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EVALUATION OF THE AGREEMENT (RSSA) BETWEEN A.I.D.'S OFFICE OF POPULATION AND THE CENTERS FOR DISEASE CONTROL (Covering 1987 through 1989)

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Table of Contents

Table of Contents i
Glossary v
Project Identification Data vii
Executive Summary ix

1. Introduction 1

1.1 Project Background 1

1.1.1 Purpose of Agreement 1
1.1.2 Historical Overview 1
1.1.3 Nature and Evaluation of the RSSA 2

2. The Logistics Component of the RSSA 3

2.1 Performance 3

2.1.1 Objectives 3
2.1.2 Description of Activities 3
2.1.3 Level of Effort 4
2.1.4 General Assessment 5
2.1.5 Innovative Aspects 5

2.2 Selection of Countries 9
2.3 Institution Building 9
2.4 Collaboration with FPLM 10
2.5 Future Directions 11

3. The Survey Component 15

3.1 Performance in Conducting Surveys 15

3.1.1 Number and Types of Surveys Conducted 15
3.1.2 Definition of Objectives and Content 16
3.1.3 Adequacy of Design and Execution 16
3.1.4 Innovative Aspects of the Survey Work 17

3.2 Selection of Countries 18
3.3 Institution building within Host Country Institutions 19
3.4 Dissemination and Use of Survey Results 20
3.5 Collaboration with DHS 20
3.6 Future Directions for Survey Work 22

4. Linkage between Project Components 25

4.1 Programmatic Linkage between Logistics and Surveys 25
4.2 Program Balance: Logistics and Survey Work 26

5. Management 29

5.1 The A.I.D. - CDC Relationship 29

5.1.1 From A.I.D.'s Perspective 29
5.1.2 From CDC's Perspective 30
5.1.3 New Directions for the A.I.D. - CDC Relationship 31

5.2 CDC RSSA Management 32

5.2.1 New Organizational Structure 32
5.2.2 Staffing 36

5.3 Planning 39
5.4 Budgeting 41
5.5 Reporting 42

5.5.1 Trip Reports 42
5.5.2 Quarterly Reports 43

6. Future Directions 45

6.1 Setting the Stage for the Future 45
6.2 Principal Recommendations 45

6.2.1 Immediate Steps 45
6.2.2 Overall CDC Role 46
6.2.3 Setting Priorities within Logistics and Survey Components 46
6.2.4 Division of Labor Between CDC and Other CAs 46
6.2.5 Coordination Among Project Components 47
6.2.6 Management 47

List of Tables

Table 1 Number of Countries Provided Logistics Management Assistance by Region and Fiscal Year FY 85-89 4

Table 2 A.I.D./RSSA International Travel Days, Allocated to Major Activities and Percent Change by Fiscal Year FY 87-89 26

Table 3 RSSA Staff: FTE Status 36

Table 4 Accrued Expenditure Report RSSA Agreement FY87-90 42

List of Figures

Figure 1 Division of Reproductive Health, Pre-Reorganization, 1989 33

Figure 2 Division of Reproductive Health, Post-Reorganization, 1990 34

List of Appendices

Appendix A Scope of Work
Appendix B Description of Evaluation
Appendix C Additional Tables and Figures
Appendix D Complete List of Recommendations

Glossary

A.I.D.	Agency for International Development
CDC	Centers for Disease Control
CCMIS	Contraceptive Commodity Management Information System
CPS	Contraceptive Prevalence Survey
CPSD	Commodities and Program Support Division (Office of Population)
CPT	Contraceptive procurement table
CTO	Cognizant Technical Officer
CYP	Couple year of protection
DHS	Demographic and Health Surveys (project)
DRH	Division of Reproductive Health (CDC)
FP	Family planning
FPLM	Family Planning Logistics Management (project)
FPSD	Family Planning Services Division (Office of Population)
FTE	Full-time equivalent
GS	Government Service
HIV	Human immunodeficiency virus
IEC	Information, education and communication
IPA	Intergovernmental Personnel Act
IRD	Institute for Resource Development, Inc. (formerly Westinghouse Public Applied Systems)
IT	Information and Training (Division -- Office of Population)
JSI	John Snow, Inc.
LDC	Less developed country
MCH	Maternal and child health
MOH	Ministry of Health
PASA	Participating Agency Support Agreement

PCS	Population Communication Services (project)
PIO/T	Project Implementation Order/Technical
REDSO	Regional Economic Development Services Office (A.I.D.)
RSSA	Resources Support Services Agreement
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development (mission)
VAK	Vasectomy Attitudes and Knowledge (Survey)
YARHS	Young Adult Reproductive Health Survey

Project Identification Data

1. Scope: Worldwide
2. Project Title: Project Development and Support
3. Project Number: 936-0502
4. Critical Project Dates: 1974 to present, negotiated annually: expiration, March 1990
5. Project Funding: $17,540,019, to date
6. Mode of Implementation: Resources Support Services Agreement (RSSA) BST-0502-R-H-2052-00
7. Grantee: Centers for Disease Control
8. Major Activities:
   - A. Family planning logistics management
   - B. Demographic and contraceptive prevalence surveys
   - C. Epidemiological studies
   - D. Family planning program evaluations

Executive Summary

Overview and Evaluation

A.I.D.'s Office of Population's long-standing agreement with the Centers for Disease Control (CDC) to provide logistics and other related assistance may have reached a major turning point. This evaluation, the first since 1976 when the A.I.D.-CDC Resources Support Services Agreement (RSSA) was only two years old, came at a moment when both organizations were eager to reassess their relationship. A major recommendation is for high-level discussions between the two organizations that would focus on how best to harmonize CDC's interest in broadening its role in family planning with A.I.D.'s own concern to maintain strong efforts in logistics.

Assessment of CDC Performance

CDC has a long track record of excellent work provided through the RSSA in both logistics management and survey work. USAID mission staff were highly favorable of in-country contributions of CDC staff. Moreover, notable technical innovations have occurred in both areas over the past few years. The most significant logistics breakthrough is the computerized Contraceptive Commodity Management Information System (CCMIS), which has only recently been installed in two countries and which has the potential to contribute to the in-country ability to manage inventory properly and thus assure that contraceptives are available when needed. In survey work, CDC has developed several useful survey instruments including the Contraceptive Prevalence Survey in 1975 and more recently, the Young Adult Reproductive Health Survey (YARHS).

CDC has placed less emphasis on institutionalizing the skills in which its own staff are strong, in part reflecting a pressure to meet mission requests, given the magnitude of the work undertaken by CDC worldwide. In survey work, for example, institutionalization has occurred -- visible improvement in individual skills plus a high level of interest and enthusiasm among host country personnel involved in survey work; yet this appears to be a fortuitous by-product of the strong technical assistance provided, rather than a clear cut objective in itself. The picture with respect to logistics is of greater concern, particularly given the long period of time that CDC and the Family Planning Logistics Management (FPLM) project (see below) have been assisting countries to forecast contraceptive requirements. A step in the right direction has been CDC's shift of emphasis from Latin America to Africa, where the need for technical assistance is clearly greater. In part due to manpower constraints, trips to any given country remain typically short and infrequent, particularly those for forecasting contraceptive requirements. This pattern has changed somewhat over the past year but will need to change more if skills are to be transferred in any meaningful way and institution building to become a primary objective.

Relationship between Logistics and Survey Components

Although logistics and survey staff usually work separately, CDC has found a number of ways to improve its estimates of contraceptive requirements through the use of surveys. The ability to link these two activities makes CDC a unique resource to the Office of Population. From the vantage point of A.I.D.'s current expectations -- that logistics receive about 60 percent of RSSA efforts -- it is appropriate that surveys be used to further the effectiveness of the logistics work. In recent years, however, the emphasis on logistics work has not increased, while that on surveys surged (at least temporarily), so that

at this point, logistics efforts may be receiving as low as 40 percent of project funding, rather than the 60 percent expected.

CDC Role within Office of Population Portfolio

The CDC RSSA, funded recently at an annual level of about $1.8 million, plays a complementary role to two larger Office of Population efforts. In the area of logistics management, CDC, together with the FPLM project, assists the Office by providing wider ranging logistics support as part of the effort to institutionalize logistics management skills in-country. In the area of surveys, CDC's counterpart project is the Demographic and Health Surveys (DHS) project. There has been good collaboration between CDC and both FPLM and DHS. The two types of collaboration are not similar, however. The relationship between CDC and FPLM is ongoing, productive, and amiable. DHS's relationship with CDC, in contrast, is courteous but infrequent and not central to either program. The Office of Population also clearly needs the incremental level of effort provided by these complementary efforts, although more thought needs to be given to how best to utilize the particular skills of each organization.

Management

From a management perspective, CDC was emerging at the time of the evaluation from a difficult period, characterized by friction with A.I.D., loose internal management of the RSSA, and serious morale problems within the logistics staff group. There was every indication, however, that the problems already had been -- or could be -- turned around, given the following developments:

- The current RSSA expires in March 1990 and A.I.D. is seriously considering renewing the agreement through a longer-term Participating Agency Support Assistance (PASA) agreement;

- CDC is reaching the end of an intensive strategic study process in the course of which it is also strengthening its involvement in international family planning and reassessing its relationship with A.I.D.;

- The Office of Population has recently changed its own management of this project and is seeking ways to make its relationship with CDC more productive; and

- The RSSA activity itself has been reorganized as part of a reorganization of the division in which it resides, with strong positive implications for the logistics staff.

If a PASA is concluded between CDC and A.I.D., there will be an opportunity to undertake the kind of long-term strategic planning that was not possible under the RSSA. The project deserves credit for its excellent record to date in satisfying all mission and A.I.D./W requests for assistance. This reactive approach, however, is partially the reason the project has had to disperse its efforts rather than attempting to institutionalize skills, an approach that has contributed to the malaise of the logistics staff.

Key individuals in CDC and A.I.D. are fully in agreement with respect to the need to move from a reactive posture to a management approach characterized by thoughtful strategic, program and project planning. On the other hand, there may be some areas of disagreement with regard to how broad a role CDC -- and the CDC logistics staff -- should assume, given A.I.D.'s continued need for improvement in the logistics systems. The need

for a dependable system to deliver commodities, preferably based on institutionalized in-country capabilities, remains paramount in A.I.D.'s view, since contraceptive availability is widely accepted as perhaps the key factor in the success of any family planning service delivery effort.

Principal Recommendations

Immediate Steps

In light of the many unresolved issues touched on above, together with the imminent expiration of the current RSSA, it is important that both agencies begin discussions as soon as possible for development of a new agreement. The steps that follow should include:

- Informal discussions at top levels of CDC and the Office of Population to acquaint each other with present thinking regarding future directions.

- If CDC and the Office of Population can agree upon an expanded scope of work for CDC, then a PASA instrument should be negotiated (see Recommendation 19).*

- CDC and the Office of Population should commence immediately with strategic planning, with results to be integrated within the Agreement to take effect in the spring of 1990 (see Recommendation 31).

The principal recommendations set forth in this report are designed to feed into the strategic planning process that is recommended above. They are repeated or paraphrased below:

Overall CDC Role

- The CDC role in family planning work should be expanded insofar as the Office of Population finds it practicable to do so in view of demand and the activities of the other Cooperating Agencies (see Recommendation 19).

Setting Priorities within Logistics and Survey Components

- A.I.D. and CDC should establish country priorities for both logistics and survey assistance being provided through the RSSA. Establishing priorities will involve reviewing current procedures for selection of countries and establishing new guidelines for this process (see Recommendations 1 and 8).

- In determining priorities, a major consideration should be to ensure that the assistance provided has the potential for achieving long-lasting program improvements and institution building, including the capacity for preparing contraceptive procurement tables (CPT) (see Recommendations 2, 3 and 11).

- CPSD should assign greater priority to management information systems (MIS) and CCMIS. Wherever possible, efforts should be directed to those countries or projects that

*Recommendations are numbered consecutively throughout the report and a list of all the recommendations is contained in Appendix D.

are ready to receive CCMIS. This should not be the exclusive focus, however; rather, efforts should be directed to MIS requirements generally (see Recommendation 4).

Division of Labor Between CDC and Other CAs

- The Office of Population should examine the division of labor between CDC and -- for logistics -- the FPLM contract and -- for surveys -- the DHS contract. Consideration should be given to transferring more of the work of forecasting contraceptive needs to the FPLM contract and to utilizing the logistics specialists within CDC in their areas of comparative advantage, providing longer-term, more intensive technical assistance in fewer high priority countries with the specific goal of increasing institutional capacity to manage logistics systems (e.g., through the CCMIS). In survey work, the Office of Population should take advantage of the CDC's more flexible mandate by allowing it to become involved in program-relevant research that may deviate from the current FP/MCH or DHS type surveys. The FP/MCH survey should remain the main focus of the CDC survey activities, however (see Recommendations 7 and 10).

Coordination Among Project Components

- CDC should devote further effort to coordinating the survey and logistics aspects of the project more effectively (see Recommendation 15).

- The Office of Population should reconsider whether the logistics component should continue to receive 60 percent of A.I.D. funding under the anticipated PASA. The decision should be made in the context of the overall new directions of the PASA, taking into account an appropriate division of labor between CDC and FPLM (see Recommendation 17).

Management

- Selection of the new supervisors (one branch chief and two section chiefs) should be completed soon so that the leadership void can be filled. In so doing, it would be wise to emphasize the leadership qualifications of the new selectees and organize travel time to minimize absence from their managerial functions (see Recommendation 25).

- If possible, efforts should be made to enlarge the scope, challenge and variety of tasks for the logistics staff to utilize their talents. The leadership should explore each person's capacities and interests and to the maximum extent possible match need with interests in making assignments (see Recommendation 26).

1. Introduction

1.1 Project Background

1.1.1 Purpose of Agreement

Since 1974, the Agency for International Development's (A.I.D.) Office of Population has had an agreement with the Centers for Disease Control (CDC) in Atlanta, GA, for assistance in logistics management and associated activities. Through this Resources Support Services Agreement (RSSA) (BST-0502-R-H-2052-00), the Office of Population utilizes CDC's expertise in logistics management, clinic management, survey work, and epidemiology to help improve family planning programs worldwide. Funding has been at an average level of approximately $1 million annually ($1.57 million for FY 1989-90), with obligations to date having totaled $17.5 million.

In the language of the agreement, CDC is expected to provide "logistics assistance, perform contraceptive requirements analyses, conduct program evaluation, evaluate and collect program data, provide necessary information and data to participating countries, and assist in the implementation of recommendations and innovative program strategies." Specifically, the agreement sets forth four areas in which CDC staff will be active:

- family planning logistics management
- demographic and contraceptive prevalence studies
- family planning program evaluation
- epidemiological studies

The major emphasis (at least 60 percent of the effort under the RSSA) is expected to be devoted to logistics management, primarily through technical assistance "to improve management and operation of family planning service programs" in less developed countries (LDC). Levels of effort for the other three areas are not specified, but demographic and contraceptive prevalence surveys are viewed as the other area of major emphasis. Family planning program evaluation, which specifically involves technical assistance in clinic management through patient flow analysis, and epidemiological studies, which address risks possibly related to contraceptive use, are anticipated to absorb only a small proportion of project resources.

1.1.2 Historical Overview

When it was initiated, the CDC agreement was oriented primarily toward general needs assessment and diagnostic studies of family planning programs and the major activity was the collection of service statistics.[1] Work with logistics and survey began soon after.

Currently, the CDC agreement, under the Population Program Development and Support Project (936-0502), is one of three closely related projects managed by the Commodities and Program Support Division (CPSD) that deals with contraceptive provision and management. The heart of the effort is the Contraceptive Procurement project, through which CPSD purchases and distributes some $60 million worth of commodities annually. The two other projects are

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[1]Resources Support Service Agreement between the Agency for International Development and Department of Health, Education and Welfare, Center for Disease Control, 1976: Attachment B to "An Evaluation of Activities of the Centers for Disease Control Family Planning Evaluation Division (AID/RSSA PIO/T 932-978-2-3267514)"

designed, in part, to assist host countries in managing these contraceptive supplies: the CDC agreement and more recently, the Family Planning Logistics Management (FPLM) project, a five-year $12 million contract with John Snow, Inc. (JSI). The JSI project was initiated in 1986 in response to the vast increases in the amount of commodities being supplied and A.I.D.'s realization that it needed reinforcements in the mammoth task of ensuring the millions of commodities involved were being properly managed. Although both CDC and JSI are involved in logistics management, JSI was seen as more narrowly focused on logistics management: the FPLM project is not involved with surveys or the other activities undertaken by CDC but it does have a special mandate to assist CPSD in its centralized contraceptive procurement activities.

CDC is also not the only A.I.D.-supported activity doing survey work: Its efforts complement those of the considerably larger Demographic and Health Surveys (DHS I and II) projects (total funding: $46 million) implemented through an A.I.D. contract/grant with the Institute for Resource Development.

1.1.3 Nature and Evaluation of the RSSA

A RSSA is an administrative device that enables one government agency to avail itself of the special skills and expertise of another agency. By their nature, such agreements do not allow for the level of direction or scrutiny accorded to cooperative agreements and contracts, the usual administrative arrangements used by the Office of Population to carry out its activities. The RSSA with CDC is simply an open-ended one-year agreement, routinely renegotiated each year, to update the funding amount and the workload estimate. Whereas contracts and cooperative agreements are regularly evaluated and frequently rebid, the first and only evaluation of this RSSA took place in 1976.

This report represents the second evaluation of this RSSA in its 16-year existence. The purpose of the evaluation was both to assess the appropriateness, quality and timeliness of the activities undertaken over the past three years and to take a broad look at the future relationship between CDC and the Office of Population (see Appendix A for scope of work of the evaluation and Appendix B for a description of the conduct of the evaluation).

From the perspective of its being a forward-looking exercise, the evaluation was propitiously timed: The current RSSA expires in March 1990 and A.I.D. is seriously considering renewing the agreement through a longer-term Participating Agency Support Agreement (PASA); CDC was reaching the end of an intensive reorganization process in the course of which it was also reassessing its goals in the area of population and its relationship with A.I.D.; the Office of Population had recently changed its management of this project and was seeking ways to make its relationship with CDC more productive; and the project itself has been reorganized as part of a reorganization of the division in which it resides, offering an opportunity for management and staff to rethink how staff roles might be changed in accord with new directions that were being considered.

2. The Logistics Component of the RSSA

2.1 Performance

2.1.1 Objectives

The task of providing technical assistance to host countries in logistics management is envisioned in the RSSA as a broad-gauged, multi-faceted effort, with the accent on diagnosing problems in existing systems and developing new approaches. Specified activities include

1) developing and evaluating logistics systems for distribution of family planning supplies and services;

2) identifying and proposing solutions for administrative and/or management problems;

3) assisting in the development, implementation, and evaluation of community-based distribution programs and other innovative delivery systems;

4) developing software for microcomputer-based inventory monitoring systems;

5) assisting in development, implementation and/or evaluation of family planning service statistics systems; and

6) assisting missions in determination of contraceptive requirements through preparation of contraceptive procurement tables (CPT).[2]

2.1.2 Description of Activities

Typically, over the past year, CDC logistics staff visits have tended to focus primarily on 1), 5) and 6) above. The identification and proposals for solution of administrative and/or management problems (analyzing patient flow to improve clinic management -- item 2 above) is now somewhat separate from logistics management, with the two individuals who do this work having recently been assigned to a separate section (see Section 5.2.1). There have been very few trips related to developing or implementing community-based distribution systems (item 3 above). Software development for host countries is done at headquarters, although its installation is of growing importance (item 4 above).

The following provides an overview of the range of activities that logistics technical assistance entails:

- General technical assistance addressing both specific logistical problems (Nigeria) and complete family planning program logistics management review (Pakistan and Dominican Republic);

- Assistance to management information systems (MIS), providing diagnostic and design support, training and implementation (Kenya, Guatemala, Costa Rica and Ecuador);

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[2]As listed in the RSSA amendment for FY 1989/90, p. 4. Omitted is the one item that relates to surveys (#5 in the document).

