is now in the 4th year of a 5 year program. The team was asked to both assess the performance of the CPFH to date and to examine program potentials and recommend needed changes in emphasis, policy and program direction.

The team consisted of Stanley Scheyer, M.D., Miriam Labbok, M.D., George Cernada, Dr.P.H., and Jack Ganley. The team met with AID ST/POP/research staff and other members of the Office of Population on May 18 and 19. They then traveled to New York and met as a group with the CPFH staff. Elizabeth Maguire agreed to attend and participate in the New York discussions. Jack Ganley met separately with the New York staff to examine the Center's administration, and financial and project management.

As the first step, the members of the team met to develop an overall framework for the evaluation. The team's point of departure was the February 18 memorandum from J. Joseph Speidel, M.D., to William E. Paupe, which defines the scope of work for the evaluation of Cooperative Agreement AID/DSPE-CA-0043 (see Appendix A). In addition, the team had available a February 4 memo from James R. Heiby to Elizabeth S. Maguire which addressed the scope of work for the evaluation (see Appendix B). These two documents plus 2 days of discussions with the AID Office of Population allowed the evaluation team to develop a framework for the evaluation. This framework formed the basis for the team's discussions with the CPFH staff in New York as well as for their visits to Sudan, Brazil, and Haiti (see site visit reports in Appendix C).

Evaluation Framework

The evaluation examined the historical evolution of operations research (OR) program goals and objectives from the standpoint of both the Population Office and the Columbia University Center for Population and Family Health. The point of departure was the beginning of the cooperative agreement in 1979, although the Office of Populations Research Division has had previous agreements with Columbia University dating back to 1969. The team examined what has evolved since the current agreement has been in place and the current thinking as to the operations research needs for the future. In examining this evolutionary process, the team took into account several major trends.

First, there has been a shift in emphasis in the past few years from demonstration projects focusing primarily on Asia and Latin America to projects in Africa. Second, the emphasis has shifted to incorporating family planning services into existing public and private systems that deliver human services, both clinical and nonclinical. Third, there is a need, as expressed by some of the research staff, to shift project emphasis from feasibility or demonstration projects limited to community-based or household distribution of contraceptives to broader based delivery systems for FP services, particularly, in conjunction with selective health interventions. Fourth, there has been increased discussion within AID/W concerning the need to shift from feasibility or demonstration projects to quasi-experimental diagnostic or experimental research designs. Given this evolution of operations research program goals and objectives, the team then attempted to define the generic processes the Center has undertaken to achieve them.

Project - Subagreements

The first program area examined was the process by which the Center identifies, selects, develops, manages, evaluates, and disseminates information on new projects.

Technical Assistance

The second program area evaluated was the technical assistance (TA) activities of the Center that are not necessarily related to the specific projects in which the Center is involved. TA was defined as including center research activities that are timely and relevant to the overall family planning service activities within a country.

Library/Information Clearinghouse

The third program area included an assessment of the Center's library/information clearinghouse function and the dissemination of information.

Self Assessment

The final part of the evaluation included an assessment of how the experiences of the Center are analyzed--how the Center collects and analyzes internally the data and experiences from the countries in which it is working and makes this information available to the specific country involved, to the Center staff, and others.

The degree of standardization of the processes outlined above was a consideration throughout the evaluation. This includes the process by which alternative solutions are examined, results are fed back, and modifications are defined while the service project

is being carried out. In all instances, the evaluation assessed how the Center has documented its processes .

The evaluation included an assessment of the Center's management. Jack Ganley examined the Center's administration, financial management, personnel, and field support activities and compared these with an assessment he made 18 months ago.

Finally, the team attempted to assess the capacity of the Center to expand its program efforts, given its present resource base. The ratio of New York to field staff and dollars was examined as well as the level of field effort carried out by the New York staff.

II. PROGRAM POLICIES, GOALS AND OBJECTIVES

PROGRAM POLICIES, GOALS AND OBJECTIVES

The International Program of the Columbia University Center for Population and Family Health (CPFH) has been the major component of AID's Office of Population-Operations Research Program (OR) for 9 years. At present it is in the 4th year of a 5-year cooperative agreement. The purpose of the cooperative agreement AID/DSPE-CA-0043 is:

- To provide support to the Center's program of assistance to developing countries in initiating public and private sector family planning programs and solving operational problems in existing programs. Special focus is on nonclinical, community-based service delivery and serving as a technical resource for programs that involve maternal/child health and basic public health services.

- To provide funding support to implement the Center's operations research, which includes activities carried out through subagreements with other institutions, in testing delivery system components, and otherwise seeking to overcome impediments to more efficient and cost-effective service delivery. Special focus is directed toward urban slum and poor rural areas of Latin America and sub-Saharan Africa, but does not exclude assistance and research in other regions.

- To improve developing country capabilities for evaluation and internal management of program operations research.

Specific Activities

Technical Assistance

The Center will provide technical assistance with the following strategy objectives:

- To respond to needs for short-term technical assistance to developing country (LDC) public or private sector program managers for the improvement of components of family planning delivery systems and the design of new systems. This assistance will concentrate on the areas of information/record systems, experimental design and data analysis, community agent selection and training, public health/epidemiology, management and program coordination, and information dissemination.

- To provide resident technical advisers to national programs in Haiti, Thailand, Peru, Guatemala, and approximately three additional countries, with emphasis on the sub-Saharan Africa region (Anglo and Francophone).

- Both resident and short-term advisers may assist AID/DS and local USAID missions in identifying promising family planning or family planning/basic health initiatives in developing countries, occasionally to entail short-term assistance to local missions in preparation of bilateral programs for community-based service delivery.

- Where possible, the above assistance and research will be coordinated with existing or potential clinical service infrastructure and will be coordinated with other international agencies whose focus is upon clinical services (e.g., IPAVS and JHPIEGO).

Subagreement Support

- The Center will provide subagreement support as follows: To asssume responsibility for support and short-term technical assistance as necessary to programs initiated previously under contract AID/pha-C-1107.

- To develop approximately five new subagreement activities for directly supporting implementation of operations research on family planning or family planning/basic health service delivery. Emphasis will be upon nonclinical, community-based systems with special focus on both Anglophone and Francophone countries of sub-Saharan Africa. The strategy is for these operations research projects to evolve toward programs to be supported by U.S. bilateral or multilateral donor assistance within 2 to 3 years of initiation.

Information and Training

- The Center will provide information and training services as follows: To assume responsibility for technical literature, library indexing and information retrieval in the field of family planning and basic health program evaluation and operations research, to be integrated with the multicenter computerized population information system, POPINFORM.

- To provide occasional short-term and long-term training, at the recipient's headquarters, for developing country technicians in the fields of program design, management, and evaluation, especially as such training compliments other assistance and activities of the recipient in specific countries.

- To assist AID/DS and AID/Africa Bureau in the development of an African regional conference of community-based family planning programs, probably to be held during the 3rd year of the agreement.

- To produce and disseminate (publish or otherwise distribute) results of technical analyses of operations research performed under this agreement and to convene seminars in LDCs, which will bring to the attention of the political and professional leadership the benefits of fertility regulation and family planning/basic health delivery systems.

III. THE OVERALL PROGRAM

THE OVERALL PROGRAM

The family planning operations research program of the Center for Population and Family Health represents a large investment of AID's time and resources over the past 10 years. The Center has made a significant contribution to understanding the complexities of planning, organizing, implementing, and evaluating family planning service outreach projects. This is especially true for the nonclinical community or household distribution of contraceptives. The Center's projects are at various stages of development, and many of the current activities will continue 15 months after the termination date of the cooperative agreeement.

AID should insure the continuity of the projects. The CPFH represents--

- A cohesive group of professionals organized within a major academic institution.
- A multidisciplinary and multilingual staff with a broad base of geographical experience in family planning and health services and in operations research.
- A unique resource in the field of family planning operations research.
- A warm, collegial, hard-working atmosphere with a high level of staff morale.
- A program representing a broad range of family planning service delivery research projects whose findings have been applied to larger programs.

Goals and Objectives of the Cooperative Agreement

The Center has achieved the goals and objectives as defined in the cooperative agreement. The scope of work outlined above is quite broad and therefore difficult to quantify. The Center's accomplishments can be broadly summarized as follows:

- The Center has initiated and secured AID approval for 11 new projects (subagreements) since the beginning of the cooperative agreement. The agreement calls for five.
- The new project activities for the most part have shifted from Asia and Latin America to Africa.
- Nine out of 11 projects have focused on the nonclinical community-based or household distribution of contraceptives.

- Resident advisers are currently in six countries. Before the end of the cooperative agreement, an additional three will be placed in Togo and Burundi.

- Although difficult to quantify, the Center, through its central and resident staff, has provided a great deal of technical assistance. This includes assistance in the design and execution of on the spot minisurveys and analyses to address questions related to a broad range of operational problems in family planning service delivery; integration of family planning services into existing service delivery programs, both public and private; incorporation of community-based distribution schemes into existing health delivery systems; and the development of indigenous operations research capabilities within the countries where they were involved.

- In projects that have been completed or are near completion, the emphasis has been on documentation of results for future application or utilization within the particular country involved. In six countries, the results have been replicated in larger scale projects or the approach has been incorporated into the expansion of an existing delivery system.

- A well functioning library and information/clearing-house has been established within the Center. This unit serves a much broader audience than just the operations research needs of the Center.

- The Center conducts an annual, month-long operations research training program each June. This activity, initially funded by private foundation grants, is now supported under a cooperative agreement with the AID Africa Bureau. The training program has served a number of functions within the Center: The establishment of contacts and relationships between the Center and Third Country (mainly African) leaders and researchers; identification of operations research project opportunities from these contacts; collection and documentation of the Center experience with the OR program to form the curriculum and the faculty of the training program.

This successful training effort plus the initiation of selected short-term in-country training programs in OR (Sudan) have more than satisfied the training requirement of the cooperative agreement.

Compatibility of CPFH's Direction with AID Trends

Since the beginning of the cooperative agreement in 1979, several major trends have occurred in AID's policy, priorities, and emphasis related to the delivery of family planning services. The Center's policy and directions have reflected these shifts and its overall program has been compatible.

- The Center has placed the highest priority on identifying opportunities in Africa consistent with AID's priorities and strategy.

- The Center's projects are consistent with the trend to integrate family planning service delivery into existing delivery mechanisms, public and private, clinical and nonclinical. For example: Women's groups in Togo; cock fights, military, malaria workers in Haiti; The Center's projects have for the most part had a broader service base than family planning, i.e., Oral rehydration therapy, growth monitoring, immunization, etc. This is consistent with an AID trend. AID has placed increased emphasis on quasi-experimental or experimental research designs and models for OR projects. The Center has been responsive to this when appropriate. With the emphasis on Africa, the Center has realistically attempted to design research efforts that are sensitive to and meet country priorities. In many African countries, quasi-experimental or experimental models may not be appropriate. AID recently has emphasized cost-effective analysis in the research design. The Center is in agreement with the emphasis and has carried out cost-effective analyses (e.g., OR activities in Brazil).

Major Conclusions and Recommendations:

The team recommends continued AID support for the CPFH international program in family planning operations research. The team concludes that the CPFH has the capacity to expand its project base. It recommends, however, that equal attention be given to new project development and analysis of the Center's overall experiences to date.

The team concludes that, with minor shifts in new staff or other resources, both can be achieved. This will require some changes in the direction, organization, and structuring of existing resources within the Center.

Our specific recommendations are outlined below. The Center has been and is in basic agreement with these recommendations. The evaluation team's presence served to catalyze a number of Center initiatives consistent with this shift in emphasis.

The CPFH program has been the largest single component of the AID ST/POP overall operations research program since its inception in 1973. The current cooperative agreement in operations research supports financially over 90 percent of the Center's international program. A decision should be made soon on AID's continued support of OR to allow the Center to plan accordingly.

Should AID decide to continue its support of the Center, the next agreement should be more specific in outlining the family planning and operations research goals and objectives and in the allocation of resources for the analysis of the Center's experiences to date.

PROJECT SELECTION, DEVELOPMENT, OPERATION AND EVALUATION

The findings and recommendations that follow relate to the future and to improving the Center's overall operations. These suggestions have been discussed with Center staff, and have catalyzed many of the ideas that staff had already considered. We hope that the team's recommendations will continue to stimulate the thinking and self-improvement process.

Project Selection and Identification

The Center's identification of projects or targets of project opportunity in the past has been based on a number of ad hoc inputs. There appears to be a consensus among Center staff on the factors that should be taken into consideration in selecting new project opportunities. The team recommendation is that the Center formalize the process, clearly defining the criteria used in making a decision on a new project. The Center agrees with this recommendation and has already initiated the process (see Appendix D, CPFH decision-making process).

The critical and analytical capacity of headquarters and field staff should be brought to bear in the selection and development of field projects. The team recommends that a formal mechanism be established within the Center that insures the input of all staff in this decision making process.

At present, the results of AID's Africa country-by-country strategies and analyses of family planning priorities and opportunities are not uniformly communicated to all staff within the Center.

The AID African Task Force on Population and Family Planning has for the past 4 years brought together all the groups within AID that are directly or indirectly involved in population or family planning activities in Africa. It has proven to be an effective means of communicating on a country-by-country basis the total range of activities in Africa. AID's population and family planning program is broad based, with a large number of groups, individuals, and organizations involved in the overall process. The Columbia University CPFH is one of many actors. From time to time representatives from CPFH are invited to participate in AID's internal review process. We recommend that--

- A senior member of CPFH and representatives from all OR contractors be designated to participate from time to time in the Task Force whenever AID conducts comprehensive country-by-country reviews.

- A formal mechanism be established within CPFH for communicating the outcomes of the Task Force or other

important meetings to all CPFH staff (New York and resident advisors).

- CPFH, in collaboration with other OR contractors, plan and develop its country-by-country project activities taking into account the current and future strategies of all actors on the scene.

Clearly, the CPFH is the major actor in AID's FP operations research. As such, it may legitimately be asked from time to time to act in a coordinating and support capacity for all OR contractors.

The annual 1-month training program conducted at the Center currently serves as a means to identify project opportunities. AID should continue to assist the Center to identify key African leaders for participation in this training.

Project Development

In Africa, Center staff has developed a two-phased approach to the development of a project. Having first identified a country that represents a target of opportunity, a preliminary round of discussions occurs among the Center's professional staff and a number of interested individuals and parties within the targeted country. If there is interest in an operational research project, a project document is prepared for review at the Center and AID/W. If approved, a preplanning or development phase is funded. This phase involves a series of discussion and planning sessions to define the details of a service project. The team recommends continued support of this two-phase approach to project design-development and recommends the following modifications:

- The first phase should examine alternate family planning service delivery research projects within a country. Ideally, no prefixed delivery option is promoted. The results of phase I should be the identification and design of a project that clearly addresses issues or questions that are relevant to the particular country at an appropriate stage of policy and program development.

- The Center should develop, in writing, a generic checklist of factors to be considered in defining research goals and objectives, defining the components of service delivery systems, and defining milestones for the implementation of the project.

- The checklist should be detailed and serve as the point of reference for whoever is developing a project. All factors considered critical to a service delivery operation should be identified. For example, the checklist should include a technical review of the

proposed contraceptive delivery process. The CPFH should define and not leave to chance the correct means of providing contraceptives.

- The Center has already begun this definitional process (see Appendix D, CPFH Decision-making Process). It should be organized and structured as a periodic, regular process within the Center.

- This guidance or norm should be analyzed and refined as experience dictates.

- The guidance, once developed, should be made available to everyone involved in the complex process of designing experimental service delivery systems.

Project Operations and Management

This section addresses the role of the Center in the day-to-day implementation and operation of service delivery projects.

Service Delivery Management/Operations

A number of the Center's projects involve carrying out family planning and health service delivery systems that vary in dependency on the Center and the Center's in-country staff to operate or directly support the service operations. As projects shift from mainly village-based or nonclinical community/household distribution of contraceptives to include other service delivery components (oral rehydration therapy, immunization, nutrition monitoring, and others), the complexity of the delivery system increases. To date, the Center has not attempted to develop guidelines or criteria that identify the complex set of generic variables in any delivery system. One of the first steps in solving operational problems is the analysis of the problem itself. In this case, it is the process of defining the essential elements of a service delivery system, the component parts, and the interdependencies and interrelationships of these parts.

It would be useful if the Center would develop a check list of issues and variables frequently encountered in service delivery operations, whether solely family planning or a mix of services. The checklist could be illustrative and not necessarily inclusive. Over time, however, the list should become refined based upon feedback and experience. The checklist would serve as a means of prompting the researcher that a particular issue or operational variable may or may not be important in a particular service delivery project, but it must be taken into consideration. Areas that deserve special emphasis in community-based family planning programs include specifics of family planning delivery, family planning logistics, and field supervision.

The CPFH resident advisers' role varies considerably from country to country. In some countries (e.g., Nigeria) the resident adviser is almost exclusively involved in assisting the country's executing organization operate the service systems. In other countries, this role is more limited and focus is more on the research or analytical aspect of the service project. The roles of the resident adviser and the central (NY) staff should be more clearly defined in relation to service delivery and research, including--

- The administration of day-to-day activities, i.e., logistics, supplies, data collection, personnel, training.

- The analysis and monitoring of the service system. Are the milestones being achieved? Conducting simple short-term analyses to identify problems.

- The definition of alternative courses. If one approach is not working, what alternatives can be considered?

These functions should be carried out for each project. Who is responsible -- resident adviser, central N.Y. staff, or others -- should be clearly defined. In some instances, it may not be possible to invest all necessary roles in one person. The person responsible to assist in project execution may not be able to perform the research or analytic functions. As will be discussed in more detail in another section, this would indicate that resident advisers within the country should be experienced individuals with a broad base of technical and management skills as well as analytic and research capabilities.

Research

Reviewing the research component is a difficult task considering its scope, complexity, and diversity and the limited time available to the team. A number of key findings and recommendations, however, seem pertinent. These include:

- OR may be described as representing a continuum from relatively simple demonstration/pilot studies through more complex quasi-experimental and experimental studies. Both AID and the Center need to clarify just what the scope of OR projects includes. In terms of the need to match projects with the actual field situations, a broad definition seems necessary. Such a definition should include a significant portion of an adviser's time, to increase the likelihood that research findings will be used in the program.

- Criteria for matching the existing field project objectives with the appropriate conceptual framework, research design, and methodology need to be listed. The

reason one selects an experimental design versus a quasi-experimental and/or a demonstration project depends upon the purpose of the project and the resources available. To some extent, these can be codified as criteria for selection of a methodology.

- More standardization of some of the basic data collection forms and built-in interim measures to facilitate rapid feedback of results (e.g., minisurveys) for practical program decision-making would be helpful. The present survey instruments vary considerably. With the strong central survey expertise, they could be more standardized, while maintaining flexibility and quality control. The use of flexible modules agreed upon by the staff would be useful.

- More documentation of the process by which a project demonstrates results and the way results are translated into program action (or expansion) is needed. Case studies should be considered.

- Relatively little attention is given, at least formally, to IEC. This area has considerable potential payoff for OR, as Asian countries have demonstrated, and deserves more focus. Possibly outside consultation might supplement the Center's limited technical resources here.

- Where feasible, primary emphasis in recruitment of new field staff should be on finding the strongest combination of field and evaluative experience. Although costs may be higher, these seem marginal to having a senior person at the primary work site. Such senior involvement is likely to lessen field problems and free HQ staff to focus on analysis.

- The flexibility built into many evolving projects needs to be maintained. Less rigorous, fluid designs in demonstration projects permit such modification when the setting changes (or as we learn more about it) and there is more freedom to manipulate variables. This flexibility is especially important when the objective is to convince a program manager or policymaker that it makes sense to carry out a particular approach on a larger scale.

- The hierarchy of design requirements for quasi-experimental designs could be clarified for benefit of future planning. The range of pretest, treatment, posttest through well matched control groups to one-shot interventions (without pretest or controls) should be documented (see Campbell-Staley typology).

- The logical reasons for choosing a particular design over another (project objectives and available resources) or demonstration/ pilot over experimental design ought to be documented. These relate less to program design, per se, and more to the setting and previous experience of a project or program with similar hypotheses, uniqueness of the intervention proposed, extent to which policy changes are to be affected by results, etc. These factors lend themselves to codification of criteria affecting choices:

- The recent checklists for identification and selection of a research project developed at the Center should be shared with field staff and expanded upon in light of experience to date.

- Project research objectives need to be stated more explicitly and revised to suit evolving situations.

- Periodic assessments of ongoing projects should be scheduled. Presently there is much informed discussion, but a formal assessment would enable the Center to focus more of its technical talent on a single project at a time.

- Project objectives need to be specific in relating to local transfer of program design, management, and problem-solving skills. This suggestion should appear in the HQ and field staff scope of work in relation to a stronger training orientation.

- The use of minicomputers in the field may help with data processing and analysis, particularly in terms of expediting reporting of interim results. Limitations to their use, however, and the need to retool operations may delay feedback of results during the transition period.

- In addition to the suggestion to increase both formal and informal training (i.e., June and in-country courses) to increase technology transfer, thought should be given to the development of minicourses. Examples include hypothesis development and experimental design, developing a survey instrument, sampling techniques, family planning update, and dealing with specific problems in family planning. These could be used for minisessions, add ons, or for distribution to the field as guidelines.

- Appendix O discusses possible research areas that AID may wish to consider for inclusion in future OR activities.

Dissemination of Information, Feedback, Replication

With findings becoming available from many projects and being applied in the field, the Center is developing a workplan with particular emphasis on documentation and dissemination. At this stage of the cooperative agreement, this plan should receive high priority.

The team recommends that this internal review of existing staff resources consider specific allocations of time and minor organization adjustments and shifts of resources to meet these needs. Specifically, it is recommended that --

- The present project monitor arrangement be adjusted to better concentrate headquarters staff talents on categorization of findings, analysis, synthesis, and documentation. This would mean having part of most headquarters technical staff time allocated to one or more subject analyses (in addition to the continuing single project monitor). The purpose would be to concentrate more energy, interdisciplinary expertise, and effort into getting results available within the next year.

As part of this assessment, the team asked the staff to develop a series of matrices to outline the experience of the Center in each of the areas outlined below. In each matrix, the countries and projects are listed on the vertical axis and the project activities are spread on the horizontal axis. A list of matrices developed includes the following (see Appendices E-I): Stages of project development; populations, contraceptive and service coverage; field workers training and supervision; type of evaluation; major findings/application and dissemination of findings.

The matrices illustrate the beginning of an ongoing process of analysis, in which the Center builds on its overall experience. The team recommends that review and assessment of the Center's overall experience is timely and should be carried out as part of the Center's regular activities. Increased emphasis on the analysis of Center projects and components should be part of any future agreement between AID and the Center. The Center's overall experience in the area of service delivery is extensive and should be documented. It should prove quite useful to those involved in the future design and operation of service projects.

- HQ and field staff should continue to develop matrices to view the ongoing OR projects. Special attention should be paid to cross-project synthesis of findings: both process and content.

- Research findings and the way they have been applied should be set forth in a simplified format to meet particular audience needs (which still need to be identified). Recently the Center has developed both a one-page matrix (see Appendix I: Major Findings/Application and Dissemination of Findings by Project) and a longer (4-10 pages) summary description (see Appendix J on Nigeria, attached). These are well done but need circulation outside the Center. A more comprehensive but simplified summary adapted from Cuca and Pierce's Experiments in Family Planning is recommended as another model for reaching busy administrators with an inventory of all projects (see sample attached as Appendix K, Modified Inventory Format).

- Larger scale sample KAP and pre and post surveys ought to have standardized modules where possible. HQ could help on a cross-project basis. It seems important, though, to integrate in-depth probing of critical issues, e.g., learning not just that people know about a contraceptive method but precisely what they know about its advantages and disadvantages. References in some materials and in the field tend to overemphasize knowledge levels about contraception rather than precisely what is known about it. The latter has far more programmatic implications.

