

November 29, 1984

MEMORANDUM

TO: S&T/H, Ann Van Dusen, Ph.D.

FROM: S&T/H/HSD, James Heiby, M.D. *JH*

SUBJECT: Management Review of the Health Development Planning and Management Project/Indonesia

A. Background. This is a five year, \$2.5 million project to strengthen the capability of the Government of Indonesia to plan and manage the use of health sector resources. This is to be achieved through a cooperative agreement with Johns Hopkins University and a subagreement with the Faculty of Public Health (FKM) of the University of Indonesia. The general approach of the project is to support FKM efforts to collaborate with the Ministry of Health in a number of ways, reflecting the broad role of the University in the U.S. and other countries. The project will assist the FKM to develop its academic teaching program to train new MOH planners and managers. In addition, the project will support FKM efforts to design and initiate short-term, in-service training in management for MOH officials. The project will also assist faculty staff in establishing themselves as consultants in the management of health programs. The project will also support FKM participation in practical research examining MOH services. Apart from the traditional teaching program, these are new activities for FKM.

The project began in September 1981 and received a mid-project evaluation in April 1984. Up to now, project activities have focused on: 1) training MOH trainers at the provincial level or below, who are then to train their colleagues in the management of their programs; 2) revising the FKM curriculum related to management and planning and training staff. Relatively few staff consultations have taken place, and there has been minimal research activity. Tentative plans for the remainder of the project include continuing staff training, increased consultation, and greatly reduced participation in on-the-job training of MOH professionals. The predominant activity will consist of a research effort termed "functional analysis" which will examine local health problems in one geographic area, then systematically analyze the MOH program in place, and finally recommend changes in services.

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1. General Issues: Few take issue with the general objectives of management and planning efforts in health programs: to design and implement programs in a manner that makes the best use of limited resources. But advocates of management improvement have not made a convincing case in most A.I.D.-assisted countries. Program managers who seek this kind of assistance remain the exception. Examples of the consistent application of management principles are even rarer. Many countries with severely limited health budgets continue to use their scarce resources in ways that management experts regard as grossly inefficient. Yet, if the claims of these experts are valid, interventions to improve the management of health programs could save lives and reduce illness much like the introduction of new technologies such as ORT.

Thus, while HDEP seeks to improve the management of MOH health programs, there is no well-established model for how this can be done. In addition to the technical, policy, and political obstacles that might hinder the project, there is also a pervasive skepticism in the field that new management approaches will prove effective. Indeed, a ranking MOH official with whom I discussed HDEP's in-service training activities expressed doubt that this training would have a significant impact. If the project is to influence the way services are delivered in Indonesia, it will be essential to (1) explain the rationale for proposed management changes, (2) give concrete evidence that they work, and (3) document the impact of the new approaches that are actually carried out.

2. S&T/H Issues: JHU reports have noted that the objectives of the Office of Health reach beyond a single country, but that S&T/H has provided only limited guidance regarding our information needs. I will attempt to outline those needs in this report. In general, I would view efforts to improve the management of health programs in Indonesia as highly relevant for a wide variety of LDC's. Particularly at the level of practical, concrete actions, there has been very little detailed analysis of how the management of these programs can be improved. Even programs set in cultures quite different from that of Indonesia could benefit from a careful description of the project's experience. This includes, of course, unsuccessful efforts and persistent problems.

HDEP has already printed 37 different reports, many of which are in English. While these reports serve other purposes, they are not, in general, oriented toward application in other countries. The most impressive potential contribution of the project is not theoretical, but rather involves real service delivery programs in Indonesia. It is the concrete efforts of the project to influence these programs, and the outcome of those efforts that contain lessons of broad interest. Available project reports do not deal with actual management problems in the Indonesian health system. Nevertheless, the FKM project staff view HDEP as evolving from a focus on theoretical management principles toward more immediate, practical service delivery problems. This is certainly a trend that the Office of Health should support.