- Training in logistics and general family planning management through both workshops and seminars (Indonesia [BKKBN], Cote d'Ivoire [AIBEF], and Niger [MSH and CEDPA]);
- Workshops on logistics (Lesotho Ministry of Health and the International Planned Parenthood Federation affiliate and Kenya workshop to systemize delivery of contraceptives);
- Training of trainers workshops (Zimbabwe, National Family Planning Council); and
- CPT trips primarily focusing on the review and analysis of previous requirements and forecasting of future demand (most countries).

2.1.3 Level of Effort

The eight individuals who spend part- or full-time on logistics work (which equates to approximately six and one-half full-time equivalents) have an impressive record, in terms of the variety and volume of technical assistance visits made under this RSSA. In FY 1988, 41 person trips were undertaken to 23 countries representing 582 travel days (see Table 1); in FY 1989, there were 45 person trips to 27 countries representing 557 travel days; and in the first quarter of 1990 alone, 34 person trips have been scheduled to 22 countries. Over the past three years, logistics support has been provided to approximately 27 countries each year, or 45 person trips annually. This translates into heavy personal travel schedules, often averaging over six trips per annum, with the average length just over 14 days. Longer trips may include more than one country (especially in Africa). Logistics staff estimate that they spend over 25 percent of their time out of the office, based on a year of 48 weeks. Supported by a similar travel effort by their counterparts in the FPLM project, the consultants collectively have visited over 50 separate countries over the last three years. These statistics are impressive and reflect the dedication and efforts made by both CDC and FPLM teams in providing in-country technical assistance.

Table 1

Number of Countries Provided Logistics Management Assistance by Region and Fiscal Year FY85 - FY89

Region	FY85	FY86	FY87	FY88	FY89
Africa	14	11	14	10	13
Asia - Near East	4	2	6	4	3
Latin America	16	10	12	9	11
Total Countries	34	23	32	23	27
No. of Person-Trips	N/A[1]	N/A	47	41	47

[1]*N/A = Not available*

In addition to the seven persons from CDC who focus primarily on logistics management, two other specialist groups contribute directly to the efforts to upgrade family planning systems: the two persons assigned to clinic management and two computer experts who support the work of this component (see Chapter 5).

2.1.4 General Assessment

With respect to the quality of their efforts, the consensus was strong among USAID mission personnel that CDC logistics consultants were both highly professional and dedicated. Missions confirmed that their efforts are well spent and that CDC is helping make important contributions toward improving host countries' service delivery capabilities. USAID mission officers were in particular very appreciative of CDC's help in the areas of requirement forecasting and general CPT compilation.

There was every indication that the confidence shown in the skills of the CDC logistics personnel was well placed. In the area of forecasting requirements, for example, the logisticians were careful to check, whenever possible, to determine if the previous year's forecast had been correct, and if not, why. Generally, sizeable discrepancies could be explained by external factors such as an unanticipated rise in demand for condoms in response to a media campaign on HIV or delays in the delivery system that caused stockouts and consequent disruption to usage patterns. These consistent efforts to examine their own forecasts can give CDC logisticians leads not only to better forecasting for the next year, but also to possible problems in the overall logistics system.

2.1.5 Innovative Aspects

CDC has earned a reputation not only of carrying out its logistics tasks with high competence, but also of developing innovative ways, often computer-based, to simplify and improve many of the routine operations involved in logistics management. Innovations have been both methodological and technological. In terms of methodologies, CDC has selected an inventory system that is appropriate for the developing world and done an excellent job in documenting and disseminating the approach widely. In the technological field, new computerized systems for forecasting contraceptive needs for logistics MIS developed through the project are beginning to facilitate considerable improvements in the LDC family planning organization's ability to manage its contraceptive commodities. Six important innovations are discussed below.

<u>Methodological Innovations</u>

- **The introduction of the maximum/minimum inventory control system relative to contraceptive management.**

CDC selected this maximum/minimum-based inventory control system, a long-established method of managing warehouse stock, as the standard system to be applied to inventory control in family planning work. The decision showed sound judgment: the methodology is not only very effective; it is very simple and thus it is far easier to implement and maintain than any of the more complex alternatives. This system has been institutionalized in the majority of the countries visited by CDC consultants. It has been recognized as the preferred approach and host country staff are fully capable of using it effectively.

- **The development of the *Logistics Guidelines for Family Planning Programs* publication and associated training materials.**

To reinforce the maximum/minimum-based inventory control system and provide documentary back-up, CDC developed logistics guidelines, which it formalized in its *Logistics Guidelines for Family Planning Programs*. This booklet was primarily designed for the benefit of

A.I.D. field personnel and mission population officers to provide specific guidance and insight into the "science of logistics." The document proved to be the first widely available manual detailing logistics management methods and techniques applicable to family planning. As a result, it was much in demand, not just by its target audience, but by LDC family planning organizations as well. Because it is written in layman's language, this booklet is able to meet the needs of both these audiences.

Again, one of the reasons for the success of this document was the simple non-technical manner in which it was drafted, complemented by the inclusion of illustrations, practical examples and checklists. Recognizing the benefits of this document, CDC has recently made efforts to improve it further, with the needs of LDC organizations particularly in mind. Improvements include reformatting so that it now follows the logistics cycle, expansion and simplification of the text in certain key areas, and some further clarifications.

A further important development -- one that ties into CDC's training strategy -- is the development of eight training modules that are linked to chapters of the revised version of *Logistics Guidelines*. The modules themselves provide an in-depth step-by-step guide for the logistics trainer including a comprehensive narrative; appropriate handouts and visual aids; and instructions concerning the sequence of the sessions and methods of utilizing workshop sessions with examples to reinforce the presentation being undertaken.

- **The publication of *Family Planning Methods and Practice: Africa*.**

Although the original publication of another document -- *Family Planning Methods and Practice: Africa* -- took place prior to the time period covered in this evaluation (1983), this handbook deserves special mention here.[3] It has been reprinted three times (most recently in September 1987) and continues to be requested, with the logistics staff its primary publicists and distributors.

Technological Innovations

- **Development of easier and more reliable ways to forecast and validate contraceptive requirements (CPTs and "Contest").**

One of CDC's earliest technological innovations included the development of computerized software for CPTs. Given the importance to A.I.D. of having accurate forecasts of contraceptive needs, this was an important development that greatly assisted those undertaking the task of CPT completion. The software not only reduced the person hours needed to complete the tables, but also eliminated the likelihood of arithmetical errors occurring in the projection of figures.

Expanding upon the initial CPT program, CDC personnel developed "Contest" software designed to review and validate CPT data through comparison with established service statistics. Further developments and enhancements in CPT software have been provided by JSI, and personnel on both projects have access to and can utilize all software in compiling and validating country requirements.

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[3]Additional publications providing guidance on contraceptive technology and associated risks have been produced through the project including *"IUD: Guidelines for Informed Decision Making and Use,"* CDC, 1986.

- **The development and implementation of computerized Contraceptive Commodity Management Information System (CCMIS) which utilizes aggregated informational input.**

Considerable work has been undertaken by CDC personnel in the field of management information systems (MIS). The rationale is that without a properly functioning system, data will not be available concerning in-country inventory levels or contraceptives usage and without this essential feedback, it will not be possible to manage inventory properly or to ensure that contraceptives are available when demanded. Since service delivery is the linchpin of all family planning organization operations, it is of paramount importance to ensure that an efficient MIS is in place.

To enhance host country capabilities in the area of MIS, CDC has developed a computerized system, the CCMIS. This effort has taken nearly five years, partially due to the availability of technology and partially due to manpower constraints in the critical area of computer analyst/systems design (i.e., a very small staff with many competing demands). The system is now completed, tried and tested, and is being installed in the first two countries. In terms of future potential, it represents perhaps the most significant technological development of the project, one that potentially represents an important tool for logistics management for any country that is ready for its use.

Technical Assessment

CCMIS was developed in a format that makes the program very easy to adapt for new countries or projects. The system was also developed in a manner to allow maximum flexibility: this facilitates the monitoring of one or more levels of distribution within a supply system. Neither the number of levels nor the number of products monitored are constrained by any artificial restriction. Additionally, the reporting period is entirely flexible and is easily adapted to reflect user requirements. The system also has the distinct advantage of language independence, and can be adapted to produce screens, messages, and reports in any language that uses Roman characters. Currently both English and Spanish versions have been implemented. To encourage maximum usage of information generated by CCMIS, CDC has developed a simple Lotus template. This allows the user to import data into a widely recognized and commonly used software with which he may already be familiar.

The system is minimalist in terms of input requirements, and requires reporting of only two critical items: use during the period and inventory on hand. This input is in the form of aggregated usage and inventory figures from the varying reporting levels. Since the system is not individual transaction-based, it minimizes the sheer volume of data to be keyed. With just these two pieces of data, however, the system tracks stock and distribution at all levels, and reports not only on the current status of all storage facilities and outlets, but also on supply imbalances, stock-outs, months of stock on hand, couple years of protection (CYP) provided by contraceptives issued, and basic service statistics (new and continuing users, either in total or by commodity).

The system in its present state represents an excellent combination of state-of-the-art capabilities and user friendliness in the context of the practicalities and constraints prevailing in the host LDCs. In requiring just two forms of information in an aggregate format, it successfully avoids being overwhelmed by excessive and extraneous data. At the same time, the system provides a considerable in-depth range of reports and management information. A major factor that makes CCMIS particularly relevant in LDCs is the basic simplicity of the system (from the users' perspective) in terms of minimal input requirements. This produces timely and accurate reporting of a comprehensive range of management information.

In addition to the obvious practical benefits of an efficient MIS (offering the capability for better forecasting and inventory management), the CCMIS may also be able to serve as an excellent tool to evaluate program performance. This capability stems primarily from the system's ability to generate CYP data. This capability may tend to be overlooked, but -- if utilized -- might have a highly significant role in decisions regarding future program direction, i.e., it could open the way for logistics personnel to play a more substantive role in program evaluation (see Section 2.1.6 below).

Practical Application

To date, CCMIS has been functionally installed in two countries -- Kenya and Guatemala -- in both cases within the Ministry of Health. The system has also been partially implemented in the Social Security Institute in Costa Rica. In addition, extensive efforts to set the stage for installation of the system have taken place in Ecuador, Zaire, and Nigeria.

Typically, considerable groundwork to install what amounts to a working manual MIS system is necessary before the CCMIS system can be installed in any country: reporting channels, and channels for distribution of contraceptive supplies, must be identified; forms that will include and record essential information must be designed; and personnel must be trained in completion and routing of the forms. This process is comprehensive, involving all levels in the family planning organization from the district clinic (outlet) back up through the regions to the central warehouse or distribution center. Because of the time involved, the process is also costly, including -- using Kenya as an example -- costs for a workshop to design the system complete with requisite forms (daily registers and quarterly report forms), a second series of workshops with district management teams, and on-site cluster training of clinic nurses.

This level of effort may not be necessary everywhere. In Guatemala, in what is probably an atypical example, supervisors were already visiting clinics on a regular basis and collecting the required data and thus it was not necessary to design new forms or train Ministry of Health (MOH) staff in data reporting. All CDC needed to do was to install the CCMIS and to train the logistics manager in its use. The manager was able to train supervisors, who now enter and process their own data.

In those cases in which a manual MIS must first be installed, this task is best done by the logistics advisors, not CDC computer staff, who are less likely to have the appropriate contacts in-country and who have many other demands on their time. Computer time can probably be cut to two separate trips, each of approximately two weeks duration. This will allow for a significant reduction, in this demand for computer analyst time; therefore, the bottleneck that may have slowed original development of the system should constitute less of a problem in the future.

In Kenya, the entire CCMIS exercise is considered a very positive experience. The mission population officer found the system both user friendly and powerful, and the MOH has committed itself to completing coverage of the entire country. The only negative feedback received was that consultants may have overemphasized efforts at the district level, at the expense of the regional or central areas. Aware of this view, both CDC and JSI have targeted these latter areas for future support but indicated the need to ensure compliance with requirements at the basic data collection and recording levels.

- **The development of a computerized warehouse management system ("Warehouse"), which controls contraceptive inventories through tracking individual transactions.**

CDC has recently developed the "Warehouse" software module, a transaction-based warehouse management system. Unlike CCMIS, this has not yet been formally implemented in the field, but is likely to be installed on a trial basis shortly in Guatemala. It is complementary to

CCMIS and will interface with the CCMIS already in place. Essentially, this system will track individual receipts and issues from storage, monitor manufacturing or expiration dates and provide inventory location data. Similar to CCMIS, "Warehouse" was designed to include maximum flexibility to ensure the widest possible range of application in different countries and projects. This system also offers similar flexibility to the end user (e.g., in reporting periods, language, etc.). The potential demand for this system should be enormous, as it will offer both better accuracy and considerable time saving in comparison with the manual systems that it would replace.

2.2 Selection of Countries

The process of country selection is in theory governed by a variety of planning mechanisms that set the stage for each year's work. The annually renegotiated RSSA contains a list of priority countries, based on A.I.D.'s own internal planning document -- the Resource Allocation Plan. The FY 1989/90 RSSA lists 18 priority countries for logistics assistance: 8 in Africa, 6 in Asia/Near East, and 4 in Latin America (among them the countries receiving the largest supplies of contraceptives). CDC staff also take into account priorities of A.I.D. regional bureaus and the regional A.I.D. offices in Africa (REDSOs for East and West Africa), although they note that there is not always agreement between the three A.I.D. groups. For CDC, its major planning exercise is an annual retreat for its own and JSI logistics staff during which a broad outline of strategies and plans for individual countries for the coming year is discussed in depth. Additional planning meetings are held quarterly. Both organizations find these meetings an indispensable facet of their modus operandi.

The regions and countries that CDC has visited are largely in accordance with A.I.D.'s priorities: logistics support visits have focused upon Africa, with 301 person days having been dedicated to service delivery in FY 1989 and 261 in FY 1988, compared to 209 and 142 person days respectively in Latin America and the Caribbean and 71 and 93 person days respectively in Asia and the Near East (see Table C-1).

In practice, CDC takes a largely passive stance toward country selection, however. In working out their travel and work plans in the course of the year, staff rely primarily on mission requests and requests from CPSD to carry out specific assignments, and indeed, CDC takes pride in its not having turned down any requests for logistics technical assistance. In some countries, these requests reflect a long-term country plan that has been worked out between CDC and the mission and is one in a series of visits that are aimed at making major, long-term improvements in the logistics system (e.g., installing the CCMIS in Kenya). Frequently, however, requests are for one-time assistance in completing CPTs or some other more routine task. Staff believe that repeat visits to a given country scheduled within a few months of each other are more valuable from an institution building standpoint than are one-time trips, but it is clear that the personnel concerned are nearing the ceiling in terms of the sheer volume of work in person days outside the U.S. Without additional resources and a clear strategy, it will be difficult for CDC/JSI to have a concentrated presence in any more countries that it has presently. There is also little likelihood that it can undertake work in any new countries -- although it is likely that there are some countries and organizations that are not requesting technical assistance but which could profit from it. In short, because of its need to be fully responsive to missions and CPSD, CDC has left little room for itself to adopt a strategic approach to country selection.

2.3 Institution Building

Technology transfer leading to institution building is an important -- in fact, the underlying primary -- goal of this project, but much remains to be done in this area. Some

observers have questioned why it remains necessary, after 15 years of effort, for A.I.D. and JSI to continue to finance technical assistance for the determination of commodity requirements.[4]

CDC maintains that it has made some progress in institution building, since its increased efforts in Africa are paired with a lesser emphasis on Latin America where the capacity to manage contraceptive supplies is considerably more developed. With respect to prospects in Africa, however, logistics staff foresee formidable difficulties in achieving any major success in the near future in institution building. This is due to inherent and overwhelming constraints, whether of an economic, organizational, or personnel nature. Such constraints tend to be endemic throughout the continent (e.g., in Ghana, the entire family planning effort is managed by one director and two assistants).

Another problem is the project's current practice of responding to every request for assistance and the resulting geographic dispersion of effort; for example, A.I.D. still requires CDC to respond to requests for assistance in Mexico and Brazil, due to the high volume and value of the contraceptive supplies they receive, although both countries are relatively advanced and would seem to have the capability of managing their logistics systems without intensive technical assistance.

In view of the need to achieve institution building, it is necessary to question the wisdom of spreading the team effort over so many countries. Capacity building requires concentrated effort within a given country to overcome the overwhelming constraints that exist. Given that, due to cost constraints, the number of consultants undertaking this task cannot be radically increased, the only alternative is that the number of countries targeted must be limited in some way.

2.4 Collaboration with FPLM

Both JSI's contract and CDC's RSSA include the requirement that the organizations cooperate extensively with one another. The stipulation was included in JSI's initial contract, and CDC's RSSA was similarly amended, to reflect the new partnership which was deemed by A.I.D. as essential to the future success of logistics support.

Since the FPLM contract was awarded in September 1986, CDC and FPLM consultants have made in excess of 50 joint trips to host countries. All parties concerned have seen working relations as generally good and affirm that the skills of the respective consultants are often complementary, creating a synergistic effect. In view of the high demand for the services of these consultants, neither party perceived any advantage in attempting to institute a policy of artificial geographical division. It was maintained that this would detract from the current flexible system and that this was undesirable.

The team approach was particularly appropriate when the JSI contract was first signed. Throughout 1987, and part of 1988, a large portion of CDC's duties involved fieldwork training and familiarization of their FPLM counterparts, who -- although they were logistics specialists -- tended to lack both family planning background and specific country knowledge. This process was perceived to have worked well by all parties concerned. Comments from USAID missions indicated that the approach had been positive and that teams had worked efficiently together. FPLM staff were particularly appreciative of the number and range of CDC contacts

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[4] *An Overview of the Centrally Funded Contraceptive Procurement Project No. 936-3018.* USAID Inspector General Audit Report No. 9-000-89-010, September 29, 1989.

both in the USAID missions and host organizations. This naturally expedited the familiarization process for FPLM personnel and minimized the potentially time-consuming task of identifying the most appropriate contact and establishing a working relationship. FPLM personnel also commented that CDC's long-established reputation in the field had opened the way for positive associations with these contacts.

Within a few years, FPLM staff had been fully familiarized, however, and it was no longer necessary to apply the team approach rigidly. CPSD's attempt at that point to formalize the policy by dictating that teams must always include one member of CDC and one of FPLM was considered highly questionable by both parties. The general policy now in operation is that consultants will travel together as a team if the assignment so dictates and if the skills are complementary. This has eased working relationships greatly.

CDC is as appreciative of FPLM's participation as the FPLM staff are of CDC's. In particular, CDC has found that the FPLM teams' largely private sector background and differing methodologies have added new perspectives to their work. Benefits have also stemmed from the increased manpower represented by the addition of FPLM staff. This has made possible both an increased number of technical assistance visits and significantly, the faster development of various computer and technical tools.

A final benefit from this collaborative effort is that it appears to have provided a stimulus to CDC to increase its efforts under the RSSA. This new and healthy competition has been useful in overcoming any inertia that may have existed prior to 1986.

2.5 Future Directions

In the immediate future, a top priority is to develop a comprehensive strategy that will address two major issues currently facing the logistics component:

- How to continue to provide sound logistics inputs to LDC family planning programs; and
- How to improve technology transfer.

One approach may be to stress implementation of MIS in host country family planning organizations. The obvious benefits of successful implementation of MIS within host country family planning organizations include increased institutional capacity and the resultant enhancement of an organization's ability to manage not only logistics but the program generally. Inherent within this will be the ability to forecast more accurately contraceptive requirements. This, in turn, implies the capability to complete the requisite CPTs and minimizes the need for future technical assistance visits primary undertaken to compile CPTs. In short, this is an area in which intensive efforts can result in tangible increases in institutional capacity and provide a management tool to facilitate greatly improved logistics management. What is more, this approach would feed into the logistics staff's desire to broaden their role since the MIS, particularly the CCMIS, can be used for broader purposes such as programmatic evaluation. Consequently, such an approach would meet both CDC and CPSD objectives.