- A checklist for research utilization might be developed based upon analysis of the process by which OR project findings are integrated into wider program activities. There is likely to be considerable commonality across projects as well as individual differences regarding obstacles and facilitating factors.

- Consideration should be given to documentation of the process involved in the identification, selection, and implementation of a field project. Such writing would take the form of a case study. Objectives might be to clarify the flexibility needed in ongoing ORT, the need for sufficient lead time in the field prior to implementation of an OR project, or the essential role of the OR adviser in general advisory capacities.

- To carry out the above recommendations, serious consideration should be given to the expanded use of outside consultation where the Center feels it is needed. The development of a case study, for example, lends itself to such outside involvement.

- Although, projects such as these will vary in many ways, process standardization in some way would clarify the lessons learned. Certain elements could be chosen for standard reporting in quarterly reports, e.g.,

supervision plan, changes, successes/failures, curriculum development, depth, trainers, pre- and posttest of various level personnel. As with family planning, one would not wish to give too many tasks to be learned at once. Therefore, one or two elements might be chosen in June to be utilized for a year and then the experience assessed.

- The recently initiated working papers series should be continued and be oriented towards sharing family planning specifics as well as elements of programming.

- Media presentations could be developed for specific projects. The presentations could be used for both in-country and external information exchange. Such presentations should be supported by in-depth information on family planning, supervision, and logistics.

- The June 1-month training programs conducted anually by the CPFH have been the most organized and structured means to date for the Center to synthesize findings and documentation of projects. The development of the curriculum and bringing together the field and Center staff as instructors has provided a great deal of cross-fertilization. The training program should be continued.

V. TECHNICAL ASSISTANCE

TECHNICAL ASSISTANCE

The Center has six persons in the field in an advisory capacity in six countries, with three others scheduled to be added. These are a vital component of the program's delivery system and as such deserve special attention since they are involved in selection, design, implementation, and analysis of OR. Furthermore, they are the major source of transfer of evaluation and management skills to local counterparts.

Overall, these field placements are in line with contractual requirements and growing emphasis on Africa (three of the six field positions). However, there are some improvements the Center should consider. These include the following:

- Plan to recruit the most talented and experienced staff for future field assignments. Concentrate as much expertise in the field as now exists at HQ.

- Provide each adviser with as much lead time in the field as possible to be able to preplan sufficiently so that the OR project meets local needs and can fulfill its objectives.

- Provide criteria to advisers for selection, implementation, evaluation, and documentation of OR projects so that formal checklists are available to help structure approaches.

- Continue to provide a formal workplan and timetable for field activities. Structure formal periodic reviews.

- Encourage field advisers to expand their role to include general advisory help. Such expansion increases the likelihood that OR projects will get integrated into larger program development.

- Recognizing the constraints in identifying counterparts, develop specific objectives and timetables related to transfer of technical OR analysis and management skills to local counterparts. The selection of field advisers with training capability would also be helpful.

- Make it clear that field advisers need to integrate interim evaluations and more rapid feedback into projects

- Set clearcut expectations for advisers about reporting requirements and standardization, where possible, which include both content and process documentation.

- Recruit more senior advisers (on a level similar to Brazil, Thailand, and Haiti). The costs of filling all the present junior advisory positions with senior persons would be marginal and could greatly increase the prospect of having results of OR used on a larger scale. It also would cut down on HQ travel time (see Appendix M).

- Explore the possibility of working with other agencies in a country (e.g., Pathfinder) to place a general resident TA adviser who might consult on all evaluation and research projects funded by outside agencies as well as OR under this contract. Such coordination could expand application probabilities and eliminate overlap of projects.

- Make greater use of field advisers to visit geographically proximate countries to assess research opportunities rather than rely entirely on headquarters staff.

- Build in more opportunities for fellowship study for local counterparts to increase local incentive for cooperation and develop local resources.

- Allow sufficient lead time in the field to adequately assess the potential of implementing a particular OR study.

- Encourage field advisory staff and counterparts to meet on some regular basis in the field and on a geographic basis (e.g., Africa). This exchange of OR experience on the ICARP model could provide valuable stimulation and exchange of learning.

- Reorganize the present HQ field support model. HQ staff with technical skills should be available to field projects/advisers on a cluster basis. Such a model of support would supplement the present monitor/project arrangement or replace it. This seems particularly important to increase analysis and written production at this stage (see organization section).

- Managing an OR project in the field without also having access to key agencies to influence the utilization of research results in program expansion is a serious disadvantage. The broader technical assistance the adviser can offer, the more likely the expansion of results. The degree of TA will vary but certainly ought be in the 25 percent of time range.

- Synthesize findings of OR work and their relationship to other OR projects conducted by other groups. This may

involve a broader mandate than the present cooperative agreement but seems a logical outgrowth of the overall project. The state of the art -- what is known about what works and what does not and how and where -- needs to be synthesized so that future OR projects and national programs can incorporate new findings.

VI. LIBRARY/INFORMATION CLEARINGHOUSE

LIBRARY/INFORMATION CLEARINGHOUSE

The library was mandated under the project agreement to assume responsibility for technical literature indexing and information retrieval in the field of family planning and basic health program evaluation and operations research, to be integrated with the multicenter computerized population information system, POPINFORM. Activities have included participation in the development of a thesaurus of family planning terms for indexing purposes; providing library services for the department and public health student body; and development of POP FAM ALERT, which is sent to selected AID/W staff, AID missions, field staff, and past attendees at Columbia training programs.

The library has been very active in document acquisition, indexing and abstracting, computer searches, and circulation of materials as shown in table 1. Of all searches, 15.6 percent are for U.S. requests. This includes students, staff, and others; 84 percent are in response from LDCs and international agencies. Furthermore, the trend has been to increased service to the field, as demonstrated in table 2.

In general, the library supports and is responsive to teaching activities of the entire CPFH within and outside the project. It also serves the student body by providing one free search and other library services. Monies for these activities are funded out of separate grants. In addition, free services are provided to the Population Council in return for their contributions to the Index. Moreover, the librarian provides technical assistance to other libraries. Therefore, the responsibilities and functions of the library and its staff are broader than the stated mandate in the cooperative agreement.

Conclusions

Although the evaluation team did not include library specialists, an assessment of this facility was attempted. It is a well run, well utilized unit serving the CPFH and related personnel. The librarian pointed out areas that could use additional support, including improved cataloging procedures; the possibility of annotated institutional memory, such as that proposed by Linda Leonard of JHU; and technology transfer to relevant libraries. At present, the emphasis is on a general library service in primary health care and family planning and indexing materials for POPLINE.

Recommendations

- There is a need to actively coordinate library support activities for AID-funded OR projects. Each institution seems to concentrate in separate areas within its family

planning library.For example, at CPFH there is a heavy concentration on primary health care, while other family planning operations research projects emphasize other areas.

- AID may choose to initiate an evaluation leading to some design for better coordination of all AID-funded library programs. Such an expert evaluation could assess the appropriateness of CPFH library documents, services, and users in relation to its mandate. This group could address the completeness of the coverage of all aspects of OR and family planning in the various facilities.

- A library facility for operations research is necessary for appropriate function of AID-funded OR contractors and should be made readily accessible to all, no matter where it is located. Therefore, it is recommended that any AID-funded OR cooperative agreement or contract include funds for accessing such a facility, including computer access (i.e., POPLINE) and funds for mailing significant numbers of documents. Over 80,000 exposures have been provided on request in 1982-83 and in 1982, CPFH provided 41.5 percent of all POPLINE documents requested.

Table 1. CPFH Library Activities

Item	Fiscal Years 1978/79	1979/80	1980/81	1981/82
Acquisitions				
Mono	308	302	228	301
Journals	1,131	1,173	1,468	1,451
Indexing/abstracting	1,192	1,512	1,731	1,808
REF: computer searches	315	320	909	1,616
Circulation	62	163	322	386

More than 3,000 books, 182 serials, less than 16,500 documents (April 1983).

TABLE 2 Computer Searches Provided and Geographical Distribution of Requesters, 1982

Month	Total	Other U.S.	N.A.	Asia	Africa	Europe	Latin America	International Agencies
January	111	21		54	18	2	10	6
February	109	15	1	56	14	1	7	15
March	174	26		74	35	8	16	15
April	164	15		78	35	7	15	14
May	124	11		60	21	2	7	23
June	208	24		89	54	6	21	14
July	214	74	2	78	24	9	13	14
August	148	20		73	33	3	9	10
September	224	44	2	94	58	6	31	9
October	186	17		78	38	8	20	25
November	163	15		89	33	5	18	3
December	214	35		101	44	4	27	3
Totals	2,059	317	5	924	407	61	194	151

SUMMARY BY AREA:
U.S. = 317 (15.4%)
Other North America = 5 (0.2%)
Asia = 924 (44.9%)
Africa = 407 (19.8%)
Europe = 61 (3.0%)
Latin America = 194 (9.4%)
International Agencies = 151 (7.3%)

VII. ORGANIZATION, OPERATION AND MANAGEMENT OF THE CENTER

ORGANIZATION, OPERATION AND MANAGEMENT OF THE CENTER

The preceding sections have addressed the major functional areas of the cooperative agreement. This section discusses how the Center organizes, structures, directs, and manages its overall program.

Organization and Structure

The Center's plan to emphasize analysis, synthesis, documentation, and dissemination needs to be clearly identified as a major component in the scope of work of each staff member.

The team recommends that an organizational matrix be developed that defines staff responsibility for geographic or project monitoring responsibility as well as specific content areas where the Center wishes to set norms and document its overall experience. For example, staff person x has responsibility to (a) monitor the Sudan project and (b) define guidelines and monitor how contraceptives are used in each project. Staff person y has responsibility to (a) monitor the Burundi project and (b) develop the guidelines and TA for the field application of microcomputers in all projects.

The quarterly work plan and timetable should be expanded to include these combined staff functions. It should include, a scope of work for field and HQ over the next year; an inventory of the findings and their applications; a list of lessons learned and implications for future projects; documentation of the process by which projects are identified, selected, developed, managed, and implemented; a cross-project synthesis of findings and application, and possible model building; methods by which these lessons are being documented and will be disseminated; extent of transfer of technical knowhow in management and analysis to local counterparts; the need for continuing these projects beyond the term of the present contract, and the prospects for bilateral or multilateral support; and likely new projects that have evolved from this work, which could be carried out beyond the term of the present contract by Columbia.

Direction

The Director of CPFH, Dr. Alan Rosenfield, has a high level of interest in and dedication to the activities of the operations research cooperative agreement. He is accessible to the New York staff and provides experience, stature, and overall program direction. Much of the credit for the high level of staff morale, sense of purpose, and professionalism is a result of his leadership.

The authority and the responsibility for carrying out the day-to-day activities of the project should be more clearly

defined. Over 90 percent of the Center's international programs are supported by the OR cooperative agreement with AID. The Center director should clarify in writing the role of the director of the international program. The international director's authority and responsibility must be clear in relation to an agreed upon work plan, assigning staff responsibilities and in monitoring overall staff activities.

Center Management and Administration

The management and administration of the Center was evaluated by Jack Ganley during a 2-day visit to New York. His full report is included in Appendix L. Ganley observed significant progress and improvement since his previous observations 18 months ago. The significant changes are as follows:

- The progressive increase in direction provided by Don Lauro.
- The addition of a well qualified business manager familiar with AID (Pat Baldi). She has recently introduced systems to monitor project resource allocations and expenditures independent of the university accounting system.
- The addition of an experienced, full-time project support person (Tom Hardy) has significantly improved the Center's logistical and administrative support to overseas projects and staff.

These trends are positive and should continue to be strengthened. As stated above, clear definition of authority and responsibility for each position should be developed.

It is the opinion of the evaluation team that Don Lauro, Tom Hardy, and Pat Baldi represent a strong management team, and they are capable of carrying out the organizational and structural changes recommended above.

Staffing

The majority of high-level expert staff are located centrally. This is appropriate only if active communication is maintained to and from field projects. Furthermore, this structure demands that central staff be extremely supportive of the field staff to provide backing and give field personnel a sense of accomplishments. As more emphasis shifts to documentation, analysis, and reporting, the relative roles of HQ and field staff will need specification. Plans could include having a single person in charge of technical matters. Some suggestions follow:

- In some situations, staff with strong writing skills may be needed, especially where the present interaction of field adviser, local counterparts, and HQ project monitor is not producing written materials.

- HQ should consider separating logistical and administrative field requests from technical assistance. Possibly, one way is to have a single person responsible for logistical matters and another for technical support. In general, however, the HQ is viewed as providing rapid and effective field assistance.

- To implement the above, another person with a strong OR technical overview may be needed to coordinate and direct technical support. This may be important to help synthesize present findings, assess potentials, and plan for the future.

Getting field staff back to HQ at completion of assignment should be encouraged whenever possible. At a minimum, a more active effort to recruit field staff when HQ vacancies occur would help.

When situations arise where special technical skills are needed, the Center ought to consider the expanded use of outside consultation. An individual with skills in evaluation of IEC, training, and field program logistics would be a valuable asset to the present staff.

The ratio of core support cost at HQ compared with in-country cost is not easy to determine, as some field projects have multiple funding sources. The ratio does seem reasonable, although a case could be made that in the future additional field projects could be supported without increasing the central staff.

Incentives for getting HQ staff into the field in future resident adviser capacities need to be explored. Such inputs could increase the potential for field success and revitalize the Center when staff return from the field.

HQ staff need to define the position of senior adviser. Confusion now exists as to what is senior and what is junior; criteria should be specified. How does a junior staff person become senior?

Prospects for developing a consortium or loose arrangement of individuals in the field doing OR work should be assessed. An arrangement along an ICARP model might help the transfer of experience not only to local counterparts but also advisers.

A useful supplemental technical advisory resource for the Center to draw upon in the future might include a continuing

consultant bank on OR selection, design, implementation, analysis, and dissemination.

Headquarters and Field Communication

The shift to Africa is becoming more evident. Approximately half of the HQ backup technical staff now concentrate on Africa (Togo, Tanzania, Nigeria, Burundi, Sudan, Egypt, Senegal). Of seven field staff (six paid under the OR cooperative agreement), three are full-time residents in Africa. This shift is clearly in concert with AID's policy, although there ought to be careful consideration of the limitations in terms of potential replication of projects on this continent and in some countries.

As in all such relationships, the quality of interaction between field and HQ can be improved. Technical logistical support to the field could be improved. One simple improvement would be a single person to handle all field requests who would give these highest priority (e.g., finding needed articles).

Higher priority should be given to HQ expediting of field requests. A simple basic OR related library for each adviser and counterpart in the field would be helpful. There are a dozen or so books that would be useful references for regular use.

Frequently the resident staff needs assistance from a higher authority to say no. HQ staff need to learn to play the role of the contract enforcer and "bad guy" when appropriate or when needed by local resident advisers.

Ways to incorporate field staff more in critical decisions about choices of countries, projects, etc., need to be developed. HQ and field staff need to outline a coordinated plan for systematic transfer of analytical and managerial skills to local counterparts. HQ support for training should be tailored to local needs.

APPENDIX A

February 8, 1983

MEMORANDUM

TO: S&T/HP, William E. Paupe

FROM: S&T/POP, J.Joseph Speidel, M.D.

SUBJECT: Scope of Work for the Evaluation of Cooperative Agreement AID/DSPE-CA-0043

I. Project Title: Operations Research for Family Planning Programs

A. Project Number: 632-0632
B. Cooperative Agreement Number: AID/DSPE-CA-0043
C. A.I.D. Project Manager: Elizabeth Maguire/James Heiby, S1/POP/R

II. Contractor: Center for Population and Family Health (CPFH), Columbia University
Principal Investigator: Allan Rosenfield, M.D., Director, CPFH

III. Purpose of the Evaluation:

The five-year Cooperative Agreement with Columbia University to provide technical assistance and financial support in operations research for family planning programs ends June 30, 1984. While the funding document does not specify that a mid-term evaluation must be held and while the overall quality of activities being supported under the Cooperative Agreement is considered satisfactory, it is felt, nevertheless, that an in-depth outside technical review would be of value not only to assess performance to date but to outline operations research priorities and future program directions.

The principal objectives of this evaluation are to:

- assess the progress achieved in fulfilling the Cooperative Agreement objectives

- provide recommendations for improvement/modification in grantee activities (management, staffing, technical assistance, project design and implementation, evaluation and dissemination of results)

- make recommendations concerning the appropriateness, size and scope of a follow-on agreement.

IV. Evaluation Procedure:

A three-member team will spend approximately three and one-half weeks evaluating the activities supported under the Cooperative Agreement. The agenda will include: examination of program documentation, records and reports; interviews with AID/W and USAID personnel; in-depth discussions with the CPFH staff in New York and overseas; on-site observation of project activities; and discussions with host country officials. It is expected that team members will visit Brazil, Haiti, Nigeria and the Sudan - countries with large ongoing operations research projects and CPFH resident advisors. In each of these countries, there has been a substantial investment of staff time and resources since the beginning of the current Cooperative Agreement.

Following the overseas visits and additional discussions with CPFH staff in New York, the team will prepare a preliminary report on its findings and recommendations to be presented at an AID/W debriefing.

Background documentation made available to the team will include the results of independent assessments of two aspects of the CPFH program: (1) administrative and financial management (reviewed by a consultant spending 1-2 days in New York), and (2) general technical assistance provided by the CPFH resident advisor in Thailand (reviewed by the USAID population officer). These assessments will be conducted several weeks prior to the convening of the three-member team.

V. Proposed Evaluation Schedule

April 18	Meetings at AID/W
April 19-22	Working sessions at CPFH - New York
April 23-May 1	Country site-visits
May 2	Follow-up discussions in New York
May 3-10	Preparation of report
May 11	AID/W debriefing

VI. Team Composition:

The evaluation team should comprise individuals with a broad range of experience and skills consistent with the activities being carried out under the Cooperative Agreement. The members should have overseas experience in the design and implementation of family planning and maternal and child health delivery systems, broad knowledge of operations research and strong quantitative evaluation skills.

The following individuals have been identified as outstanding candidates to perform the evaluation of Columbia University's Cooperative Agreement "Operations Research for Family Planning Programs":

1. Stanley C. Scheyer, M.D. - Vice-President and Director, Family Health Division, University Research Corporation

An international expert in the organization, financing, delivery and evaluation of family planning and maternal and child health services in the U.S. and in the developing world - with strong program management and research skills, fluency in French and 20 years of extensive overseas experience, particularly in Africa.

2. George P. Cernada, Dr. P.H. - University of Massachusetts

A medical sociologist with strong programmatic and analytical skills and many years of overseas experience, particularly in Taiwan, where he has done pioneering work in family planning operations research.

3. Miriam Labbok, M.D., M.P.H. - Johns Hopkins University

A pediatrician with broad knowledge of operations research in FP/MCH service delivery, expertise in program design and evaluation as well as field experience in community-based contraceptive distribution programs in Morocco and Kenya.

4. John L. Ganley - Deputy Director, Family Health International

A program administrator and financial management expert who was formerly A.I.D. Auditor General. Mr. Ganley conducted an informal review in September 1981 of the CPFH's organizational structure, administrative procedures, intra-office communications and financial controls. During the course of one to two days at the Center, he would conduct an updated assessment of these areas.

ST/POP/R staff Elizabeth Maguire, James Heiby and Richard Cornelius will serve as technical resource persons for the evaluation team.

VII. Estimated Cost of the Evaluation:

Consultant fees, travel and per diem, secretarial and miscellaneous costs will be financed through the A.I.D. Contract with APHA. Preliminary cost estimates total $29,500.

VIII. Project Background:

The Center for Population and Family Health (CPFH) is a division of Columbia University's School of Public Health and part of the Faculty of Medicine's International Institute for the Study of Human Reproduction. The Center directs local community education and health care programs, a large teaching program, an extensive library and statistical unit as well as major international program activities which are supported by grants from A.I.D., UNFPA and private foundations.

The Office of Population's involvement with Columbia University extends over a 14-year period - from a series of task orders during 1969-1975 for family planning program evaluation and extensive library activities, to a four-year contract (7/1/75 - 6/30/79) and a five-year Cooperative Agreement (7/1/79 - 6/30/84) to provide interdisciplinary technical assistance in operations research for family planning programs.

The Center for Population and Family Health was awarded the contract and successor Cooperative Agreement on the basis of sole source, predominant capability in view of its unique multidisciplinary, multilingual staff who have extensive experience in operations research and in the development, implementation and evaluation of innovative family planning/maternal and child health delivery systems throughout the developing world. Indeed, CPFH

activities have formed the cornerstone and principal component of the Office of Population's operations research program since its inception in 1973. The Center's key role in operations research and its strong track record of technical assistance and responsiveness to A.I.D. and host country needs were reaffirmed during the last evaluation which took place in December 1978.

The present five-year Cooperative Agreement has three primary objectives:

(1) To provide assistance to developing countries in initiating public and private sector family planning programs, and solving operational problems in existing programs, with special focus upon non-clinical, community-based service delivery, and serving as a technical resource for programs that involve maternal and child health and/or basic public health services.

(2) To provide funding support to implement operations research ... in testing delivery system components and otherwise seeking to overcome impediments to more efficient and cost-effective service delivery.

(3) To improve developing country capabilities for evaluation and internal management of program operations research, and to improve the availability of information about international experience in family planning operations research.

Over the past three and one-half years, the CPFH has provided technical assistance in family planning and primary health care program design, management and evaluation in a wide variety of developing country settings. New York-based staff undertake frequent short-term consultancies, and resident advisors have been stationed, for varying periods of time, in Brazil, Guatemala, Haiti, Nigeria, Peru, Sudan, Tanzania and Thailand. In addition to these countries, operations research projects have been implemented in Bolivia, Mexico, Peru and Sri Lanka. New projects are pending final approval in Burundi and Togo along with proposals for expanded activities in Nigeria and the Sudan. Operations research initiatives in other parts of Africa and Latin America are also being explored.

Under the Cooperative Agreement, numerous short-term training opportunities have been provided to host country officials - locally and in New York - through the CPFH one-month course, "Family Planning, Nutrition and Primary Health Care in Developing Countries: Program Design, Management and Evaluation" (supported through other funds). Considerable time and resources have also been devoted to the documentation and dissemination of project findings, technical analyses and reports such as the chartbook Family Planning: Its Impact on the Health of Women and Children. Another major component of A.I.D. support to the CPFH is the indexing of technical literature in family planning/maternal-child health program evaluation and operations research, for integration into POPLINE.

ST/POP/R staff have closely monitored the activities supported under the Cooperative Agreement, through regular meetings with senior CPFH staff, participation in project design and periodic site visits to monitor and assess field activities.

IX. Issues to be Addressed in the Evaluation

Listed below are the areas which will be covered in the evaluation along with a series of illustrative questions:

A. Management/Administrative Issues

The evaluation will include an assessment of the internal organizational structure of the CPFH as it relates to the Cooperative Agreement as well as administrative, financial and technical management and budget levels.*

- Are current administrative procedures dealing with personnel, travel, project development, monitoring and reporting, etc., operating smoothly and providing for increased efficiency and timeliness?

- What mechanisms have been established to keep careful track of overall costs and subagreement expenditures as well as future budgetary needs? Is there regular exchange of budget information between technical and financial management staff to ensure effective program monitoring?

- Are there ways in which the secretarial, administrative support and management information systems can be improved?

- Have funding levels been adequate to achieve intended outputs? Has there been a cost-efficient allocation of funds within the Cooperative Agreement total budget, and are overall core support costs reasonable compared to in-country costs and outputs?

B. Staffing Patterns

The CPFH staff, in New York and overseas, represents a broad range of field experience, technical expertise and language capabilities. The Cooperative Agreement draws upon the resources of staff members, contributing varying percentages of time, as well as of outside consultants. The evaluation team will examine, in terms of the objectives and activities of the Cooperative Agreement, the appropriateness of the existing organizational structure, staff expertise/experience and level of effort.

