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MID-TERM EVALUATION
OF REACH
(RESOURCES FOR CHILD HEALTH PROJECT)

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The evaluation was performed during the period September 12, 1988 through October 11, 1988. The team worked primarily in Washington, D.C., but also made trips to Kenya, Zaire, Indonesia and Bolivia.

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LIST OF ACRONYMS AND ABBREVIATIONS

ARI	Acute Respiratory Infection
CCCD	Combatting Communicable Childhood Diseases Project
CDC	Centers for Disease Control
COSAS	Coverage Evaluation Survey Analysis System
EPI	Expanded Program of Immunization
HCF	Health Care Financing
HEALTHCOM	Communications for Child Survival Project
ISTI	International Science and Technology Institute
LAC	Latin America and the Caribbean
LDC	Less Developed Country
NGO	Non Governmental Organization
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PHC	Primary Health Care
PHS	Public Health Service
PID	Project Implementation Document
PP	Project Paper
PRITECH	Technology for Primary Health Care Project
PVO	Private Voluntary Organization
REACH	Resources for Child Health Project
S&T/H	Bureau of Science and Technology/Office of Health
TA	Technical Assistance
TAG	Technical Advisory Group
UCI	Universal Child Immunization
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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EXECUTIVE SUMMARY

The REACH project is a highly successful effort by S&T/Health to provide essential technical assistance in two key areas: Expanded Program Immunization (EPI) as one of the most cost-effective interventions for Child Survival, and in Health Care Financing (HCF) as an increasingly essential ingredient in sustaining health care services worldwide. Several features of the project have accounted for its unusual degree of popularity with its clients:

- o The flexibility and responsiveness of both the project and the contractor to AID Bureau, Mission and host-country needs;
- o The highly useful and successful buy-in mechanism for relatively easy access by Missions;
- o The generally high quality and timeliness of the consultant services provided by REACH;
- o The close coordination, especially in EPI, with other donors; and
- o The demonstrated dedication and professional competence of its staff.

A. EPI

In the area of EPI, REACH is one of several important actors, but has identified for itself a role which is recognized to complement that of other donors and to fill an important gap; helping identify most cost-effective delivery mechanisms, developing methodology and related information systems for monitoring coverage, strengthening the capacity of non-governmental providers, and developing training and informational materials.

Conclusions and Recommendations:

1. The design of the REACH EPI component is sound, the role it performs necessary and effective, the quality of its assistance has been good, and the demand for its service argue convincingly for its continuation.
2. The technical performance, day to day management and overall administration of the EPI component are recognized as good. Some attention needs to be given to ensure that consultant reports are completed in a timely way.
3. The Technical Advisory Group (TAG) has not performed its originally intended role of in-depth technical review of REACH strategy

and programs. It has fulfilled a secondary objective as a donor coordination mechanism, but this function can be met more economically through other means. The TAG (reduced in size) should be required to play a more active role in quality control and dissemination of "lessons learned".

4. Coordination with other donors, an essential ingredient of the project, has been generally carried out well. Briefing and debriefing of consultants with WHO (and PAHO where appropriate) should be given higher priority by REACH.

5. The buy-in demand is the most tangible evidence of REACH success. Much unfinished work needs to be done, and Missions are willing to pay for it. The buy-in ceiling for EPI should, if possible, be raised by \$990,000. If not, S&T/H should consider the initiation of a new project prior to the termination of this one.

6. In addition to REACH's present concentration, it should continue to give priority to:

- o Emphasis on sustainability of immunization services;
- o Promoting PVO and other private sector involvement where feasible and cost-effective; and
- o Assisting in the development and initiation of sound social marketing strategies.

7. Overall, the management, leadership, and performance of REACH in the EPI component has been of high quality and demonstrated effectiveness.

B. HCF

There is much less clear understanding within AID, REACH, and within the development community generally on the proper focus and priority within the HCF component. What is certain is that the demand for interventions in this area is growing dramatically, and the U.S., with its bias toward an energetic role for the private sector, has a distinct comparative advantage.

We believe that the key to effective HCF is in cost recovery and revenue generation implying highest priority for the initiation of viable activities for user fees, insurance and other prepayment schemes, and the privatization of services. While cost-savings and related "institutional reform" efforts are essential and are almost always more acceptable politically than measures related to cost recovery, they can never substitute for the latter in ensuring sustainability of quality health care.