The other important consideration is how to increase the effectiveness of the various efforts by concentrating in fewer countries. Despite the exciting potential of the CCMIS system, CDC is aware that this system cannot be installed everywhere, at once, but rather, that a strategy is needed for phased installation. Some thought has already gone into where and how this should be done; specifically, priorities may be accorded as follows:

1) countries awaiting CCMIS implementation (Organization of Eastern Caribbean States, Barbados, and Thailand).

2) countries in which initial discussions have been held and some MIS development efforts, either manual or automated, are already under way (Bangladesh, Ecuador, Mexico, Morocco, Zaire, and Zambia); and

3) countries in which MIS issues have been identified and/or MIS development efforts are under way but in which CCMIS implementation has not been discussed (Botswana, Brazil [private sector], Lesotho, Nigeria, Senegal, Tanzania, Turkey, and Zimbabwe).

Three other countries -- Ghana, Tunisia and Uganda -- were also considered possible if various technical or political issues could be worked out.

Recommendations

1. **A.I.D. and CDC should establish priorities among countries receiving logistics assistance through the RSSA. Establishing priorities will involve reviewing current procedures for selection of countries and establishing new guidelines for this process. A strategic planning meeting should be held soon to initiate this process.**[5, 6]

2. **In determining priorities for the logistics component, a major consideration should be to ensure that the assistance provided has the potential for achieving long-lasting program improvements and institution building.**

3. **Although CPSD would still maintain a fiduciary responsibility to validate CPTs, the objective of technical assistance should be to develop the LDC organization's capacity to prepare CPTs.**

4. One option of the strategic selection process would be to review countries identified as high priority due to the value and volume of aid they receive and to determine whether they have the ability to manage and distribute contraceptives and forecast future requirements without technical assistance. If so, the country should be downgraded in terms of receiving technical assistance and the effort spent instead on less advanced LDCs, even if it is not a major recipient of commodities.

5. CPSD should assign greater priority to technical assistance in MIS and CCMIS. Wherever possible, efforts should be directed to those countries or projects that are ready to receive CCMIS. This should not be the exclusive focus, however; rather, efforts should be directed to MIS requirements generally.

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[5]Recommendations that appear in bold face are the principal recommendations of this report (see Executive Summary and Chapter 6).

[6]Strategic planning as used in this document refers to the basic decisions regarding the kinds of activities that CDC will undertake under its Agreement with A.I.D., the criteria for priorities by country and function that will guide the program, the division of roles of CDC versus JSI, and the DHS contracts, definition of the primary clients for the work of CDC, the kinds of in-country objectives toward which the CDC effort is to be devoted, the general time frame for the Agreement, whether institution-building is to be a main objective of TA, whether long-term resident advisors are to be utilized and ways in which to join efforts with companion programs such as child survival and maternal health programs.

6. Consideration should be given to encouraging USAID missions in priority countries to buy into the new PASA for MIS/CCMIS assistance, if funds are limited.

7. The Office of Population should examine the division of labor between CDC and the FPLM contract. Consideration should be given to transferring more of the work of forecasting contraceptive needs to the FPLM contract and to utilizing the logistics specialists within CDC in their areas of comparative advantage, i.e., providing longer-term, more intensive technical assistance in fewer high priority countries with the specific goal of increasing institutional capacity to manage logistics systems (e.g., through CCMIS). CDC and JSI should continue their close collaboration through regularly scheduled meetings.

3. The Survey Component

3. The Survey Component

3.1 Performance in Conducting Surveys

3.1.1 Number and Types of Surveys Conducted

CDC was the pioneer in developing and implementing the contraceptive prevalence survey (CPS) used to measure the percentage of women of reproductive age using contraceptive methods, the source of their method, and a number of related variables related to program issues. The first CPS was carried out in 1975 in El Salvador, followed by a similar survey in Paraguay in 1977. These early studies by CDC gave birth to the larger Contraceptive Prevalence Surveys project (awarded to Westinghouse Health Systems in 1977), which was in turn the precursor to the current Demographic and Health Survey (DHS) project. At present, both CDC and DHS are actively engaged in this type of survey work, though each institution approaches the task in a somewhat different manner. The current evaluation focuses on CDC, but the historical relationship between the two is of some importance in understanding certain aspects of the CDC RSSA.

The original CPS questionnaire developed by CDC in 1975 included five basic modules: contraceptive use, source of methods, reasons for non-use, demand for services, and children ever born. As of 1979 the need arose to broaden the scope of the CPS to include MCH as well as family planning issues. The modules that came into use between 1979 and 1984 included breastfeeding, postpartum amenorrhea, child immunization, child health (diarrhea) and prenatal/well baby care. This expanded survey was known as the family planning/maternal-child health (FP/MCH) survey. From 1985 to the present, 10 additional modules have been developed including topics of interest to specific countries, such as female circumcision, and topics with universal application, such as infant and maternal mortality. The name for this further expanded version is the family health survey. Despite the variations, all are surveys among women of reproductive age, which provide information on contraceptive prevalence and source of method. Since 1975, CDC has provided technical assistance to 35 such studies.

In 1985 the CDC was instrumental in the development of a second type of survey: the Young Adult Reproductive Health Survey (YARHS). This type of survey differs in emphasis from the CPS (and its above-mentioned variations) in that it includes both males and females; it focuses on the age group 15-24; and it provides data on sexual activity and contraceptive use among non-married (as well as married) young adults. Such information is useful, first, in developing programs directed to the needs of this young adult population; and second, in providing data on the current use and potential demand for contraceptives among this group, used to improve the forecasting of the contraceptive needs of the country. CDC has provided technical assistance to 9 such studies during the period from 1985 to the present.

In addition to the two main categories of studies, the CDC has assisted in the development of two studies on knowledge and attitudes of men toward vasectomy in 1988 and 1989. Also, they have expanded their surveys on contraceptive use to include adult males (in Swaziland in 1988 and in Haiti in 1989). This brings to 44 the total number of studies conducted by CDC from 1975 through 1989 under the RSSA with the Office of Population. (The type of study, country, and participating agencies is listed in Tables C-2 and C-3). With current staffing, they are able to do 4 to 6 surveys per year, though in 1988 they were involved in a total of 9, in an effort to accommodate countries that could not be covered by the DHS I project.

3.1.2 Definition of Objectives and Content

Status of Performance

The primary objective of the FP/MCH survey (and its variants) is to measure the percentage of contraceptive use among married women of reproductive age, their source of contraception, and related program variables. With the addition of new modules, however, there are multiple secondary objectives, which are much broader and which differ from one country to another, depending on the modules used.

With regard to the YARHS, the primary objective is to determine the proportion of young adults at risk of unintended pregnancy. The questionnaire also covers a number of related topics including socio-economic characteristics of the respondents, sex education, reproductive history, sexual experience and use of contraception, attitudes toward family planning and sexuality, and (in selected cases) knowledge of transmission and prevention of AIDS.

Countries interested in conducting a survey may select those modules of greatest interest to local needs; and within modules, they may add or omit specific questions. According to reports from persons in the field, the CDC tries to assist the host country organization in tailoring the questionnaire to its own needs, rather than imposing a ready-made instrument upon them. (By contrast, the DHS is generally bound by contract to maintain standardized modules to assure cross-national comparisons.) Persons interviewed both in the U.S. and in the field repeatedly commented on this flexibility, which is considered one of the strong advantages of the CDC model. There was general consensus among those interviewed that the study objectives fulfilled the needs of the host country organizations and of the local USAID missions.

Key Issues and Conclusions

There is a trade-off between flexibility and cross-national comparability. If each country is allowed to select those items of greatest interest to them, there is no assurance that cross-national comparisons will be possible in subsequent analysis. At present, the CDC estimates that approximately 80 percent of the questions are "standard" (i.e., selected by almost all countries).

Data from both CDC and DHS have appeared in comparative form in publications such as the 1985 issue of *Population Reports* on "Fertility and Family Planning Surveys: an Update," which gave major trends in contraceptive knowledge, use and related variables. In general, there has been little cross-national data analysis, however.

The RSSA does not call for comparative data analysis, and the emphasis has been on the implementation of additional studies rather than on such comparisons. Whereas the DHS contract specifically calls for cross-national studies, this has not been the case in the RSSA. It should be the responsibility of the Office of Population to determine the extent to which such comparisons are a priority, given that the resources invested in such comparative studies would leave few person-months to conduct additional surveys in the field.

The program's flexibility is viewed at the field level as a key asset. It engenders good will with the implementing agencies and gives them a greater sense of ownership of the study.

3.1.3 Adequacy of Design and Execution

USAID population and health officers were effusive in their praise of CDC staff in all stages of the fieldwork, from design to data processing and analysis. They considered that the quality of the work was high, in part because of CDC's approach to technical assistance:

maintaining a high degree of involvement in all aspects of the study process, but giving the host country counterparts the maximum amount of responsibility that they could shoulder in light of their own technical capabilities. Thus, in a country with strong counterparts and previous survey experience, such as Brazil, CDC limited its recent involvement to assistance on the sampling, questionnaire design, and the use of the data entry/editing program. By contrast, in a country with little experience in any aspect of sampling or data collection, they would provide assistance at all stages.

On the whole, this aspect of CDC performance has been highly satisfactory and the CDC staff should be encouraged to continue to provide this same quality technical assistance in the future. The major technical problem is the substantial time lag between data collection and production of a final report (8 to 12 months). A preliminary report is generally available within three to four months, however. Moreover, this kind of time lag is not unique to CDC. The procedure of doing multiple surveys simultaneously, even when the start-up dates are staggered, may increase the turnaround time slightly (since the person responsible for a critical step may be traveling elsewhere or be otherwise occupied). This is almost inevitable, given the heavy demand for surveys and the limited staff available to work on them. In addition, in many cases, the time lag results from factors beyond the control of CDC staff, such as the skill level of the counterparts or competing activities, which determine the speed of the process.

3.1.4 Innovative Aspects of the Survey Work

Status of Performance

The key innovations that have come out of the RSSA can be summarized as follows:

- the very development of the CPS survey as a tool for program management and logistics forecasting in 1975;
- the addition of modules on MCH and other health issues which are responsive to broader health concerns;
- the development of the YARHS to guide in development of programs targeted at this group and to refine estimates of use and potential demand from them -- estimates that can then be fed into forecasting of contraceptive needs (1985);
- the development, testing and implementation at the field level of a data entry/edit program named "SURVEY" (1985); and
- the development of a five-year calendar to register birth events, breastfeeding, contraceptive use and female employment (first used on the 1986 survey in Costa Rica).

With regard to SURVEY, this program facilitates the task of data entry by providing the user with images on the computer screen that mirror the layout of questions on the paper copy of the questionnaire; it edits the data at the time of entry by refusing codes that are out of range for a specific variable; and it provides a list of any inconsistencies found between variables on a given questionnaire. Once the data are entered, this system produces an ASCII file, complete with variable labels and dictionary, which can then be processed using either SPSS or SAS. Although the "screens" for data entry must be rewritten for each questionnaire to reflect the exact wording and placement of questions on the page, local staff can easily be trained to do this. The value of this program is (1) that it greatly reduces the time between the end of fieldwork to the production of preliminary tables (to approximately 3 weeks) and (2) that it increases the quality

of the data by providing rapid feedback to interviewers on errors they are committing. Moreover, SPSS is now available in many developing countries, and thus the data set produced by SURVEY can be used for additional analysis by host country counterparts, independent of CDC.

Conclusions

It is difficult to speculate on what else CDC could have done in its survey work. It significantly increased the utility of the survey instrument by developing additional modules and it introduced a major innovation in terms of data entry, which had an immediate and positive impact on the turnaround time between data collection and final report. Thus, CDC performance in this area is judged to be very satisfactory.

3.2 Selection of Countries

The major emphasis of the survey work has been in Latin America and the Caribbean (37 surveys), with a much lesser involvement in Africa (4 surveys) and the Near East (3 surveys). Within Latin America and the Caribbean, the countries with the largest number of CDC surveys are Brazil (14) and El Salvador (3) (see Table C-2).

Regarding the selection of countries, the Office of Population does not give CDC a priority list of countries to cover (as it gives the DHS or even as it provides for the logistics component of this project). Rather, CDC becomes involved in specific surveys through one of three mechanisms: (1) a USAID mission in the field will specifically request their technical assistance on a survey, (2) an USAID mission will approach the DHS project, which if unable to fulfill the request, will refer it to CDC, and (3) host country institutions wishing to conduct special topic studies (e.g. YARHS) will contract CDC directly with concurrence from the local USAID mission. The second type of request is generally passed to CDC via the CTO of the DHS project; such requests have resulted in CDC's involvement in 5 surveys to date (Paraguay, Costa Rica, Swaziland, Turkey and Somalia -- see list in Table C-2.

CDC's role on these surveys is to provide technical assistance, and the RSSA covers all technical assistance costs related to CDC salaries, travel, per diem, and data processing incurred at CDC. The RSSA agreement does not fund the local costs of planning and implementing the study (whereas the DHS does). Instead, these are covered by the local mission or from some other source (such as UNFPA, Regional A.I.D. bureaus, or another Cooperating Agency). To date, the CDC has not refused any request for technical assistance on surveys, provided that funding to cover the local costs could be obtained elsewhere.

CDC's concentration on Latin America can be partially explained by three factors. First, CDC began in Latin America and thus USAID missions from this region are more likely to know of and request their services than missions in other regions. Second, since the DHS project has the mandate to focus heavily on Africa, they have satisfied the demand for services in that region to a large extent. (One recent exception was Swaziland, which the DHS could not do and which CDC accepted.) Third, in 1988-89, nearly one-third of the CDC surveys have been YARHS's, which are much more appropriate for Latin America than Africa (where the focus should remain on women of reproductive age, until the basic informational needs are met in this area) or for Asia (where adolescent pregnancy is not a major issue).

Key Issues

The main issue is whether the current passive mechanism for the selection of countries has led to a situation whereby the CDC tends to return to "favorite countries" rather

than to expand its net and make its services more widely available to other countries. A second drawback of passive response is that countries that may need assistance but do not actively seek it out are not even considered.

With regard to Brazil as a favorite country, it is true that a large number of surveys have been conducted here. There are, however, arguments in support of this strong concentration. The 14 surveys in Brazil include 10 different states; and certain states in Brazil have a population size larger than some individual countries in Central America. Regarding the use of single staff member to cover this country, there are few statisticians trained in this area who speak Portuguese. The population officer in Brazil highly values CDC's technical assistance and readily admitted that he would like as much of this CDC staff member's time as he could get, because of the benefit to the local program.

3.3 Institution Building within Host Country Institutions

Institution building with regard to surveys may differ from other areas of technical assistance in that it is virtually impossible for host country counterparts to participate in the different stages of a survey and not come away from the experience considerably more knowledgeable in the process. The speed of skills acquisition and the eventual level of proficiency depend greatly on the previous education and experience of the individuals involved, and will differ greatly among countries. In some highly specialized areas such as sampling, it may be unrealistic to expect a host country institution to master this skill unless the counterpart in question has had formal training in the area.

CDC's record on institution building with regard to surveys has generally been strong. Staff tailor their technical assistance to the specific situation and do not send in advisors to cover a specific area if there is a host-country counterpart capable of doing the job. On the other hand, they provide ongoing assistance at all stages of the process to institutions with little or no previous experience. As a result of this on-the-job training, these individuals gradually develop proficiency in different aspects of survey work.

One example of this transfer of skills occurred in Brazil, where the Federal University of Bahia in Salvador and the Maternal/Child Center of Sao Paulo were responsible for conducting young adults surveys in these two states in 1987-88. As these studies were nearing completion, the request came from the Johns Hopkins University Population Communication Services (PCS) project to collaborate on a vasectomy knowledge and attitudes survey. PCS had an extremely low budget with which to do the work. CDC, however, realized that by using the already trained survey teams in these two locations, it would be possible to conduct the vasectomy survey using the budget available, since the training costs would be greatly reduced. Although CDC had not set out with the objective of institution building, it in fact succeeded at increasing the skills level of the two institutions in question, with a positive spinoff for related population activities in that country.

Conclusions and Key Issues

One of the most important contributions of CDC staff has been to instill a sense of genuine interest and enthusiasm for survey work in counterparts, which is an important step in the institution building process. It has not been so successful, however, that host country institutions can now conduct the entire process on their own. CDC has yet to "graduate" any host country institution in terms of survey work. There are one or two examples of host country organizations with well-trained personnel who have mastered almost all elements of the survey process, yet they continue to request that CDC maintain some involvement in the process. In short, to date, institution building has occurred as a fortuitous by-product of strong technical assistance given to host country counterparts at each stage in the survey process.

3.4 Dissemination and Use of Survey Results

With the advent of the data entry program SURVEY, CDC now attempts to produce preliminary tabulations within 3 weeks of the completion of data collection, a preliminary report within 3 months, and a final report within 8 to 12 months, depending on analytical complexity and the skills level of local counterparts.

In recent years, the usual procedure for presenting the final report has been as follows. The staff of the host country organization and/or of CDC are responsible for drafting a near final version of the report. This is presented at an in-country workshop or seminar, to which a large audience is invited: family planning administrators, policy makers, university researchers, other health service professionals, etc. During the workshop the participants review the key findings of the report and have the opportunity to raise questions regarding the methodology, analysis, etc. During the workshop they break into smaller groups, which draft recommendations based on the results of the survey for program management or policy change. This process is designed to ensure that (1) key players in the population field are exposed to the results of the survey, (2) they have an opportunity to vent their doubts and criticisms in a forum at which experts are present to address their questions, and (3) they gain a sense of proprietorship over the data. In some cases the recommendations that come from the workshops are then published as part of the final report for the survey.

In addition, CDC staff disseminate their findings to the population community through presentation of results at professional meetings and publication in international journals of family planning/public health. These are useful vehicles for reaching the scientific community, but less so for the decision makers within a specific country.

Conclusions and Key Issues

The in-country workshops represent a major step in attempting to reach decision-makers with the findings of the surveys. This may not be adequate, however. The art of distilling research results into short, attractive and readily digestible booklets or brochures has advanced significantly in the past few years, in part through the efforts of the IMPACT project. Because CDC does not control the local costs, either for data collection or the production of the final report, it has not taken an active role in producing such materials. It is unrealistic to recommend that CDC take an active role in the production process, but they could work with the IMPACT project to develop a prototype booklet that would highlight the major findings of the report and present the information in an attractive, highly digestible format. Such a prototype would provide host country organizations with a model to follow in reaching a larger audience including the country's decision makers.

3.5 Collaboration with DHS

The DHS project is a centrally funded activity through the Policy Division of the Office of Population, whose objectives are to collect basic fertility, family planning and health data from developing countries. The Institute for Resource Development/MACRO Systems, the prime contractor on this project, is responsible for conducting a total of 25 surveys under the current "DHS II" agreement.

As mentioned above, the Westinghouse CPS project (the precursor to DHS I) was a direct offshoot from the CPS surveys conducted by CDC in El Salvador and Paraguay in the late 1970s for the purposes of family planning program evaluation. Whereas the CPS had a shorter questionnaire more narrowly focused on family planning program issues, the DHS questionnaire has evolved into a longer instrument which more nearly resembles the questionnaire of the World Fertility Surveys.