- What future changes, if any, should be made in the number, range of technical skills and experience, and percentage of effort of professional and key support personnel? How much emphasis should be placed on the use of outside consultants?

- Is each staff member able to handle the workload and devote the allotted percentage of time to the Cooperative Agreement, given other responsibilities at the Center/University? Are technical staff allowed sufficient time both to think and write about operations research and lessons learned from the field?

---

* This component of the evaluation will be conducted separately by a program administration and financial management expert.

- Does the present organizational structure provide for orderly delegation of authority?

- Are effective mechanisms being used to monitor and evaluate staff performance?

C. Communications

- How effective are communications: (a) within the Center; (b) between the Center and field staff; (c) with AID/W and USAIDs; and (d) with other population organizations and host country institutions?

- Is there regular exchange of information among senior staff concerning operations research questions, the status of individual projects, service delivery problems and corrective actions, and lessons learned?

D. Technical Assistance

A major component of the Cooperative Agreement is technical assistance in the design, implementation, modification and evaluation of FP/MCH service programs. As mentioned above, this technical assistance is provided through frequent short-term trips, through resident advisors (currently in Brazil, Haiti, Nigeria, Sudan, Tanzania and Thailand) as well as through short-term training. The activities and future role of the resident advisors will be examined by the evaluation team. Other questions to be addressed are:

- How responsive and effective has CPFH technical assistance been to host country officials and institutions, to AID/W and to USAIDs? Has this assistance led to the improvement of program management and evaluation capabilities in target countries?

- Should the CPFH continue to have flexibility, under ST/POP/R funding, to offer a wide range of technical assistance to host country counterparts which is not exclusively related to operations research? Should ST/POP/R continue to support, for example, long-term general technical assistance to Ministries of Health and USAIDs, as is the case in Thailand and to a lesser extent in Haiti?

- Should there continue to be two different types of resident advisors - the highly experienced researcher with a correspondingly high salary vs. the less experienced and skilled field representative who provides more administrative backstopping?

E. Project Development and Implementation

The evaluation team will conduct a careful review of the development process and implementation of projects supported under the Cooperative Agreement, particularly those which are ongoing. Questions to be addressed include:

- How effective has CPFH staff been in identifying and pursuing opportunities for project development and technical assistance, particularly in the priority region of Africa?

- Does the number of operations research projects and technical assistance activities supported under the Cooperative Agreement seem reasonable given CPFH staff and financial resources.

- What is the involvement of senior staff in the project development and review process?

- Do the research proposals adequately describe project objectives, inputs and outputs. Are FP/MCH service delivery problems and appropriate mechanisms to address these problems defined in sufficient detail?

- Has CPFH technical and administrative backstopping served to provide efficient and effective monitoring of project activities? Is there periodic discussion and assessment by senior staff of individual projects?

- Have appropriate and timely modifications been introduced in the design of projects in response to problems identified and/or changing program needs and priorities?

- How much attention has been placed on the transfer of program design, management and problem-solving skills?

F. Project Evaluation and Information Dissemination

The evaluation team will review the timeliness, quality and usefulness of technical analyses and reports. Among the questions to be addressed are:

- Have operations research projects received careful quantitative as well as qualitative assessments?

- What have been the major constraints in data processing and analysis?

- How effective have the different reporting mechanisms been in documenting project development, implementation and findings? Have they provided a useful framework for taking corrective actions as well as for building a solid institutional memory?

- Have sufficient time and resources been devoted to technical analyses and to the dissemination of project findings - through reports, working papers, conference presentations, journal articles, publications and seminars?

G. Library Activities

The evaluation team will examine the activities of the CPFH library and provide recommendations regarding its future role, scope and level of A.I.D. support. One of the specific objectives of the Cooperative Agreement is "to assume responsibility for technical literature library indexing and information retrieval in the field of family planning and basic health program evaluation and operations research, to be integrated with the multicenter computerized population system, POPLINE." The team will review, in particular, the roles of CPFH and PIP (Johns Hopkins University) in this regard and suggest appropriate mechanisms for the future. Key questions include:

- How important have the library's collection, indexing and abstracting activities been to the principal goals of the Cooperative Agreement, i.e., providing assistance in the design, implementation and evaluation of cost-effective family planning/maternal and child health service delivery programs?

- Has the CPFH library been successful in expanding significantly the availability and use of information about operations research and FP/MCH program design, implementation and evaluation?

- How responsive has the library been to requests for literature searches and technical assistance? Has it coordinated and collaborated effectively with other population organizations?

H. Assessment of Program Impact

In assessing the impact of CPFH-supported activities, the evaluation team will address questions such as:

- What contributions have been made under the Cooperative Agreement to operations research methodologies and to issues relating to the design, implementation and evaluation of cost-effective family planning and maternal and child health delivery systems?

- What has been the impact of CPFH operations research projects, technical assistance and information dissemination activities on local, regional and national family planning programs and policies? Have lessons learned from demonstration projects been applied successfully to larger-scale MCH/FP service delivery programs?

- What progress has been made in strengthening local family planning management and research capabilities and in institutionalizing operations research in target countries?

I. Future Directions

Based on its overall assessment of the Cooperative Agreement with Columbia University and its role in A.I.D.'s family planning operations research program, the evaluation team will provide recommendations concerning the size and scope of a follow-on agreement, if such action is deemed appropriate. The team will offer suggestions concerning future program objectives and priorities, commenting on such areas as operations research issues and methodologies to be examined, service delivery interventions, program management and evaluation tools.

X. Reference Documents

A. Cooperative Agreement AID/DSPE-CA-0043 and Amendments

B. Annual Reports (1979-80; 1980-81; 1981-82)

C. Project Summary Notebooks, including trip and progress reports and other documentation

D. Working Papers, publications, presentations

42

E. Selected correspondence and memoranda

F. Operations Research Project Paper

G. R. Rochat, C. B. Park and G. Turner, "Operational Research for Family Planning Programs with Columbia University's Center for Population and Family Health," APHA, Washington, DC, 1979.

H. R. W. Osborn and W. A. Reinke, eds., Community-Based Distribution of Contraception: A Review of Field Experience, The Johns Hopkins University School of Hygiene and Public Health, January 1981.

Recommendation: That you approve the scope of work, as outlined above, for the evaluation of the Cooperative Agreement "Operations Research for Family Planning Programs" with Columbia University.

Approved: _____

Disapproved: _____

Date: _____

Clearances:

ST/POP/R, JDShelton (draft)
ST/POP, DGGillespie (subs)
BCase _____
ST/PO, FCampbell _____
KMilow _____
GEaton _____

Drafted by: ST/POP/R, ESMaguire:vle:2/7/83:x59686

APPENDIX B

February 4, 1983

MEMORANDUM

TO : ST/POP/R, Elizabeth S. Maguire

FROM : ST/POP/R, James R. Heiby

SUBJECT: Proposed Sections for the Scope of Work for the Evaluation of the Columbia University Cooperative Agreement

1. Overall Conceptualization of Operations Research

The Cooperative Agreement is studiedly vague regarding the nature of the operations research to be carried out. The state-of-the-art of refining low-cost delivery systems for family planning and health services is quite primitive, lacking well-defined models. The initial focus of the Operations Research (OR) Program, including CPFH projects, was demonstrating the feasibility of strategies usually termed community based distribution and household distribution. These approaches are familiar to the evaluation team.

Recently, in several instances, the Research Division has encouraged the addition of quasi-experimental research designs to these demonstration projects. These two elements require separate consideration.

a. Delivery Systems

The establishment of a low-cost delivery system in a rural LDC setting is a formidable task influenced by a number of variables over which CPFH consultants have limited control and which in many instances could not be predicted by the most careful planning.

With these limitations in mind, the team should assess the delivery systems in the proposed sample of projects, specifically considering the following features.

(1) Design

It is highly desirable that the role of each category of personnel be explicitly defined in terms that are measurable. For service workers, such a definition should describe each desired task in terms of both quality of care and coverage. The role for field supervisors and all higher level service delivery personnel should be similarly defined. The

corresponding training for each category should be included in the design. Similarly, since the objective of operations research is to improve regular service delivery programs, the design should constitute a plausible step towards a large-scale, indigenous delivery system.

(2) Monitoring

The overall effectiveness of a delivery system is the net result of a large number of tasks carried out by a sizeable number of people, even where the number of services provided is small. The practical difficulties involved in implementing even the most detailed plan in a rural LDC setting are well recognized: apparently simple but important tasks may be carried out ineffectually or not at all. A given task may appear to be well implemented on first glance, while a detailed evaluation by an expert may reveal subtle but important shortcomings. Or a component of the delivery system may be carried out according to the design, but prove ineffective, suggesting the need to redesign that element. The evaluation team should examine this central component of technical assistance. Among the chief considerations are the following:

-Problem Identification: In many instances, the local project staff will themselves accurately identify various service delivery problems and bring them to the attention of the CPFH representative. However, it is also the responsibility of the consultant to take the initiative in assessing the various elements of the delivery system. The team should consider the extent to which this process is systematic, including the attention accorded to previously identified problems compared to a random sampling of tasks that are not thought to be problematic.

-Problem Intervention: This is the least well-understood component of technical assistance and one that merits particularly close assessment by the evaluation team. The following should be considered in this analysis:

-Alternatives: Most substantial problems in service delivery are likely to have more than one possible solution. It would be of interest to examine the range of alternative solutions considered for a given problem. The possibilities put forth may reflect a high degree of innovation or may be fairly stereotyped; they may adhere to a realistic concept of what is replicable on a large sclae or tend to rely on the project's special resources.

-Follow-up: It is imprudent to assume that a given intervention will resolve the problem addressed. Repeated assessments and trials of alternative approaches should be applied in the case of persistent problems. When such a difficulty

significantly hinders the project, it would be appropriate to request assistance from the senior CPFH staff of consultants. In some cases, the design of the delivery system itself may require basic modification.

-Use of Local Hierarchy: Since effective problem-solving is one of the most fundamental features of a successful delivery system, the importance of training the local staff in these skills is obvious. Sometimes, time pressures militate for effectively bypassing the staff and resolving an issue directly, but CPFH should still make efforts to transfer the skills involved. The team should also consider the extent to which CPFH makes use of measures other than training and "assistance" to resolve service delivery problems through the project staff, including both incentives and sanctions. They should consider the different ways in which funding authority can be used to support these activities, as well as personnel actions, training programs, awards, bonuses and oral praise or criticism.

(3) Evaluation of Delivery Systems

There is no discrete dividing line between the routine monitoring of a project and its evaluation, but the latter term is traditionally limited to planned, formal studies. Beginning with the earliest demonstration projects carried out under the OR program, large-scale sample surveys to measure the level of contraceptive use at the beginning and at the end of the project were virtually universal features of these efforts. As health interventions became a frequent component of these projects, investigators added corresponding questions to the surveys. None of these measures, however, describe the effectiveness of health-related activities with the precision and relative facility usually associated with contraceptive prevalence measures. This reflects the intrinsic difficulty of measuring health impact. This suggests the need for the evaluation team to consider the appropriate place for these surveys in OR projects relative to alternative evaluation approaches, as well as any modifications of the surveys that seem indicated. The following factors should be weighed in this assessment:

-The methodologies involved in the survey estimation of contraceptive use prevalence are highly refined. The practical application of these data and their contribution to the objectives of the OR program is far more subjective. Large samples provide very precise estimates that can demonstrate moderate increases in prevalence with a comforting certainty. The substantial evolution of the OR program should, however, provoke a re-examination of the need for this expensive precision. The contribution of these measures to the improved cost-effectiveness of large scale service delivery merits explicit comment. Similarly, the traditional survey strategy should be compared to alternative combinations of smaller surveys and increased efforts

to improve service statistics, applying the same standards of practical impact, feasibility, and cost. The evaluation team should also specifically consider the increasingly common situation in which a project has reached the stage where actual transfer of the delivery system to a purely service-oriented organization is the chief objective.

-Most projects have a research staff and budget that is distinct from service delivery elements. The focus of this component has traditionally been on the survey activities discussed above, generally emphasizing the measurement of the impact of the delivery system. These data, however, provide little direct information on how individual elements of the design of the project were in fact implemented, nor do they provide substantial insights into practical ways for improving the delivery system. While one could view implementation as the responsibility of service delivery personnel, there is no apparent reason why the resources of the research staff could not be used to analyze and refine the details of service delivery. In a number of instances, the Research Division has encouraged such efforts, but the field itself is relatively undeveloped and should receive the explicit attention of the evaluation team.

b. Research Component

In contrast to the issues related to the implementation of a given design for a delivery system, the formal research component of OR projects deals with the comparison of alternative designs. Where the implementation of the delivery system is relatively ineffective or where the level of effectiveness is simply not well known, the value of these comparisons is greatly diminished. In practice, a relatively small proportion of project resources are devoted to these comparisons in most cases, particularly where a delivery system must be established virtually de novo under the difficult circumstances of a rural LDC setting. The evaluation team's report should discuss the utility of these comparisons, particularly the potential of selected designs for influencing large-scale service delivery.

2. Documentation

The ultimate value of a project to the cooperating country, CPFH and A.I.D. depends to a large degree on the quality of its documentation. To the extent that the available reports of the project staff and CPFH consultants describe the essential details of the project objectively and thoroughly other sources of information should be largely comfirmatory. The team should assess the overall written record that documents the projects that are examined in detail.

47

3. Standardization

A previous evaluation of the OR program recommended increased efforts to standardize selected features of OR projects. The widely varied circumstances of different projects and the differing priorities of the principal investigators are obstacles to any standardization. The team's report should note any opportunities where uniform practices across projects would be likely to prove both feasible and beneficial.

4. Suggested Methodology of Analysis

Since each delivery system that will be visited by the team is quite complex, the Research Division recommends that the team devote substantial attention to the details of selected elements and issues, rather than limiting their approach to a broad and necessarily superficial overview. The team may assume that A.I.D. monitors are familiar with the overall strategy and history of the projects and concentrate on developing insights into specific issues and forming independent judgements.

cc:

ST/POP/R, JBailey
JDShelton
RMCornelius
ST/POP, DGGillespie
Col U, ARosenfield

43

APPENDIX C

Sudan Site Visit: May 1, 1983

Purpose: To evaluate the involvement of the Columbia University Center for Population and Family Health in Sudan*.

Executive Summary:

The project in the Sudan is generally on target for the major objectives. Dr. El-Tom strongly desires to expand the effort to the new area, and the Sudanese staff are highly motivated and enthusiastical about this.

This evaluation concentrated on the role of Columbia University with the following findings:

1. Research: There should be an effort made to state specific objectives and outline specifics research methodologies appropriate to assessing those objectives during the project planning stages. Once implementation begins it is often too late to carry out this sort of plan.

2. Information Feedback: The expansion phase of the project will be highly dependent on the district health personnel. However, there is not sufficient inclusion of central MOH personnel in the planning stages to assume their active involvement. This might be remedied through development of a review or executive board to meet regularly and receive feedback on project progress. Workshop and religous leaders involvement should continue. Columbia University can play an increasing role in facilitating documentation and developing media presentations to facilitate feedback within the Sudan.

3. Family Planning: Some elements of the services delivered need greater clarification as noted in the text of this report. Columbia University should provide excellent up-to-date technology at all times and should carefully review and monitor all family planning inputs.

4. Logistics: Columbia University should assure careful documentation of the specifics of training curricula commodity logistics and field workers logistics (i.e., pattern of coverage). This documentation would aid greatly in the expansion and would allow for replicability by other regions of the MOH.

5. Technology Transfer: Dr. El-Tom states that he welcomes continued Columbia input in the areas of research, management, and planning. Since these are areas of felt need, every effort should be made to transfer these technologies to Sudanese personnel. At present, Dr. El-Tom is hiring an excellent researcher, but research support, management (especially supervision, logistics and internal evaluation) and planning will be continuing areas of emphasis by Columbia.

   In these areas, as well as in family planning specifics, Columbia University should continue to share its experience and inform point of view on these issues clearly and completely, and where possible follow up with documentation or media tools so that new ideas can be fully considered by the appropriate Sudanese personnel. I found all personnel most welcome to additional information in the area of family planning and logistics and clearly several have benefitted from past training in New York and in the Sudan.

6. Field Advisor: If a mid-level field personnel at mid-level is chosen again (Dr. El-Tom prefers a high-level colleague) every effort should be continued to actively support this personnel. Examples of activities that would aid in this effort include: He/she could accompany Dr. El-Tom and others to technical meetings, should receive support from Columbia visitors during group meetings, and should be given specialized training in a specific area so that technology transfer can occur. The field advisor, whenever possible, should have the role of facilitator/advisor rather than carrying out project administrative functions.

7. Columbia University in general: More effort could be made to continually reexamine the role that Columbia is playing both in this project and in the Sudan family planning effort in general. Dr. Micka feels that competing the Columbia University contract would be fair and would promote a more proper, responsive relationship between all parties, however, at this stage in this project, my feeling is this is an inappropriate time for disruption of activities.

   Conclusions: There is a need for more expeditious collaboration between all parties (USAID/Department of Community Medicine/AID/W/Columbia University) which could be facilitated through a one-time meeting to discuss mutual objectives and set mutually agreed upon

50

self-imposed time lines for approvals/decisions/ evaluation. This evaluation found Columbia University highly responsive and cooperative. An ongoing and perhaps more carefully delineated role in collaborating with the Sudan project and the Sudan in general has good potential.

Attachments

1. Personnel Contacted

2. Field Staff Report, March 29, 1983 - Mr. Haythan Matthews, USAID F.P./POP activities in the Sudan.

3. March, 1983 - Dr. Mary Ann Micka, First Progress Report.

4. April 2, 1983 - Dr. Abdul Aziz Farah.

5. SFCA Special Issue, February, 1983.

52

Introduction and Methods

The concept of the Sudan Community-Based Health Project as it presently exists was originated by Dr. El Tom, Department of Community Medicine, Faculty of Medicine, University of Khartoun in collaboration with Columbia CPFH personnel expecially Dr. Don Lauro and Dr. James Heiby AID/W based on earlier discussions in Sudan including Dr. D. Gillespie. It is supported through a tripartite agreement including the Research Division of the Office of Population, AID/W; the Department of Community Medicine, University of Khartoum, and the Center for Population and Family Health, Columbia University. Funds are dispersed and mointored through the offices of USAID/Khartoum.

The original project period, February 1980 - April 1983, now extended through August 1983, was budgeted at $755,065 for in-country costs, however, currency devaluations have resulted in savings that allow for extension of the project. At present, the proposal for extension has been under discussion for over a year and closure is sought by all parties as soon as possible.

The original project objectives included*:

1. Service

   a. Plan, develop, test and demonstrate appropriate low cost, effective, and broadly replicable means of meeting the health, nutritional, and family planning needs of the village population.

   b. Collaborate with the Ministry of Health, the Ministry of Social Affairs, and other appropriate agencies in the accomplishment of specific objectives enumerated below with a view to promoting broad scale replication of those program elements which are judged successful.

   c. Add family planning information and services to the existing package of health services potentially available to the population.

2. Training

Reorient through short term courses the traning of the existing categories of village and small community based health personnel, expecially village midwives (not TBAs), health visitors (female), medical assistants (male), community health workers (male), and nurses (male and female) so that they become knowledgeable about family planning as well as other health and nutritional services.

*Taken from CP/FP document proposed for the evaluation.

3. Research

a. Assess the health/family planning status, problems, and needs of the rural population, especially of women of reproductive age and children 0-4 years of age in the project area through a family health status/contraceptive prevalence pre-survey.

b. Determine the factors underlying the present health/family planning situation (described in no 3a above) and investigate the relationships bewteen health and nutrition and family size.

c. Experiment with community education designed to promote community involvement and the assumsption of greater local responsibility for the provision of health, nutritional, and family planning care.

d. Demonstrate that properly supervised village midwives (VMWs) can deliver an integrated package of health, nutrition, and family planning education and services that will effect a significant improvement in the health status of the Sudanese village population.

e. Evaluate the effectiveness of the village based delivery systems established through simple service statistics and changes in status and prevalence of health and family planning indicators bewteen the pre-survey (no. 3a above) and a similar post-program survey.

4. General

Carry out the service, training, and research activities needed for the accomplishment of the above objectives.

The activities were implemented in 90 villages north of Khartoum on both the east and west banks of the Nile. A total of 103 village midwives (9 months formal training) were given a three-week course in family planning (provision of oral contraceptives and referral for IUD), nutrition (encouraging breastfeeding, timely supplementation, O.R.T.) and immunization motivation. Fifty additional supervisory personnel were also trained.

The approach taken in this site visit evaluation was to assess the project components utilizing the same conceptual framework as was utilized in the evaluation of CPFH, New York. Attempt was made to assess past planning and execution, the present situation and the future expectations. In addition,

decision-making and feed-back systems were examined as related to project goals and as related to the future of family planning in the Sudan. Interviews were held with Sudanese and American personnel both within and outside of the project. Intensive discussions were held with the Columbia CPFH field advisor, Mr. Haytham Mathews concerning the entire CPFH effort and the role of field advisor as well as the points mentioned above.

The project constitutes a brave departure from existing MOH practices in the field of family planning, demonstrating that the village midwife can serve a larger role. The role of Columbia University in certain aspects of this project are assessed below as pertaining to project elements. This evauation is not meant to be a project critique but rather an assessment of the part CPFH international division has played and can play to aid in meeting project objectives.

1. Internal Processes. The Sudan Community-based Health Project (SCBHP) under the directorship of Dr. El Tom is based in the Department of Community Medicine of the Medical Faculty, of one of the major universities on the African continent, the University of Khartoum. Being a university-based project, there are inherent advantages and constraints. The major advantages include 1) personnel with strong educational background in training, and 2) a group that has the respect of major decision makers in the field of interest. Constraints include the fact that university departments are not generally organized as strong management/administrative/logistic units, that any single department tends to contain a focussed area of expertise, tht the roles of education and service deliverer are quite different, and that, as a university department, there is not usually direct influence on national level decision-making (see point 5 below).

Within these parameters, Dr. El-Tom has succeeded in developing a strong cadre of bright and enthusiastic personnel. Although there is no organizational diagram, Dr. El-Tom describes some of the roles as follows:

Dr. El-Tom, Director
Suzan Wesley and Nayla Mubarak - Supervisors of the West and East Bank project activities, respectively.
Social Workers - help with village contacts and resarch elements
Haytham Matthews - liaison with USAID, reporting and general support.

Decision making is generally through discussion of selected smaller staff groups, sometimes with additional outside expertise invited, with the final decisions in the hands of the director. The project supervisors are able to make some field

55

decisions but in general, any substantive decisions must be made or approved centrally. Feedback of information is far more often through meeting and discussion than through written documentation. Columbia University staff are invited to play a significant role in research and planning development.

This style of strong central management may benefit from frequent and ongoing regular meetings and from documentation of field activities and field decisions. This would allow expeditious definition of the central management point of view on specific parameters and would increase two-way communication by providing a specific focus for discussion. This management style may also be facilitated by careful delineation of the parameters of decision making at each level.

New personnel are being considered for addition in the extension phase of the project. Since much of responsibility for extension activities will lie with Provincial health workers, the resources of the Community Medicine staff may more directly address the research, planning and documentation tasks. Much time and effort must go into development of several levels of curricula, descriptive manuals for all levels of field staff concerning commodity logistics supervision data forms and data collection (if any are planned), and the conceptual framework for future research. All of these should be completed before extension activities begin and all research tools sould be appropriate to the questions raised (see point 3 below).

2. Setting of Objectives. The original project objections were developed by the University of Khartoum and Columbia University in collaboration with AID personnel. The objectives of a collaborative project such as this should fall within the perviews and capabilities of the institutions involved. The general heading of service, training and research in health and family planning are therefore appropriate for this project.