Finally, I should note that this review is based primarily on a one week visit to Indonesia, supplemented by a review of English language project reports. Despite the courtesy and full cooperation of the FKM project staff, some of my impressions of this complex project may be in error. I welcome suggestions for changes.

B. In-Service Training. The MOH has a special unit to support in-service training for its staff. One of the major HDPM activities has been the development of a three week course on planning and management to be taken over by the MOH training unit. The course was designed to be replicated by the trainees and included topics on training techniques. Thus, it is known as a "training of trainers" (TOT) course. By the third course (September 1984), MOH staff had largely taken over actual training responsibilities. The content of the course has evolved also, with more time devoted to specifically Indonesian case studies. I was not able to review any of these case studies. The topics covered include:

1. group dynamics
2. the systems approach
3. the national health system
4. the health development plan
5. health insurance
6. the government's 3-tiered system for rating the performance of health centers
7. integrated reporting (national system)
8. the monitoring and control of programs
9. health service referrals
10. food and drug regulation
11. basic principles of management
12. the problem-solving cycle
13. priority setting
14. operational plan development
15. health center services
16. communication, motivation, leadership, supervision
17. basic health planning principles
18. health information system
19. principles of teaching and learning
20. methodologies of teaching and learning
21. development of a teaching and learning plan
22. the epidemiological approach to planning
23. financial and budgetary control
24. MOH policies regarding monitoring, control, and evaluation of health programs
25. program evaluation
26. organizational methods for health programs
27. organizational development, part 1

28. organizational development, part 2
29. the role of the education and training center in supporting development programs
30. the educational approach to community participation

The courses were evaluated by asking the participants to rate topics in terms of importance, clarity of presentation, benefits to the trainee, and relevance to the trainee's work.

The staff has given priority to making the training self-sustaining. Every province has been represented in the course, and the 60 trainees have in turn trained about 500 MOH officials. The chief issue was raised in a 1983 JHU report: the need to assess the influence of this training on management practices. A thorough evaluation of this kind would be extremely difficult. Dividing measures of the performance of managers is itself a difficult task. Many would regard changes in actual program management as unlikely from a three week course covering such a broad range of topics. The influence of second generation training is even more doubtful: TOT graduates were required to adapt general management principles from the course to specific local issues, something their mentors have little experience with themselves.

Despite these difficulties, there is an argument for some effort to evaluate the effectiveness of the TOT courses. The question of how to train health professionals in management is an important one and few programs have yet produced useful information. A small but imaginative effort to examine the effects of this training, perhaps on a sample basis, could make a valuable contribution to the field. It would be unfortunate if an activity of this magnitude were to produce no insights of general interest.

C. The FKM Degree Program. The professional level training of MOH officials is obviously relevant to their performance as managers. Under this component of the project, JHU consultants have reviewed curricula and suggested changes and have conducted seminars for the FKM faculty. In addition, several FKM staff have been sponsored for training at JHU. Apart from seminar presentations, several of which have been printed as working papers, this is the least documented project activity. If there are elements of this experience of potentially general interest, they are not contained in available reports. Since both USAID/Jakarta and S&T/H expect to support the development of schools of public health in the near future, it is reasonable to ask for an analysis of the HDPM experience in this area. Reports make only a general reference to gaps and overlaps in management-related curricula. There are similar references to the need for more practical management tools and experience, but without elaboration.

There are also some questionable activities in this component that merit comment. A number of faculty have been brought to JHU to attend the same course, and more are scheduled. It is difficult to justify this degree of duplication of such expensive training, particularly when financial resources and staff time are in short supply. Regarding seminar topics, I could discern

no overall strategy or coherence. One of the topics, the impact of an aging population in the U.S., is by any reasonable standard, outside the scope of work of the cooperative agreement.

D. Technical Assistance. Faculty members in universities in the U.S. frequently apply their technical expertise as consultants. This is not an established role for the FKM staff, but it is one of the major activities anticipated by the cooperative agreement. This is an area that has received low priority within HDPM. Only recently has FKM selected a mechanism by which staff may be paid for such work. Many staff will continue to be hampered in this area by the requirements of their private medical practices.