As CDC added the MCH modules and later the family health modules to its questionnaire and as the DHS has covered some of the same areas as CDC in child health and maternal care, there is substantial overlap between the two survey instruments. Indeed, they both provide the basic data needed for logistics work, namely estimates of contraceptive prevalence and method mix by source, based on a probabilistic national sample of the population. While specialists in the area of survey research are aware of the differences between the two, many members of the international population community would argue that the CDC FP/MCH surveys and the DHS provide similar types of information. Moreover, they are far closer to each other in the types of surveys they conduct and in the instruments they use than to any of the other A.I.D. cooperating agencies.

The Office of Population has encouraged both institutions to collaborate with the other, though this has not formed part of their contractual agreements nor has a formal mechanism been established whereby this exchange of information might take place.

Discussions with both groups provided a very similar perspective on this issue of collaboration. Both concurred that the focus of their collaboration to date has been the selection of countries that will be surveyed. For example, there are five countries that requested a DHS but were turned down; they were referred to CDC, who agreed to take them on.

A second area of collaboration has been in Latin America, where the DHS was to conduct a survey in a country previously surveyed by CDC. In both Guatemala and Brazil, either the USAID mission or the local implementing agency requested that CDC also participate to assure comparability with the previous survey. Because of differences in approach and blurred lines of authority, however, this type of collaboration was not ideal. Unless specific circumstances of a given country would dictate it in the future, this type of collaborative effort during the planning and data collection phases of a project is not recommended.

A third area of collaboration includes a minimal amount of exchange with regard to questions used on the respective surveys. The DHS has requested the AIDS module developed by the CDC (but to date have not acted upon incorporating it into their questionnaire). The CDC has used DHS questions on postpartum amenorrhea and coital frequency on their own surveys.

Finally, the two institutions do circulate copies of their reports to each other and do participate at the same professional meetings. Beyond these examples, there is little collaboration between the two groups. For example, CDC was invited to one of the large-scale meetings at the beginning of the DHS I project; however, they are not invited to serve on the Scientific Advisory Committee. (A DHS representative explained that if CDC were invited, then other institutions in the population field would expect to be as well, and this was considered to be problematic.) DHS has consulted with staff in other divisions of CDC on issues related to diarrhea, anthropometric measurement, immunization, and other health topics, but these were not the CDC staff supported by the RSSA.

Another example of these two institutions working in parallel fashion rather than in direct collaboration is that during the mid-1980s neither institution contacted the other while they were independently developing data-entry programs with built-in editing capacity. Both claim to like the specific features that their own programs afford, but one could argue that a technical dialogue during this phase might have been beneficial to both.

There is a mutual respect for the work done by the professionals in each organization. They feel, however, that the projects are sufficiently different that further collaboration may not be warranted. Moreover, the distance between Atlanta and Columbia, Maryland, may constitute a further obstacle to the direct exchange of ideas.

The Cognizant Technical Officers (CTO) of both the CDC and the DHS projects feel strongly that such a collaboration should exist, yet despite their encouragement of the two institutions in this direction, it has not materialized.

3.6 Future Directions for Survey Work

CDC is well respected for its survey work by members of the international population community, USAID mission personnel and counterparts in host country organizations. Its strengths lie in (1) the ability to be responsive to local needs in establishing the study objectives and content of the questionnaire, (2) providing quality technical assistance to the degree necessary in a non-threatening manner, (3) increasing the skills level of counterparts in different aspects of the research, and (4) producing a quality final product, which is useful both for planning purposes and for academics with interest in this field. Also, the CDC has been able to expand into new (though related) topic areas, such as the Young Adult Reproductive Health Survey or the Vasectomy Knowledge/Attitude survey to meet specific local needs.

In view of the above, the Office of Population should capitalize on the demonstrated expertise of the CDC to do survey work, but should make an effort to increase its effectiveness by considering the recommendations provided above and summarized below.

Recommendations

8. **A.I.D. and CDC should establish priorities among countries receiving survey assistance through the RSSA. This effort should include a review of the procedures for the selection of countries and the establishment of guidelines for this process. A strategic meeting should be held soon to initiate this process (see Recommendation 1).**

   The priority list should be made taking both CDC and DHS into account. The Office of Population, in consultation with these two Cooperating Agencies, should determine the most effective approach to the division of labor.

   One option would be to maintain the status quo, whereby the DHS is given a list of priority countries to cover and CDC serves to fill in the gaps where DHS cannot meet the demand. As long as CDC has the resources to respond to all requests that come from the field (either directly or via the DHS), this option gives maximum flexibility to the Office of Population to respond to the needs of field.

   A second option would be to divide more evenly the priority countries between CDC and DHS. Because CDC does not fund local costs, it could be argued that all priority countries should be assigned to the DHS.

   Whichever option is adopted, the first consideration should be that priority countries are covered, especially where the needs for information are the greatest (i.e., Africa).

9. Countries that receive large supplies of A.I.D. commodities should continue to receive priority for surveys, even if there is a downsizing of logistics support (see Recommendation 4).

   Continuation of assistance in survey work is appropriate since the survey data adds precision in forecasting the contraceptive needs of the country, no matter who is doing the forecasting.

10. **Given that the DHS project has a fixed product, the Office of Population should take advantage of the CDC's more flexible mandate by allowing it to become involved in program-relevant research that may deviate from the current FP/MCH or DHS type surveys (e.g., YARHS and the Vasectomy Attributes and Knowledge [VAK] surveys in Brazil). The FP/MCH survey should remain the main focus of the CDC activity, however, in part because of its direct link with the logistics work.**

11. CDC should capitalize on its successes in institution building by making the transfer of specific skills to counterparts an explicit objective in future surveys (see Recommendation 2).

    CDC should develop a mechanism to assess the skills level of the host country organization before and after the implementation of a given survey. In doing so, CDC staff would in effect be evaluating their own effectiveness in transferring specific skills and the institutionalization of survey research skills. Although some counterparts will acquire skills more rapidly that others (independent of what the CDC does), the proposed "assessment" would focus the attention of the CDC staff on institution building as well as completion of the survey itself.

12. CDC should work with local counterparts to reduce further the lag time between data collection and the production of the final report. One approach might be to analyze more closely the different steps in the process to identify how remedial actions can be undertaken.

13. CDC should encourage counterpart organizations to produce a summarized version of the main findings of surveys in a format that would be appealing to decision-makers and to the lay public.

14. The CTOs of CDC and DHS should meet to define the areas in which they believe collaboration between DHS and CDC would be most productive. Suggested areas include: (1) participation of a CDC member in the advisory board meetings held by the DHS; (2) an in-depth review of what works and what does not in different countries or regions, and (3) a more systematic exchange of information regarding the creation of new modules or changes in questionnaire content. The CTOs should then meet with the project directors of the two institutions to discuss their views on these and other areas in which this collaboration could be achieved. The product of these meetings should be a plan that defines the types of collaboration expected and the mechanisms for insuring this collaboration. This plan should then be cited in the new agreement with CDC and included in the next DHS contract.

4. Linkage between Project Components

4. Linkage between Project Components

4.1 Programmatic Linkage between Logistics and Surveys

The two main components of the CDC RSSA -- surveys and logistics -- are interrelated (though they were originally developed for independent reasons). This puts CDC in a key position for improving the linkage between the two, since it is the only Cooperating Agency that does both surveys and logistics. The other main logistics contractor (JSI) does not do surveys, and the other main survey contractor (DHS) does not do logistics.

CDC began to work in the area of family planning service statistics in the early 1970s, which predated its involvement in either surveys or logistics (both of which came on line around 1974-75). The first CPS survey (in El Salvador) was conducted to verify estimates of prevalence based on the service statistics of family planning providers by comparing them to the population-based data from the survey. The conclusion from the early surveys was that service statistics tended to overestimate use of reversible methods while underestimating use of permanent methods.

Interest turned to the issue of finding an indicator based on service statistics that would accurately reflect contraceptive use within a given population. This led CDC to a closer examination of CYP (couple years of protection) as an indicator of family planning performance. The CDC staff worked to promote the use of the CYP, emphasizing the need for reporting of the actual quantity of each contraceptive (by brand) dispensed to users (not simply shipped to the field). These data have become a key element in forecasting contraceptive use and commodity needs in subsequent years.

CDC has found that estimation of the contraceptive needs of a given country can be improved by survey data in several ways. First, in some countries (especially Africa) it is difficult to obtain accurate and timely data on the quantity of contraceptives used in a given calendar year; in the extreme case there are almost no data on use. The survey findings on percentage of women of reproductive age using methods and the types of methods used by source (institutional service provider) constitute a base on which logistics personnel can estimate future needs.

Second, even in a country with service statistics, it is still important to have correct information on method by source in accurately estimating commodity needs. For example, the Population Officer in Ecuador considered this information so crucial for the correct forecasting of commodity needs that he asked CDC to do a mini-CPS in Ecuador in 1989 (which was later combined with a child health survey, creating economies to the mission) to obtain this specific piece of information when a previous survey did not yield sufficiently precise information on the source question.

Third, CDC has used surveys to verify the consistency of data obtained from service statistics (e.g. the MIS) and from a random sample of the female population of reproductive age interviewed in the survey. This comparison works best in a country in which both types of data are available for a given year and there is only one main supplier of contraceptives in the country. In some cases, however, (as has been found in Latin America) CYP and survey data may both be correct but not consistent. For the use of pills, CYP data reflect a higher usage than do survey data. For condoms, the discrepancy occurs principally because the surveys report only married women 15-44 and do not accurately reflect premarital or extra-marital usage of methods. This explains why condoms -- often used for extra-marital sex -- are underreported in surveys.

In addition to the CPS (and its variants), the CDC has developed two complementary surveys which contribute to improving estimates for contraceptive needs. First, the

YARHS provides information on demand for contraceptives among the young, unmarried segment of the population. Second, CDC has now conducted four CPS-type surveys with a male subsample, which provide more accurate data on condom use both within and outside marriage.

Although there is some concern that there is not sufficient linkage made between the survey and logistics aspects of the CDC project, the evidence above indicates that CDC has been focusing on this issue. CDC staff doing logistics work also consider it very helpful to have survey data (from either CDC or DHS) in undertaking commodity forecasting.

4.2 Program Balance: Logistics and Survey Work

Although the RSSA anticipates that the level of effort to be attributed to logistics will be approximately 60 percent of total person hours provided, this does not appear to be the case. It is impossible to ascertain with any certainty the amounts of time allocated to the family project components because the project tracks only time spent traveling, not time allocations in Atlanta (see Section 5.2.2, below). Over the last three years, however, logistics travel has amounted to only approximately 45 percent of all CDC RSSA activity international travel days (see Table 2). Moreover, the desk work created by logistics activities tends to be less time-consuming than that needed for either the survey or epidemiological work, apparently reducing still further the relative emphasis on logistics. Thus, it is possible that the logistics component currently comprises as little as 40 percent of the total person hours provided through the RSSA. This estimate accords with one estimate provided by the Project Coordinator that service delivery improvements amounted to just over 44 percent of the total person hours. Service delivery improvements include both logistics support and clinic management, and if the small proportion of effort devoted to clinic management were subtracted, the total proportion of time provided by the logistics staff might easily equal the 40 percent estimated above.

Table 2

A.I.D./RSSA International Travel Days Allocated to Major Activities and Percent Change by Fiscal Year FY 1987-89

Major Activities	Fiscal Year FY87	FY88	FY89	Percent Change 87-88	88-89
Logistics Management	539	582	557	+ 8.0	- 4.3
Survey Activities	428	471	702	+10.0	+49.0
Reproductive Health Epidemiology	113	78	32	-31.0	-59.0
Clinic Management/Program Evaluation	101	94	31	- 6.9	-67.0
Other	19	11	13	-42.1	+18.2
Total	1200	1236	1335	+ 3.0	+ 8.0

Moreover, the amount of international travel time allocated to logistics has varied only slightly over the past three years, whereas between 1988 and 1989, the travel time allocated for survey work increased by 50 percent. The surge in survey work reflected in part an unprecedented increase in surveys that might otherwise have been carried out through DHS, and has fallen off subsequent to its peak in 1988. Nonetheless, the perception remains that the logistics component is not receiving the priority anticipated in the RSSA.

Emphasis on survey work also appeared to be taking increasing precedence over the two smaller project components -- reproductive health epidemiology and clinic management/program evaluation -- at least from the perspective of the downward trend in travel time allocated to these activities in comparison to the rise in survey-related travel.

Recommendations

15. **CDC should devote further staff resources to coordinating the survey and logistics aspects of the project more effectively**; this could include (1) planning surveys in countries in which use data are scarce or nonexistent, and (2) improving forecasting with data on condom use among men and on method use among unmarried women.

16. CDC should continue to refine the methodology for linking survey data, service statistics (CYP) and logistics. These techniques should be diffused beyond the JSI/CDC team to other members of the population community involved in survey work, program evaluation, or related areas. It would be useful to the population community (including USAID population officers and others who must assist in preparing commodity tables) for CDC to produce a short booklet which describes the linkage between the two and how data from three types of surveys (prevalence among married women, YARHS, and male surveys) can be used in improving estimates of contraceptive needs.

17. **CPSD should reconsider whether the logistics component should continue to be targeted for 60 percent of A.I.D. funding under the anticipated PASA. The decision should be made in the context of the overall new directions of the PASA, taking into account an appropriate division of labor between CDC and FPLM** (see Recommendation 7).

5. Management

5. Management

5.1 The A.I.D. - CDC Relationship

5.1.1 From A.I.D.'s Perspective

Nature of Relationship

For A.I.D., a relationship with CDC has traditionally offered an opportunity to tap into the resources of the lead U.S. agency for health promotion and disease prevention. CDC has a comparative edge in many directions: its access to domestic experience in family planning programs, its stable mission and staff not dependent on any contract or funding fluctuations, its research activities that can enrich its assistance, its science-based activities in reproductive health that add an in-depth component to its work, its access to and prestige with the medical and scientific community to exchange its findings and to attract resources to key areas of activity, and its capacity to attract resources from other organizations that serve to multiply its work in family planning.

A.I.D. does not have the level of control over activities carried out through its RSSA, however, that it has with its partners in cooperative agreements or through contracts. A.I.D. and CDC are instead sister organizations, and CDC's larger agenda will always be shaped independently, primarily by its own mission and not by what A.I.D. may wish. The nature of a RSSA agreement -- which in theory should require comparatively little management oversight by A.I.D. (see Section 1.1.3) -- grows logically out of the nature of the relationship between these two government agencies.

Recent Developments

A.I.D. learned recently that it can be counterproductive to lean too heavily on CDC to carry out an A.I.D. agenda. From 1987 to mid-1989, CPSD's management style was marked by a highly directive style more appropriate to contract arrangements than to a government agency, a tendency to micromanage the logistics function and a generally negative attitude toward the logistics assistance provided by CDC. CPSD also insisted that heavy emphasis be placed on the logistics component, and less on surveys and other activities. The logistics staff, the most immediately affected, found this approach grating (see Section 5.2.2). CDC officials at a higher level also did not appreciate what was viewed as an encroachment on their autonomy.

From A.I.D.'s perspective, too, this approach was not in keeping with its traditional relationship with CDC. Therefore, starting in September 1989, there was a change in personnel at CPSD, which has brought a renewed interest in the potential of CDC for family planning activities as well as a positive attitude in dealings with the RSSA personnel in CDC. A visit in September 1989 by key personnel from the Office of Population was a key factor in reshaping this relationship.

This experience may suggest a number of management lessons to the Office of Population with regard to the handling of RSSAs. Foremost among them is the primacy of the role of the CTO, together with the need to spell out the scope of his or her authority. Even now, this is not entirely clear, and the overstepping of an implicit boundary became the cause of much of the friction in 1987-89. Another issue is the relationship between the CTO within CPSD and CTOs in other divisions who play a role in supervising RSSA activities that relate more to their areas of authority (e.g., most of the survey work under the RSSA is supervised by a CTO in the Policy Development Division). Finally, although other factors came into play, it is possible that if the Office of Population had had access to some kind of an informal, interim evaluative instrument that could have pointed up the problems, a solution might have come sooner.

5.1.2 From CDC's Perspective

For CDC, its RSSA with the Office of Population falls somewhat outside the mainstream of its activities. Not only is the focus of the organization primarily domestic, but reproductive health has not always been a prime CDC mandate. CDC is in the process of developing a higher profile in the international family planning field, however, and the result may be a firmer position for the RSSA within the agency's overall strategic goals.

Top Management

CDC appears to be on the brink of expanding its activities in international health, and particularly in family planning. Although CDC's focus is predominantly domestic, the organization now has about 500 persons involved in international health activities part time and another 150 full time. At a little more than 10 percent of the total staff of CDC, this is a not inconsequential proportion. The possibility of expanding this level of involvement stems from a recently completed six-month strategic study that explored the agency's stance toward its work in international health.[7]

The study examined how CDC might move away from its traditional, reactive role in the international health arena to one in which CDC would be governing its own priorities and plans. On a preliminary basis, at least, priorities were selected, including family planning, child survival, environmental health concerns and training of epidemiologists, with family planning perhaps at the top of the list, especially in Africa. The strategy emphasizes institution building and, when appropriate, the use of resident advisors either in-country or at a regional level, just as the child survival program is now seeking to do in Africa in conjunction with A.I.D./Africa Bureau. If these new directions are accepted, it is likely that funding will follow and that constraints on personnel ceilings can be overcome.[8]

RSSA-Level

There is also a fresh current in the prevailing thinking of the Division of Reproductive Health (DRH) (which manages the RSSA) about its role in international health. Specifically, DRH believes that it should take the lead within the Public Health Service for developmental projects related to maternal and child health/family planning service delivery improvement, population-based surveys, and training and research in reproductive health epidemiology. For high priority countries, the DRH believes it should be able to provide needs assessments, policy assistance, training, program design, improvement of service delivery, demographic research, and program evaluation. Such a role would draw upon the CDC expertise in epidemiology, demography, public health policy, health systems design and program evaluation. DRH envisions applying this broader role to its RSSA with the Office of Population. In the process, DRH believes it would be appropriate for A.I.D. to place a greater burden on the JSI contract for routine requests for logistics support in non-child survival countries designated as non-high-priority.

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[7]The study involved many prestigious inside and outside authorities. It has not yet been published but its conclusions have been shared with CDC's Director Elect who is reputed to be favorably impressed.

[8]A precedent exists in A.I.D.'s child survival program for which Congress has provided 50 additional positions to CDC, with funding to come from outside agencies. Through a PASA with A.I.D., a number of child survival positions have been created, funded by A.I.D. and for which CDC provides staff. Indeed, three positions have been allocated to this RSSA because of its overlap with the maternal and child health survival efforts.

In line with organization-wide thinking, DRH wants to move away from operating under an agenda shaped by responding to priorities of donor agencies and in-country programs. Rather, DRH believes that to be effective, it must focus more intensive assistance and provide more frequent contact in fewer countries. In DRH's view, this might involve reducing assistance for lower-priority countries. It might also involve assigning technical assistance for family planning programs to CDC staff in child survival posts. This might be an innovative approach. It would bring added resources along with an integration of family planning with maternal and child health assistance, an approach usually well received by host countries and the medical and public health community.

5.1.3 New Directions for the A.I.D. - CDC Relationship

In many respects, CDC's rethinking of its role in international health and family planning fits nicely with A.I.D.'s own notions about the future of the RSSA. Most striking is the congruence on the need for better planning: all are in agreement that it is imperative to develop an administrative remedy for the current short-term approach. Specifically, all parties appear ready to replace the RSSA with a PASA, which provides for five-year funding with annual program and budget reviews and offers the possibility for mission buy-ins. Such an approach should help provide a longer time frame, a strategic setting, and more flexibility together with financial continuity and stability for CDC's activities.

On the other hand, CDC has not fully explored with the Office of Population the wider role it envisions for itself in international health and family planning, nor has it made a major effort to become familiar with the Office of Population's portfolio. Therefore, it is not clear how CDC, if it became involved in program management, evaluation, and other new areas, would fit into the work of other Cooperating Agencies included in the Office of Population's current portfolio.