The service delivery system and the conceptual framework for research methodology should both derive from the set objectives. The project can be evaluated by examining each objective and then assessing the appropriateness of the delivery system and the chosen research tools.

The first objective is to plan, develop, test and demonstrate low cost, effective, and broadly replicable means of providing health, nutrition and family planning to villages. The service program as developed was not low cost in absolute terms, however. This should not be considered a detriment of the program. The objective of a low cost service should not be mandatory in a demonstration project. However, use of funds in a manner that is not replicable on a larger scale for elements other than research and evaluation should be avoided if

possible. In this project, the most appropriate and relatively low cost worker was chosen. The cost analysis of this project has not been completed as yet but may shed some additional light as to other ways of reducing costs in replication.

Effectiveness of a health intervention is often measured by a change in prevalence of use of the intervention since health itself is a difficult parameter to measure. The program was designed to increase prevalence of use of proper infant nutrition practices, oral rehydration salts, immunization, and family planning. There was an increase in prevalence of all interventions during this project but this increase was modest in some areas. There, are, however, other ways to assess effectiveness of a program. Process variables can be reflective of program success, e.g. coverage, content of household visits, quality of supervision, strength of the logistic system and continuation of impact of the effectivenss of a program. On the whole, these process variables deserve greater attention when impact on prevalence is limited.

Replicability depends on many things: political interest, funding capability, documentation of curricula, all elements of supervision and logistics, and appropriate choice of sites. Careful attention should be paid to each during planning and implementation. Evaluation should include assessment of the extent to which replicability has been facilitated.

A second objective includes collaboration with Ministeries and other agencies in accomplishing objectives with the view towards replicaton. The extension proposal takes stronger steps towards achieving this objective as well as the other objectives stated above.

A third objective is to add family planning to existing health services. The demonstration service delivery program must therefore be similar to existing health services. However, as the project has evolved, many elements of the existing services have been modified (e.g. supervision, school lectures, logistics, salaries). Any element that must be modified for project success should be carefully monitored and documented to allow for its incorporation into existing systems. If the modifications necessary are complex or costly, they may not be feasible in the existing system. Furthermore, concerns of the existing system (e.g. safety issues, midwife competence in unusual situations) should be addressed in the research design to provide data that will assure decision makers.

The objective of training in the pilot areas has been well carried out. Although outlines are available, careful description of curricula teaching methods are not as yet prepared for the extension. Replicability depends on availability of such documents since the project personnel will not always be on site.

The research objectives should derive from the overall project objectives and be closely related to the services objectives. Many of the stated research objectives include statements concerning the family planning needs. The extensive baseline questionnaire assesses prevalence but does not address desired family size. Other objectives are not evaluable by the research methods used (e.g. experiment with community education).

To summarize, this project clearly went through much careful planning, rigorous monitoring and active survey work. However, research tools did not always address and were not always appropriate to the stated research objectives. In turn it is not entirely clear how the research design addresses the overall objectives of the project. A great effort has been made to clarify many of these in the extension proposal. Columbia University, in its role as research, management, and planning coordinator must be actively involved in maintaining appropriate emphases, developing the conceptual framework for research to allow appropriate selection of methodologies, and assuring careful documentation of any project elements that are a change from the existing MOH delivery system.

Furthermore, it is clear that some of the written objectives were stated for purposes other than project goals. USAID has emphasized low cost and increased prevalence as mandatory objectives and, therefore, they are repeated in this project. A joint decision is necessary between AID and Columbia University whether or not this emphasis must be continued when it is not desired by project personnel. The project in the Sudan is an exciting model for increased availability of family planning for the existing health system and yet it is not nor was it planned to be extremely low cost (excluding research costs, there are $2,500 input per couple year protection provided) or to cause a great increase in prevalence (midwives were advised to be conservative in their choice of the women with whom they would discuss family planning and to offer only one cycle each return visit). If USAID decides to continue these objectives as mandatory, contractors should be encouraged to comply. However, it is recommended that alternative objectives might be chosen which are more appropriate for demonstration projects as long as no element of the project precludes future cost reduction or would impact negatively on prevalence. Columbia University is sensitive to these considerations as demonstrated in reports and from discussions in The Sudan, I feel that Dr. El-Tom would welcome discussion of the above issues.

3. Family Planning. Since population funds constitute 50% of Columbia University's funding, it is appropriate to assess the family planning component of the SCBHP. The family planning curriculum and methods of distribution were developed by the SCBHP in collaboration with Columbia personnel. A few points arose during discussion that need clarification.

a. Curricula for all levels of personnel to be trained are not available in sufficient detail as yet, to allow assessment of the specifics of community distribution and usage. Detailed curricula will be a major aid in future replication.

b. Pill use was taught based on a method sometimes used with 21-day cycles (i.e. start pills on fifth day of menses each month). This can lead to prolonging the intercycle period when women do not begin menses within two days of the last pill. The resulting overuse and underuse can result in allowing accidental pregnancies and unnecessary side effects.

c. Two cycles of pills were to be distributed on the first visit to be followed by only one cycle per visit thereafter. There is no medical nor supervisory reason to distribute only one cycle after it has been determined that they are being used correctly and safely. Further limiting distribution in this can lead to unnecessary discontinuation due to a missed or late visit by the distributor.

d. A mini-survey showed that women were stopping use due to a vague set of side effects. It was decided, based on this, that more studies were needed to clarify these. Neither further studies, nor the obvious intervention of increased midwife training in dealing with side effects, were initiated. The research findings should be used to effect timely improvements.

e. Continuation rate at three area sites visited was extremely low. Although they may be the exception, it was clear that there is no ongoing organized household visiting nor new acceptors in these areas. Careful attention must be paid to this during the extension and appropriate changes should be initiated to assure continuing services.

f. In one area, all users were taken off pills due to an hepatitis outbreak. This highlights the need to add another method to the program. USAID experience clearly shows that one-method programming is not efficacious. Some Sudanese experts consulted feel that condoms ("gloves") are well known and may be acceptable for a short-term alternative.

Recommendation: Columbia University continue to make updated information and data results available in a timely manner.

4. External Feedback

The collaboration between Columbia University and the University of Khartoum has resulted in a demonstration of the capability of a specific health personnel, the village midwife, to serve as an active health service provider in the Sudan. This demonstration has a great deal of potential significance in the Sudan, where the health care system is in a dynamic state of development, the Ministry of Health (MOH) has developed an MCH/FP effort, led by Dr. Baldo and sponsored by WHO/UNFPA, which is attempting to integrate those efforts into the expanding of primary and limited care system. Decentralization and limited resources have been special considerations in this effort. At the same time, the village midwife training and placement is an ongoing and active element in many parts of the country. Therefore, this demonstration of their capabilities reveals a new potential health care provider who is often already in place and available to the community. This is during a period of time when the MOH is actively developing and planning health care system modification.

Discussions with personnel within and outside of the project reveal that this potential has not as yet been entirely recognized by the central MOH. Although there may be a variety of reasons for this, one point that was emphasized is that information concerning the Sudan Community Based Health Program (SCBHP) has not been made readily available to decision makers since the workshop. Those in the MOH capable of making such broad personnel decisions are not presently actively included in the planning or discussions of SCBHP. The extension proposal calls for the development of an advisory board, composed of Provincial MOH personnel in part. However, active involvement of the central MOH decision makers in planning and development of the specifics of the extension (e.g. curricula, logistics) could serve not only to inform them concerning the project, but also to allow for technology transfer in these areas from the Faculty of Community Medicine to the MOH. Technology transfer is a legitimate role of a national university and should be welcomed by MOH officials. This may also afford the MOH personnel the opportunity to share their concerns and obstacles with the University Faculty, thus encouraging the Faculty to study those problems of importance to the MOH program. The friendships between SCBHP leadership and high level Ministry personnel facilitates such collaboration.

5. Role of Columbia U/AID/U of Khartoum. Since this is a project that has many actors, every effort should be made for coordination and nutuality of purpose. At present there are clearly differing but compatible agendas. The compatibility should be emphasized through meetings to expedite interactions and decisions.

Persons Contacted

USAID: Mary Ann Micka, M.D., M.P.H.,
Population/Health/Nutrition Officer, USAID/Khartoum
Joyce Jett, USAID/Khartoum
Richard Cornelius, AID/POP/R

Project Personnel

Dr. Abdul Rachman El-Tom, Chairman of Community Medicine Department, University of Khartoum and Director, Community Based Family Health Project
Dr. Nayla Mubarak
Ms. Suzan Wesley
Dr. Abdul-Azziz Farah
Nadia Bushra
Ilham Abdallah Beshir

Field Staff

Dr. Haidr - Assurab Health Center
Mr. Saadi - Medical Assistant
Saadidena Ahamed Mohamed - Community Health Worker
Oom Hagem Mahmoud - Village midwife
Zachira Djad - Village midwife
Plus 6 additional village midwives, a Sr. Medical Assistant and a Health visitor in the areas visited

Ministry of Health, MCH/FP Unit

Dr. Baldo - Director
Dr. Amal Abou-Bakr

Columbia University

Haytham Matthews, Field Advisor

Others

Dr. Hamid Rushwan, Chairman, Obstetrics and Gynecology, University of Khartoum, Executive Director, SFCS
Dr. Hadi El-Zein El Nahas, Ob-Gyn, Active in all family planning activities
Dr. Amal Adnan, Department of Community Medicine
Dr. El-Deeb, Member, National Community on Population and SFCS Board
Sharon Epstein, FHI consultant on family planning research
Dr. Nur
Dr. Monica Khalifa
Dr. Musheinhat

BRAZIL SITE VISIT

PERIOD: 23 April - 1 May

PURPOSE: Review Columbia University's Cooperative Agreement in Brazil with one of the largest ongoing operation research projects and a resident advisor

CONTACTS:

RIO: key BEMFAM staff and the Center's Resident Advisor Jim Foreit and Consultant Karen Foreit

PIAUI: key local project administrators/supervisors.

BRASILIA: Sam Taylor, USAID

SUMMARY: This project has implemented and continues to carry out a wide variety of operational research projects in the state of Piaui in Northeast Brazil (pop. 2.1 million). These range from observational studies through pilot/demonstration projects to quasi and experimental studies. The major focus has been on the CBD program, particularly impact, improved delivery service, and cost-effectiveness but newer approaches are being introduced.

Major projects of the O.R. and evaluation component include: (1) a new system of program launch; (2) a baseline contraceptive prevalence survey; (3) an investigation of the cost-effectiveness of post-types; (4) an assessment of household distribution; (5) a trail of additional contraceptive methods; (6) a test of the feasibility of extending service delivery to remote villages; (7) an experiment to reduce supervisory frequency without harming post performance; (8) the development of new supervisory materials; (9) an evaluation of the contribution of physicians to the program; and (10) a survey of physician's interest in receiving training in clinical family planning methods. These have yielded many results of a practical program and policy significance to BEMFAM administrators.

O.R. projects currently underway include: analysis of contraceptive distribution post dynamics; the use of alternative posts (markets, bus stations); improved supervision; post-partum; development of clinical components; tests of new supervisory and inventory systems.

Most importantly, the findings of many of these studies have found their way not only into the active Family Planning and Community Health Education Program in Piaui (with its 300+ distribution posts) but also into other state programs. In addition, some materials developed here have been used in Morocco, Indonesia and Guatemala.

The resident advisor along with his counterparts has done an excellent job of designing, implementing, analyzing, and documenting results as well as played an important role in getting results utilized. It is clear that the operational research capacity of both BEMFAM and Piaui has been increased significantly in this process.

All in all, this is an impressive project with considerable potential for further development, should it be possible to negotiate an appropriate workplan with BEMFAM calling for increased evaluation capacities and more allocation of resident advisory services to Piaui.

ITINERARY

Key administrative staff of BEMFAM and Center staff were met in Rio, the USAID advisor in the nation's capital, Brasilia, and project personnel in Teresina (the state capital of Piaui). Additional field trips were made to Camp Maior, a small city near Teresina and to a rural area, Melanseias to view health and alternative distribution posts, the postpartum project, supervisory and local volunteer working procedures and training, supply logistics, educational approaches, record keeping forms, reporting, and data collection and analysis.

Piaui is a state of 2.1 million persons in Northeast Brazil. It is as large as France with 250,000 km^2 but has a density of only 8.5 persons per km^2. The total fertility is estimated at 5.9, the CBR at 40. The rate of population growth at 2.4%. The contraceptive use rate among MWRA was 31% in 1979. It is considered the poorest, least developed state in Brazil.

FINDINGS AND RECOMMENDATIONS

(1) The list of findings of O.R. is impressive. The fact that many findings have been integrated into Piaui's programs as well as those of other states adds to the impressiveness. A summary of the major findings and how they have been applied should be read (see Attachment A).

(2) Project identification and development has been flexible enough to allow modifications in design and implementation in response to changes in overall program needs, obstacles met, and budgetary priorities.

(3) The kinds of findings that flow from the training, supervision and field observation of ongoing projects are important to replication elsewhere and have had a fair amount of attention in Piaui. This process documentation needs continuing.

63

(4) The technical analysis of data has involved considerable quantitative assessment which is of high calibre. Most of this has been done in the field. Although qualitative analysis is less frequent, it has been done, particularly on field observation, and has proved valuable.

(5) Interestingly, it is the quantitative findings that are the major focus of papers although it appears as if much of the qualitative findings are fed back into the program's supervision system in Piaui.

(6) It would be valuable to synthesize and collect the findings to date and their application. A preliminary attempt was made by the Center using recently-developed matrices which provided some useful data. This should be expanded upon. (See Attachment A).

(7) Because of the rich variety of O.R. experience, Brazil would be an ideal setting for a case study analysis. The need to preplan large scale O.R. by spending considerable time early in the field and the role of the advisor in relating O.R. to other technical advisory assistance could be illustrated well in this context.

(8) Dissemination of findings locally has been done, most often informally. Dissemination at the Center has been less effective and probably a plan for this purpose needs to be drawn up.

(9) The transfer of technical capabilities has been reasonably effective. There exist a data collection and processing capability in Piaui as well as a strengthened evaluation unit at BENFAM.

Recent improvements include a quarterly reporting system to track state performance, training of state evaluation units in program management and evaluation techniques, and development of new service statistics forms to monitor newly-introduced contraceptive methods. There, however, is some indication that recent losses of trained staff reflect morale factors which need attention. It also would be helpful if a specific timetable and program for such transfer were developed in terms of individuals, type of training, and possible financial support.

(10) The problem of research design in the first large "ABC" experimental O.R. study clearly demonstrated the pitfalls of planning a project in New York City and Washington and implementing it without time in the field to determine its appropriateness. The value of resident advisory staff and sufficient lead time to tailor a design to local circumstances is a lesson learned with implications elsewhere for all O.R. projects.

(11) Documentation is perhaps stronger in Brazil and Haiti than elsewhere.

An excellent summary of the program's objectives, historical evaluation and project implementation prepared by the Center (May 1983) is now available (Appendix B). This deserves wide circulation. Generally, a reasonable amount of writing has been done on the Brazil project and a large number of papers are in progress. A listing, primarily in English, is attached. (see Appendix C). Much of it is recent and in the format of a paper presentation at national conferences. Relatively little has appeared in journals. Most is circulating in typed version.

Several papers have been submitted to the Center's Working Paper Series but have yet to be selected.

The communication on publications between the field and the Center could be strengthened by more specifics about what the Series wants. There also ought to be a plan at the Center for getting these Brazil papers into printed circulation. There also could be more guidance from the Center as to what sort of documentation the field advisor should be doing -- at least in terms of articles.

On the other hand, a number of publications have appeared in Portuguese and findings of the various projects are integrated into a number of Brazilian publications, particularly those of BEMFAM. Also as indicated elsewhere (see # 1), many project findings are being integrated into a larger program context -- which is their major purpose.

In addition, a series of quarterly reports are forwarded from the field to the Center which represent well-documented and detailed progress reports (15-20 typewritten pages).

(12) There is at present not much in the way of linkage with universities. Although there may be political and bureaucratic obstacles, these may represent a potential source of training and technical assistance as well as a group needing additional experience in field program and analysis.

(13) A good deal of ongoing, continuous evaluation of program functioning has been carried out. This evaluation has had considerable program application. Included would be locational analysis, cost-effectiveness, continuation of contraceptive use, community awareness (minisurveys), work sampling, client characteristics and prevalence surveys. Some of these deserve replication elsewhere, e.g., mapping acceptors and minisurveys, particularly in Africa.

(14) In selection of a particular project and design it would be helpful at this stage to list the criteria used so that

some sort of checklist could be available for true use and comparison elsewhere. What seems least clear is to whom the project is directed, that is who is being convinced of what works best, most cost-effectively, etc.

(15) One danger in focusing on cost-effective studies, e.g., alternate posts and quarterly or monthly supervision is that limitations of the application may not be recognized. The financial implication for further work may not be foreseen. The finding that health posts are most costs-effective than alternate posts has to be reported in terms of the fact that only a small percent of people have access to health posts. More attention to establishing posts in alternate places needs trial. Quarterly supervision may be no worse than monthly but a strong effort also needs to be directed toward defining what could be done to improve such supervision. There also ought to be no surprise when Pathfinder cuts funds for supervision -- i.e. the political or financial implications need to be clearly laid out before a study begins.

(16) Projects deserving of future trial include community farm store posts, use of mobile vehicles, increasing contraceptive continuation, male condom distributors, varying education content, paid fieldworkers.

(17) Logistical support for Brazil from the Center seems thin. One back-up person is on 10% time. The analysis is done in the field. Little technical advice is provided from the Center. The field has difficulties getting publications requested., Some adjustment to field priorities seems needed. Possibly having a student T.A. on hand to fill field requests rapidly would help.

(18) More attention to the sort of chartbook presentation developed in East Asia might be useful to target messages to various influential audiences (in-country, AID, international agencies, other countries).

(19) The use of minisurveys and ways of integrating mechanism to get interim results from larger surveys is helpful to more rapid feedback of results to programs and deserves expansion.

(20) It was not clear whether BEMFAM had access to the rich variety of OR done by Columbia and other agencies. Having summaries of projects might help stimuate others in Brazil.

(21) The methods of selection and training of field staff, which has spread from Piaui to other states, particularly the involvement of local mayors in selection ought to be disseminated more widely by the Center since it has potential for application in many countries.

(22) BEMFAM has a strong interest in expanding in-country training for its staff and technicians of the Secretary of Health in several states with the backing of Columbia. This deserves consideration.

(23) BEMFAM wishes to have the continued availabilty of a full-time resident advisor stationed in Rio. Programmatic considerations lend themselves to serious consideration of such a request, particularly if a solid plan and budget for strengthening BEMFAM technical evaluation capacity and field supervsion were provided. Such advisory inputs would be gest centered in Piaui where the demonstration projects are operating. This would necessitate a reversal of the present 1/4 Piaui, 3/4 Rio time allocation.

(24) The quality of advisory input has been high and Foreit is respected by the Brazilians he works with. He has been able to accomplish a good deal under difficult circumstances. Possibly he would have been able to do even more had N.Y. more adamantly played the "bad guy" role to expedite getting his visa and back up some of his program concerns.* Had BEMFAM agreed to its resident advisor spending even a majority of his time in Piaui, many more promising leads from ongoing projects could have been profitably followed up. It is essential to have the continuing on-the spot observation to help projects evolve to their full potential or to be scrapped when they prove of limited value.

(24) An end-of project report summarizing what has been learned and how it was applied as well as a prioritized list for possible future project interventions should be requested prior to the present advisor's impending departure. He also should be provided several months writing and debriefing time in N.Y.

61

BRAZIL

Expenditure Summary

July, 1979 - June, 1982

Personnel	$721,649
Research Costs	$120,032
Data Processing	$ 9,796
Travel	$179,139
Information and Education	$ 33,518
Equipment	$ 17,797
Contract Services	$ 14,219
General Administration	$242,696
Indirect Costs	$200,827
Total	$1,539,673

68

Brazil

1. Project Summary

A. Project Title:

Collaborative Operational Research Project: BEMFAM and the Center for Population and Family Health, Columbia University.

B. Cooperating Agency:

BEMFAM (Sociedade Civil Bem Estar Familiar No Brasil).

C. City, Country:

Rio de Janeiro, Brazil

D. Project Director:

Dr. Walter Rodrigues, Executive Secretary, BEMFAM

E. CPFH Project Monitor:

Martin Gorosh

F. CPFH Resident Advisor:

James R. Foreit
Karen Foreit, Consultant

G. Type of Agreement

CPFH Subagreement

H. Project Period:

April 1, 1979 - June 30, 1983

I. Budget Totals:

July 1, 1978 - June 30, 1979 $95,049 (AID pha-C-1107)
(Project actually initiated on April 1, 1979)

July 1, 1979 - June 30, 1983 $1,542,166

SOURCE: Columbia Ctr.

69

J. Project Objectives:

The overall goal of this project is to establish in BEMFAM an operational research and evaluation capability to identify and develop possibilities for research on planned variation in selected components of the CBD system. Consequently the organization will be able to undertake on its own operational research towards increasing the effective community coverage of the CBD system. Specific objectives are as follows:

1. To conduct pre-program and impact surveys in the new CBD program in the State of Piaui.

2. To measure the impact of planned variations in the basic CBD model in Piaui including:

   a. wider community penetration by agents outside of the health service structure.

   b. home visiting and household delivery of contraceptives by agents outside of the health service structure, and

   c. experimentation with a higher ratio of distribution agents to supervisors.

3. To measure the impact of planned variations in the CBD programs in other states, including:

   a. the introduction of additional contraceptive methods in experimental regions of Rio Grande do Norte, Pernambuco, Paraiba, Alagoas, and Parana, and

   b. the contribution of the physicians employed to backstop the CBD programs.

4. To develop projects for additional planned variations in the CBD program including (but not limited to):

   a. a trial in which distributors are compensated for their efforts either through the sale of contraceptives on a salaried basis or via retention of a percentage of income from the sale of contraceptives, and

   b. an experiment in which parasite control and/or health components and commodities are added to the contraceptive distribution system.

5. To strengthen the State and Central evaluation activities of BEMFAM, particularly in regard to the new operational research projects described above.

10

a. Centrally, to streamline evaluation activities to assure that high quality, accurate, prompt, and useful data are available for policy and decision making on a BEMFAM - wide basis.

b. At State and local levels, to refine existing systems for prompt feedback and use of management information to assist area supervisors and state coordinators to administer the program effectively.

6. To conduct a program impact survey in RGN, Pernambuco, Paraiba, and Alagoas during the second year of this project.

In the Spring of 1981, the objectives of the project were revised. While the overall goal remained unchanged, some specific additions were made as follows:

1. To perform secondary analyses on Northeast prevalence survey data to help answer questions related to the impact and cost effectiveness of the CBD program.

2. To explore the feasibility and to begin planning for additional variations in the CBD approach. The variations which may be explored include, but are not limited to:

   a. Combining household distribution of contraceptives with an inoculation campaign.

   b. Expansion of use of community agents.

   c. Study of the effect of follow-up on program continuation rates.

Final revisions and additions to the objectives of this project were made in 1982. Within the overall goal more direct attention was given to conducting operations research in Piaui to demonstrate how improved service delivery and a more cost-effective program can result from application of operation research. Specifically, CPFH technical and financial assistance were to be directed at:

1. opening and evaluating "Alternative" family planning posts in bus stations, markets, etc., to determine if they can make a meaningful, cost-effective contribution to the problem of rural service delivery;

2. conduct an experiment to see if the activities of supervisors and distributors can be altered to improve program continuation rates;

3. test a simplified lower cost inventory and service statistics systems;

11

4. use supervisors to develop a demonstration post-partum/post-abortion family planning project in major hospitals around Piaui state;

5. study the feasibility of involving indigenous nurse-midwives in the family planning project;

6. develop a clinical component to include IUD insertion and sterilization;

7. study post dynamics to learn how a post attracts clients;

8. conduct a prevalence survey some three (3) years after the start of the program to measure program impact.