More important than these mundane obstacles, in my estimation, is the lack of demand for TA services, particularly on the part of the MOH. I can see no reason to expect the MOH to provide consulting work to FKM staff in order to build their expertise and reputations. On the contrary, I would expect the MOH to turn to the FKM only once their expertise is established. Thus, if the project is to develop this component, it will be important to demonstrate the staff's ability to deal with practical problems. The proposed functional analysis may be able to provide an opportunity for such a demonstration.

E. Health Services Research and Functional Analysis. In its first three years, HDPM has dealt with concrete service delivery issues to only a very limited degree. Project documents offer few insights into immunization coverage, the followup of children treated for diarrhea, the nature of supervisory visits, and similar details of how health services are actually delivered. Nevertheless, virtually everything the project seeks to accomplish in management and planning depends on influencing these discrete activities. Thus, a proposal to focus the remaining two years of the project on an examination of functioning MOH delivery systems is a welcome development.

It is no simple matter to systematically describe how a health delivery system works, analyze its strengths and weaknesses, and propose specific changes to improve its performance. In the present instance, the HDPM staff is proposing a technique known as "functional analysis." This approach was developed by a JHU team more than 15 years ago. As a technique for documenting what program personnel really do and for indicating how they can be more effective, functional analysis has found surprisingly few applications in that period. On the other hand, neither are there more prominent alternative methodologies. Overall, the practical description and analysis of PHC delivery systems is a field marked by slow progress. Success in this area could allow HDPM to make a contribution to the state-of-the-art in PHC of worldwide relevance.

The HDPM staff note that none of the data collection techniques proposed are unique to their functional analysis methodology: they are prepared to use two minute interval observations of staff, epidemiological surveys, checklists, semi-structured interviews with managers, and any other technique that seems useful. All of these techniques have been used in other methodologies. Rather, the proposal defines "functional analysis" as follows: (1) Categorization of all observations into certain service and management "functions". For services, this might include curative care, MCH, family planning, communicable disease control and sanitation. Supportive management functions might be divided into reporting, supervision, training, physical plant maintenance, and meetings. Previous functional analyses have measured how much time different personnel devote to these "functions". The premise here seems to be that these functions are the most useful units to describe a delivery system and that there is no satisfactory substitute for direct measurement. (2) To decide what a health program should be doing, one must directly assess "community needs" and on this basis select the most desirable division of resources among the various functions. (3) Each function can be subdivided into a number of specific tasks for purposes of analysis.

In summary, the HDPM staff are ostensibly proposing a moderately well-defined activity, not merely an analysis of the functions of different MOH personnel. Available reports on previous functional analyses illustrate the kinds of insights that can be expected from this approach. These include measures such as: (1) average number of illness episodes per person by age, (2) per cent effort devoted to MCH, sanitation, and other functions by different workers, and (3) different services expressed in minutes per day and number of patient contacts per day, by category of worker.

The stated objectives of the current proposal go far beyond the kind of results illustrated above. The HDPM staff propose to also achieve such outputs as to: (1) define local health care priorities, (2) assess the service and management tasks of MOH personnel--i.e., evaluate the specific activities that comprise a "function" like MCH, (3) determine which discrete tasks should be carried out by the various categories of personnel, thereby establishing ideal job descriptions, (4) prepare management protocols, (5) develop improved management systems for selective supervision, continuing education, financial management, logistical support, and information flow, and (6) develop training programs based on the new job descriptions.

None of the materials available to the Office of Health, including the draft proposal, provide examples of how any of the above objectives is to be achieved. In particular, it is unclear to me how the unique characteristics of functional analysis bear on these obviously worthwhile objectives. Examples, hypothetical or from previous studies, should be included to show how the functional analysis technique can produce information of this kind. If, on the other hand, these objectives do not follow from a standard functional analysis per se, but rather depend on the logical interpretation of

data and other factors, each deserves a separate discussion. If the credibility of the projected results cannot be based on experience elsewhere, then the proposal should outline how the validity of the results will be assured.