<u>Recommendations</u>

18. **The CDC role in family planning work should be expanded insofar as the Office of Population finds it practicable in view of demand and the activities of the other Cooperating Agencies.**

19. If CDC and the Office of Population can agree upon an expanded scope of work for CDC, then a PASA instrument should be negotiated.

20. The CTO role for this project should be defined in terms of duties and authority, not only within CPSD, but also for any other divisions whose workscope covers areas that might be included as part of CDC's new PASA (e.g., Policy, Information and Training [IT], Family Planning Service Delivery [FPSD]). The CTO role should be included in whatever Agreement is signed with the CDC so that expectations are shared. For example, a lead CTO could be designated for the overall coordination of the Agreement assisted by technical CTOs assigned by other divisions for their particular sets of activities.

21. The Office of Population should consider undertaking more frequent evaluations using informal in-house mechanisms (i.e., use of annual management reviews).

22. Division Chiefs of both agencies involved in the RSSA and even higher level officers should have a line of communication available to each other whenever they feel it useful to discuss progress or problems.

23. The CDC idea of utilizing child survival posts abroad to incorporate family planning activities should be explored by the Office of Population and promoted wherever possible.

5.2 CDC RSSA Management

5.2.1 New Organizational Structure

As noted in the Introduction to this report, this evaluation coincided with a major reorganization both of CDC and of the Division of Reproductive Health (DRH), the administrative home of the RSSA. The reorganization began in 1988 and although complete on paper, is not fully effective. (Figures C-1 and C-2 indicate how this Division now fits within CDC as a whole.)

From DRH's own perspective, the way it has been reorganized within CDC (see Figures 1, 2, and C-2) has both its pluses and its downside:

- On the plus side, the reorganization resulted in the transfer of several new functions to the DRH and addition of staff.

- On the downside, DRH is one of six divisions in the Center for Chronic Disease Prevention and Health Promotion and may be in competition with newer divisions that could, at least initially, have a greater claim on the attention of the Center Director (see Figure C-2).

For the RSSA, the effect is expected to be primarily salutary:

1) Logistics staff have been transferred to a newly created Program Services and Development Branch (see Figures 1 and 2). This Branch was created to put a greater emphasis on the programmatic aspects of the Division's work. Now the Division is making a clearer distinction between the scientific, technological aspects of its work and the extension of assistance to state, county and international organizations. The reorganization acknowledges differences in staff outlooks of two types of work: in one, the scientific focus of the personnel is best suited to research and innovation; in the other, the extension of the knowledge to user organizations requires more of an operational focus and sensitivity to the variety of user organizations.

   This reorganization recognizes the basically different kind of activity involved in technical assistance versus scientific endeavor, and thus should help give the new Branch the visibility, status and internal support from the DRH that such functions need. It should also serve to accord more recognition of the significance of the role of the logistics staff as technical assistance personnel, whose ultimate goal is to institutionalize skills among host-country personnel.

2) The RSSA coordinator function has been shifted to the staff member who will be in charge of the logistics staff -- namely, the Chief of the Program Services and Evaluation Section, which will be comprised solely of the RSSA logistics staff. This is a major change from the earlier situation, in which the logistics staff were being supervised by an individual who was not only RSSA coordinator but also the supervisory statistician in charge of survey work (see Figures 1 and 2). The creation of a new leadership structure, together with identification of a new RSSA Coordinator, should serve to eradicate what was perceived by logistics staff as one

Figure 1
Division of Reproductive Health
RSSA Activities: Pre-Reorganization
1989

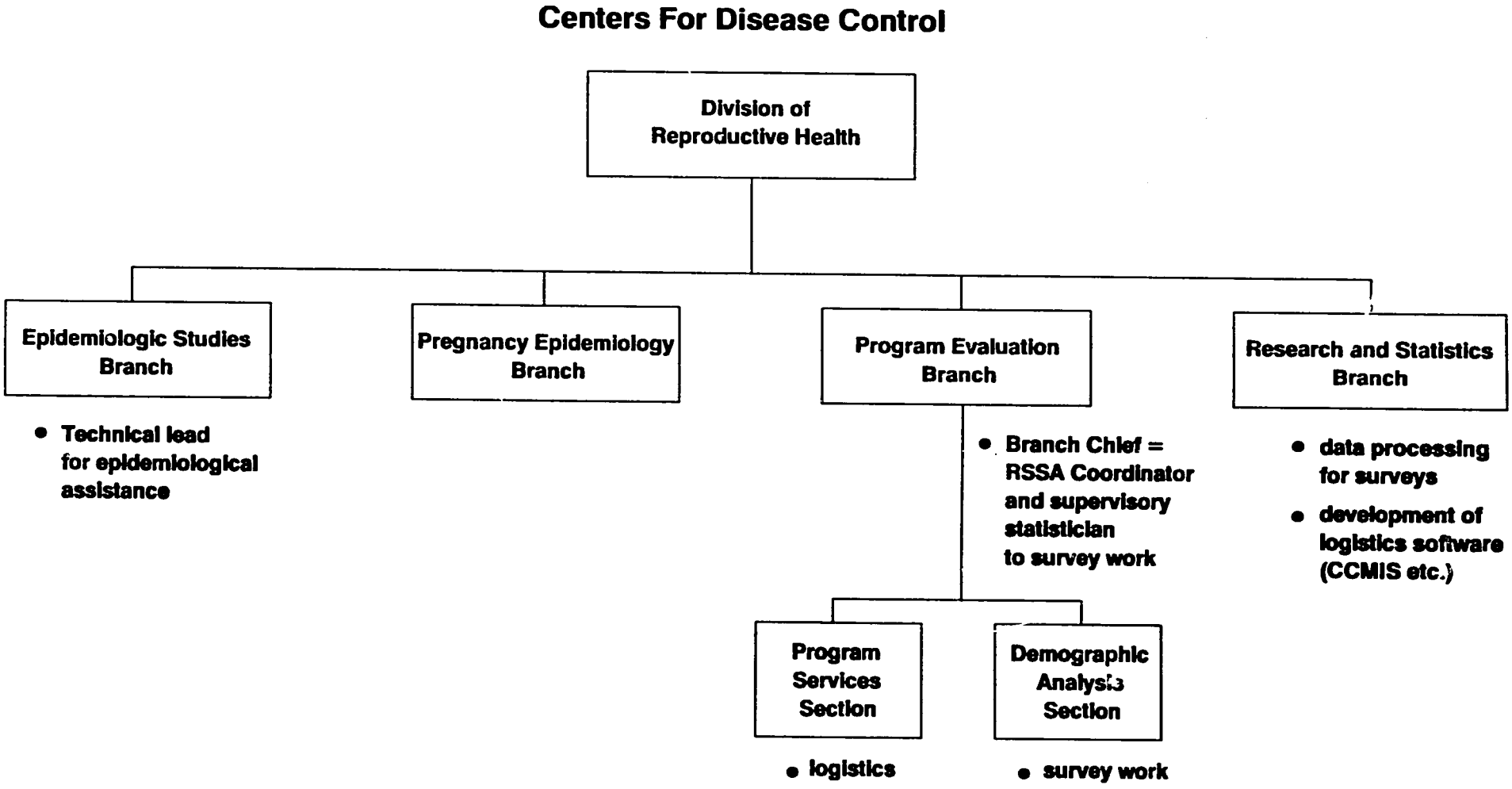
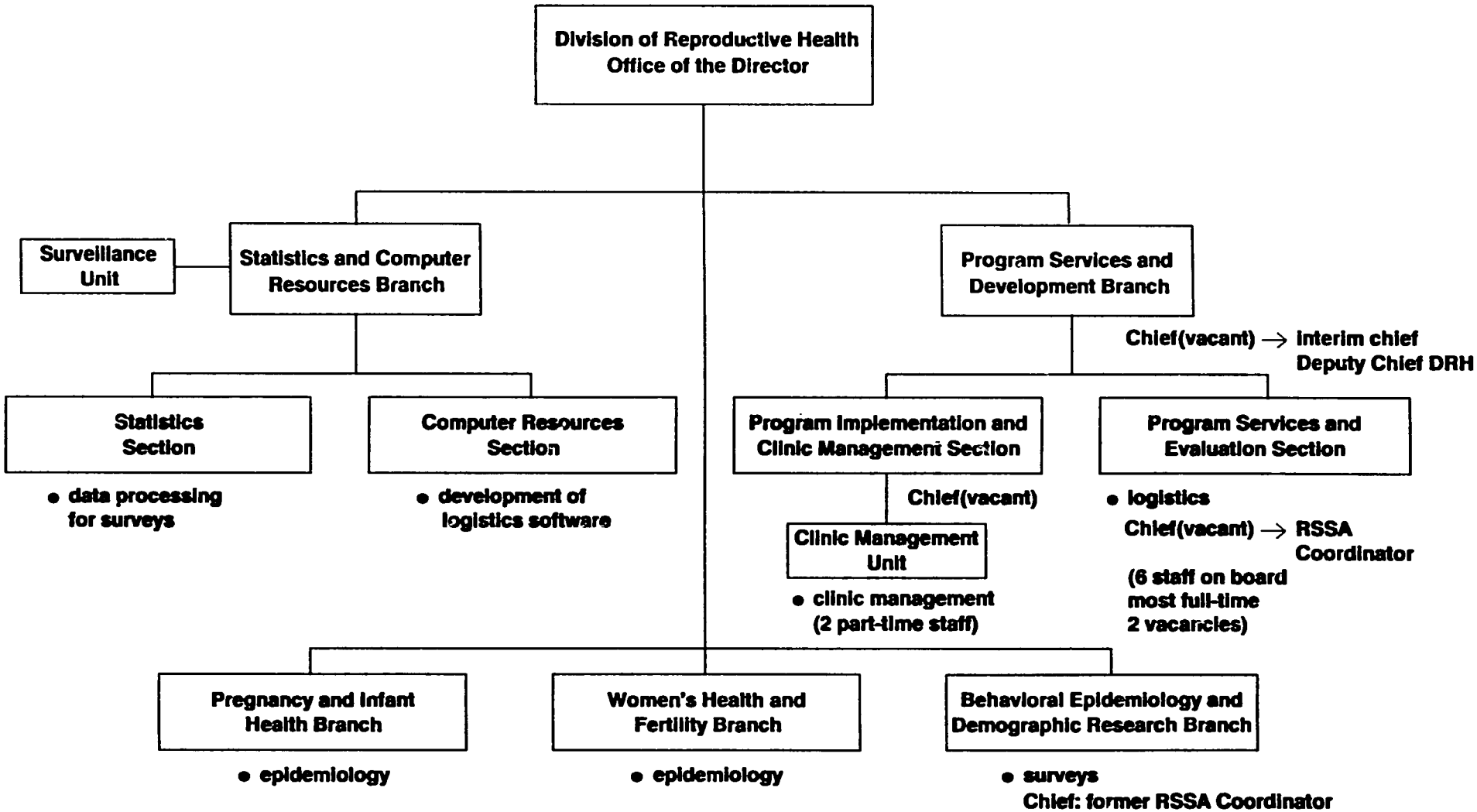


Figure 2
Division of Reproductive Health
RSSA Activities: Post-Reorganization
1990



of the prior organization's weakest points -- that of absentee management. In his role as a survey technician, the RSSA chief was too often absent on field duty, leaving no one with delegated authority to deal effectively with logistics staff or to represent them in dealings with the Division. A related issue was that, in the opinion of some logistics staff, an individual from the survey side could not adequately appreciate their roles or represent their needs. Overall, the logistics staff characterized the style of leadership under the old organization as "laissez faire."

3) The functions of logistics support and clinic management have been separated and two staff (25 percent time on the RSSA) who carry out patient flow analysis have been assigned to the new Program Implementation and Clinic Management Section. This has proved a very satisfactory arrangement.

4) Arrangements that have worked well have not been changed. Computer backup will continue to be furnished by the same individuals in the renamed Statistics and Computer Resources Branch. The talent and commitment of these individuals should continue to be a major asset for the RSSA. Likewise, support will continue to be provided from the Women's Health and Fertility Branch for maternal and child health. The former RSSA Coordinator remains as the Supervisor of the enlarged Behavioral Epidemiology and Demographic Branch and thus will continue to supervise all project surveys, and to conduct a substantial number himself, assuring continuation of the good survey work.

Issues

Assigning the RSSA coordinator role to a lower echelon position -- a Section Chief in one Branch -- will require horizontal communication and coordination with the other branches, including the branch chief who was formerly RSSA Coordinator. DRH leadership is aware that this will call for sensitive direction on their parts in order to maintain proper support and cohesion of efforts among coequal branches. This approach, known as matrix management, is presently utilized in several other areas (e.g., with respect to statistics and computer support and epidemiological work under the RSSA) and has proved workable.

Much of the future success of the reorganization will depend on the individuals who are assigned to fill the newly created jobs of Chief of the new Program Services and Development Branch, Chief of the Program Services and Evaluation Section, and Chief of Program Implementation and Clinic Management Section (see Figure 2). The logistics staff have a particularly strong interest in who these individuals might be. Part of their frustration has arisen from their perception that none of them was in line for any of these jobs. At the least, they want an opportunity to communicate with Division leadership their ideas about the kind of leadership they feel they need: in their view, someone both dynamic and interactive with them. DRH is aware of their position and is giving it due attention along with a keen understanding of the need that the new Coordinator offer management leadership and an understanding of the realities of work in developing countries.

5.2.2 Staffing

Full-Time Equivalents Assigned to RSSA

Under the FY 1989-90 RSSA, CDC is committed to assigning 18.9 full-time equivalents (FTE) to work on the tasks described in the agreement. These FTEs involve time (ranging from as little as 8 percent to 100 percent) from some 25 specified individuals plus composite time of others (see Table 3). Logistics is the only function to which a critical mass of nearly full-time individuals is assigned (seven individuals). This group will grow with the addition

Table 3

RSSA Staff:
FTE Status

Staff Category	Percent of Time On RSSA
Clinic Management	25
Clinic Management	25
Computer	50
Computer	50
Computer	50
Senior Statistics	8
DRH	23
DRH	15
Epidemiologist	15
Logistics	69
Logistics	85
Logistics	85
Logistics	92
Logistics	85
Logistics	85
Logistics Composite	50
Medical/Epidemiologist (Composite)	75
Surveys	75
Surveys*	100
Surveys	25
Surveys	75
Surveys	75

**Spends most of time on logistics.*
In addition, some nine administrative personnel have varying amounts of their time charged to the RSSA.

of three newly created FTE positions, two located in Atlanta and the third in Rosslyn.[9] By contrast, only three survey staff devote most of their time to the RSSA, supplemented by short-term efforts of others from a variety of sources (e.g., a Kellogg Fellow and an Emory University professor). Both logistics and survey work have benefited from the large time blocks available from three individuals in the Statistics and Computer Resources Branch. The smaller time allocations from other individuals in CDC seem to have been adequate.

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[9]These three new positions have been made available by the central CDC Office of International Programs as authorized by Congress for Child Survival. Two are assigned to the new Section for use in child survival-related family planning assistance. The third position has been designated for duty in the Office of Population to assist with RSSA activities related to contraceptive procurement and supply management.

Estimates of Time Allocations to RSSA

The time allocations provided in Table 3 are approximations of the percentage of staff time that is anticipated under the agreement. CDC has no reporting system to verify that these time allocations are adhered to or to determine charges to A.I.D. for work done under the RSSA. Rather, logistics, survey, and management staff simply rely on their memories or some private record to keep track of how much time they spend on the RSSA. In its quarterly reports to A.I.D., CDC uses time spent in travel to identify geographical effort under the RSSA. Thus, each staff member reports time spent on travel and then estimates the amount of time spent domestically to follow up on the international work. The only exception to this practice is the Statistics and Computer Resources Branch, which keeps a record by hour for each of the programs it services. Thus, it is easy for them to provide accurate period reports for A.I.D.

Although it is impossible to determine how much time has been spent on the RSSA, there is no basis for believing that the number of weeks per person spent on RSSA activities is overstated. Rather, it is more than likely that some individuals are understating the amount of time they spend on work for the Office of Population.

Staff Morale

Project staff are generally enthusiastic about their work under the RSSA, particularly survey and computer staff, who feel a real sense of accomplishment in the progress that has been made over the years.

Among the logistics staff, however, there is a major morale problem which urgently needs to be addressed. This stems from a number of causes, including that the value of logistics is not fully appreciated at all levels of CDC. With the exception of those individuals actually undertaking the work, logistics was apparently perceived as of secondary importance to epidemiology, demography and indeed, any other activities being undertaken by CDC. The logistics staff were acutely aware of this attitude and were very demoralized by it. They felt that as long as they performed the mundane but necessary work associated with logistics, A.I.D. and the field would remain satisfied and the other CDC staff could continue to accomplish what were considered the more important tasks under the RSSA. To their great credit, the CDC logisticians have nevertheless individually and collectively continued to maintain their professional attitude and dedication to the task at hand.

To some degree, the attitude described above has come about as a result of a perceived narrowing of the role of the logistician in recent years. Originally, in line with the somewhat broader scope of the RSSA itself, the role of the staff dealing with logistics was also viewed quite broadly. As CPSD's need for accurate CPTs and more efficient logistics systems increased, the contraceptive needs forecasting became magnified to the point that now the logisticians have earned the dubious title of "condom counters."

In view of the wide range of activities that the logisticians undertake (as described in Sections 2.1.1 through 2.1.5), the notion that their roles are limited to counting condoms is seriously flawed. The logistics staff, however, do see the CPT work as the least challenging and interesting aspect of their efforts. The slow pace of institutionalizing skills in predicting contraceptive requirements is as frustrating to them as to outside observers (see Section 2.3). In their view, their diagnostic and evaluative efforts have a greater potential for long-term impact. Even this work can pall, however, and individual members expressed an interest in expanding their efforts into related areas such as operations research, survey work, or even the very demanding area of family planning program design.

Logistics staff face another dispiriting fact in their professional lives: they perceive their positions as essentially deadend jobs. Most of the staff are in their fifties and feel stuck at the GS 13 level, which is the top grade available to technicians. It is interesting to note that there was considerable interest in the newly created logistics positions, with 40 applicants for the three positions. The jobs have been set at the GS 9 and GS 12 levels, and the persons to be selected are in their late twenties and early thirties, which will help to balance the age composition of the staff.

The dissatisfaction of the logistics staff poses a serious challenge for the project. Many of the causes may be remediable, if some adjustments are made in job descriptions and new leadership is sensitive to their concerns and potential. It may even be possible to decrease their travel load somewhat with the addition of the three new positions and to offer them some new training opportunities, a desire expressed by a number of these individuals.

Indeed, DRH has already prepared a position paper that outlines a considerably broadened role for the logistics staff. This paper reflects the logistics staff's own desire for a greater role in service delivery generally and other areas of family planning activities as well. The exact span of activities envisioned was still under consideration and had not been explored with CPSD at the time of the evaluation.

The issue now is to balance the desire of CDC and its staff to broaden the scope of the logistics task against A.I.D.'s continuing need for logistics support. CPSD has an extremely high regard for the importance of logistics as a key factor in the success of any family planning program. From its perspective, one of the most serious problems that can beset any family planning organization is disruption to the continuity of supply and resultant stockouts. Indeed, in CPSD's view, unreliable commodity supplies are more likely to negate increasing prevalence rates than any other factor. Although CPSD takes this position within the Office of Population, it has not succeeded in conveying it to the CDC upper echelons, including the Center Director's Office, or to some other units in A.I.D.

Conclusions

It is clear that staff morale has suffered from both internal DRH management and CPSD direction. It is surprising that the low morale of the logistics staff has not translated into a negative impact on the field work done with host countries and missions. This is a tribute to the dedication of the staff. It is also clear that the DRH has an opportunity with the reorganization to take many of the corrective actions regarding leadership. This, together with the change in direction from the Office of Population, provides excellent timing for actions that may improve staff morale and at the same time coincide with a future reshaping of the RSSA.