K. Narrative Summary of Project:

Since its inception in April 1979, the Integrated Family Planning and Community Health Education Program in Piaui has become a strong and unique project. It has an excellent record for meeting the demand for non-clinical contraception in the poorest State in Brazil through its network of 300 distribution posts which have recruited 72,000 new clients through December 1981.

In addition to its service orientation, the program incorporates a major operational research and evaluation component which makes Piaui a laboratory for all State CBD programs. Operations research projects yielded many results of practical and policy significance to BEMFAM administrators, including: (1) a new system of program launch; (2) a baseline contraceptive prevalence survey; (3) an investigation of the cost-effectiveness of post-types; (4) an assessment of household distribution; (5) a trial of additional contraceptive methods; (6) a test of the feasibility of extending service delivery to remote villages; (7) an experiment to reduce supervisory frequency without harming post performance; (8) the development of new supervisory materials; (9) an evaluation of the contribution of physicians to the program; and (10) a survey of physicians' interest in receiving training in clinical family planning methods.

Operational research projects currently underway include:

1) Analysis of post dynamics,

2) Alternative posts,

3) Program impact module of follow-up survey,

4) Improved supervisory function,

17

5) Test of new supervisory and inventory systems,

6) Post partum project,

7) Involvement of parteiras (traditional birth attendants),

8) Development of a clinical component to include IUD insertion and voluntary surgical contraception.

The findings from operational research in Piaui have been applied in Piaui and in other state programs and some of the materials developed in the Piaui laboratory have found their way to Morocco, Indonesia, and Guatemala.

The conduct of these operational research activities from April 1979 to the present time has served to create and maintain an operational research and evaluation capability at BEMFAM.

L. Country Background (From the International Encyclopedia of Population)

Covering 8.5 million square kilometers (3.3 million square miles), Brazil is the fifth largest country in the world surpassed only by the Soviet Union, the United States, The People's Republic of China, and Canada. With an estimated population of 119 million in 1980 and an estimated growth rate of 2.5 percent during the 1970s, Brazil is the sixth most populous nation and one of the fastest-growing countries among those with more than 100 million people.

The household sample surveys conducted by Brazil's census bureau indicate a rapid fertility decline during the 1970's. The concentration of Brazil's population in the younger age groups implies that, even with the decline in fertility rates currently under way, the population will continue to increase well into the next century because of the large cohorts that will reach reproductive age.

A number of factors may have contributed to the recent liberalization of Brazil's policy regarding family planning. First of all, knowledge of Brazil's demographic parameters has improved dramatically since the publication of the 1970 census. There is also growing recognition of the fact that selective access to family planning information and services can aggravate an already skewed pattern of income distribution: it is precisely the couples who can least afford an unplanned child who run the greatest risk of having one. Morever, rapidly growing sales of contraceptives through commercial channels have probably had an indirect effect on the climate of government opinion, as have the family planning services offered by the Sociedade Civil Bem-estar Familiar no Brasil (BEMFAM) and the biomedical research carried out by Brazilian universities.

13

Pending final resolution of the matter at the federal level, it is important to note that a de facto policy of "states' rights" apparently exists with regard to family planning. Several states of Brazil's underdeveloped northeast have implemented agreements with BEMFAM for statewide programs.

M. Relationship of Project to Country Characteristics and Needs

Piaui is a large, thinly-populated State in the Northeast of Brazil. Its 251,000 km^2 make it approximately as large as Guatemala and Nicaragua combined. The 1980 Census recorded a resident population of about 2.1 million inhabitants, and a density of 8.5 persons per km^2. The only large city in Piaui is Teresina, the State capital, which has a population of 339,000. The rate of population growth is 2.4% per year. The total fertility rate is estimated at 5.9 and the Crude Birth rate at 40. Socioeconomic indicators rank Piaui as the poorest, least developed State in Brazil. Despite the lack of development, however, a 1979 contraceptive prevalence survey found a high level of contraceptive use (31% of MWRA), indicating a high level of acceptance for family planning even prior to the introduction of an educational and service program.

In Piaui, BEMFAM operates under the auspices of the State Secretary of Health, which provides facilities in health posts and distributors for the program, BEMFAM also operates additional family planning posts in non-health facilities. The Secretary of Health has a strong interest in integrating the many State Health Programs. This interest complements BEMFAM's desire to explore the possibility of extending the CBD approach to the delivery of basic health services.

N. Sketch of Cooperating Agency

BEMFAM is the major source of subsidized family planning services in the country. BEMFAM was founded in 1965 by a group of prominent obstetricians and gynecologists alarmed by the 1.5 million illegal abortions estimated to have occurred in Brazil in 1964. By the end of 1966, it had opened nine family planning clinics attached to leading medical schools, with support from the International Planned Parenthood Federation. In spite of a nationwide birth control controversy in 1967-1968, BEMFAM's clinic program grew rapidly, and it was no longer confined to university teaching hospitals. In 1971, when BEMFAM was awarded tax-exempt status (utilidade publica) by the federal government, and signed agreements with two state governments, the number of clinics grew to sixty-eight.

Since 1973 BEMFAM has revised its program to replace its clinic network with statewide community-based distribution programs, through formal agreements with state governments. These programs make family planning services available in

14

the smaller cities and towns rather than forcing clients to travel long distances to reach a few scattered clinics. BEMFAM has been highly successful in mobilizing and training local volunteers, many of them paramedics, to serve as educators and distributors of contraceptives. In addition, the community-based distribution programs make efficient use of the existing state health and education infrastructure. Given the active participation of state governments and local volunteers, BEMFAM's responsibilities are increasingly limited to training, evaluation, and the provision of contraceptives and educational materials.

O. Description of Operations Research:

Operations research projects in Piaui have investigated many subjects of practical significance to BEMFAM program operations. The research in Piaui has had broad, system-wide implications, and the projects have resulted in the development of materials and procedures that have been used in other projects.

1. Program Launch

Piaui was the proving ground for several new program launch techniques. These techniques enabled the program to become operational in 113 of Piaui's 114 counties in a period of approximately 45 days. In similar circumstances in other states, BEMFAM had extended the program gradually, taking 1-2 years to cover all counties. In Piaui, however, the proposed statewide operations research project precluded such a deliberate pace. New processes of implementation, training, and administration were developed. Cadres were selected from existing programs and sent to every county in Piaui to implement the program.

2. Baseline Survey

A baseline prevalence survey was undertaken in Piaui in July, 1979, with the technical collaboration of the U.S. Center for Disease Control (CDC), Altanta. The survey was based on a two stage probability sample of 3,045 households. A total of 2,038 women ages 15-44 were interviewed.

State-wide contraceptive prevalence in Piaui, was found to be a surprisingly high 31 percent of married women. The policy implication of this finding is that even in the poorest regions of Brazil, there exists an enormous demand for family planning services.

Large urban-rural differentials were found in both fertility and contraceptive prevalence levels. The total fertility rate (TFR) in Teresina was estimated at 3.4 while the TFR for the rest of the state was 6.8.

75

Prevalence in Teresina was 45 percent while in the rest of the state it was 29 percent. These results suggested that the greatest need for family planning services is in the interior areas of Piaui, where about three-fourths of the population lives.

3. Non-Health System Service Delivery Point

Operations research into non-health system delivery points has focussed on two issues. The first is the problem of the relative cost-effectiveness of different post types, and the second is the question of whether or not an increased number of service delivery points would increase program performance.

a. Cost-effectiveness

Nationally, about 40 percent of BEMFAM's 1900 CBD posts are located in private homes, community centers, town halls, and schools. Health posts are located in health centers and hospitals. Given the very large number of posts involved, and given the fact that BEMFAM must often choose from among several alternative locations for CBD posts, the effectiveness and efficiency of various post types is an important operational question.

We have found that health posts are substantially more cost-effective than non-health posts. Therefore in a given locality, whenever there is a choice between a health center and non-medical site, BEMFAM should choose to locate its family planning post in a health post.

Health post locations are most cost-effective than non-health post locations primarily because they attract many more clients. A secondary reason for the superior cost-effectivenss of health posts is that they experience less distributor turn-over than non-health posts.

b. Service Delivery Points and Program Effectiveness

Health posts and non-health posts, when clustered in the same small communities, are competitive rather than complementary and BEMFAM should avoid placing more than one post in the typical small county seat. And, as demonstrated by the cost-effectiveness analysis, this post should be a health post.

After it was clear that clustering all additional posts in The Sedes (the county seats) of Piaui did not improve program performance, posts were opened in small rural villages outside the county seats.

16

In all, 37 posts were opened in Povados (rural communities of approximately 1,000 population) in March, 1981. Wherever possible, posts were opened in health settings. However, as the program expanded into rural areas both marginal cost per acceptor and the difficulties of supervision increased markedly.

4. Home Visiting And Household Delivery of Contraceptive

The original research design called for home visiting and household distribution of contraceptives in 1/3 of the State of Piaui. The activity was a failure largely due to BEMFAM's reluctance to develop a policy which would support home visiting and household distribution. Thus home visiting occurred infrequently and household distribution hardly at all.

In the 113 counties with BEMFAM posts in 1979, 675 home visits took place during the period April-December. This is an average of slightly less than six home visits per county during the eight month period, or less than one per county, per month. In 1980, the number of home visits was 2074 and the home visiting rate increased to over 18 per county, or about 1.5 visits per county per month. Contraceptives were seldom, if ever, left in the home during these visits. Rather, the visits were used to gather information useful to BEMFAM's information and education campaign.

The low level of home visiting is attributable to the reluctance of unpaid volunteer distributors to undertake extra duties without payment or other incentives. Piaui supervisors report that most distributors are forthright about their desire to receive payment in return for making home visits. Failure to leave contraceptives in the homes that were visited was due primarily to a fear of negative community response.

5. Physicians' Contribution

In an attempt to provide county level medical supervision to all CBD distributors, BEMFAM pays physicians retainers of approximately $50 per month, per county covered. For example, in December, 1980, BEMFAM paid retainers to 417 physicians throughout Brazil who were responsible for supervising 757 counties. In view of the large sums of money involved in these payments, BEMFAM has undertaken to assess the contribution of physicians to the CBD program.

Piaui data are available for the period February-December, 1980. During this 11 month period, BEMFAM paid retainers to an average of 62 doctors per month to

cover Piaui's 114 counties. Overall, these payments totaled about $62,700, or an average of over $1,000 per physician for the 11 month period.

Overall, about 3.4 percent of new clients during the period were screened by physicians, and the ratio of returning clients seen by physicians, to the total number of revisits is 1:143. Contracted physicians saw an average of less than 2 clients per month. If we assume that attending clients is the most important function of program physicians and assign all costs to this activity, the cost per client attended in Piaui in 1980 was $58.93.

Each physician gave an average of 3.8 family planning talks, or an average of slightly more than 2 talks per municipio. Altogether these talks were attended by 13,947 persons, a number equivalent to 6 percent of eligible women or roughly 1.5 percent of the total population aged 15-44.

In view of the very modest and relatively costly measurable contributions documented for physicians to the Piaui program, BEMFAM halted payments to physicians in Piaui. An attempt will be made to assess the political impact of this move.

6. New Methods

In late 1980, condoms, foam and tablets were added by BEMFAM to what had previously been a pill only program. The new methods were added when it was recognized that most state family planning projects were plateauing at fairly low (10%-12%) program prevalence rates. It was argued that the new methods would increase both acceptance and continuation. There was, however, concern that the new methods would compete with, rather than complement, the pill and that pill users in large numbers would be induced to discontinue use in favor of less effective barrier methods.

It was possible to address both concerns using routine service statistics from Piaui, the location of the only statewide trial of the new methods. Clearly, the addition of the new methods to the program is substantially increasing the number of new clients. Also, preliminary evidence suggest that pill acceptance has not been harmed by the new methods. Finally, the rate of switching from the pill to the new barrier methods is very modest, indeed. Eventually, new methods acceptors will likely begin switching to the pill, largely compensating for the number of clients who abandon the pill in favor of the new methods. Even if this does not happen we can assume that switching from the pill to a barrier method will improve rather

than harm continuation. This is because a woman who changes methods is abandoning one that she had found unsatisfactory in favor of a method that she believes to be more suitable to her needs.

The following Table compares 1981 program performance with 1980 and 1979 program performance. The table shows new clients, revisits, and quantities of contraceptives distributed by method for each of the three years.

PROGRAM PERFORMANCE PIAUI 1979 - 1981

METHOD	NEW CLIENTS			REVISITS			SUPPLIES*		
	1979	1980	1981	1979	1980	1981	1979	1980	1981
Pill	21,966	19,519	19,156	26,088	62,789	72,539	100,230	207,886	236,773
Condom	-	-	8,569	-	-	6,438	-	-	335,659
Foam	-	-	1,408	-	-	1,512	-	-	4,112
Tablets	-	82	966	-	88	1,512	-	-	59,248
Foam-Condoms	-	-	254	-	-	188	-	-	-
TOTAL	21,966	19,601	30,353	26,088	62,877	81,828			

*Units = Pills: 1 cycle; Condom: 1 condom; Foam: 1 can; Tablet= 1 tablet. Supplies given to foam and condom users are listed separately under foam and condom.

7. Supervisory Experiment

In April, 1981, a new operations research activity was begun. This activity consists of a supervisory experiment and ancillary projects. The major purpose of the supervisory experiment is to determine if the BEMFAM system of monthly supervision can be changed to a system of quarterly supervision, augmented by selective supervisory visits, without reducing post performance. Secondary purposes of the experiment are to determine if the focus of supervision can be changed from distri-

butor's record-keeping to factors assumed to influence distributor performance, and to test the feasibility and efficacy of selective supervision.

In the experimental group, supervisors visit posts quarterly. One third of all posts are visited in each month of a quarter (for example if the quarter is April-June, roughly one third of the posts will be visited in April, one third in May, and one third in June). These regular supervisory visits are augmented by selective supervisory visits. Selective visits are permitted if they meet one or more pre-established criteria (an emergency such as a stock-out of contraceptives, poor performance, such as an exceptionally large decrease in the total number of visits to a post, etc.). In the control groups, the regular system of monthly supervisory visits to each post is being maintained.

Supervisors have maintained their respective quarterly and monthly visiting schedules. Experimental group supervisors averaged 1.2 visits per post during the period of April-June, while control group supervisors averaged 2.9 visits per post during the same period.

In addition to changing the pattern of supervisory visits, an attempt was made to focus the attention of supervisors, administrators and distributors on program performance through the development of new materials. These materials include an immediate feedback form, monthly reports of supervisors' activities and post performance, spot checks, and work sampling of supervisor-distributor interaction.

The results of this operational research project were clear: quarterly supervision and the new supervisory practices were documented not to harm the program. This innovation was introduced throughout BEMFAM's CBD network producing annual savings estimated at $100,000.

8. Post Dynamics and Alternative Posts

Preliminary analysis of post dynamics was conducted. Results suggest that it may be possible to predict the types of locations that will result in high levels of client recruitment and in high proportions of rural clients. Identification of strategic locations, and the establishment of posts in them, if done at the time of program launch, could maximize cost effectiveness by making it possible to limit the total number of posts required to provide a high level of availability.

Through mapping activities we have found that the Piaui program provides considerably less rural than urban

coverage. Posts in rural villages appear to draw from relatively minute geographic areas, and urban neighborhood posts probably draw more from within the confines of the neighborhood. The emerging pattern strongly suggests that almost all posts draw from an extremely limited geographic area. The exceptions appear to be a few large posts. Therefore, the most important part of the research on geographic availability now being conducted in Piaui focusses on the exceptional posts. The aim of this research is ultimately to produce a valid set of guidelines on post locations that will maximize the geographic availability of the program, thereby maximizing program prevalence.

Three "Alternative" posts have been established in two "strategic" locations, a bus station and two municipal markets. For the first two months the bus station post has recruited about 200 new acceptors. The rate of 100 per month can be compared to the overall state average of 8 per post per month. No extraordinary costs are involved in the bus station post, indicating that it is roughly 12 times as cost effective as the average Piaui post. No data are as yet available on the other alternative posts.

9. Physicians Survey

The purpose of the Piaui physicians survey was to test the interest in and acceptability of training in IUDs and mini-laporatomy. BEMFAM was interested in establishing a clinical component in Piaui offering these methods, but wanted to be certain of the reaction of the medical community.

Supervisors were trained to administer the questionnaire and over 260 physicians were contacted. A short, preliminary report, in Portuguese, containing the most important results was completed by mid April. Detailed reports in English and Portuguese followed. Physicians in Piaui proved to be tremendously interested; between 60% - 70% of those interviewed were interested in training and/or receiving supplies.

10. Continuation

Preliminary estimates of program continuation have been produced for the 1979 acceptance cohort. Working with a sample of 2144 clients, we have estimated 12 months continuation and discontinuation, immediate drop out rates (failure to return within 12 months after receiving one cycle of pills), cycles per acceptor, etc. Rates were calculated by number of living children and by age of acceptor. These rates are of interest because (1) they will predict the impact of constantly decreasing mean age at acceptance on continuation and

(2) will reveal if age or number of living children is more important in driving continuation. Due to the need to have an adequate number of cases per cell for this finer grained analysis, we have expanded the sample to include acceptors from the first six months of 1980. All work is done by hand, with minimum manpower, so the final analysis will not be complete for some time.

Twelve month continuation rates for 1979 pill acceptors were calculated in January and February of 1982. The methodology is the same as used by Gorosh et al., (Dec. 1979, International Family Planning Perspectives, 5:150-159) in calculating service statistics continuation rates for pill acceptors in the BEMFAM CBD program in Rio Grande do Norte.

Based on a random sample of 2144 clients, recruited between April-December 1979, we estimate a 12 month continuation rate of 41%. If this rate is adjusted to exclude those with grossly irregular visiting patterns (those who received no more than four cycles of pills in a 12 mo. period), the rate declines slightly to 39%. These rates are similiar to the continuation rates obtained from other BEMFAM CBD programs, as shown in the table below:

PROGRAM CONTINUATION RATES FOR PILL USERS IN FOUR CBD PROGRAMS IN THE NORTHEAST OF BRAZIL

STATE	N	12 Mo. CONT.	ADJ 12 Mo. CONT.
Piaui (1979)	2144	41%	39%
Paraiba (1975)	1982	30%	N.A.
R.G.N. (1974)-1976	2058	43%	N.A.
Pernambuco-(1978)	6629	35%	33%

N.A. = Not available

Rio Grande do Norte from Gorosh et al. (1979) all others unpublished BEMFAM data.

11. Program Prevalence

The publication of the preliminary results of the 1980 census allows us to revise program prevalence estimates. We estimate that 1979 MWRA (15-44) was 242,000, 1980: 248,000 and 1981: 254,000. The table below presents two estimates of program prevalence for each year between 1979-1981. Column (a) rates are based on total MWRA. Column (b) rates are based on "eligible women" - MWRA who are not surgically sterile, subfecund, or menopausal. This rate provides a truer picture of the CBD program's penetration of the market for contraception than does the rate based on total MWRA, which is presented for comparative purposes. The number of eligibles during 1979-1981 was 193,000, 198,000 and 203,000 respectively.

PIAUI: ESTIMATED PROGRAM PREVALENCE RATES
DEC. 1979 - DEC. 1981

Year	(a) MWRA	(b) ELIGIBLES
1979*	6.9%	8.7%
1980	9.6%	12.0%
1981	12.6%-13.8%	15.8%-17.2%

The baseline survey conducted in 1979 showed statewide contraceptive prevalence to be 31%.

Estimates of 1981 pill prevalence only are 10.7% and 13.3%, respectively. Program prevalence has virtually

doubled between 1979 and 1981. A very rough estimate of the net gain in contraceptive prevalence attributable to the program can be made if we assume (1) that previous users and new contraceptors have similiar continuation and (2) that all previous users among active clients would have continued using from their original source in the absence of the program. Thus the net gain is obtained by simply multiplying program prevalence rates by (1 - the substitution rate.) Thus we estimate a net addition to total prevalence in Piaui of about 5% as a result of slightly less than three years of program activity. This corresponds to a TFR reduction of about 4.5%. Given the high level of sterilization and the pharmacy availability of low cost pills in Piaui, a total prevalence increase of 9% - 10% between 1979-1982 does not seem unreasonable. It appears that there has been a very respectable increase in prevalence of 3% per year.

12. BEMFAM's Evaluation Capacity

In addition to the results to date, the evaluation department of BEMFAM has been strengthened in a variety of ways over the past months, including:

a. A quarterly report system has been developed which allows BEMFAM to identify changes in State performance.

b. State evaluation units have been trained in the uses of evaluation and in evaluation techniques. This is a first step in transforming these units from clerical departments to contributing members of a program management team.

c. New service statistics forms have been developed to accomodate the new methods of contraception that are being introduced into the program.

13. Contraceptive Prevalence Surveys

Surveys were taken in Piaui and Amazonas in the second half of 1982. The CPFH has contributed $6,000 to the Piaui survey and questionnaire modules to both surveys. To aid in operations research evaluation, the Piaui survey contained three strata rather than two (Teresina, interior). These three strata are Teresina, other urban, and rural. The Piaui program is located primarily in urban areas, and the inclusion of a rural strata will allow us to better evaluate both the urban and rural impact of the program. The Piaui questionnaire contains two operations research modules, one on rural availability (Q's 607-611) and one on infant and childhood diarrhea (Q'a D6-D15). The Amazonas questionnaire was augmented with an ideal family size question

84

and a Coombs scale (Q 40).

Results of the Piaui follow-up survey are expected in Spring 1983.

14. Clinical Component

The research design was completed in July, 1982. In August, the Piaui State Secretary of Health agreed to allow the clinics to function in state regional hospitals on the condition that he select the hospitals and that no clinic begin functioning before November 16, 1982 (the day after elections). Hospitals selected are located in the communities of Oeiras, Barras, Picos, Piripiri and Sao Raimundo Nonato. The support of Piaui state in this venture is an important advance towards institutionalization of family planning. BEMFAM anticipates creation of a clinic and training center funded by AVS in Teresina in 1983. Plans call for training 20 physicians in the first year. These physicians will establish clinics in all remaining State Regional hospitals, including Parnaiba.

Research and evaluation instruments were developed in August and September. A referral and service statistics system is completed and in place. Training has been arranged for the 10 physicians who will manage the first five clinics, and training began in late October and was completed by late February, 1983.

Research will center on three areas a) Physician behavior change b) Amount of services provided by the clinics and c) functioning of the system of referrals between the CBD program and the clinics.

15. Post-Partum Project

About 46% of all births in Piaui occur in hospitals and health centers. For this reason BEMFAM is testing a post partum family planning project as a way to recruit an important and susceptible proportion of the target population. The project consists of a talk on family planning and the importance of breastfeeding which is given to women in the hospital after delivery. Participants are offered a supply of condoms and a referral card directing them to the BEMFAM post most convenient for them. The offer is packaged in a baby album. The album has room to record information such as date of baby's first tooth, etc., as well as breastfeeding and family planning information and a complete innoculation schedule. The album contains two pockets designed to hold the strip of condoms, referral coupon and birth certificate. A special family planning flip chart that emphasizes use of the condom has also been developed. The Brazilian govt. (W.H.O.) flip chart on breast feed-

ing is also used in the project.

The post partum program began functioning in a maternity hospital in Campo Maior, a small city near Teresina in early October. The hospital has about 1,500 births per year. Plans call for expanding the project to all Piaui hospitals where a large number of births take place.

Operations research will focus on determining (1) the proportion of all obstetrical patients that accept condoms and a referral and (2) the proportion of all referred patients who actually become BEMFAM clients, and the number of new clients (first time BEMFAM acceptors) recruited. The service statistics system necessary to measure these variables has been designed and all forms and records have been produced.