1. Data Collection Methodologies. The proposal lists the following major data collection activities:

a. Population based survey: The emphasis here is measuring "community health needs," including reported morbidity and mortality, health-related beliefs and practices, and selected physical measures such as anthropometry and hemoglobin. This survey constitutes three-fourths of all data collection efforts.

b. Interviews with local leaders: These focus on subjective ideas regarding health-related priorities and the willingness of the community to participate in some way in providing health services.

c. Review of routine service statistics and reports: Depending on what is available, this might include counts of services provided, personnel information, supplies, and an attempt to summarize the use of routine information in managing the program.

d. Direct observation of staff: Observers would record the activities of service personnel both in the clinic and during field work. They would also use checklists to summarize any supervisory contacts that take place.

e. Interviews with district staff: Questions on management problems and activities would be supplemented by asking the staff to maintain activity diaries for about two weeks. The project would also review any available reports at this level.

2. Data Analysis and Interpretation: The proposal suggests that this step of the functional analysis will be carried out by several small groups comprised of representatives of HDPM and the MOH. The anticipated results include:

a. Identification of priority health problems: This would combine measures of morbidity, mortality, community perception, preventability and other factors.

b. Selection of appropriate services: A working group would consider the newly-identified health priorities, make some overall judgement regarding what the health system is capable of, and then select the best combination of services for the situation. By implication, this is expected to be substantially different from the current package of services.

c. Task analysis and role reallocation: A working group would take each of the proposed services and, based on unspecified criteria, break them down into the "specific technical tasks" that someone must perform to make the service available. Some, but probably not all, of these tasks will already be assigned to specific MOH personnel. The working group is then to make a judgement regarding who can best carry out a given task. In doing so, they are to consider the practical limitations of the MOH program and the possibility of transferring some responsibility to community groups. This finally leads to new job descriptions for MOH staff.

e. Selection of a management approach: Working groups would describe the current management system based on the data collected and then propose alternative approaches, possibly drawing on the experience of organizations outside the health system. The proposal offers no indication of how this complex task is to be carried out.

f. Management task analysis and role reallocation: A working group of management experts and administrators would be asked to break down all the functions of management into "specific tasks". They would then use this standard to evaluate current management practices. Finally, they would develop job descriptions to cover all of the management tasks and integrate these with the service-related job descriptions developed previously.

3. Utilization of Results. The proposal indicates that the various job descriptions that will result from the functional analysis should help define the training curricula for various MOH professionals. Since there is no concrete reference to applying the results of the study in the field, these curricula would apparently follow a hypothetical ideal job description rather than actual practice. The proposal also anticipates four additional functional analyses in other provinces for the final year of the project.

4. Discussion: The proposal presents an extremely ambitious agenda that is both insightful and practical. If HDPM is even partially successful in this effort, the results will be impressive. It is difficult to find examples of successful efforts to systematically describe a PHC system, outline its shortcomings in every major service, and then specify how these shortcomings can be addressed under local conditions. Unfortunately, this assessment also seems to apply to previous "functional analysis" applications. At most, the proposed activity has some overlap with what has been labeled functional analysis. In a field that is so underdeveloped, it is only reasonable to take advantage of any available experiences that may be relevant. But there is a potential pitfall in labeling this study a "functional analysis" in that a well-defined, established methodology does not require an explicit rationale for each step. The most important conclusions of the analysis will be based primarily on logic, experience, and professional judgement. No amount of data will redesign a delivery system by itself. Thus, it will be important to carefully explain the reasoning behind the data analysis and corresponding proposals for changing the program. MOH decision makers should be able to examine the basis for a given conclusion and argue with the project staff where they disagree. Documentation of these discussions is also desirable. The present proposal does not address this point.