Recommendations

24. To the extent possible, all levels of RSSA staff should participate in developing some of the future directions being discussed in the DRH. This would help enrich the end result as well as serving to mitigate some of the alienation now felt by the staff.

25. Selection of the new supervisors (one branch chief and two section chiefs) should be completed soon so that the leadership void can be filled. In so doing, it would be wise to emphasize the leadership qualifications of the new selectees and organize travel time to minimize absence from their managerial functions.

26. If possible, efforts should be made to enlarge the scope, challenge and variety of tasks for the logistics staff to utilize their talents. The leadership should explore each

person's capacities and interests and to the maximum extent possible match need with interests in making assignments.

27. Efforts should be made to arrange training to help meet some of the new directions the DRH is taking. For example to address the unanimous interest in more institution building, it may be appropriate to provide training in this area and even to develop a manual on the subject for general use.

28. CPSD should impress on CDC staff the importance it attaches to efficient logistics systems and the contributions to family service delivery made by CDC logistics personnel.

29. Logistics staff should be utilized to make presentations both within CDC and A.I.D./W regarding some of the innovations and accomplishments of their work, especially CCMIS. This would not only assist the DRH in its relationships and program development but also help counter the poor image which the staff now believes it has.

30. A time reporting system should be instituted for persons doing work under the RSSA to provide an accurate basis for management and financial reporting. A simple record similar to those kept by consulting firms could be devised whereby the individual simply jots down each day how much time has been spent for what project. On some periodic basis such as weekly, this time record from each person would be aggregated by the Administration Office and utilized for both accounting and management reporting.

5.3 Planning

As suggested in Chapters 2 and 3, it has not been feasible for project leadership to carry out much strategic planning to shape their work.[10] Choice of countries for both logistics and survey work has been governed largely by requests received rather than by strategic choice. Little effort has been made to plan for or to track the allocation of resources among project components, or to develop an explicit strategy that demonstrates the links between surveys and logistics work. Division of tasks between CDC and FPLM and between CDC and DHS has been worked out to a large degree on *ad hoc* basis, rather than with regard to the strengths of each organization. Overall goals, and priorities among them, have not been clearly articulated, nor has the achievement of goals been set within any particular time frame.

Likewise, program planning has not been practiced in the project.[11] The annual workplan now contained in the RSSA is no substitute for a formal program plan, which would contain clearly articulated output targets that could be achieved over a multi-year time period, and estimates of the resource levels needed to meet these targets. Not only is the RSSA too short-term to accommodate meaningful targets; the stable level of financing it contains is not necessarily related to needs and priorities of the countries in which project activities are taking place. The result is that many assignments are simply two-week consultations once or twice a year, far too low

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[10]Refer to footnote 6 for definition of strategic planning.

[11]Program planning is defined as the set of decisions that establish output targets (number of countries, number of surveys, etc.), the resource levels to be utilized in terms of funds and human resources along with a time phasing of these activities and coordination with affected external projects such as FPLM and DHS.

a level of effort to achieve any capacity-building. Likewise, the annual $1.5 million spent on the RSSA becomes only a dribble for a given country client organization.

Even project planning within specific countries[12] has received little attention, although some planning goes on as a normal part of good technical assistance. For example, there was extensive planning for the Nigeria technical assistance which involved a number of Cooperating Agencies as well as field work to determine the inputs for CDC in consonance with other inputs from the Nigerian government and the CAs. Country planning as such has not occurred for any country in which CDC has operated, although there has been incipient planning for a specific client organization as, for example, for the development and installation of the CCMIS in Kenya and Guatemala. Again, given the limited number of visits per country that have been typical during the project life, it has not been feasible to prepare project plans with the accompanying time, cost and data needed for such planning. A sign that country-specific efforts were being intensified came in 1989, when the average number of visits per country doubled to four. This trend reflects the concern of CDC logistics staff that their efforts should have a longer-term impact.

In conclusion, the use of a RSSA to implement CDC activities has served as a genuine constraint to long-term or even shorter-term planning. Other factors have entered in as well, however, including, on CDC's part, A.I.D.'s interest that CDC be as responsive as possible to CPSD's and USAID missions' needs and requests. Now, with a growing concern that technical assistance efforts show results in terms of institution building, with A.I.D.'s constrained resource base, with the FPLM project well established, and with CDC's apparently growing interest in making a mark in international family planning, the time is clearly ripe for more consistent efforts at planning.

Both CDC and the Office of Population have agreed that it is time for strategic planning for their joint efforts. The CDC's long-term strategic review of its entire international effort, and the DRH's efforts in this direction, are evidence that CDC is serious about this issue. The Office of Population likewise is concerned with a longer term strategic framework for its planning.

Recommendations

31. **CDC and the Office of Population should commence immediately with strategic planning, with results to be integrated within the Agreement to take effect in the spring of 1990.**

The first step should be a visit by top officials of CDC to the Office of Population early in 1990 to exchange views regarding the thinking that is going on in each organization about strategic issues. Such a meeting should be followed by a statement from CDC proposing a strategy for the ensuing period of the relationship.

Meetings, discussions, and negotiations should be held to adopt a mutually approved strategy to serve as the framework for program and project planning. Since the present RSSA ends in March 1990, the agreement will need to be made in time to be reflected in the subsequent agreement.

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[12]Project planning is the specification of desired outputs within a goal and purpose framework, along with the activities necessary to achieve the outputs and a time phasing of inputs (funds, personnel, training, commodities, etc.) necessary to achieve the outputs. Examples are: conduct of a survey for a given organization in a country, design and installation of a family planning supply system for an organization, etc.

Once the strategy is set, it need not be redeveloped annually. Rather, strategic issues can be defined and addressed as needed during the year, taking into account results of performance monitoring as recommended in Recommendation 32 below. Periodic judgments should be made, however, as to whether a basic review of strategy is once again necessary. Since PASAs can run for five years, the termination of a PASA can serve as a time to question the strategic plan, its continued relevance and effectiveness. It is usually best to link strategic planning to the program planning and funding decisions that follow.

32. A definitive program plan should be made for the first year period, performance monitored against output targets, and plans updated annually based upon the results of the past year.

33. CDC should develop project plans for in-depth, longer term technical assistance and to that end should provide its professional staff with training in the A.I.D. procedures for project design, implementation and evaluation.

5.4 Budgeting

The budget for the RSSA has been prepared along typical lines required by the A.I.D. financial process -- i.e., a budget organized by objects of expenditure such as salaries, travel, printing, supplies, etc. (see Table 4 for a three-year statement of expenditures under the RSSA). Although this approach is valid as far as it goes, these budgets are at best statements of input. A budget and expenditures by program output such as surveys and logistics projects are not available -- although these would be more meaningful to program managers in CDC and A.I.D./W. Without a program budget, efforts to carry out program planning cannot be successful. Indeed, development of a program budget must be an integral part of any program planning process.

To identify breakouts of cost and effort by surveys, logistics and other program activities, CDC must now review travel schedules for the past year, estimate what proportion of the salaries and travel have been allocated to various program categories, and then guess at the breakdown of cost by program. This procedure results in a very imprecise estimate of how much of the RSSA is being allocated for logistics, surveys, and other categories.

Development of a program budget would require accounting for expenditures by program categories. This should be relatively easy for the Administration Office to do. Indirect costs such as supplies, rent, and overhead can be allocated proportionately to the programs or handled separately as indirect costs.

Recommendation:

34. The RSSA or PASA activities should include a program budget and require program expenditure statements along with the present system of budgeting and expenditure reporting by objects of expenditure. The program categories should be defined jointly by CDC and the Office of Population and take effect with the new Agreement in 1990.

Table 4

Accrued Expenditure Report
RSSA Agreement
FY 87- FY 89

Description	FY87	FY88	FY89	(Oct-Dec) FY90	Cumulative Total
Salaries & Benefits	$970,613	$848,710	$852,618	$201,116	$2,873,057
Travel	287,215	352,226	359,427	97,743	1,096,611
Rent/Communications	23,975	21,920	29,681	3,645	79,221
Printing Reproduction	65,497	2,736	3,640	15,237	87,110
Supplies	2,865	2,335	1,582	251	7,033
Equipment	23,348	27,989	55,179	35,642	142,158
Other, Misc.	27,740	38,243	16,493	7,269	89,745
Overhead	280,251	258,832	263,724	72,181	874,987
Total	$1,681,504	$1,552,991	$1,582,344	$433,084	$5,249,922

5.5 Reporting

5.5.1 Trip Reports

CDC staff and FPLM staff have differing views regarding the client for their services. FPLM believes the client is the host country organization receiving the technical assistance whereas CDC believes it is the USAID mission. This difference is reflected in CDC staff trip reports. FPLM staff write their trip reports in the language and mode needed to assist the client organization to adopt the changes proposed. CDC staff write theirs primarily for USAID use and internal CDC reading. The distinction is an important one, and it is possible that FPLM's approach is more effective, if the prime goal is to have a lasting impact on practices of a given host country organization. Of course, all reports must be discussed and coordinated with the local mission and in some instances there may even be an adjunct report for the mission when it is needed. There should be no slighting of the reporting need to the recipient organization, however.

CDC tends to have difficulties in submitting final trip reports to A.I.D./W in a timely fashion. Copies of preliminary reports are left in the field along with CPTs. When CPTs are done, these are always submitted promptly to A.I.D. In addition, copies of the preliminary reports, or summaries thereof, are also often provided to A.I.D. shortly after the end of the trip. Final trip reports, on the other hand, are treated in CDC as in-house documents that need to be cleared through upward channels and also cleared with the administrative office for payment of travel vouchers. Delays in submission of these reports have resulted primarily from slow clearance of

travel vouchers by the Administration Office because the only person qualified to process the vouchers has recently been busy training other staff who will subsequently be decentralized to the divisions. This has caused a backlog for several months during which the CDC staff have been kept waiting for their payments from one to three months. A side effect has been the delays in the release of trip reports. The Administration Office reported that the training should be completed by the end of February 1990, and that the backlog on travel vouchers would then be reduced. With respect to upward clearance, CDC has released draft copies of trip reports to A.I.D. without awaiting in-house clearances. This could easily obviate not only backlogs in the Administration Office but also clearances within the several offices and echelons within CDC.

5.5.2 Quarterly Reports

Quarterly reports under the RSSA follow a format designed to meet the various needs of diverse audiences within CDC and A.I.D./W. Earlier reports tended to focus on number of trips, brief statements of assistance and financial data. When some program offices within CDC asked for more substantive reporting on the nature and substance of the assistance, the reports were expanded to include brief summaries on the substance of the assistance.

Nonetheless, these reports still provide little in the way of analysis of impacts of project activities, whether these be surveys, family planning program improvement, or other undertakings. Such information would be helpful to A.I.D. in monitoring this project effectively. Other audiences may have other needs, but an effort is needed to define these audiences and identify their information requirements.

<u>Recommendations</u>

35. Reports of technical assistance to host country organizations should be written to and for them in whatever way is most useful to them. Cover sheets for these reports could be prepared for CDC headquarters and A.I.D./W which would be tailored to the special concerns of those audiences.

36. Copies of draft reports rendered both to client organizations and local missions should be forwarded to A.I.D./W without the delays of internal CDC clearances.

37. As a part of whatever agreement is adopted this year, CDC and the Office of Population should define the various audiences needing progress reports along with the most useful format and timing of such reports. Reports need not be limited to written documents but could also include slide presentations on topics of special interest.

6. Future Directions

6. Future Directions

6.1 Setting the Stage for the Future

Within the Office of Population, the majority perspective is that its relationship with CDC should be continued and that the organization's role should be expanded. This expansion is viewed in such terms as a need for more innovation, better use of staff talents, a longer time frame for planning (i.e., a PASA arrangement), the need for a strategic framework for the collaboration, and emphasis on institution building.

The time may well be ripe for CDC to take on the expanded role in family planning envisioned by the Office of Population. Encouraging developments within CDC include its expected expansion in the international family planning field backed by support from the highest levels, the new interest within the DRH in taking a leading role in many areas related to reproductive health, and the reorganization within DRH that should strengthen its ability to respond even better to mutually agreed upon tasks for A.I.D. Furthermore, the rationale for A.I.D. to maintain a relationship with CDC is as valid today as it was when the first RSSA was signed in 1974. CDC remains the preeminent organization in the U.S. in the field of health promotion and disease prevention and its resources and skills can only serve to strengthen the Office of Population's own endeavors in international family planning.

There is currently sufficient compatibility of objectives and directions in both agencies to warrant an in-depth discussion as a part of a strategic planning process. The overall CDC reorientation of its international health efforts coincides precisely with the mission of the Office of Population. Moreover, CDC's desire to broaden its functional scope is consistent with the current RSSA scope of work. Finally, there is compatibility of objectives in moving to an institution building focus with longer-term involvement in key country programs.

It is not yet clear whether the Office of Population has need for the broad expansion of activities envisioned by DRH, but this is subject to discussion by both parties in the light of the roles of other Cooperating Agencies whose activities could overlap with those suggested by the DRH. The actual implementation of a new role for CDC is of course dependent upon mission and country needs, the roles of other Cooperating Agencies, and the capacity of CDC to fulfill such requests.[13] Given the powerful and unique combination of advantages brought by CDC to its work in family planning, however, it is unquestionably worth the effort for the Office of Population to explore how best to integrate CDC into its overall program.

6.2 Principal Recommendations

6.2.1 Immediate Steps

In light of the unresolved issues touched on above, together with the imminent expiration of the current RSSA, it is important that both agencies begin discussions as soon as possible about development of a new agreement. The steps that follow should include:

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[13]At the same time, the relaxation of the constraints on personnel ceilings by use of consultants, IPA (Intergovernmental Personnel Act) personnel, and additional positions authorized by Congress with funding from other agencies will make it easier to meet increased demands for personnel.

- Informal discussions regarding future directions should begin at top levels of CDC and the Office of Population.

- If CDC and the Office of Population can agree upon an expanded scope of work for CDC, then a PASA instrument should be negotiated (see Recommendation 19).

- CDC and the Office of Population should commence immediately with strategic planning, with results to be integrated within the Agreement to take effect in the spring of 1990 (see Recommendation 23).

- To the extent possible, all levels of RSSA staff should participate in developing some of the future directions being discussed in the DRH. This would help enrich the end result as well as serving to mitigate some of the alienation now felt by the staff (see Recommendation 25).

The principal recommendations set forth in this report are designed to feed into the strategic planning process that is recommended above. They are repeated or paraphrased below:

6.2.2 Overall CDC Role

- The CDC role in family planning work should be expanded insofar as the Office of Population finds it practicable to do so in view of demand and the other activities of the other Cooperating Agencies (see Recommendation 19).

6.2.3 Setting Priorities within Logistics and Survey Components

- A.I.D. and CDC should establish country priorities for both logistics and survey assistance being provided through the RSSA. Establishing priorities will involve reviewing current procedures for selection of countries and establishing new guidelines for this process (see Recommendations 1 and 8).

- In determining priorities, a major consideration should be to ensure that the assistance provided has the potential for achieving long-lasting program improvements and institution building, including the capacity for doing CPTs (see Recommendations 2, 3 and 11).

- If a country receiving large supplies of A.I.D. commodities is capable itself of managing and distributing commodities, it should be downgraded in terms of receiving technical assistance (see Recommendation 4). Countries that receive large supplies of A.I.D. commodities should, however, continue to receive priority for surveys, even if there is a downsizing of logistics support (see Recommendation 9).

- CPSD should assign greater priority to MIS and CCMIS. Wherever possible, efforts should be directed to those countries or projects that are ready to receive CCMIS. This should not be the exclusive focus, however; rather, efforts should be directed to MIS requirements generally (see Recommendation 4).

6.2.4 Division of Labor Between CDC and Other CAs

- The Office of Population should examine the division of labor between CDC and -- for logistics -- the FPLM contract and -- for surveys -- the DHS contract. Consideration should be given to transferring more of the forecasting of contraceptive needs to the FPLM contract and to utilizing the logistics specialists

within CDC in their areas of comparative advantage, providing longer-term, more intensive technical assistance in fewer high priority countries designed specifically to increase institutional capacity to manage logistics systems (e.g., through the CCMIS). In survey work, the Office of Population should take advantage of the CDC's more flexible mandate by allowing it to become involved in program-relevant research that may deviate from the current FP/MCH or DHS type surveys. The FP/MCH survey should remain the main focus of the CDC activity, however (see Recommendations 7 and 10).

6.2.5 Coordination Among Project Components

- CDC should devote further staff resources to coordinating the survey and logistics aspects of the project more effectively (Recommendation 15).

- CPSD should reconsider whether the logistics component should continue to receive 60 percent of A.I.D. funding under the anticipated PASA. The decision should be made in the context of the overall new directions of the PASA, taking into account an appropriate division of labor between CDC and FPLM (see Recommendation 17).

6.2.6 Management

- Selection of the new supervisors (one branch chief and two section chiefs) should be completed soon so that the leadership void can be filled. In so doing, it would be wise to emphasize the leadership qualifications of the new selectees and organize travel time to minimize absence from their managerial functions (see Recommendation 25).

- If possible, efforts should be made to enlarge the scope, challenge and variety of tasks for the logistics staff to utilize their talents. The leadership should explore each person's capacities and interests and to the maximum extent possible match need with interests in making assignments (see Recommendation 26).

Appendices

Appendix A

Scope of Work

Appendix A

Scope of Work

EVALUATION OF S&T/POP AGREEMENT
WITH THE CENTERS FOR DISEASE CONTROL

Under the Project Development and Support Project (936-0502), the Office of Population has an agreement with the Centers For Disease Control (CDC) for assistance in logistics management and associated activities. The agreement was last evaluated in 1976, and, therefore, it is clearly time for another external review of their activities. Following is some basic information on the CDC agreement:

I. Basic Project Information

Project Name and Number	Project Development and Support (936-0502)
Agreement Number	BST-0502-R-H-2052-00
Agreement Value	$17,540,019 (to date)
Obligations to Date	$17,540,019

II. Purpose of the Evaluation

The objective of the CDC agreement is to improve the performance of family planning programs in developing countries. To achieve this objective the CDC staff provides assistance to developing country programs in four areas:

1. family planning logistics management;
2. demographic and contraceptive prevalence studies;
3. epidemiological studies;and
4. family planning program evaluation.

The bulk of CDC's time and resources are devoted to assistance in the first two areas: logistics management and prevalence studies.

The major focus of the evaluation is to assess the appropriateness, quality and timeliness of the activities conducted through the CDC agreement. The evaluation team will also be asked to highlight the significant accomplishments of the project and to examine the evolution of project activities over the past 3-5 years. The team will be asked to examine the level and extent of cooperation with other CAs - especially the John Snow logistics project and the Demographic and Health Survey project. Finally, the team will be asked to identify innovative activities that could be undertaken through the agreement, and provide guidance to the Office on other activities that would enhance the efficiency and effectiveness of the Agency's contraceptive supply system.

Since 1974, the Office of Population has supported the family planning logistics needs of developing countries through a Resources Support Services Agreement (RSSA) with CDC. While logistics assistance consumes the bulk of the RSSA's resources, it has proved impossible for the CDC staff to fully meet developing country needs for assistance in contraceptive logistics management. Therefore, in 1986 the Office began a five-year contract with John Snow, Inc. (JSI) to complement CDC's logistics work. The two organizations have worked together during the past four years in providing logistics assistance to A.I.D. and to developing country family planning programs.

The CDC agreement has also supported contraceptive prevalence studies in numerous developing countries over the past five years. CDC complements the work of the DHS project by conducting studies that are outside the scope of the DHS (e.g. the young adult studies, and sub-national prevalence studies) or that cannot be accommodated by DHS (e.g. the 1988 Turkish Prevalence Survey). In addition to the logistics and survey activities, which constitute most of CDC's work under the RSSA, CDC has undertaken epidemiological studies and evaluations of family planning programs on an ad hoc basis. Because these two tasks comprise only a small portion of the RSSA, the team should not focus undue attention on them.