16. Other O.R. Activities

Other operations research activities during the period have included a preliminary condom continuation study, continued expansion of alternative posts, and creation of a physician information program. The latter is intended partly to compensate the loss of revenue experienced by Piaui physicians because of the halting of honorarium payments, and partly to help publicize the availability of IUD's and mini-lap among doctors who could serve as referal sources.

Results of the condom continuation study indicates that the one year continuation rate for males is approximately 24%, while the rate for females is about 41% (equivalent to that of the pill). About 42% of males and 34% females never returned after the first visit. The high rate of immediate drop out suggests that, especially in view of the necessity of importing condoms, the BEMFAM policy of giving 20 condoms to new acceptors should be changed, at least, for males. Fewer condoms given at the first visit would probably reduce wastage without having a negative impact on continuation.

More alternative posts were opened during August and September, all in public markets. These posts have all been opened in a single supervisory region. Results on the alternative post research should be available by mid-1983.

17. Liaison With Other Donors

Throughout the period of this project CPFH New York and Brazil based staff have been in constant contact and collaboration with numerous agencies involved in BEMFAM's programs, including:

IFRP - contraceptive prevalence surveys and other research projects.

CDC - contraceptive prevalence surveys

WESTINGHOUSE - contraceptive prevalence surveys

AVS - program development, service delivery and evaluation

PATHFINDER - program development, service delivery, evaluation, and research.

[BRAZIL]

CPFH Publications 1979-1983

BRAZIL

Articles and Books

1979

Gorosh, M., J.A. Ross, W. Rodrigues and J.M. Arruda. "Brazil: community-based distribution in Rio Grande do Norte." International Family Planning Perspectives 5(4):150-159, Dec. 1979.

1981

Rodrigues, W., J.M. Arruda, L. Morris and M. Gorosh. Pesquisa sobre Saude Materno-Infantil e Planejamento Familiar, Piaui 1979. Rio de Janeiro, Sociedade Civil Bem-Estar Familiar no Brasil (BEMFAM), Mar. 1981.

In Press

Foreit, J.R., et al. "A cost-effectiveness comparison of service delivery systems and geographic areas in Piaui State, Brazil." In Evaluating Population Programs; International Experience with Cost-Benefit and Cost-Effectiveness Analysis, I. Sirageldin and D. Salkever (eds.) Boston: M.I.T. Press (in press)

Conference Papers

1979

Rodrigues, W., J.M. Arruda and M. Gorosh. "New directions for CBD (community-based distribution) in Brazil." Paper presented at American Public Health Association Annual Meeting, New York, Nov. 1979.

1980

Rodrigues, W., L. Morris, J.M. Arruda, M. Gorosh, J.E. Anderson and H.C. Chen. "The importance of conducting a baseline survey prior to the initiation of community-based distribution program." Paper presented at American Public Health Association Annual Meeting, Detroit, Oct. 1980.

1981

Rodrigues, W., J.M. Arruda, L. Morris, B. Janowitz, M. Gorosh and H. Goldberg. "Contraceptive practice and CBD program impact in northeast Brazil." Paper presented at American Public Health Association Annual Meeting, Los Angeles, Nov. 1981.

1982

Morris, L., B. Janowitz, W. Rodrigues, J.M. Arruda, M. Gorosh, H. Goldberg and D. Covington. "Contraceptive practice and community based distribution program impact in northeast Brazil." Paper presented at the American Public Health Association Annual Meeting, Montreal, Nov. 1982.

Rodrigues, W., J.M. Arruda, C. Valladao, M. Thome, E. Reis, J. Foreit and M. Gorosh. "Piaui State Brazil: Growth of a program for community based distribution of family planning." Paper presented at American Public Health Association Annual Meeting, Montreal, Nov. 1982.

Papers in Progress

Foreit, J.R., et al. "How does a family planning post attract clients? An inquiry into the dynamics of a health program."

Foreit, J.R., et al. "Improving the cost effectiveness of community based family planning programs by reducing the frequency of routine supervision: An experimental study."

Foreit, J.R., et al. "Prevalence and treatment of infant and childhood diarrhea in Piaui."

Foreit, J.R., et al. "Reducing costs and improving supervisory productivity in family planning programs: The results of an operational research experiment in Piaui State, Brazil."

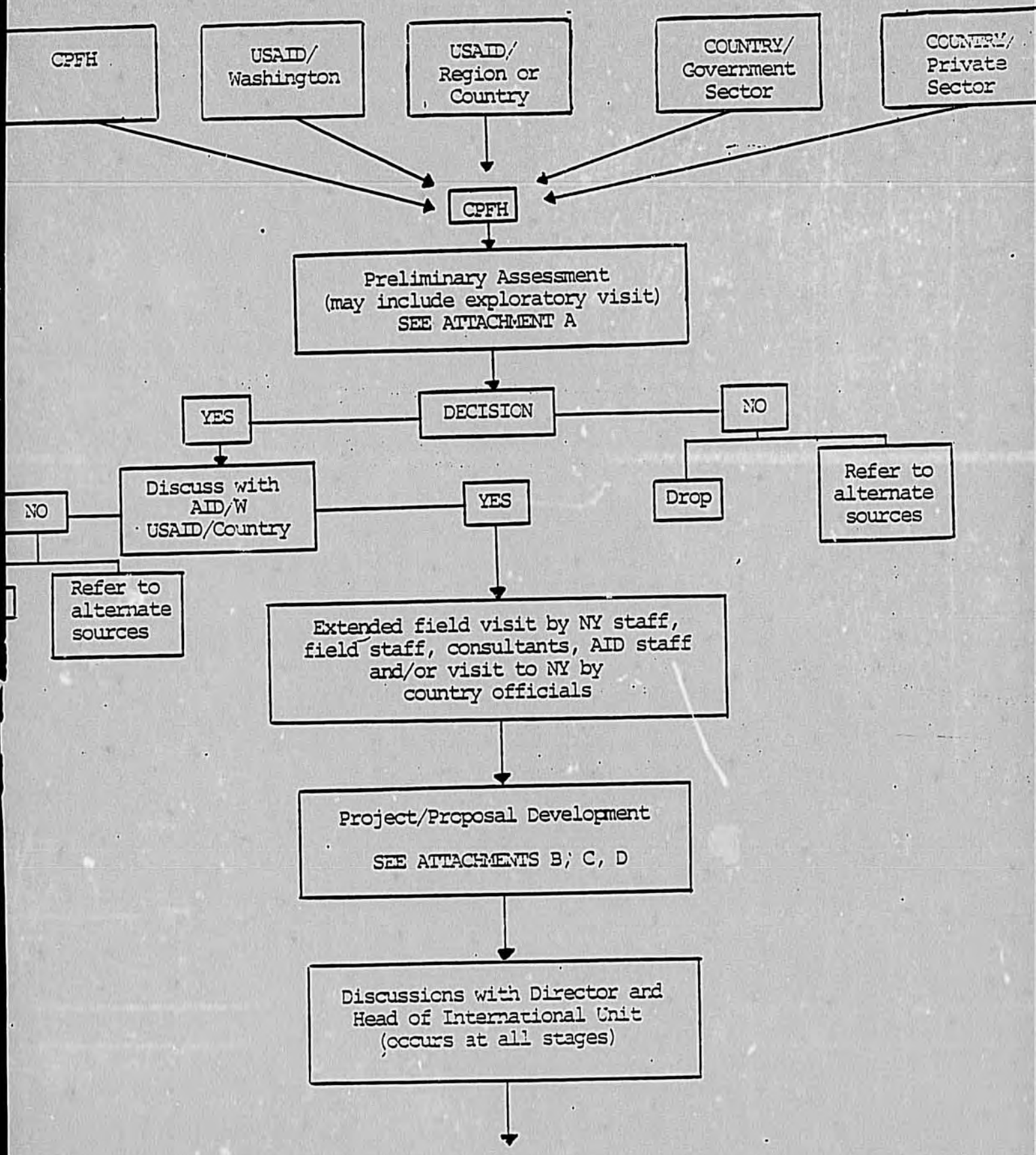
Foreit, K.G., et al. "A multivariate areal analysis of the determinants of family planning programs acceptance in Piaui State, Brazil."

Foreit, K.G. "Performance feedback for family planning workers."

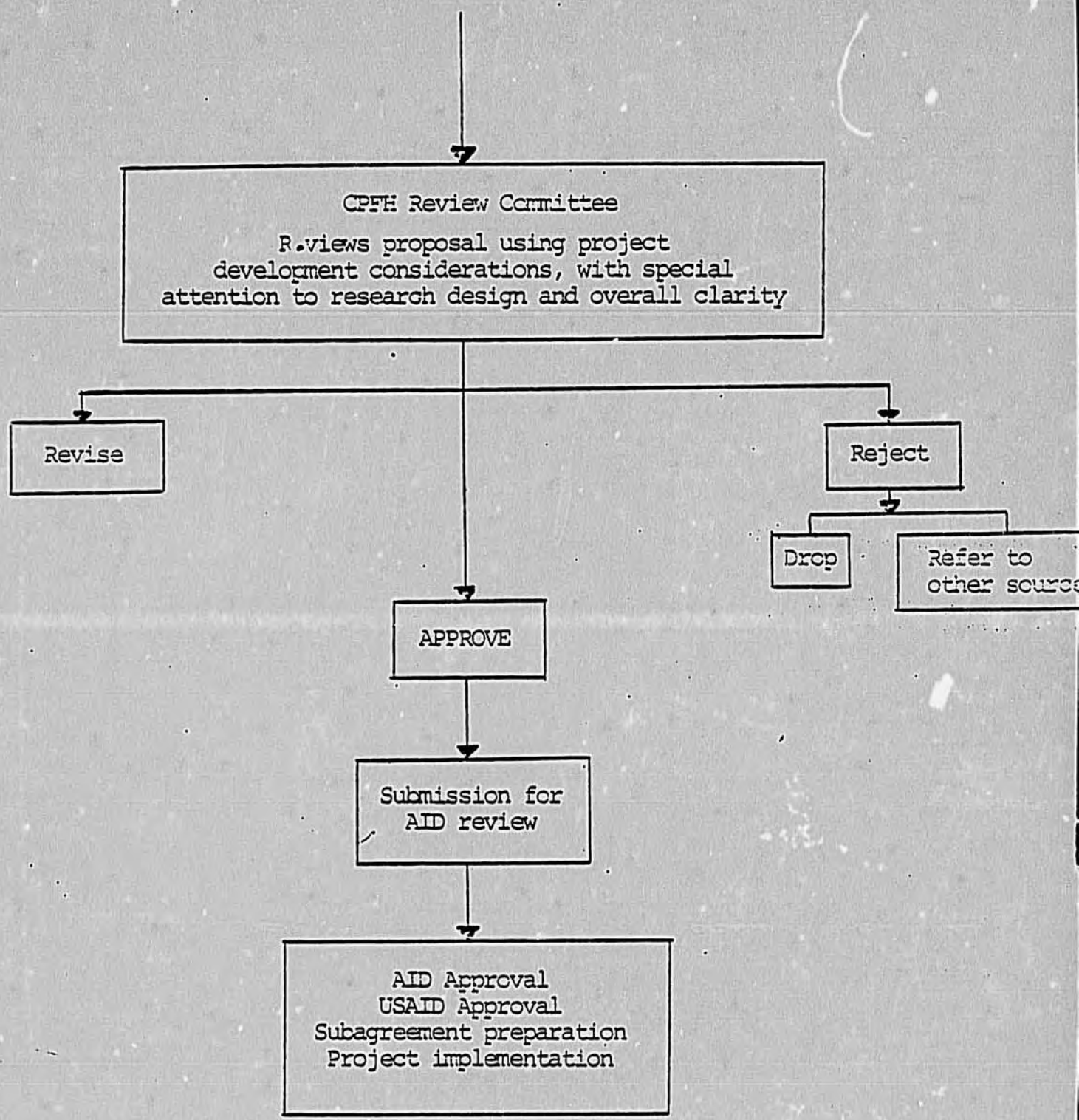
Rodrigues, W., et al. "Piaui physicians, current participation in family planning service delivery and desire for additional training in contraceptive technology."

Rodrigues, W., et al. "The results of the 1982 Piaui follow up survey."

CPFH Decision-Making Process



continued next page


CPFH Review Committee
Reviews proposal using project development considerations, with special attention to research design and overall clarity
Revise
Reject
Drop
Refer to other source
APPROVE
Submission for AID review
AID Approval
USAID Approval
Subagreement preparation
Project implementation

ATTACHMENT A

CHECKLIST FOR PRELIMINARY ASSESSMENT

CPFH

Within our interest
Is project "researchable"
Do we have:
- staff
- expertise
- staff available
- funds available
- alternate sources of funds
- time required

USAID priorities:
- research
- geographic

Are we there
Do we have personal and professional relationships
Do we have previous experience with institution/country

PROJECT

Relevance to:
- country needs
- international needs

Replicability:
- in country
- elsewhere

Potential impact:
- long vs short term
- program
- policy

Counterpart institutions:
- strengths
- connections

Counterpart individuals
- competence
- commitment
- relevant experience

Project framework:
- size
- scope
- cost
- duration

TA requirements

92

ATTACHMENT B

PROJECT DEVELOPMENT CONSIDERATIONS

1. Program Priorities of
   Host country institutions
   CPFH
   AID/W/Res. Div.
   USAID/Pop. Off.

2. Policy Considerations
   a. Country situation
      - presence/absence of services
      - level of development
      - country policy
      - institution's program orientation
      - institution's capacity to implement project, carry out research and evaluation
      - importance of institution
      - likelihood of program findings being incorporated in program or otherwise having an impact
      - involvement-collaboration with other agencies

   b. CPFH
      - implications for staffing and monitoring
      - fit with Center priorities
      - budget or other constraints
      - likelihood of producing useful research findings

3. Project Design
      - appropriateness - feasibility
      - research, demonstration, other
      - rural or urban slum
      - solve operational problems
      - village based or other non-physician delivery
      - sufficiency of F.P. component
      - size of project area or population
      - relationship to other (CPFH) projects
      - methodological soundness

4. Administrative/Financial considerations
      - Personnel - both country & CPFH
      - Logistics & supplies
      - Budget
        - size
        - cost of research/service
        - subcontract/N.Y. costs

93

ATTACHMENT C

PROPOSAL DEVELOPMENT ELEMENTS

1. Objectives
   - clarity
   - feasibility
   - importance

2. Needs & resources assessment
   - baseline survey or not
   - who assesses - how

3. Program design strategies

4. Research strategies

5. Personnel selection

6. Training

7. Logistics

8. Supervision

9. Information systems

10. Reporting

11. Administration and Finance

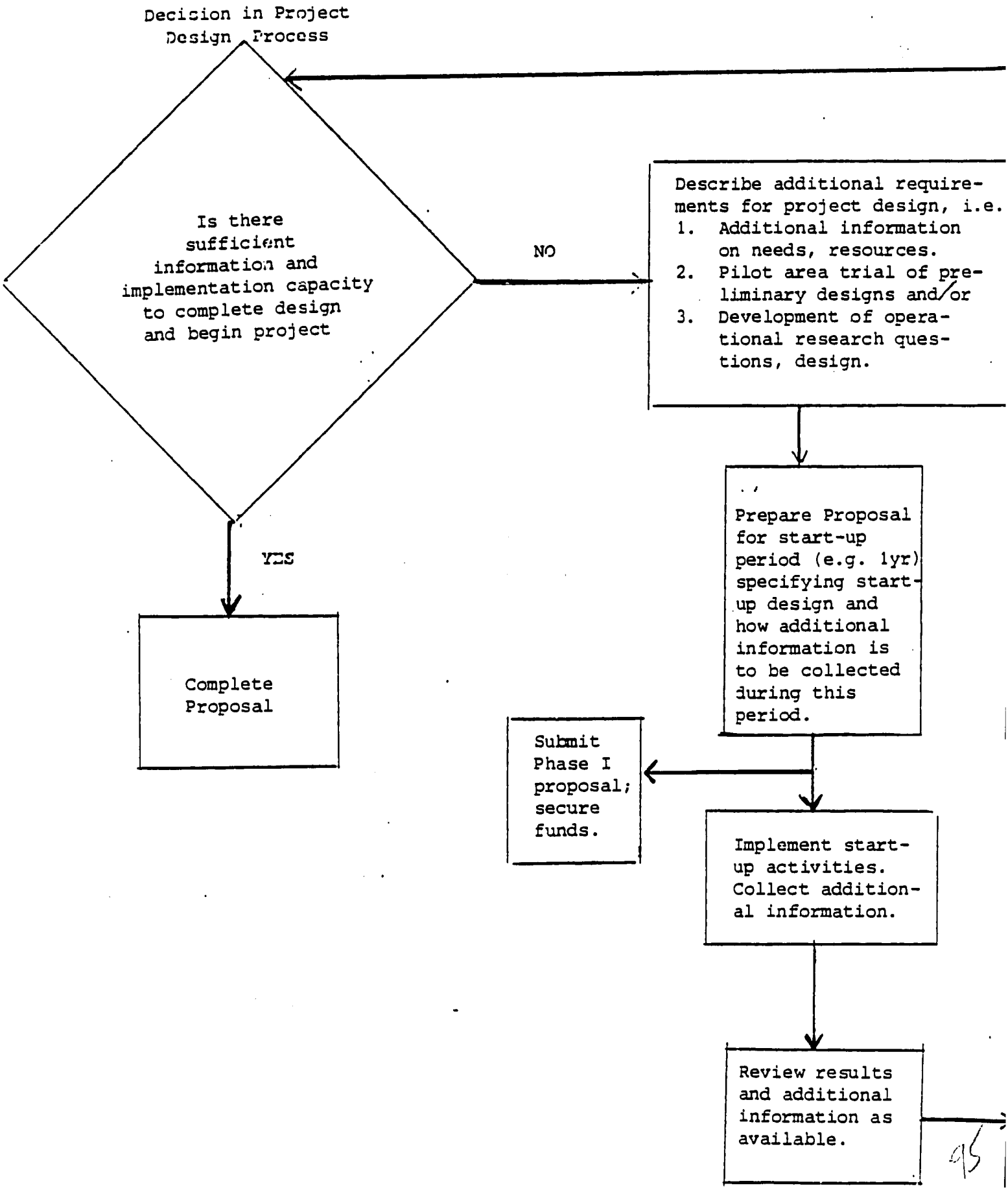
12. Evaluation

13. Implementation plan

94

ATTACHMENT D

FOR ALL PROJECTS, BUT PARTICULARLY FOR DEMONSTRATION PROJECTS:



APPENDIX E _ PROJECT DEVELOPMENT MATRIX

PROJECTS	DATE OF INITIAL CONTACT	CONTACT AGENCY/ INSTITUTION	STAGE OF DEVELOPMENT (DATES) PLANNING	IMPLEMENTATION	MODIFICATION	REPLICATION &/or EXPANSION	CURRENT STATUS
SRI LANKA	6/79	Family Planning Association of S.L.	6/79 - 1/80	1/80	---	---	Project completed - 3/31/83
SUDAN COMMUNITY BASED FP PROJECT	Spring, '78	Department of Community Medicine, University of Khartoum.	4/80 - 2/81	3/81 - 7/81	---	Proposal for projec expansion has been submitted for AID review.	Special studies continue in original project area; expansion likely to begin in 9/83.
TANZANIA	6/81	Lutheran Synod of Arusha Region: Masai Health Services Project.	9/81 - 4/82	Phase I: 4/1-11/82	Phase II: 12/1/82 -		Implementation, Phase II in pastoral and agricultural communities on basis of pilot area (P.I) experiences.
TOGO							
a) Women's Groups	11/81	DGCF	Phase I: 6/83-2/84	---	---	---	Proposal in development.
b) MOH	11/81	MOH	Phase II 8/83-4/84	---	---	---	Proposal in development.

PROJECTS	DATE OF INITIAL CONTACT	CONTACT AGENCY/ INSTITUTION	STAGE OF DEVELOPMENT (DATES) PLANNING	IMPLEMENTATION	MODIFICATION	REPLICATION &/or EXPANSION	CURRENT STATUS
BOLIVIA	7/81	Center for Social Investigations	7/81 - 9/82	11/82 - Present	---	---	1)Training materials drafted. 2)Questionnaires being drafted and pre-tested. 3)First trial seminars held 3/28-29.
BRAZIL	CPFII involvement since before 1970. CBD evaluation & OR activities since 4/74.	BEMFAM	7/78 - 3/79	4/79 - Present	#1 5/81 #2 6/81 #3 1/82	---	Activities now underway nearing completion. No new activities planned.
BURUNDI	12/81	University of Burundi	6/83 - 3/84 (Phase I)	3/84 - 6/86 (Phase II)	---	---	Proposal submitted and approved.
GUATEMALA	10/78	APROFAM	3/79 - 6/79	6/79 - 2/81	11/79	---	Project presently ongoing without foreign technical assistance.
HAITI (IHD)	Fall, '76	Division d'Hygiene Familiale	1/77 - 12/77	1/78 - 12/81	---	Key elements in use in current project.	Project terminated 12/81. Papers in press.
HAITI (OR)	11/80	Division d'Hygiene Familiale	11/80 - 10/81	10/81 - Present	---	---	Project ongoing.
MEXICO	1/81	Chihuahua Coordinated Public Health Services & central gov't MCH/FP agencies.	2/81 - 11/81	11/81 - 12/81	---	---	Project terminated by Mexican gov't. 12/81. Baseline survey analysis now underway.
NIGERIA	4/79	University College Hospital (UCH) FP Unit.	4/79 - 4/80	4/80 - 9/80	---	12/82 Expansion is approved.	Project ongoing; expansion underway with joint funding with Pathfinder.