The most important theoretical contribution of previous functional analysis, in my view, is the principle that health services can best be analyzed by first subdividing them into a number of discrete tasks. The proposal does not dwell on this way of thinking about service delivery or illustrate what constitutes a discrete task. Nor does the proposal address the importance of constructing objective measures for the performance of these tasks. Nevertheless, this perspective leads one to view a delivery system as a very large number of distinct and partially independent activities, any one of which can potentially be objectively measured and improved. Indeed, if the

investigators cannot evaluate a given task carried out by a given health worker and then effectively resolve any shortcomings, there is little reason to be optimistic about large scale improvements. If, however, the research staff shows that it can deal with a variety of tasks individually, the chief issue of the functional analysis becomes how to address the large numbers involved. The functional analysis promises to make an important contribution to both FKM and the MOH by simply directing attention to the concrete activities of the program.

A second central feature of the methodology is the assessment of community health needs. The implicit focus here is on the overall design of the delivery system--whether or not it is responding to the most important health problems, based on epidemiological measures and local perceptions. Previous functional analyses have produced findings such as those showing that a certain program emphasized curative care at the expense of promoting sanitation, even though diarrhea was a common problem.

It is obviously important to know something about the health problems the program is trying to address. It is no doubt true that few health programs correspond precisely to what is needed. I do, however, have reservations regarding the level of effort proposed for this portion of the study, relative to the value of the insights that can be expected to result. I would propose that HDFM can make a more valuable contribution by giving more emphasis to the effectiveness with which various activities are implemented. Further, I am skeptical that even the sizable survey proposed will be able to arrive at a generally accepted, objective determination of what services are really needed by the population. A high level of precision does not seem warranted.

Technical discussions of the functional analysis methodology consistently refer to a step in which service activities are categorized into a relatively small number of "functions" like family planning or curative care. None of the papers discuss the rationale for this process. I infer that the objective is to create a manageable number of units of service delivery in order to simplify the analysis--such as describing how a number of categories of health workers spend their time. Apart from facilitating quantitative analysis, I would question the practical value of these fairly crude units. Managers have only limited use for precise measures of how their personnel divide their time among these functions. In contrast, I would expect managers to directly apply the results of task-level analyses that objectively measure performance and show how it can be improved. It is also at this level of concrete activities that one can demonstrate the role of different management principles. It is also here that one can find case study material to compliment the current FKM curricula.

The proposed data gathering activities include a wide range of techniques that promise to greatly expand our understanding of how the program operates. The proposal describes these techniques in fairly general terms, leaving room for interpretation. Some of my comments on data collection may simply reflect faulty inference from a general outline of activities.

a. Defining performance: The view that a delivery system consists of a large number of discrete activities or tasks, such as explaining ORT to the mother of a child with diarrhea or identifying cases of malnutrition, is central to the proposed analysis. The overall performance of the program is largely the net result of the performance of hundreds of these distinct activities. Defining these tasks in terms that allow some objective measurement of performance should be one of the first steps of the analysis: If the actual, concrete activities of the program staff cannot be measured by some scale, it is difficult to see how one goes about trying to improve them. Where the program currently has no such definition for a given activity, the functional analysis should point this out. If the health worker's responsibility is expressed as simply "promote breastfeeding," there is no objective, consistent basis for evaluating this activity. Demonstrating why a definition like this is a serious problem could be an important contribution of the functional analysis.

It is unclear to what extent the analysis will address this area. Through interviews or self-filled questionnaires, health personnel will be asked about their major tasks, both service and managerial. A review of available records may reveal detailed official job descriptions. But unless investigators are specifically examining this issue, I am doubtful that the project will produce a systematic description of what managers want their staff to do and what personnel think their job is. Similarly, the functional analysis itself will be handicapped if a number of important program activities are left vaguely defined. This is particularly true where none of the program staff spontaneously mention an important activity as part of their responsibility: The investigators should begin with a clear idea of what they are looking for. I would expect one of the earliest steps in the functional analysis to be defining program tasks in measurable terms.

b. Effectiveness in service delivery: If the HDPM staff can set measurable standards for at least some individual activities, then we could say that where these standards are not met, a "problem" exists. In my estimation, understanding how the delivery system identifies concrete problems of this kind should be a basic objective of the study. If the functional analysis is unable to generate insights into why a given field worker is unsuccessful in bringing immunization coverage to a certain level, how can it prescribe ideal job description for that worker and the involved supervisors?