IV. Evaluation Questions

The current evaluation will cover four topics:

1. performance in logistics assistance;
2. performance in survey assistance;
3. project management; and
4. future directions and new initiatives.

1. Contraceptive Logistics Assistance

a. How would the team assess the overall performance of CDC in the contraceptive logistics field? e.g. Have the activities adequately addressed A.I.D. and host country needs for logistics assistance? Have the activities been implemented in a timely and professional manner and in response to clear objectives? How are country assistance activities identified and prioritized? Is there an overall plan and strategy for logistics assistance?

b. What proportion of the RSSA resources have been devoted to logistics assistance? Is this level of effort appropriate given A.I.D. and developing country needs and project resources? Are the resources available for logistics work being devoted to the priority logistics tasks? What proportion of staff time is spent on logistics assistance for A.I.D. and for local family planning programs?

c. What methodological or technical innovations has CDC brought to the field of contraceptive logistics? What innovations can/should CDC be working on to improve the logistics management in developing country family planning programs?

d. Under the current RSSA agreement CDC developed a contraceptive MIS system which is being used in Kenya and Guatemala. Can, and should, this system be adapted for use in other family planning programs? What would be the costs of such adaptations? What additional assistance can/should be provided by CDC to improve the availability and reliability of information on contraceptive use?

e. Does the assistance provided by CDC strengthen the ability of local family planning organizations to manage their logistics systems? To date, what level of effort has been devoted to developing local capacity in contraceptive logistics management? Within the current level of resources (both financial and staff), what more can and should the project do in this area?

f. To what extent has CDC collaborated with JSI in providing contraceptive logistics assistance? How can future collaboration be facilitated?

2. Contraceptive Prevalence Studies

a. How would the team assess the overall performance of CDC in conducting contraceptive prevalence studies? Have the surveys been well designed and executed, particularly with respect to local needs? Have local organizations been involved to the maximum extent possible in the design, execution and analysis of the surveys? Are standard questionnaires used that would permit cross-national analyses; if not, should standard forms be promoted? What can be done to minimize the lag between field work and the availability of results?

While it may be difficult to get detailed answers to these questions without visiting selected countries, the team should be able to get a general picture through telephone interviews with A.I.D. missions and the collaborating institution.

b. Have the survey activities been designed in response to clear objectives on the paart of both A.I.D. and the host country? How are countries selected for prevalence surveys; what strategy and prioritization underlie the selection of countries? Is the current level of effort devoted to surveys appropriate given the project's objectives?

c. Are there systematic plans for the dissemination of survey findings, especially to local policymakers and program administrators? What is done, and should be done, to

92

provide local policymakers and program administrators with easily digestible summaries of key results?

d. What technical and methodological innovations has CDC brought to the field of contraceptive prevalence surveys? What has CDC done to use their survey activities to support their contraceptive logistics work? (e.g. To what extent can CDC use the surveys to provide or validate contraceptive data needed for logistics management?)

e. In designing and conducting contraceptive surveys, has CDC collaborated with the DHS program? (e.g. Where appropriate, has CDC used any of the DHS protocols in their surveys?) What is the nature of the collaboration, and how can future collaboration be facilitated?

3. Project Management

a. Is there sound internal management of project resources by CDC? Is the current management structure of the project adequate in terms of project objectives and A.I.D. and developing country needs? Is there adequate and timely communication and division of labor among project staff?

b. What type of management practices does CDC use to ensure that resources (i.e. staff, financial, and material) are appropriately allocated to various tasks? Are the management systems adequate and do they function efficiently? Are annual workplans developed and is performance monitored on a periodic basis? Are reports submitted in a timely manner, and in a useful format? What should be done by CDC, and S&T/POP to improve the management of the project?

c. Has S&T/POP provided adequate, timely, and consistent guidance on project strategies and project implementation? Is there adequate and timely communication between project staff and the field (i.e. A.I.D. missions and host country organizations)?

d. How is staff time allocated by task? Is there a good match between the allocation of staff (and financial) resources and the priority of the task? Is there a good match between project tasks and staff skills? What are the staffing constraints facing the project, and what can be done to alleviate them?

e. What has been the pace of expenditures in this project over the past 3-5 years? How have the financial resources been allocated by task and are they adequate given the priority of the activity?

4. Future Directions

a. What new and innovative activities can be added to our agreement with CDC that would complement the project's objectives? (e.g. Closer collaboration with CDC field staff in developing countries, especially the child survival fellows). What innovations can be made to the logistics and survey activities that would strengthen the capability of developing country organizations in these areas? Can CDC do more to ensure that the logistics and survey activities are integrated into family planning service delivery programs.

b. Should the family planning evaluation and the epidemiological activities be continued in the next agreement with CDC? If so, what is the appropriate level of effort for these tasks and how should they be integrated with the survey and logistics work?

c. How can the project mode of operation be shifted from its current reactive mode to a more active and anticipatory mode? (The project currently operates largely by responding to existing logistics "crises" and responding to field or country generated requests for survey assistance.) Under this project, what more can CDC do to increase developing country (and A.I.D.) recognition and understanding of the importance of good contraceptive logistics management?

Appendix B

Description of Evaluation

Appendix B

Description of Evaluation

This evaluation was undertaken over a five-day period, January 16 through 20, 1990, by a four-person team charged with assessing all aspects this Resources Support Services Agreement (RSSA) between the Centers for Disease Control (CDC) and A.I.D.'s Office of Population. Arrangements were carried out through the Population Technical Assistance Project (POPTECH).

The team included four persons:

- Edward Rizzo, team leader, consultant in development administration, who reviewed management aspects of the RSSA;
- Jane Bertrand, specialist in family planning research and Associate Professor, Tulane University, who reviewed the survey component;
- Christopher Hesling, logistics specialist, Director, Purchasing and Supply, International Planned Parenthood Federation, who reviewed the logistics component, and
- Dorothy B. Wexler, senior editor, POPTECH, who coordinated the report preparation.

The evaluation began with a full day of briefings with Office of Population staff in Rosslyn, VA. The team spent the following four days at CDC headquarters in Atlanta, GA. Meetings were held with the senior-level staff at CDC who are responsible for CDC activities in international health and family planning. In particular, the Director and Deputy Director of the Division of Reproductive Health made large blocks of time available to the team. Interviews were also held with virtually every staff member of the RSSA, and a two-hour session with 9 staff members, including most of the logistics staff, provided additional insights on this aspect of the RSSA (see Attachment 1). CDC provided documentation to the team, including reports prepared routinely for A.I.D. and a number of special tables and documents prepared especially for this evaluation (see Attachment 2).

The team reassembled during the week of January 22 at the POPTECH offices, where they conducted telephone interviews with a sampling of USAID mission population and health officers and with representatives of Cooperating Agencies that work with CDC. A standard questionnaire was drawn up by the team and used in its discussion with USAID mission staff, (see Attachment 3). The bulk of the report was completed during that week.

Although the time provided for field work was relatively brief, this did not represent a constraint in this evaluation. In part this was due to the very forthcoming and helpful participation of everyone involved at CDC. It was also because the team was instructed to focus more on the future than on the past, since a number of changes were taking place within CDC and A.I.D. that were setting the stage for a new chapter in the relationship between these organizations. A.I.D. was thus less interested in an exhaustive analysis of CDC's performance under the RSSA and more in CDC's vision of the future.

Attachment 1

List of Persons Contacted

CDC

Joe H. Davis	Assistant Director for International Health
Jeffrey P. Koplan	Director, Center for Chronic Disease Prevention and Health Promotion (CCDPHP)
Virginia S. Bales	Deputy Director, CCDPHP
Andrew N. Agle	Assistant Director for Operations International Health Program Office

Division of Reproductive Health (DRH)

Carol J. R. Hogue	Director, DRH
Patrick J. McConnon	Deputy Director, DRH
Leo Morris	RSSA Coordinator and Chief, Epidemiology and Demographic Research Branch
Herbert Peterson	Chief Medical Epidemiogist, Women's Health and Fertility Branch
Nancy Lee	Deputy Chief Medical Epidemiologist, Women's Health and Fertility Branch
Hani Atrash	Chief Medical Officer, Pregnancy and Infant Health Branch
Robert N. Evans	Assistant Chief, Management

RSSA Staff

Program Services and Evaluation Section

J. Timothy Johnson
Neal H. Ewen
Jack L. Graves
Richard S. Monteith

Program Implementation and Clinic Management Section

Maurice Glatzer
Anthony A. Hudgins
Brian J. McCarthy — WHO Collaborating Center

Behavioral Epidemiology and Demographic Research Branch

Raul A. Romaguera
Joan Herold

Computer Resources Section

Jack Smith
Jeanne C. Gilliland
Steven A. Kinchen

A.I.D./Washington

Richard Cornelius
John Crowley
Carl Hemmer
Elizabeth Maguire

Other Organizations

John Snow, Inc.

Richard Owens
Pete Hagan
Elise Levin
Brice Atkinson

DHS

Martin Vaessens
Ann Way

Family Planning International Assistance

H. McKinley Coffman

Management Sciences for Health

Ken Heise
Brian McCarthy

Population Communication Services

Phyllis Piotrow

Current or Former Population Officers in the Field

John Coury	Jamaica (formerly)
Howard Helman	Brazil
Jayne Lyons	Guatemala
Keys MacManus	Nigeria (formerly)
David Oot	Kenya
John Roberts	Botswana
Michael White	Haiti and (formerly) Senegal

Attachment 2

Materials Reviewed

"An Overview of the Centrally Funded Contraceptive Procurement Project No. 936-3018," Audit Report No. 9-000-89-010, United States Agency for International Development, Office of Programs and Systems Audits, Washington, D.C., 9-29-89.

Croley, Thomas H. and Wishik, Samuel., "An Evaluation of Activities of the Center for Disease Control Family Planning Evaluation Division," Assgn. No. 1100-030, U.S. Agency for International Development, Washington, D.C., 1976.

Elkins, Henry G. Jr., Goldberg, Howard and Tsui, Amy O., "Evaluation of Demographic and Health Surveys," Report No. 87-135-068, POPTECH, Inc., Arlington, Virginia, 5-6-88.

"Family Planning Methods and Practice: Africa," Centers for Disease Control (CDC), Center for Health Promotion and Education, Division of Reproductive Health, Atlanta, Georgia, 1983.

Kangas, Lenni, Hesling, Christopher and Thomas, Suzanne.,"Midterm Evaluation of Family Planning Logistics Management Project," Report No. 88-010-083, POPTECH, Inc., Arlington, Virginia, 5-19-89.

"Resource Support Services Agreement," Quarterly Reports, FY 1986-1989, Department of Health and Human Services, Atlanta, Georgia.

Attachment 3

QUESTIONS REGARDING CDC PERFORMANCE IN THE FIELD

Person contacted:_____

Title/Country:_____

Person conducting interview:_____ Date:_____

1. Have you had any involvement in the past with the CDC personnel who provide in-county technical assistance? In what countries? Over what period of time? In what what types of activities (surveys, logistics, MIS, etc.)? If you have not had direct involvement with the CDC personnel, who in your Mission has? Can you name the CDC staff that have worked most in the host country?

Note: Questions 2-5 are concerned with logistics.

2. Regarding the logistics work done to date in your country, are you aware which consultants are from CDC and which are from JSI? Do you request consultants by name?

3. When both JSI and CDC staff are involved in logistics assistance, is there adequate coordination and cooperation between the two?

4. Who determines the needs for TA and the scope of work in terms of logistics on CDC assignments? Do you feel that the CDC staff are making unnecessary/too frequent trips, too few trips, or the right number?

5. What do CDC consultants actually do when they are in country on a logistics assignment? Do the consultants visit the field (outlying districts) or do they focus entirely on activities in the main city?

Questions 6-8 primarily concern survey work:

6. Did the survey objectives address the interests and problems of the local AID mission? Of the host country implementing agency?

7. How have the study results been disseminated? How have they been incorporated into program management or policy development?

8. (Question to host country institutions) Were you involved to the maximum extent possible in the design, execution, and analysis of the studies? Would you be better able to conduct surveys in the future based on the survey experience to date? In what areas do you feel the "transfer of skills/technology" was inadequate?

<u>Questions 9 to 15 apply to both logistics and surveys</u>:

9. Are the TA activities implemented in a professional and timely manner? What feedback has the Mission received from the target organization(s) receiving the CDC assistance? Are you aware of any problems between the CDC staff and the implementing agency in regard to the execution of the logistics or survey activities? Who in the HC organization(s) could comment on this?

10. Is the USAID mission kept informed by CDC staff on progress? Do the CDC staff provide departure briefings if requested and a Draft Report of their work? Are their recommendations usually practical for the situations they meet?

11. Are CDC staff innovative wherever this is appropriate? How?

12. Do you perceive any lasting benefits or improvements in the local organization that have resulted from CDC TA visits? What more can and should CDC do for institution building?

13. Can or should the CDC staff be utilized for more than surveys and logistics? Is there interest/need for CDC assistance to improve Family Planning program design and management? What new or innovative activities could/should CDC undertake? Do you foresee the need for longer term TA in-country using a resident Advisor or Regional level Advisor?

14. Would the Mission be interested in a buy-in to CDC services if this were available? In what fields? Would there be a significant increase in demand for CDC services?

15. On a scale of 0 to 10, how would you rate the overall effectiveness of CDC in survey work? in Logistics? other?

16. Do you have any further comments on other aspects of CDC's performance in country?

Thank you for your time and assistance...

Appendix C

Additional Tables and Figures

Appendix C

Additional Tables and Figures

Tables

Table C-1	A.I.D. RSSA Travel Days by Country
Table C-2	List of Surveys Conducted under RSSA 1975 - 1989
Table C-3	Detailed Information on Surveys Conducted under RSSA 1988 and 1989

Figures

Figure C-1	Centers for Disease Control: Organization Chart
Figure C-2	Center for Chronic Disease Prevention and Health Promotion: Organization Chart

Table C-1

A.I.D. RSSA Travel Days by Country
PRH/CCDPHP/CDC
FY 1989 (October 1988-September 1989)

Country	Total Persondays	Persondays by Purpose: Logistics/Clinic Management	Survey	Repro. Hlth Epidem.	Other
Barbados	8	8	-	-	-
Brazil	152	17	129	-	6
Chile	31	-	31	-	-
Costa Rica	69	54	15	-	-
Dominican Republic	9	9	-	-	-
Ecuador	205	19	186	-	-
El Salvador	17	7	10	-	-
Guatemala	26	24	2	-	-
Haiti	142	22	120	-	-
Honduras	7	7	-	-	-
Jamaica	103	14	89	-	-
Mexico	62	28	5	16	13
Venezuela	3	-	3	-	-
Subtotal	834	209	590	16	19
Botswana	25	25	-	-	-
Ghana	14	14	-	-	-
Ivory Coast	19	19	-	-	-
Kenya	53	53	-	-	-
Lesotho	34	34	-	-	-
Malawi	25	25	-	-	-
Niger	20	20	-	-	-
Nigeria	22	22	-	-	-
Senegal	8	8	-	-	-
Swaziland	88	5	83	-	-
Tanzania	16	16	-	-	-
Togo	16	8	-	-	8
Zaire	13	13	-	-	-
Zimbabwe	39	39	-	-	-
Subtotal	392	301	83	0	8
Indonesia	16	-	-	16	-
Jordan	16	16	-	-	-
Pakistan	14	14	-	-	-
Philippines	20	20	-	-	-
Tunisia	1	1	-	-	-
Turkey	39	20	19	-	-
Subtotal	106	71	19	16	-
Other Foreign	3	3	-	-	-
Subtotal	1335	584	692	32	27
A.I.D./W Travel	91	77	4	-	10
Retreat	61	61	-	-	-
TOTAL	1487	722	696	32	37

Table C-2

List of Surveys Conducted under RSSA
1975 - 1989

1975	El Salvador CPS, Female 15 - 49
1977	Nicaragua (Boaco Province) FP/MCH, Ever Married/In Union Female 15-44 Paraguay CPS, Female 15 - 44
1978	Brazil (Sao Paulo State) CPS, Female 15-49 El Salvador CPS, Female 15-44 Guatemala FP/MCH, Female 15-44
1979	Brazil (Piaui State) FP/MCH, Female 15-44 Panama FP/MCH, Female 15-44
1980	Northeast Region - Brazil (4 states) FP/MCH, Female 15-44 •Bahia •Paraiba •Pernabuco •Rio Grande de Norte
1981	Southern Region-Brazil (3 states) FP/MCH, Female 15-44 •Parana •Rio Grande de Sul •Santa Catarina
1982	Senegal (Sine-Saloum) FP/MCH, Ever Married 15-49 Brazil (Amazonas State) FP/MCH, Female 15-44 Brazil (Piaui State) FP/MCH, Female 15-44
1983	Guatemala FP/MCH, Female 15-44 Jordan FP/MCH, Female 15-44 Ever Married
1984	Montserrat CPS, Current in Union, Female 15-44 Panama FP/MCH, Female 15-44 St. Kitts/Nevis CPS, Female 15-44 Current in Union
1985	Jordan Husbands CPS, Followup of Females 1983 FP/MCH Mauritius CPS, Females 15-49 Kenya (Chogoria) Community Health Survey, Females 15-44 Grenada CPS, Females 15-44 Mexico City, YARHS, Males and Females 15-24
1986	Costa Rica FHS, Females 15-49 Guatemala City, YARHS, Males and Females 15-24
1987	Paraguay CPS, Females 15-44 Jamaica, YARHS, Males and Females 14-24

1988	Swaziland FHS, Males 15-59, Females 15-49 El Salvador FHS, Females 15-44 Caribbean FPS, Females 15-44 Turkey FP/MCH, Females 15-49 Brazil (Sao Paulo and Salvador) VAK I, Ever Married Males 25-49 Chile (Metro Santiago), YARHS, Males and Females 15-24 Brazil (Sao Paulo), YARHS, Males and Females 15-24 Ecuador (Quito and Guayaquil), YARHS, Male and Female 15-24
1989	Jamaica CPS, Females 14-49 Ecuador FP/MCH, Females 15-49 Haiti FPS, Males 15-49, Females 15-44 Brazil (Sao Paulo and Salvador) VAK II, Ever Married Males 25-49

Table C-3

Detailed Information on Surveys Conducted Under RSSA
1988 and 1989

Year and Country or Area	Type of Survey*	Dates of Field Work	Implementing Organization	In-Country Contact Person (DRH Contact Person)	Respondents	Completed Interviews	Status as of January 1990
1988							
Caribbean (Antigua, Barbados, Dominica, St. Lucia, St. Vincent)	FPS	Jan.-Sept.	Caribbean Family Planning Affiliate-	Tirbani Jagdeo (H. Goldberg)	Females 15-44	6,000 Females	Final reports in progress.
El Salvador	FP/MCH	May-July	ADS	Mario Caceras (R. Monteith)	Females 15-44	3,579 females	Preliminary report published 9/88; final report dated 3/89 pub. 6/89. (English language report published 2/89.) Seminar held 9/89.
Turkey	FP/MCH	Aug.-Oct.	Hacettepe University	Aykut Toros (H. Goldberg)	Females 15-49** Males 15-59***	5,257 2,264	Seminar held 5/89 and report published 6/89. Secondary analysis in progress.
Chile (Metropolitan Santiago)	YARHS	Sept.-Nov.	Univ. Chile	Maria Valenzuela (J. Herold)	Males/Females 15-24	865 females 800 males	Preliminary report dated 3/89 issued 6/89. Seminar held 7/89. Final report published 10/89.
Brazil (Sao Paulo, Sao Paulo)	YARHS	Sept.-Dec.	C.M.I.	Joao Carlos Vaccarelli (L. Morris)	Males/Females 15-24	804 females 750 males	Preliminary report issued 8/89. Final report in progress.
Swaziland	FP/MCH	Oct.-Dec.	MOH	Mduduzi Hlope (T. Johnson)	Females 15-49 Males 15-59	4,261 females 2,273 males	Preliminary report issued 3/89; Seminar held 6/89; Final report in progress.