APPENDIX F - POPULATION, CONTRACEPTIVES AND SERVICE COVERAGE MATRIX

PROJECTS	POPULATION IN GEOGRAPHIC AREA	% OF POP. COVERED/ CONTACTED	TYPE OF PROJECT	CONTRACEPTIVES					OTHER SERVICES					
				Combined O.C.	IUD	Foam/ Tablets	Condoms	Sterilization	ORT	Nutrition	Basic Medicaments	Immunization	First Aid	Other
BOLIVIA	3,000	100	Seminars on FP/ Health + FP services.	X	X		X	X	education only					
BRAZIL - I	n/a	n/a	Improve Headquarters and evaluation capacity.	X	X	X	X	X						
BRAZIL - II Northeast	20 million	20	CBD	X		X	X			Information		Information		
BRAZIL-III Piaui	2.1 million	20	CBD	X	X	X	X	X		Information		Information		
BURUNDI	85,000		CBD	— WILL BE SPECIFIED FOR PHASE II —										
GUATEMALA Indigenous	12,000	90	Village Leaders as educators & distributors	X	referral		X	referral	oralyte	education	vitamins, aspirin, & parasite control		X	
HAITI (HHD)	30,000	100	CBD Household Delivery	X		X	X							
HAITI (OR)	25,000	100	CBD, HHI	X	referral	X	X	referral	oralyte	X	X	X		
MEXICO Chihuahua	246,500		C-B Primary Health Care Including FP	X	referral		X	X	oralyte	X	X		X	
NIGERIA	original: 85,000 expanded: 250,000	est. 50%	CBD	X		X	X		oralyte		X		X	

PROJECTS	POPULATION IN GEOGRAPHIC AREA	% OF POP. COVERED/ CONTACTED	TYPE OF PROJECT	CONTRACEPTIVES					OTHER SERVICES					
				Combined O.C.	IUD	Foam/ Tablets	Condoms	Sterilization	ORT	Nutrition	Basic Medicaments	Immunization	First Aid	Other
SRI LANKA	15 million		Commercial Retail Sales of pills & condoms.	X		X	X							
SUDAN	110,000	90% of women with children.	CBD	X	referral			X	oralyte	education		DPT, Polio, BCG		
TANZANIA	200,000	To be determined.	Village Health Workers.	X				X	Local mix under investigation: oralyte ordered for trial.	X	anti-malarial, eye-ointment		simple injury dressings	Education MCH; Child Spacing; Hygiene; Sanitatio
TOGO														
a)women's groups	50,000+		Women's cooperative.	TO	BE	SPECIFIED	FOR	PHASE	II					
b)MOH	est. 100,000		CBD	TO	BE	SPECIFIED	FOR	PHASE	II					

APPENDIX G - FIELD WORKERS TRAINING AND SUPERVISION MATRIX

PROJECT	FIELD WORKERS			TRAINING			SUPERVISION	
	TYPE	SEX	COMPENSATION	TYPE	WHERE	DURATION	WHO	FREQUENCY
SRI LANKA	Marketing officers	M	salary & commission	on-the-job	FPASL	3 mos. and 6 mos. probation	Marketing Supervisor	monthly
SUDAN	Govt. Village Midwives	F	Financial Compensation given to both midwives & supervisors during 1st year of project; midwives also kept moderate fee charged for cycle of pills	Formal course which covered project intervention followed by short retraining sessions conducted in villages	Centralized at Khartoum midwifery Schools	3 weeks	Community Paramedics Health Visitors	weekly monthly
TANZANIA	Ikoma Health Workers	M,F	none	phase training	in village	1-3 wks. per modules over a period of approx. 3-4 mos.	a. dispensary staff b. project central team	weekly approx. monthly
IOOO Women's groups	Women's group leaders	F	none	phased: one intervention per session	village	phased training over approx. 1 yr.	Regional Promotion Agents	monthly
IOOO - MOH	1. Mobile Health Workers	M	Salary (monthly)	Formal	Lome	6 mos.	Clinic Hlth. Worker	
	2. Village Level Volunteer	M,F	none		local health center	varies	Itineranf Agent	

G

PROJECT	FIELD WORKERS			TRAINING			SUPERVISION	
	TYPE	SEX	COMPENSATION	TYPE	WHERE	DURATION	WHO	FREQUENCY
BOLIVIA	none			Seminars for Workers	Factories and Unions	short meetings	none in the conventional sense	
BRAZIL	Distributors	F	Volunteers	Classroom: screening record-keeping, logistics	Central Training Sites	3 days	Field Supervisors	monthly/ quarterly
				Refresher courses as above	Central Sites	3 days		
				By supervisors in the field	In the field	Ongoing		
	Supervisors	F	Salary	Classroom and Monthly Supervisor Meetings	Training Sites and state headquarters		State HQ and Central HQ staff	Monthly
GUATEMALA	Village leaders (12)	M,F	monthly salary	health care	Berkorst Clinic/ rural Guatemala	6 weeks	2 supervisors	Bi-Monthly
				family planning monthly meetings	APROFAM-capital Project office in rural Guatemala	1 week monthly		
HAITI (IHD)	Community Distributors	M,F	Salary	1-stage intensive	central	4 weeks	Community Dvlpt. Specialist	weekly
	volunteers	M,F	training & end-of year bonuses	training/retraining	local	4 weeks		
HAITI (OR)	Community Volunteers	M,F	Periodic Bonuses	Training/Retraining	local health facilities	2 wks. w. refresher training	Health agents or Health promoters	variable
CHIHUAHUA, MEXICO	Community Health & Family Health Workers	mostly F	500 pesos/month (US $20.00)	Sequential (in stage - 1 groups)	Small towns	3 stages of 7 weeks	Nurses (Groups I)	variable
				Sequential, individual training (2nd group)	own communities	variable length visits by mobile professional team	Mobile professional team with MD, Nurse, Social Worker (Group II)	variable
NIGERIA	TBA (115)	F	$15/mo.	Practical and Lecture	Local Maternity	3 weeks in-service	Nurse/midwife	1-2× monthly in a meeting
	Voluntary Health Workers (50)	M	$15/mo.	Traditional Style Presentation	Local Maternity	bi-annually for 2 days	also wardmaid (informally)	variable

10

EVALUATION OF PROJECTS

PROJECT	BASELINE SURVEYS	SERVICE STATISTICS	MINI-SURVEYS	QUALITATIVE STUDIES	CASE STUDIES	FOLLOW-UP SURVEYS	COST/EFFECTIVE-NESS	OTHER
BOLIVIA	X	X		X	X		X	
BRAZIL	X	X	X	X	X	X	X	Mapping & Post Location
BURUNDI	X	X	X	X				
GUATEMALA		X		X				1. referrals to health posts & rural clinics for contraceptives 2. contraceptive sales in pharmacies
HAITI (IHD)	X	X	X	X		X		Participant observation studies
HAITI (OR)	X	X	X		X	X	X	
CHIHUAHUA, MEXICO	X	X	X	X	X			
NIGERIA ORIGINAL	X	X	X	X		X		
EXPANDED	X	X	X	X		X		
SUDAN	X	X	X		X	X	X	
SRI LANKA		X					X	special studies: 1. dealers 2. pill users 3. condom users
TANZANIA	X	X		X		X		

102

EVALUATION OF PROJECTS

PROJECT	BASELINE SURVEYS	SERVICE STATISTICS	MINI-SURVEYS	QUALITATIVE STUDIES	CASE STUDIES	FOLLOW-UP SURVEYS	COST/EFFECTIVENESS	OTHER
TOGO								
WOMEN'S GROUPS	X	X	X			X		
MOH	X	X				X		

BOLIVIA

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	CITY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
Major Component: Measure cost of pregnancies to employers through summation of maternity leaves, leaves for breastfeeding, and absences related to pregnancies. Both retrospective and prospective measurement.	X													
Major Component: Develop and test training materials for seminars that can be widely used in Bolivia.	X				X									
Major Component: Provide family planning services through factory or union clinics	X			X	X									

BRAZIL

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	CITY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
1. Pre-project activity-- follow-up survey of clients in Rio Grande do Norte.	x	x	x	x	x	x	x	x			Gorosh et al., 1979. Pop Repts J19 Pop Repts J17		High acceptance, moderate continuation, need for other methods.	Contributed to the design of service delivery and OR in Piaui.
2. Program Launch	x	x		x	x	x	x	x	Gorosh et al APHA, 1979. Rodrigues et al., APHA '82	Forelt Summary, 1981.		Forelt to S.Taylor -- 6/81	Experienced central & state staff helped cover state in 30 days.	Used in launching subsequent state programs.
3. Baseline Survey	x	x	x	x	x	x	x		Rodrigues et al., APHA'80	"	Rodrigues et al., 1980 in Portuguese.	"	High prevalence; high sterilization; high early substitution effect.	Women in need. Need for other methods. Confirm accuracy of service statistics.
4. Home Visiting and Household Distribution	x	x		x	x	x	x		Gorosh et al APHA, 1979	"		"	Policy and promotion needed to start this initiative was lacking. Reluctance of unpaid volunteers to undertake additional duties.	Not appropriate for CBD Program with Volunteer Workers.
5. Cost-effectiveness of different types of posts.	x	x		x	x	x	x		Rodrigues, et al, St. Michaels, '81. Rodrigues, et al, APHA 1982.	"		"	Health posts more cost effective than non-health posts. Health posts have less distributor turnover.	Post location.

105

BRAZIL

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	O'LY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
6. Can an increased number of delivery points increase performance?	X	X	X	X	X	X	X		Rodrigues, et al, St. Michaels,81. Rodrigues, et al., '82 Charlottesville.	Forelt Summary, 12/81		Forelt to S. Taylor--6/81 "	When clustered, posts are competitive, not complementary.	Post location
7. Alternative posts develop guidelines on post location to maximize geographic availability of the program	X	X	X	X	X	X	X		Rodrigues, et al, APHA 1982	"			Despite early optimism, data on 14 alternative posts show low levels of performance.	Partial solution to improving geographic availability.
8. What would occur when condoms, foam, and tablets are added to a pill-only program?	X	X		X	X	X	X		Rodrigues, et al, APHA 1982.	"	Gorosh et al, 1978.	"	Increased new clients. Pill acceptance not harmed. Only modest switching from pill.	New methods introduced in all state CBD progs.
9. Were physicians paid to backstop the program making an important contribution?	X	X		X	X	X	X		Rodrigues, et al.,APHA 1982	"		"	Paid physicians were making a trivial contribution.	Payment to physicians discontinued.
10. Physician survey to learn about physician interest in receiving training & equipment for IUD insertion & surgical contraception.	X	X	X	X	X	X	X			Rodrigues, et al., '82			High level of physicia interest document.	Development of project to offer IUDs & sterilization as CBD program component.

BRAZIL

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	DAILY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
11. Supervision to determine if the existing monthly supervisory system be changed to a quarterly system, augmented by selective supervision, without reducing performance. Develop new supervisory tools.	X	X	X	X	X	X	X			Forelt Summary, 12/81 Forelt, et al., 1983.		Forelt to S. Taylor-- 6/81	Quarterly supervision and non-supervisory practices were found not to harm the prog.	Introduced thru CBD network. Annual savings estimated at $100,000.
12. Impact of CBD in northeast Brazil. State prevalence surveys in Rio Grande do Norte, Pernambuco, Parnaiba, Alagoas & Bolivia.	X	X	X	X	X	X	X	X	Rodrigues et al., APHA 81 Morris et al APHA 1982		Individual state reports published in Portuguese.		Higher acceptance, ever use, and continued use by CBD clients.	Documentation of impact.
13. Oral contraceptive continuation in CBD programs.	X	X	X	X	X	X	X		Rodrigues et al, APHA 1982.				Twelve month continuation for Piaui = 39 - 4190.	Consistent with rates for other CBD States.
14. Condom continuation in a CBD program.	X	X		X	X	X	X		Rodrigues et al, APHA 1982.				Twelve month rates: male 24%; female 41%. female rate is same as for pill.	Documentation. Reduction of quantities supplied to new clients as a result of drop-out rate.
15. Program prevalence estimated from service stats.	X	X		X	X	X	X		Rodrigues et al, APHA 82				Total prevalence increase of 9-10% from 1979 - 1982.	Documentation of Piaui impact in context of high baseline prevalence.

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	DAY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
16. Clinical component for the CBD program. Can CBD in Piauí be expanded to include systematic referral for IUD insertion and surgical contraception.	X	X	X	X	X	X	X						Training completed. Referral & service statistics systems in place.	Demonstration, awaiting results.
17. Post-partum project. Can client recruitment be improved by providing FP info and referral in hospital obstetrical context.	X	X	X	X	X	X	X						Training completed referral and service statistics system in place.	"
18. Follow-up Prevalence survey	X	X		X	X	X	X						In final stages of analysis.	Documentation of program impact.
19. BEMFAM's evaluation capacity	X	X	X	X	X	X	X		X				Through involvement in all of the above activities the evaluation capability of central and state has been improved.	New quarterly report system. Training of state program staff. New service statistics systems to accommodate new program components

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

GUATEMALA - INDIGENOUS MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	CITY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
1. Villagers as providers of education only - not services	X	X		X	X		X	X					1. Services must be provided	Incorporated in APROFAM CBD program
2. Health or FP delivery alone	X	X		X			X	X					2. FP acceptable within health context	"
3. Home visits v. group meetings	X	X					X	X					3. Home visits more effective than group meetings	"
4. Husband's involvement	X	X		X			X	X					4. Husband should be involved in contraceptive decisions	"
5. Use of surveys and questionnaires	X	X					X	X					5. Avoid use of surveys and questionnaires they will not be answered honestly	"
6. Indian acceptance of FP	X	X		X	X		X	X					6. Guatemalan Indians will accept FP if services delivered humanely and with above points in mind	"
*CPFH also provided technical assistance to APROFAM's evaluation unit.											Bertrand et al., 1979; Bertrand et al., 1980; Bertrand et al., 1982.			

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

HAITI
(Household Distribution)

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	CITY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
1. Liberalness of contraceptive distribution		X		X	X	X		X			Bordes, et al '83 (3 articles)		Liberal distribution results in higher acceptance and continuation rates	Nationwide program will use liberal distribution policy
2. Formation of community	X	X		X	X	X		X			"		Group formation serves to enhance contraceptive availability and continuation	Community leaders nationwide are encouraged to foster grp. formation
3. Commercial sales of contraceptives after household distribution	X	X		X	X	X		X			"		Acceptors reluctant to pay for services previously offered free; but multiple outlets effective in sustaining usage among many acceptors.	Multiple retail outlets now used throughout program.
4. Use of unpaid volunteers to continue distribution after household delivery completed	X	X		X	X	X		X			"		Volunteers can be effective distributors; but lack of payment may contribute to low continuation rates.	Volunteer-based program is contemplated nation-wide. Community leaders will provide non-monetary incentives.

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

HATII
(Operations Research)

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	DAILY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
1. Integration of health delivery and community development.	X	X			X	X						Project Proposal		
2. Institutionalization of operations research capability.	X	X		X	X	X						"		
3. Effectiveness of volunteer workers.	X	X			X	X						"		
4. Effectiveness of varied training programs.	X	X		X	X	X						"		
5. Effectiveness of different supervisory personnel and supervision systems.	X	X		X	X	X						"		
6. Commercial distribution of services.	X	X			X	X						"		
7. Community support of MCH/FP services delivery.	X	X		X	X	X						"		

NIGERIA

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	CITY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
1. Male vs. female workers re. family planning promotion.	X				X					mini-study write-up			Generally, males needed to discuss FP with males & females with females.	In expanded proj test of female vs. male volunteers.
2. Role of ward maids in CBD supervision, FP education.	X			X	X					"			Ward maids important as a)supervisors of CBD workers, and b)FP educators	Training given to wardmaids. Plans in expanded proj to test ward maids as FP educators w/ monthly stipnd.
3. FP sensitivity	X			X	X				X	"			Difficulties in speaking about FP without offending people.	In-service training on how to talk about FP.
4. Can illiterate IBAs provide accurate CBD work records.	X			X	X	X	X			"			Illiterate IBAs can be taught to keep accurate records of their services through use of pictographs on a "tally sheet." Problems with initial forms used.	Revisions (2) of recording form resulting in more accurate records. In-service training.
5. Are field workers getting out to neighboring hamlets.	X				X	X				"			IBAs and VIWs are visiting neighboring hamlets/villages for home visits and treatments.	

NIGERIA

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	DAILY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
6. Is proper treatment of illness being given?	X			X	X	X				Mini-study write-up			Correct treatment of prescribed illnesses is given in large majority of cases. Problems in a few areas.	In-service training given for problem areas.
7. How well is project received by villagers and State gov't?	X				X	X			X	"			Very positive reception given by village leaders, political leaders & by State Health Ministry.	Decision to expand project with State govt joining in as executers.

113

SRI LANKA

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	OTLY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
1. Feasibility of FPA Management of CRS	X	X			X		X		X				a. FPA has clearly demonstrated feasibility. b. For pill distribution FPA took over and increased pill distribution when commercial distributors withdrew.	Continued distribution of pills nationwide.
2. Increased outlets and sales: comparison of principal agent vs. commission agent system.	X	X			X		X		X				a. Pills-FPA took over successfully. b. Condoms-sales similar -commission agent increased outlets.	
3. Development of innovative marketing techniques.	X	X			X		X		X				Commission Agent System more flexible.	Introduction of new product lines Development of direct distribution (to retailer) model in one district.
4. Recovery of costs of distribution.	X	X			X		X		X				Commission agent system more successful in cost recovery.	Reduced request for outside assistance.

SRI LANKA

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	QTLY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
5. Record Keeping System for CRS.	X	X		X	X		X					Presented in International meeting in Indonesia.	Commission Agent Systems produces precise sales figures down to outlet level.	Provides basis for evaluating all prog. inputs. Provides model for national review of distribution (in process
6. EAP - PITT & Condom users, CRS Program and dealers.	X				X								Characteristics of dealers and users.	Expansion of sales network, promotional activities.

115

SUDAN

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	Q'LY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
Field Implementation	X	X		X	X	X	X	n/a	Charlottesville conf. 1982; APHA paper, 1983.	Hopkins OR monograph, 1982.			Integrated services should be implemented in a sequential and phased manner.	Has been applied in several other CPTH projects (Haiti, Nig., Tan.)
Supervision	X	X		X	X	X		n/a	APHA, 1983.	Working paper in draft			Existing system of vertical supervision is inadequate; community paramedics have functioned well to fill the gap.	Has been adopted in Nigeria proj.
Training	X	X		X	X	X		n/a		Working paper #2, '83			Short, focused retraining sessions within phased service delivery programs improving performance; decentralized training may be a less costly and equally effective alternative to centralized training.	Being applied in expanded Sudan project.
Household Delivery of Services				X	X			n/a					In the Sudan it's difficult to convene groups and provide services, especially FP services.	Being applied in expanded project

SUDAN

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	CTLY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
Oral Rehydration	X		X	X	X	X	X	n/a	Icort,1983				Needs & resources assessment at the INI level is an important prerequisite to effective ORT program design.	Being applied in expanded proj. applied in Haiti and Nigeria.
Survey Data Coding & Analysis	X	X		X	X	X		n/a		W.P. #4			In-country data coding though less costly can be far too time consuming.	Micro-processors currently being considered as means to reduce time and cost.
Mini-surveys	X	X		X	X	X		n/a		W.P. #4			Mini-survey is a useful tool for getting information quickly.	Mini-survey has become a useful tool for OR.

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

TANZANIA MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	DAILY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
(Phase I - Issues of implementation and determination of operations research questions)														
1. Feasibility of training boma residents	X	X		X	X							Phase I proposal	Boma residents not available for central training	Decentralization of BHW training to village level
2. Characteristics of project service areas (density, mobility, attitudes toward services, including family planning)	X	X		X	X							"	Major difference between 2 settled areas (Sellan & Kissongo) and 5 pastoral areas	Division of project into 2 different regions
3. Role of dispensaries in village-based services	X	X		X	X							"	1. Dispensary staff essential for phased training and supervision 2. Many dispensary staff require refresher courses in basic skills	Modification of design for phase II, to train & utilize dispensary staff more intensively. Development of additional training for dispensary staff
4. Community Support of BHWs	X	X		X	X							"	Community favorable to BHW, but no con-	Seeking more concrete

MAJOR FINDINGS AND DISSEMINATION/APPLICATION

TANZANIA MAJOR CONCERNS/COMPONENTS/ OBJECTIVES	TRIP REPORT	O'LY REPORT	CONSULTANT RPT.	FORMAL OFFICE MEETING	INFORMAL OFFICE MEETING	JUNE TRAINING	SPH COURSES	FINAL REPORT	CONFERENCE PRESENTATION/ PAPER	WORKING PAPER OR MONOGRAPH	PUBLISHED ARTICLE	OTHER	FINDINGS	APPLICATION
													pensation for sacrifices required	commitments in phase II exploring other support networks
5. Logistics of training in villages	X	X		X	X							Phase II proposal	Identified limits on travel, food, water needs, capacity of BHWs for training	Modified schedule for training in phase II
6. Ability to carry out surveys and collect individual data among pastoral Masai	X	X		X	X		X					" "	Project team, with local BHW able to collect individual and boma data	Survey design modified and expanded
7. Priority operational research issues (identified in pilot areas)	X	X		X	X		X					"	Major issues so far include community support, role of dispensary staff in training, logistics of supervision, expansion of family planning services.	Design of Phase II to focus on alternative solutions to these problems

119

APPENDIX J - OPERATIONS RESEARCH DESIGN

NIGERIA

Description of Operations Research:

Research and evaluation activities in the original project include the collection of pre- and post-survey data and routine service statistics. Mini-surveys of service users and providers were conducted as a means of quickly answering specific questions about program performance.

The original operations research design was to investigate various intensities of supervision, different fees for services, and the differential impact of community agents based at the health center versus those in hamlets some distance away. This was to be carried out by assigning various combinations of the different program elements to each health center. However, this design could not be adhered to. The population served was three to four times larger than anticipated, requiring a much larger service delivery system. Because of the proximity of the centers to each other, the utilization of the same supervisory personnel throughout, and the tremendous difficulties encountered in implementing the services it was not possible to have carefully controlled variations and a similar program was introduced at all of the centers. However, because of unplanned variations which have occurred, and the evolution of others through a trial-and-error procedure, quite a bit has been learned.

In the expanded project, survey, mini-survey and service statistics data will continue to be relied upon to monitor and evaluate activities. In addition, an experiment has been designed which will allow for the testing of several key program variables. The service package will be systematically varied in each of the three new (separate) health zones of the project. The effects of monetary incentives paid to fieldworkers, the level of supervisory personnel, and the type of fieldworker (TBA, male volunteer, female volunteer) will be examined. The results should provide a useful basis for health planners in Oyo State to expand the CBD program throughout the state, as the government has indicated that it wishes to do.

Summary of Principal Findings:

1. As demonstrated by the pre-survey, the families of the project area practiced almost no modern family planning (2% ever use), knew very little about it, and had no access to family planning services.

2. Postpartum sexual abstinence is universally practiced, typically for two to three years in the rural communities. Most (but not all) use of modern family planning is as a substitution for abstinence; as such, it has a very strong taboo attached to it. Open and cross-sex (male/female) communication about family planning is very difficult. Thus, it is important to have both male and female community agents introduce and promote modern contraceptives in these rural areas.

3. Over 5,000 disbursements (one to three month supplies) of modern contraceptives have been made by the voluntary health workers and TBAs since the initiation of community-based services almost two years ago. Most acceptors have used oral contraceptives, though use of condoms is growing rapidly (currently 45% of acceptors).

4. Much has been learned about supervision. It is suggested that CBD projects: limit the number of community agents to be supervised to no more than 20 at each health center; train auxilliary staff at the health centers (ward maids) to be additional supervisors; maintain the same nursing staff over time (normally, a change takes place every two years or so); develop written assessment/supervision forms to be used on a routine basis; provide either vehicles or financial payment for supervision visits the villages.

6. The distribution and re-supply of drugs and contraceptives is a major program element. The initial use of imported medicines proved impossible to continue due to being out of supplies for unacceptable periods of time. It has been found that the local purchase of almost all items is possible at a reasonable cost. Nursing staff, however, were unfamiliar with a system of differential resupply -- giving each field worker what he needs, when he needs it. The ingrained tradition is to give everybody the same thing at standard intervals. The project has developed a recording system that indicates differential use and appropriate resupply.

6. The development of a mechanism to record the activities of the fieldworkers, most of whom are illiterate, has been a notable achievement. A pictograph-based sheet, turned in once a month, has been developed. It is simple, usable by illiterates, records the type of service and the type of patient. A series of mini-studies has assisted in the evaluation and consequent improvement of this "tally sheet".

7. The project has been very well received by the community and the state government. Thus, a request for assistance in expanding the project was made, and this expansion is now in progress. This will facilitate the testing of certain key elements of the CBD program: type of

fieldworker, use of ward maids for family planning education, centralized full-time supervision, and the effectiveness of volunteers not receiving small monthly emoluments.

8. Illiterate villagers have been taught to effectively diagnose and treat a few common illnesses. Use of pictographs for instruction and labels help ensure correct dispersement of treatments. Nevertheless, indications are that literate fieldworkers are more effective in community education.

9. Villagers willingly pay small fees (30-80 cents) for CBD services. However, it is the belief of the political party in power that medical services should be free. Thus, future services will be provided without charge.

10. This is a large CBD program (170 community agents). It requires full-time administration, with full-time personnel for financial and logistical activities. It cannot be adequately administered by people who have other jobs and are given the management and supervision of the CBD program in addition.

APPENDIX K - MODIFIED INVENTORY FORMAT

TAIWAN

Agent Incentive

Time and place: Summer 1971, islandwide. Incentives were not new to Taiwan's family planning program; since 1966 payments had been offered to rural midwives for each referral for an IUD.