The service delivery problems found through the analysis will themselves be of broad interest. Equally important is an understanding of how the delivery system identifies and monitors these problems, or fails to do so. A number of proposed data gathering techniques could be useful here, but none of them specifically focuses on identifying problems. This orientation probably requires more explicit attention.

c. Problem resolution: There is obviously little point in identifying service delivery problems unless one is prepared to do something about them. In most cases, responsibility for both identifying and resolving problems falls to the supervisory system. From this perspective, the supervisory system is central to any realistic effort to improve the effectiveness of service delivery activities. I am therefore concerned that the proposed data gathering techniques do not appear adequate to describe the desired role of the supervisory system. The work sampling approach constitutes only about three per cent of the proposed data collection effort, although the proposal does mention a checklist specifically for describing supervisory visits. The study may also include a review of supervisor reports. Staff activity diaries could conceivably contribute information on the identification and resolution of problems. But on balance I see a need for substantially greater emphasis on the role of the supervisory hierarchy in identifying and resolving concrete service delivery problems. This orientation is missing from the management assessment carried out in NTT province, where data on supervision is limited to five or six multiple choice questions. Both the FKM and the MOH need a more thorough analysis of this central process.

d. Use of program information: The proposal gives substantial attention to making use of routine service statistics. References to documenting how the MOH staff itself uses these data are less clear, although "tracking of information flow and use" is mentioned as part of reviewing records.

Beyond the traditional documentation function usually associated with information systems, there is an important role in supporting the supervisory system. An organized hierarchy of supervisors is responsible for monitoring hundreds or even thousands of discrete activities. When a given activity is found to be problematic, we expect the supervisor to take some action. Eventually, there will be a need for the supervisor to re-evaluate that particular activity. Some problems will prove persistent and should be referred to a higher ranking supervisor. All of this requires an organized information system capable of following a given activity over time. If the program under study does not have such a system, it is important to document the limited ability of the program to deal with difficult, concrete problems. If the program does attempt to follow problems until they are resolved, this effort merits explicit attention in the study. None of the proposed methodologies is well-suited to following a service delivery problem over time.

e. Skills and knowledge of program staff: Since the proposal comes from two educational institutions, it is surprising that it does not include a systematic effort to directly measure the skills and knowledge of MOH personnel at different levels. There is mention of using staff interviews to identify "training needs," but this is not elaborated. This kind of assessment inevitably involves sensitive issues. On the other hand, few pieces of management information are as useful as this or as easy to obtain. This area deserves more attention in the functional analysis and should be carefully distinguished from the staff's subjective opinions regarding their own training needs.

f. Coverage: The proposed household survey should provide a number of useful measures of the coverage of the program. Because it is a population-based survey, it will also provide an estimate of health problems that never come to the attention of the health system. It could also provide an overall estimate of community outreach visits.

Some important issues in coverage are, however, difficult to address with a single large survey. We expect the program staff, especially supervisors, to make some effort to measure population coverage for many services. We also expect them to carry out interventions to raise coverage in some instances. At this level, supervisors must deal with specific activities of a given individual worker, not global averages. Thus, the study should also attempt to document how the program staff estimate coverage and describe their efforts to raise it. To provide a standard of comparison for efforts by individual supervisors, the study should also measure the coverage of selected services on a local level.

g. District level management: Here, the proposal addresses a difficult topic where progress has been slow. HDPM efforts to define management issues in concrete terms will be of broad interest, whatever the results. Perhaps understandably, this is one of the least developed areas of the proposal. In general, the research staff will interview district level personnel, ask them to maintain an activity diary, and review available data. This information is expected to indicate the most important management needs, describe current practices, and suggest new "management packages" that correct old shortcomings.