Year and Country or Area	Type of Survey*	Dates of Field Work	Implementing Organization	In-Country Contact Person (DRH Contact Person)	Respondents	Completed Interviews	Status as of January 1990
Ecuador (Quito and Guayaquil)	YARHS	Oct.-Dec.	CEPAR	Magdalena Torres (L. Morris)	Males/Females 15-24	1,656 females 1,562 males	Preliminary report published 6/89. Final report in progress. Seminar held 12/89.
Brazil (Sao Paulo and Salvador)	VAKI	Nov.-Dec.	PRO-PATER (CMI and UFBA)	Bernadette de Castro (L. Morris)	Ever-Married Males 25-49	1,115 males (600-SP) (515-BA)	Salvador report issued 11/89; SP report at printer.
1989							
Jamaica	FPS	Feb.-Apr.	National Family Planning Board	Newton Forbes (C.W. Warren)	Females 14-49	6,333 females	Preliminary report issued 8/89. Seminar held 11/89. Final report in progress.
Ecuador	FP/CSS	July-Sept.	CEPAR	Magdalena Torres (R. Monteith)	Females 15-49	7,500 females	Fieldwork completed. Preliminary report in progress.
Haiti	FPS	Aug.-Oct.	Child Health Institute	Tony Agustin (J. Friedman)	Males 15-49 Females 15-44	1,206 males 1,996 females	Fieldwork completed. Preliminary report in progress.
Brazil (Recife, Rio, Curitiba-UNFPA funded)	YARHS	Aug.-Nov.	BEMFAM	Jose Maria Arruda (L. Morris)	Males/Females 15-24	3,000 males 3,000 females	Fieldwork in progress in Recife; completed in Rio and Curitiba.
Brazil (Sao Paulo and Salvador)	VAK II	Oct.-Nov.	PRO-PATER (CMI and UFBA)	Bernadette de Castro (L. Morris)	Ever-Married Males 25-49	1,060 males (511-SP) (549-BA)	Fieldwork completed.

Year and Country or Area	Type of Survey*	Dates of Field Work	Implementing Organization	In-Country Contact Person (DRH Contact Person)	Respondents	Completed Interviews	Status as of January 1990
1990							
Costa Rica	YARHS	Mar.-May	Seguro Social	Victor Gomez (D. Hernandez)	Males/Females 15-24	2,000 females 2,000 males	Pretest completed 11/89.
Mauritius	FPS	July-Sept.	MOH	B. Radhakeesoon (J. Friedman)	Females 15-44	5,600 females	Planning trip completed 10/89. Pretest scheduled for 4/90.
Somalia	FP/MCH	Aug.-Oct.	Ministry of Planning	A.M. Farah (R. Monteith)	Females 15-44	Pending	Technical assistance trip 11/89. Followup scheduled 3/90.
Belize	FP/MCH	Pending	Family Life Association	Bibi Essama (USAID) (C.W. Warren)	Females 15-44	2,000 females	Technical assistance trip planned 3/90.
Venezuela	FP/MCH	Pending	PLAFAM	Luis Blanco (Leo Morris)	Females 15-44	4,700 females	Draft questionnaire reviewed 12/89; pretest pending availability of funding.

*YARHS - Young Adult Reproductive Health Survey
FPS - Family Planning Survey
FP/MCH - Family Planning/Maternal Child Health Survey
FP/CSS - Family Planning/Child Survival Survey
VAK - Vasectomy Attitudes/Knowledge Survey
**Ever-married females
***Sub-sample of husbands

Figure C-1

Department of Health and Human Services
Public Health Service
Centers for Disease Control (HC)

APPROVED: CDC
DATE: 10/1/89

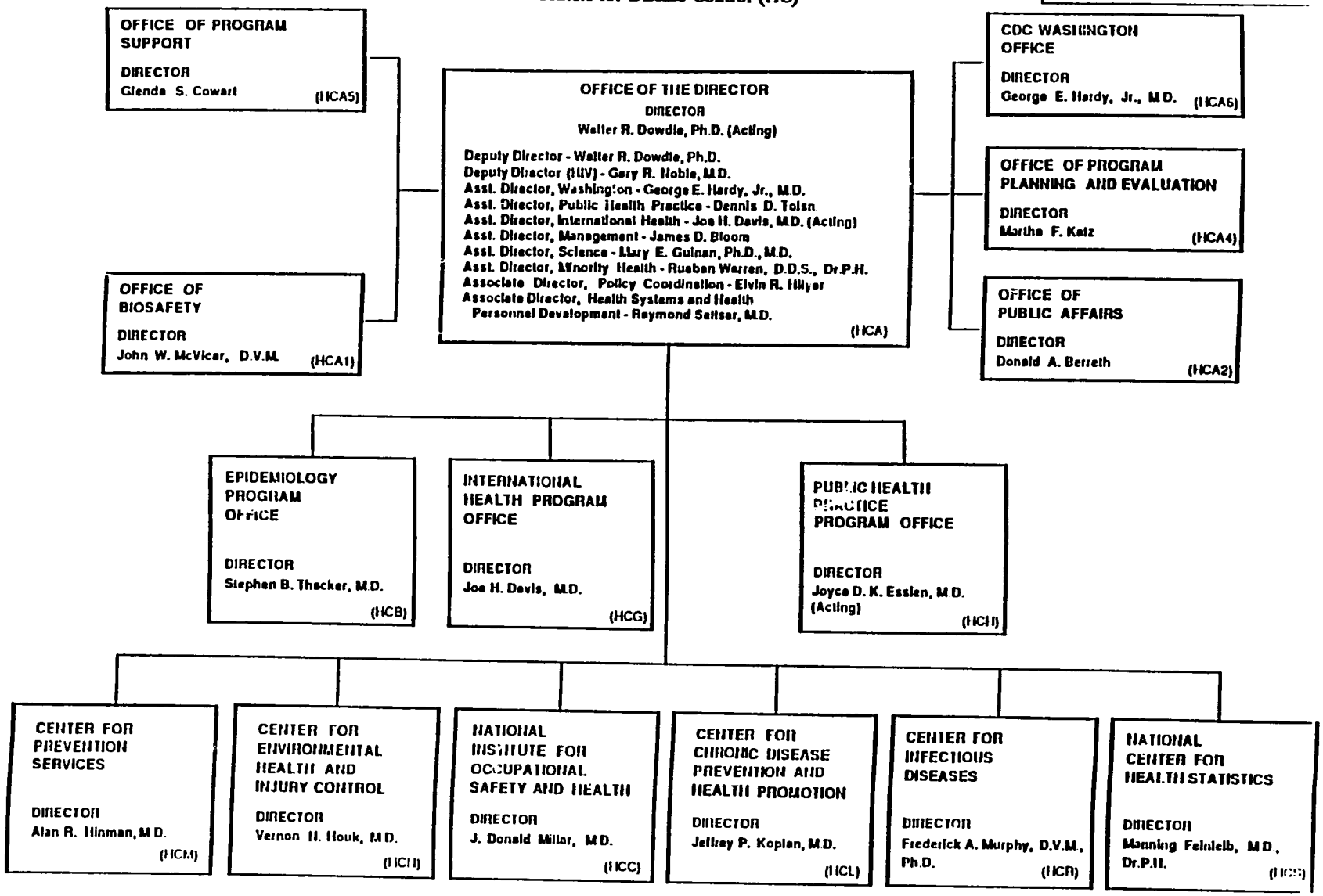
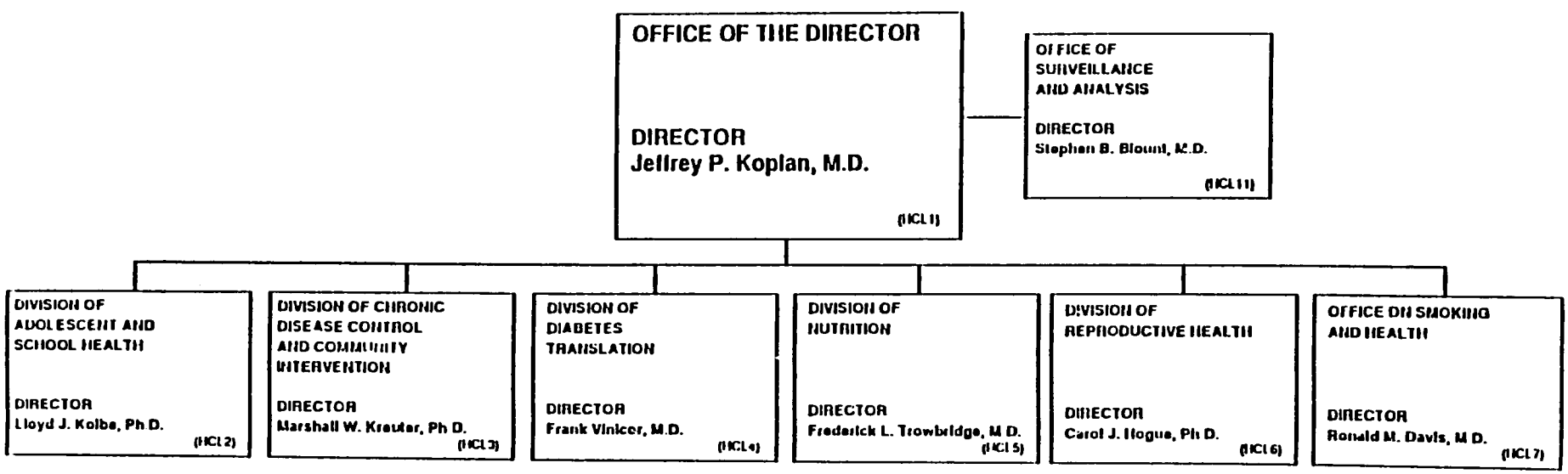


Figure C-2

Department of Health and Human Services
Public Health Service
Centers for Disease Control
Center for Chronic Disease Prevention and Health Promotion (HCL)

APPROVED: CDC
DATE: 10/1/89



Appendix D

List of Recommendations

Appendix D

List of Recommendations

1. **A.I.D. and CDC should establish priorities among countries receiving logistics assistance through the RSSA. Establishing priorities will involve reviewing current procedures for selection of countries and establishing new guidelines for this process. A strategic planning meeting should be held soon to initiate this process.**[1]

2. **In determining priorities for the logistics component, a major consideration should be to ensure that the assistance provided has the potential for achieving long-lasting program improvements and institution-building.**

3. **Although CPSD would still maintain a fiduciary responsibility to validate CPTs, the objective of technical assistance should be to develop the LDC organization's capacity to prepare CPTs.**

4. One option of the strategic selection process would be to review countries identified as high priority due to the value and volume of aid they receive and to determine whether they have the ability to manage and distribute contraceptives and forecast future requirements without technical assistance. If so, the country should be downgraded in terms of receiving technical assistance and the effort spent instead on less advanced LDCs, even if it is not a major recipient of commodities.

5. CPSD should assign greater priority to technical assistance in MIS and CCMIS. Wherever possible, efforts should be directed to those countries or projects that are ready to receive CCMIS. This should not be the exclusive focus, however; rather, efforts should be directed to MIS requirements generally.

6. Consideration should be given to encouraging USAID missions in priority countries to buy into the new PASA for MIS/CCMIS assistance, if funds are limited.

7. **The Office of Population should examine the division of labor between CDC and the FPLM contract. Consideration should be given to transferring more of the work of forecasting contraceptive needs to the FPLM contract and to utilizing the logistics specialists within CDC in their areas of comparative advantage, providing longer-term, more intensive technical assistance in fewer high priority countries designed specifically to increase institutional capacity to manage logistics systems (e.g., through the CCMIS).** CDC and JSI should continue their close collaboration through regularly scheduled meetings.

8. **A.I.D. and CDC should establish priorities among countries receiving survey assistance through the RSSA. This effort should include a review of the procedures for the selection of countries and the establishment of guidelines for this process. A strategic meeting should be held soon to initiate this process (see Recommendation 1).**

9. Countries that receive large supplies of A.I.D. commodities should continue to receive priority for surveys, even if there is a downsizing of logistics support (see Recommendation 4).

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[1]Recommendations that appear in bold face are the principal recommendations of this report (see Chapter 6).

10. **Given that the DHS project has a fixed product, the Office of Population should take advantage of the CDC's more flexible mandate by allowing it to become involved in program-relevant research that may deviate from the current FP/MCH or DHS type surveys. The FP/MCH survey should remain the main focus of the CDC activity, however, in part because of its direct link with the logistics work.**

11. CDC should capitalize on its successes in institution-building by making the transfer of specific skills to counterparts an explicit objective in future surveys (see Recommendation 2).

    One means of fostering this process would be to develop a checklist of the tasks to be accomplished in the planning and execution of a survey: to rate the counterpart institution on its ability to do each before undertaking a given activity, and to again rate them on the same points at the close of the survey. In the process, CDC staff would in effect be evaluating their own effectiveness in transferring specific skills. Although some counterparts will acquire skills more rapidly that others (independent of what the CDC does), the proposed mechanism would focus the attention of the CDC staff on institution-building as well as completion of the survey itself.

12. CDC should work with local counterparts to reduce further the lag time between data collection and the production of the final report. One approach might be to analyze more closely the different steps in the process to identify how remedial actions can be undertaken.

13. CDC should encourage counterpart organizations to produce a summarized version of the main findings of surveys in a format that would be appealing to decision-makers and to the lay public.

14. The CTOs of CDC and DHS should meet to define the areas in which they believe collaboration between DHS and CDC would be most productive. Suggested areas include: (1) participation of a CDC member in the advisory board meetings held by the DHS; (2) an in-depth review of what works and what does not in different countries or regions, and (3) a more systematic exchange of information regarding the creation of new modules or changes in question content. The CTOs should then meet with the project directors of the two institutions to discuss their views on these and other areas in which this collaboration could be achieved. The product of these meetings should be a plan that defines the types of collaboration expected and the mechanisms for insuring this collaboration. This plan should then be cited in the new agreement with CDC and included in the next DHS contract.

15. **CDC should devote further staff resources to coordinating the survey and logistics aspects of the project more effectively**; this could include (1) planning surveys in countries in which use data are scarce or nonexistent, and (2) improving forecasting with data on condom use among men and on method use among unmarried women.

16. CDC should continue to refine the methodology for linking survey data, service statistics (CYP) and logistics. These techniques should be diffused beyond the JSI/CDC team to other members of the population community involved in survey work, program evaluation, or related areas. It would be useful to the population community (including USAID population officers and others who must assist in preparing commodity tables) for CDC to produce a short booklet which describes the linkage between the two and how data from three types of surveys (prevalence among married women, YARHS, and male surveys) can be used in improving estimates of contraceptive needs.

17. **CPSD should reconsider whether the logistics component should continue to receive 60 percent of A.I.D. funding under the anticipated PASA. The decision should be made in the context of the overall new directions of the PASA, taking into account an appropriate division of labor between CDC and FPLM** (see Recommendation 7).

18. **The CDC role in family planning work should be expanded insofar as the Office of Population finds it practicable in view of demand and the other activities of the other Cooperating Agencies.**

19. If CDC and the Office of Population can agree upon an expanded scope of work for CDC, then a PASA instrument should be negotiated.

20. The CTO role for this project should be defined in terms of duties and authority, not only within CPSD, but also for any other divisions whose workscope covers areas that might be included as part of CDC's new PASA (e.g., policy, IT, FPSD). The CTO role should be included in whatever Agreement is signed with the CDC so that expectations are shared. For example, a lead CTO could be designated for the overall coordination of the Agreement assisted by technical CTOs assigned by other divisions for their particular set of activities.

21. The Office of Population should consider under taking more frequent evaluations using informal in-house mechanisms, (i.e., use of annual managmeent reviews).

22. Division Chiefs of both agencies involved in the RSSA and even higher level officers should have a line of communication available to each whenever they feel it useful to discuss progress or problems.

23. The CDC idea of utilizing child survival posts abroad to incorporate family planning activities should be explored by the Office of Population and promoted wherever possible.

24. To the extent possible, all levels of RSSA staff should participate in developing some of the future directions being discussed in the DRH. This would help enrich the end result as well as serving to mitigate some of the alienation now felt by the staff.

25. **Selection of the new supervisors (one branch chief and two section chiefs) should be completed soon so that the leadership void can be filled. In so doing, it would be wise to emphasize the leadership qualifications of the new selectees and organize travel time to minimize absence from their managerial functions.**

26. **If possible, efforts should be made to enlarge the scope, challenge and variety of tasks for the logistics staff to utilize their talents. The leadership should explore each person's capacities and interests and to the maximum extent possible match need with interests in making assignments.**

27. Efforts should be made to arrange training to help meet some of the new directions the DRH is taking. For example, to address the unanimous interest in more institution building, it may be appropriate to provide training in this area and even to develop a manual on the subject for general use.

28. CPSD should impress on CDC staff the importance it attaches to efficient logistics systems and the contributions to family service delivery made by CDC logistics personnel.

18

29. Logistics staff should be utilized to make presentations both within CDC and A.I.D./W regarding some of the innovations and accomplishments of their work, especially CCMIS. This would not only assist the DRH in its relationships and program development but also help counter the poor image which the staff now believes it has.

30. A time reporting system should be instituted for persons doing work under the RSSA to provide an accurate basis for management and financial reporting. A simple record similar to those kept by consulting firms could be devised whereby the individual simply jots down each day how much time has been spent for what project. On some periodic basis such as weekly, this time record from each person would be aggregated by the Administration Office and utilized for both accounting and management reporting.

31. **CDC and the Office of Population should commence immediately with strategic planning, with results to be integrated within the Agreement to take effect in the spring of 1990.**

The first step should be a visit by top officials of CDC to the Office of Population early in 1990 to exchange views regarding the thinking that is going on in each organization about strategic issues. Such a meeting should be followed by a statement from CDC proposing a strategy for the ensuing period of the relationship.

Meetings, discussions, and negotiations should be held to adopt a mutually approved strategy to serve as the framework for program and project planning. Since the present RSSA ends in March 1990, the agreement will need to be made in time to be reflected in the subsequent agreement.

Once the strategy is set, it need not be developed annually. Rather, strategic issues can be defined and addressed as needed during the year, taking into account results of performance monitoring as recommended in 32 below. Periodic judgments should be made, however, as to whether a basic review of strategy is once again necessary. Since PASAs can run for five years, the termination of a PASA can serve as a time to question the strategic plan, its continued relevance and effectiveness. It is usually best to link strategic planning to the program planning and funding decisions that follow.

32. A definitive program plan should be made for the first year period, performance monitored against output tagets,a dn plans updated annually based upon the results of the past year.

33. CDC should develop project plans for in-depth, longer term technical assistance and to that end should provide its professional staff with training in the A.I.D. procedures for project design, implementation and evaluation.

34. The RSSA or PASA activities should include a program budget and program expenditure statements along with the present system of budgeting and expenditure reporting by objects of expenditure. The program categories should be defined jointly by CDC and the Office of Population and take effect with the new Agreement in 1990.

35. Reports of technical assistance to host country organizations should be written to and for them in whatever way is most useful to them. Cover sheets for these reports could be prepared for CDC headquarters and A.I.D./W which would be tailored to the special concerns of those audiences.

36. Copies of draft reports rendered both to client organizations and local missions should be forwarded to A.I.D./W without the delays of internal CDC clearances.

37. As a part of whatever agreement is adopted this year, CDC and the Office of Population should define the various audiences needing progress reports along with the most useful format and timing of such reports. Reports need not be limited to written documents but could also include slide presentations on topics of special interest.