Institution: Taiwan Committee on Family Planning and Population Council.

Relation to overall program: Field-workers used nationally; paid salaries monthly.

Objective: To determine the difference in the performance of field-workers when offered a salary only and a salary plus incentives.

Research design: A true experiment, this was only one phase of a larger effort to maximimize acceptance. An islandwide sample of 1,530 women who had not previously accepted contraception was selected from the participants in a 1970 study of knowledge, attitudes, and practice; 1,340 of these women in twenty counties were successfully visited. The counties were randomly divided into two groups of ten for experimental and control purposes.

Experiments in Family Planning

Intervention: Field-workers made home visits to offer free IUD insertion, three cycles of pills, or a dozen condoms. In ten randomly selected counties field-workers received the equivalent of US$2.50 for each IUD referral and US$0.50 for each acceptor of pills or condoms in addition to their regular salary. In another ten counties field-workers received only a regular salary.

Results. In the incentive areas 6 percent of the women visited accepted an IUD and 14 percent accepted some contraceptive; excluding pregnant women and those who were already users, acceptance was 20.7 percent (475 women were visited by 37 workers). In the nonincentive areas 2 percent of the women accepted (883 women visited by 52 workers). There was an absolute increase in practice from 37.6 percent to 44.0 percent of the women visited.

Reference: M. C. Chang, G. P. Cernada, and T. H. Sun, "A Field-Worker Incentive Experimental Study," Studies in Family Planning, vol. 3, no. 11 (November 1972), pp.270-72.

Family Health International • Research Triangle Park, NC 27709 USA • 919/549-0517 • Telex 579442

May 9, 1983

Dr. Stanley C. Sheyer
Team Leader
CPFH Evaluation Team
University Research Corporation
5530 Wisconsin Avenue - Suite 1600
Chevy Chase, Maryland 20815

Dear Stanley:

In accordance with our agreement at the team's meeting on April 19, following are my comments on the management and administrative aspects of the Cooperative Agreement for the Center for Population and Family Health (CPFH) at Columbia University. My review, which took place on April 11-12, was, at the suggestion of the Agency for International Development (AID), an update of an informal study that I did a year or so ago.

My report is organized around the answers to questions which AID posed in its work scope for the team study, interviews with key personnel and staff, and a general look-around. I reviewed the internal organizational structure, the administrative and financial controls, internal communications, project development and project control.

SUMMARY

The management of CPFH, as it relates to the Cooperative Agreement, has been improved in the last year and is adequate to do the job currently required of it. While there is always room for improvement, the organization is performing at a satisfactory level, and, if necessary, could probably handle a small amount of additional funding without much increase in the support staff. From an administrative and financial point of view, the field organization is being adequately supported and communication is good. Senior management continues to maintain a high level of interest in assisting developing countries to initiate and assess public and private sector family planning programs. Columbia University, as an institution, also remains committed to providing a support system for the Center.

REVIEW

Response to specific questions posed by AID staff and a few observations will constitute the bulk of this report:

1. Are current administrative procedures dealing with personnel, travel, project development, monitoring and reporting, etc., operating smoothly and providing for increased efficiency and timeliness?

In order to establish a basis for an answer to this question, the undersigned reviewed administrative procedures and interviewed the business office personnel, as well as a representative group of administrative and project staff. The administrative procedures covering personnel and travel, as well as other basic administrative functions, are well established and are being administered in such a way as not to impose too much of a

burden on professional personnel while at the same time providing a sufficient degree of control to maintain a reasonable level of administrative discipline. Previous reviews and evaluations of the Center have raised the question of the need for "job sheets" and personnel evaluation systems. The current method of an annual review of the professional personnel, which is somewhat informal, is in the process of being upgraded to a more formal system. The support staff, which are members of an administrative "union" in the university, are covered by a bargaining agreement which require job definitions. These definitions provide a base adequate for performance review.

Project development and monitoring systems are in place and, while they are still fairly new, appear to be meeting a need for formal control that was not previously satisfied. There are operating plans for the programs and there are now established milestones sufficient to permit the Director of the Center and the Manager of International Operations to test progress against program plans. The number of programs is relatively small and loss of program control, given the personal, day-to-day interest of both Don Lauro and Dr. Rosenfield, seems to be fairly remote. However, given the program slippages that seem to occur in any developing country program, the program managers must be alert to the need for plan revisions and the effect of slippages on resource allocations. This is less important at the beginning of a funding cycle than at the end, but needs to be recognized.

2. What mechanisms have been established to keep careful track of overall costs and subagreement expenditures as well as future budgetary needs? Is there regular exchang of budget information between technical and financial management staff to ensure effective program monitoring?

The acquisition of a competent, AID knowledgeable, business manager has led to the establishment of a good budget system in the Center and the capability to track costs against the various programs. CPFH does not have its own autonomous accounting system but must rely on the University system. Performance of that system has been spotty and slow, but it is improving and a more professional relationship between the Center and the University financial people is developing. The recent upgrading of a small wo processing system to provide an "in-house" back-up financial/budget reporting capabili has made a big difference. The managers now have a constant flow of data with respect to expenditures against budget. Information, which in previous years was in the syste but was actually denied staff members, is now being funneled to them on a regular basi and, as the members become more familiar with the data flow, their ability to manage their projects will be stronger. The financial management staff, under the direction of the new business manager, has achieved a much closer working relationship with proj staff. This situation is reflected in the more timely response of staff to management questions.

This reviewer was particulary interested in the way in which staff time was charged to the Cooperative Agreement. Basically, under the Columbia University system, which the Center follows, each member of the staff's time is budgeted three months in advanc on a percentage basis. In other words, a staff person might well be slated to be on the Cooperative Agreement for as much as 100% for the next three months or as little as 10%. These allocations are subject to review by University monitors. This system, which may not be the most precise way of accounting for time, seems to work, was teste by the reviewer during the visit and appears adequate. The system accommodates change if needed, during the quarters.

3. Are there ways in which the secretarial, administrative support and management information systems can be improved?

In general, the administrative support and management information systems are being operated at a level commensurate with the skills available and the needs of the Center. Almost any MIS system can be improved by better input data and more investment in distribution hardware. The recent improvement in budget control is due in large measure to the Center's imaginative use and growth of a small word processing system. The Center might well expand its use of MIS over the next 2-3 years, if it could be assured of a funding base sufficient to justify investment in the necessary equipment. However, unless the number of field projects increases, it is hard to see where expensive systems would help improve controls. When one looks at the ratio of secretarial and administrative support to the professionals on board, adds to those counts the number of casuals that are hired for specific jobs and the number of formal consultancies that have been used, one gets the impression that the Center is doing well in its use of administrative support.

4. Have funding levels been adequate to achieve intended outputs? Has there been a cost-efficient allocation of funds within the Cooperative Agreement total budget, and are overall core support costs reasonable compared to in-country costs and outputs?

The funding levels appear adequate to handle the number of projects approved by AID and the allocation of funds as between core support costs and in-country costs seem to be reasonable. A rough cut at estimating in-country technical support and direct expenditures indicates that about 50% of the expenditures in the last three years has been basically field related.

OTHER COMMENTS

As with almost all of the AID intermediary organizations, the Center is relatively thin in back-up personnel. Dr. Rosenfield maintains a strong personal interest in every aspect of the Center's activity and his stamp is all over the organization. While Dr. Wray is certainly a competent administrator, it doesn't appear to the undersigned that he has been groomed for the top job. Don Lauro has come a long way and I believe he has the day-to-day operations of the program well in hand. I would think that, as part of the team's final meeting, that we might want to consider a review of all of the senior personnel to see what kind of back-up potential there is.

One might also question the expenditure of 7-8% of the total funds available under the Coop Agreement for library services. This function, while certainly important, might more properly be funded by some other support mechanism, particularly at a time when funds for operations research might be relatively scarce.

Sincerely,

John L. Ganley
Executive Vice President

JLG/vl

Department of State

INCOMING TELEGRAM

PAGE 01 BANGKO 15246 01 OF 02 291113Z 4926 008797 A103118
ACTION A:3-00

ACTION OFFICE POP-01
INFO ASEN-02 ASPT-02 ASDP-02 ASPO-03 ASTR-01 STHE-01 SAST-01
NHS-00 RELO-01 STHP-01 MAST-01 /023 A2 C31

INFO OCT-00 EA-11 OES-00 /036 W
003141 291113Z '33

R 291022 MAR 83
FM AMEMBASSY BANGKOK
TO SECSTATE WASHDC 2625

UNCLAS SECTION 01 OF 02 BANGKOK 15246

AIDAC

FOR SST/POP/R

EO 12356: NA
SUBJ: POPULATION: EVALUATION OF COLUMBIA UNIVERSITY ASSISTANCE

REF STATE 058008

1. USAID WELCOMES OPPORTUNITY TO COMMENT ON TONY BENNETT'S WORK IN THAILAND. FOLLOWING COMMENTS ARE KEYED TO QUESTIONS RAISED IN PARA TWO OF REFTEL.

- A. BENNETT IS INTIMATELY INVOLVED IN EACH OF THE RELEVANT AREAS OF THE BILATERAL POPULATION PROJECT. THESE INCLUDE DESIGN AND INSTALLATION OF A NEW COMPREHENSIVE MANAGEMENT INFORMATION SYSTEM, DEVELOPMENT AND TESTING OF QUOTE REAL UNQUOTE OPERATION RESEARCH APPLICATIONS, AND EFFORT TO IMPROVE COMMODITY PLANNING AND MANAGEMENT. HE CONTINUES TO PLAY A KEY ROLE IN HELPING TO IDENTIFY PROGRAM RESEARCH ISSUES AND IN THE DESIGN, IMPLEMENTATION, AND ANALYSIS OF RELATED RESEARCH. FINALLY, HE HAS CONTINUED TO WORK WITH HIS COLLEAGUES IN THE NFPP SERVICE STATISTICS IN AN EFFORT TO IMPROVE THE FORMAT, ENCOURAGE ANALYSIS, AND DISSEMINATE RESULTS.

- B. THE FAMILY HEALTH DIVISION OF THE MOPH HAS OVERALL RESPONSIBILITY FOR ORGANIZING AND MANAGING EFFORTS TO IMPLEMENT POPULATION POLICY (PARTICULARLY WITH RESPECT TO FAMILY PLANNING) IN THAILAND. BECAUSE BENNETT IS LOCATED IN THE DIVISION, HE IS IN A POSITION TO INFLUENCE MANY ASPECTS OF THE PROGRAM. HIS SKILLS ARE ESPECIALLY IMPORTANT WITH REGARD TO RESEARCH AND EVALUATION. UNLIKE SOME OTHER COUNTRIES, HE IS THE ONLY FULL-TIME EXTERNAL CONSULTANT ENGAGED IN ASSISTING NATIONAL FAMILY PLANNING PROGRAM EFFORTS. THIS ROLE, BOTH AS A CATALYST, AND IN PROVIDING ON-THE-JOB TRAINING TO HIS COUNTERPARTS, IS INVALUABLE. HE IS ALSO A FREQUENT SOURCE OF INFORMATION AND GUIDANCE TO THE DONOR COMMUNITY REGARDING THE STATUS AND UNMET NEEDS OF THE THAI NFPP.

- OVER THE PAST TWO YEARS, HE HAS BEEN VERY INVOLVED IN DESIGNING AND IMPLEMENTING STUDIES OF SUCH POLICY AND PROGRAM ISSUES AS:

- (A) RECOVERY OF PROGRAM COSTS THROUGH THE COMMUNITY-BASED SALE OF CONTRACEPTIVES;

(B) STRATEGIES FOR INTENSIFYING [illegible] AND SERVICE DELIVERY IN LOW PERFORMANCE AREAS; AND

BANGKO 15246 01 OF 02 291113Z 4926 008797 A1
- (C) INITIAL DEVELOPMENT OF A SYSTEM FOR FORECASTING FUTURE CONTRACEPTIVE REQUIREMENTS. FYI: THIS WAS A KEY FACTOR IN HELPING TO BRING ABOUT A SUBSTANTIAL INCREASE IN THE RTG BUDGET FOR CONTRACEPTIVES. END FYI.

C. BENNETT IS EXTRAORDINARILY ACTIVE, PROVIDING TECHNICAL SUPPORT TO A WIDE RANGE OF PROGRAM ACTIVITIES. DURING THE PAST TWO YEARS, HE HAS PLAYED A MAJOR ROLE IN DESIGNING AND/OR IMPLEMENTING MORE THAN 20 STUDIES AND ACTION-RESEARCH PROJECTS. HE SERVES AS A MEMBER OF THE NFPP'S PROGRAM RESEARCH WORKING GROUP AND PROVIDES ASSISTANCE, OFTEN AFTER-HOURS, TO A NUMBER OF ACADEMIC AND NON-GOVERNMENTAL ORGANIZATIONS ENGAGED IN POPULATION-RELATED RESEARCH.

- THE OVERALL QUALITY OF HIS WORK, AS JUDGED BY BOTH HIS COUNTERPARTS AND USAID, IS EXCELLENT. IT IS IMPORTANT TO NOTE THAT BENNETT'S CULTURAL SENSITIVITY AND FLUENCY IN BOTH SPOKEN AND WRITTEN THAI, HAS ENABLED HIM TO ESTABLISH EXCEPTIONALLY GOOD RAPPORT WITH HIS COUNTERPARTS. PERHAPS THE BEST TEST OF THE PERFORMANCE OF AN ADVISOR IS THE EXTENT TO WHICH HE IS SOUGHT OUT AS A SOURCE OF PROFESSIONAL ADVICE AND SUPPORT. IN BENNETT'S CASE, HE IS, IF ANYTHING, SOMETIMES OVER EXTENDED BECAUSE OF THE HIGH DEGREE OF TRUST AND CONFIDENCE THAT HIS COLLEAGUES HAVE IN HIM.

- D. IN SUM, USAID AND OUR THAI COUNTERPARTS STRONGLY RECOMMEND THAT BENNETT'S SERVICES BE CONTINUED. WE DO SUGGEST, HOWEVER, THAT AN INCREASED EFFORT BE MADE TO:

Best Available Document

127

.E 01 BANGKO 16246 02 OF 02 291114Z 5308 000798 AID3246
.CTION AID-00

ACTION OFFICE POP-04
INFO ASEM-02 ASPT-02 ASDP-02 ASPD-03 ASTR-01 STHE-01 SAST-01
HHS-09 RELO-01 STHP-01 MAST-01 /028 A2 031

INFO OCT-00 COPY-01 EA-12 OES-09 /057 W
----------004531 291446Z /44

R 291102Z MAR 83
FM AMEMBASSY BANGKOK
TO SECSTATE WASHDC 2626

UNCLAS SECTION 02 OF 02 BANGKOK 16246

- (1) OBTAIN AGREEMENT FROM NFPP TO FOCUS BENNETT'S EFFORTS ON A SMALLER NUMBER OF HIGH PRIORITY ACTIVITIES (E.G. IMPROVED LOGISTICS REPORTING AND DATA ANALYSIS, IN-HOUSE STUDIES); AND

- (2) TO THE EXTENT POSSIBLE, ALLOCATE INCREASED TIME FOR THE PURPOSE OF TRANSFERRING SKILLS. FYI, ATTEMPTS TO DO THIS TO DATE HAVE OFTEN BEEN THWARTED BY NEED TO MEET TIGHT DEADLINES AND FREQUENT STAFF TURNOVER IN DIVISION'S RESEARCH AND EVALUATION SECTION END FYI.

. PLEASE ADVISE OUTCOME THIS EVALUATION, ESPECIALLY S IT AFFECTS BENNETT. DEAN

128

APPENDIX N

Country Expenditures

COUNTRY EXPENDITURES 7/1/82 - 6/30/83 (Through March 31, 1983)

	Bolivia	Brazil	Burundi	Haiti	Mexico	Nigeria	Sri Lanka	Sudan	Tanzania	Thailand	Togo
Salaries	23097	44142	28389	57055	50053	45908	20779	43104	41330	35651	19083
Fringe	5785	11046	7108	14275	12524	10187	5205	14006	10340	8924	4781
Travel	4261	4474	6316	1977	246	14974	3821	10054	15894	0	10878
Consultants	0	6000	3800	0	0	0	0	1500	0	0	0
Rental	0	10000	0	6000	0	0	0	10000	0	6321	0
Services	0	10090	0	2329	0	1481	0	946	0	1520	0
Subagreement	20000	181723	In development	0	17467	70000	35101	0	25000	0	In development
Total CPPH	53143	267475	45613	81636	80290	142550	64906	79610	92564	52416	34742
Central AID				*126000				110000			
Pathfinder		146000				*187000					
Other									100000		
Grand Total	53143	413475	45613	207636	80290	329550	64906	189610	192564	52416	34742

*To fiscal year ending September 1983

Ratio of Support Costs to Project Costs	1.65	.26	N/A	.64	N/A	.28	.84	.72	.54	N/A	N/A

Suggested Future Research Areas

A review of the variety of OR projects suggests that several areas may deserve additional attention in selected countries: (1) IEC approaches (e.g., mailings to special audiences, telephone in key urban areas, the variety of ICARP-type projects conducted in East and Southeast Asia in the early 1970's); (2) ways to increase contraceptive continuation rates; (3) the role of salaried and/or incentive-based fieldworkers; (4) observation of content of face-to-face interaction between clients and workers and methods to improve it; (5) improvement of logistical supplies; (6) improvement of training, particularly nonformal education techniques and training of trainers; (7) improved field supervisors.

Some detailed suggestions (adapted from Cernada, "Research Needs in Family Planning Program Promotion," Int'l Quarterly of Community Health Education, 4:1, 1983.) about possible studies of provider/user interaction, continuation, source perception, comparative educational approaches, marketing studies follow:

(1) Provider/User Interaction

The need to study provider/user interactión came in for considerable discussion at the first ECAFE (Economic Commission for Asia and the Far East) Working Group on Communication Aspects of Family Planning in Singapore in 1967. This area of applied research also was one of nine selected as potential regional research projects by the 21 social scientists at the 1973 Seminar on Social and Psychological Aspects of Fertility in Asia. Few discussions of training, supervision, and job descriptions of family planning field workers take place without attention to the dynamics of interaction in the field.

Yet, relatively little is known about the content of face-to-face communication and virtually nothing about which educational approaches are more suited to the potential user's frame of reference. Just what is it that successful field workers say and do in the field? What role does the husband play in decision-making? Such research lends itself to a wide variety of methodological approaches, such as case studies done by participant observation, post-session interviews, use of skills, defining situations through grounded theory approaches, experimental manipulation of content and process in field interaction, and adaptability to modern visual and audio monitoring technology. Other factors being equal, what makes a successful field worker successful and can it be taught to other such workers?

(2) Continuation

With the current contraceptives being used in national family planning programs, one can assume that about half of those accepting a method will have stopped using it within 2 years. Even if we ignore the many loosely defined definitions of an acceptor (e.g., receiving a single packet of oral contraceptives by nonrequested mailing), and accept the fact that some persons have side-effects which are not easily dealt with, there is a serious problem of continuation. Research, however (see Ross), tends to focus upon the demographic profiles of acceptors, identifying concomitant variables (age, parity, education) which are not readily amenable to change.

Nine (most still relevant and not implemented) action research subjects on continuation which were presented to the ICARP session in Manila in 1973 include:

1. Reviewing the findings of followup studies of contraceptive acceptors (both clinic and mass sample surveys) to determine the best time, if any, to provide post-acceptance visits for reassurance or treatment of side effects.

2. Experimenting with some simple control studies of educational inputs in initial preservice field worker training to find out the relative effectiveness of curriculum units (on group discussion with satisfied acceptors and other approaches). Which approaches build up confidence of workers in the contraceptive methods?

3. Instituting a newspaper column or telephone service in larger cities to find out if they can help answer questions about side effects to better improve continuation.

4. Starting an experimental study which involves both husbands and wives in contraceptive counseling and compares their continuation rate with couples where only the wife is involved.

5. Designing educational materials intended for the use of couples after acceptance of the contraceptive, pretesting them, and providing to one group of couples and not to another (matching group) to measure effect on continuation.

6. Designing leaflets about female contraceptive methods (e.g., IUD and pill) that are intended for males, pretesting them, and assessing their effectiveness in increasing both acceptance and continuation.

7. Designing a manual for management of side effects (psychological and physiological), pretesting it, and assessing its effectiveness.

8. Conducting an action-oriented field survey of the potential local supply depot possibilities for condoms and oral contraceptives and carrying out a large-scale field trial of its value in increasing continuation rates over previous or current approaches.

9. Assessing more fully (by use of skills, on-the-spot indirect and participant observation, and post-session interviews with both patient and service provider) what actually goes on in patient/physician, field worker/patient face-to-face sessions so that these can be improved educationally.

(3) Source Perception

Possibly the single most obvious and yet most ignored area of needed research in the family planning program promotion model is the attitude of the public to the source of the message. Western research in the communication and persuasion area alerts us to be sensitive to an audience's perception of the source of a message. Both trust and expertise seems to be involved in terms of credibility of the source. Many governments (the United States is no exception) are sensitive to probing in this area, but knowing to what extent villagers are likely to trust a county or state or national government or governmental agency to be competent is important to consider in family planning program planning. This delicate area needs attention. At the field worker/villager level, this has implications for the tradeoffs involved in selection of a local less skilled person to do the family planning promotion job versus a more highly trained outsider. Some of this research may lend itself to following the experimental study programs of social distance and communicators done earlier in the Western tradition and with which Asian family planning programs have ample experience. For example, the World Bank's study of Experiments in Family Planning (Cuca & Pierce) describes some 50 Asian experimental and quasiexperimental studies. It, however, needs to be balanced by use of a different model of communication than that suggested by Lasswell or even Berelson; e.g.,

NOT WHO

SAYS WHAT
IN WHICH CHANNEL

TO WHOM
WITH WHAT EFFECT?

132

NOT SOME KINDS OF COMMUNICATION
ON SOME KINDS OF ISSUES
BROUGHT TO THE ATTENTION OF SOME KINDS OF PEOPLE
UNDER SOME KINDS OF CONDITIONS
HAVE SOME KINDS OF EFFECTS.

(Berelson)

BUT WHO SELECTS WHAT COMMUNICATIONS
ON ANY ISSUES
ONLY FROM WHOM THEY WISH
AND ONLY THROUGH THE CHANNEL THEY SELECT
AND WHATEVER EFFECT THERE IS
DEPENDS UPON WHOSE INTERPRETATION OF THE PLACE OF THAT MESSAGE, THAT SOURCE, THAT CHANNEL IN THEIR OWN REAL WORLD.

(Cernada)

(4) Comparative Educational Approaches

Although there have been studies done on comparative educational approaches (types of incentives, various media, group versus home visit education), there is ample reason to suggest that each country reinvent the wheel again. Few countries, for example, have tried systematically testing whether female or male field workers would be preferable, especially if they approached different audiences in different ways. The emphasis on community participation and control at the village level in Indonesia, for example, speaks to the value of more trials of similar approaches adapted to other cultures. Educational materials directed to husband as well as wife or vice-versa also needs more trial.

(5) Marketing Approaches

Marketing studies and advertising approaches that emphasize shifts in brands by consumers have implications for family planning promotion. In business, the purpose is to switch consumers into consumption practice that increases per unit profits, often to compensate for lack of rapid increase in volume of sales. In family planning, the purpose would be to shift acceptors to contraceptives that are more effective or better meet their needs. The methodologies peculiar to these business approaches seem amenable to adaptation to public programs as well.

Perhaps as important, the experience of marketing research into places, companions, styles, and meanings associated with products in specific social groups seems to be applicable to contraceptive products as well. The use of simple pretense to ask respondents about the meanings they read into our promotional literature would be an eye-opener.

xxx

Selections from C. Cernada, "Research Needs in Family Planning Program Promotion," International Quarterly of Community Health Education, 4:1, 1983.