As with service delivery, the conceptual approach emphasizes subdividing management functions into a larger number of "specific tasks" which are not illustrated or discussed. Nor does the proposal discuss how this view of management will influence data collection efforts. Rather, the investigators will define specific management tasks only as part of their analysis of the data. Thus, the proposal seems to take the position that one can describe management without reference to a model of what managers should be doing, that it is not important to be looking for certain features.

The proposed interviews can certainly produce an overall picture of how managers spend their time and of their opinions on a range of issues. But this approach does not seem well-suited to analyzing the actual effectiveness of most of a manager's daily activities. Surely this is a legitimate area of concern for the functional analysis. If the investigators were to list the most important management tasks before rather than after data collection, it is likely that they would develop rather different data collection instruments. Some important issues may require entirely different techniques.

h. Implementation of proposed changes: The proposal lists as one of its basic objectives the application of functional analysis findings in the MOH program. This is an area that is as delicate as it is important. Findings that seem unequivocal to the investigators may fail to influence program managers for reasons outside the control of both parties. Even taking these difficulties into account, however, the proposal's treatment of the actual implementation of changes in the service program is non-committal. An expressed interest in applying findings is not mentioned as a factor in choosing the study site. Higher level MOH interest in using the findings of the study is not discussed. Even the investigators make no explicit commitment to assisting any such application, evaluating the results, and documenting the process. Realizing such improvements in the health program is the stated goal of the cooperative agreement. It is inconceivable that direct experience of this kind would fail to strengthen FKM's teaching function. If there are obstacles to expanded planning in this area, the proposal should discuss them explicitly.

i. Selection of appropriate services: On the basis of the data they will collect, the investigators plan to develop "proposed service packages" through small working groups that will include MOH officials. Apart from the size and composition of the groups, the proposal has little to say regarding how they will develop a better program design. I doubt that the data by themselves will make more than a few program design decisions obvious. Yet the credibility of the recommendations coming out of the study will be the major determinant of its practical utility. Thus, it would be prudent to explicitly address the question of why should the MOH accept HDPM's idea of what is "appropriate". In some case, I gather that this argument might be based on experience and logic. Perhaps there is a role for more formal systems tools, such as multiple criteria utility assessment. There may be instances where a specific field trial will be necessary to convince officials of a proposed change. At the very least, the proposal should provide assurances that there will be an explicit, documented rationale produced for every major change that is proposed.

j. Early focus on ORT: A.I.D. plans to sponsor conferences on implementation issues in oral rehydration therapy programs, for Asia in early 1985 and a worldwide conference in November 1985. Both of these conferences offer a good opportunity to further HDPM objectives. I would recommend that the staff consider the feasibility of an early focus on ORT, possibly

functioning as a pilot phase for the full functional analysis. Many of the issues and approaches outlined in the proposal are not only relevant to ORT services, but also address the least understood elements of this important PHC technology.

k. Fieldwork by health professionals: The ability of senior professionals in FKM, JHU, and the MOH to spend time in the field is a longstanding issue. If the data collection process is to be largely delegated to nonprofessional interviewers and inexperienced personnel, many essential techniques must be ruled out. The ability of the HDPM staff to arrange for field time by the most qualified professionals is obviously limited. But there are potential alternatives to relying solely on interviewers. Short-term salary supplements may be feasible or it may be possible to hire full time experienced professionals for the fieldwork period. If it is impossible to avoid frequent commuting from Jakarta, a nearby location for the study is critical. The proposal should discuss the level of effort of individual professionals in Jakarta and the field.

l. Funding: The functional analysis directly addresses the central objectives of the cooperative agreement. Both the Office of Health and USAID/Jakarta consequently view this as the highest priority activity for the coming year. My impression is that representatives of FKM, MOH, and JHU also accord priority to the study. Therefore, while we welcome shared funding with an Indonesian institution, project funds should not be committed to lower priority activities until full funding for the functional analysis is secure. Because of potential overlap with a USAID/Jakarta project, it is also essential that any proposed HDPM activities with other faculties of public health in Indonesia receive the explicit concurrence of the mission.

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