Reviewing experience under the project we make several observations:

- o REACH, with S & T/Health encouragement has been extremely responsive to Mission requests (mostly in the cost savings area). However, it runs the danger of becoming inundated with involvement in "institutional efficiency and reform" to the neglect of the more difficult, but more promising interventions on the revenue side. (While the limited pay-off of some cost-savings activities is sometimes acknowledged both by Missions and REACH, they are often seen as "windows of opportunity" for future involvement in cost recovery);
- o AID Health Care Financing guidelines, followed by REACH, give inadequate priority to cost recovery vis-a-vis cost savings and thus provide an inadequate basis for more selective screening of Mission requests to REACH;
- o Given the experience under this project, AID and REACH are in a position to increase the economic sophistication of Missions' "policy dialogue" with their host country counterparts in HCF, by greater concentration on promising experience in cost recovery;
- o Cost savings and "institutional reform" are legitimate and important subjects for Mission assistance in the primary health care field (and elsewhere within the health sector), and alternative funds to those under the REACH project are often not now available to address these concerns; and
- o REACH was plagued during part of the early period of the project with staffing problems on the HCF side and inadequate economic talent making refinement of strategy under this component more difficult.

Conclusions and Recommendations:

1. AID oversight of REACH in the area of HCF should be significantly improved through:
 - a) refinement of AID's Health Care Financing guidelines to give greater priority to cost recovery and revenue generation;
 - b) appointment of an economist either in S&T/Health (or possibly in PPC) to participate actively in the general management of the project; and
 - c) helping REACH develop a more coherent strategy in the HCF area less responsive to lower priority Mission requests and giving greater priority to promising interventions in revenue generation.
2. REACH should use the remainder of this project to the following tasks in the order of priority listed:

a) develop a more refined Health Care Financing strategy which is approved within AID/W and circulated to the Missions;

b) give high priority to requests for activities directed specifically at insurance and prepayment schemes, cost recovery mechanisms and privatization of services;

c) respond to those Mission requests for TA in cost-savings and related "institutional reform" where these offer some promise to lead to a more effective HCF intervention later.

3. It should limit any future long-term interventions and concentrate information dissemination on activities related to 2 b) above.

4. Alternative provision should be made by AID for financing worthwhile "institutional reform" and cost-savings studies and short-term assistance through:

a) encouragement of use of existing Mission and Regional Bureau funds for that purpose (thus liberalizing somewhat the present agency concentration on Child Survival and primary health care to allow significant interventions in cost-savings elsewhere in the system provided agreement exists that such savings will be applied to strengthening Child Survival and the primary health care services).

b) use of Systems Support funds unrelated to HCF under this project, PRITECH, HEATHCOM, and others managed by S&T/Health.

5. Quality and timeliness of REACH consultant services have been good, but rising demand for HCF assistance suggests that greater use be made of subcontractors as true project collaborators involved in pursuing an agreed-upon strategy. REACH should clarify its plans and policies with respect to future use of subcontractors in the HCF area and discuss its conclusions with both AID and the subcontractors.

6. The TAG related to HCF has been expensive with less benefit than anticipated. It should be discontinued under this project and replaced by carefully selected outside technical review of the new Health Care Financing Strategy paper and of specific project plans and outputs.

Overall Project Recommendations and Conclusions:

1. The combination of EPI and HCF, useful at the time of project initiation, should be discontinued. In every vertical intervention (EPI, ORT, etc.) there must be adequate provision for analysis of cost-effectiveness and financial viability. This, however, is not equivalent to the scope of Health Care Financing in a generic sector-wide sense concentrating primarily on revenue generation and resulting issues of equity. HCF needs its own follow-on project as does EPI.

2. The initiation of a project, world-wide in nature, and involving a wide variety of long and short-term interventions in two independent areas of concentration required the development of complex yet practical management systems, including financial record-keeping and reporting, personnel procedures, coordinating mechanisms, administration of overseas operations, etc. JSI in the REACH project has devoted a great deal of attention to setting up the management structure of the project in a way which is both highly responsive to AID and conducive to efficient program implementation.

3. One of the most useful contributions S&T has made is the initiation of projects with the buy-in provision. Successful projects like REACH are marked by great Mission demand for their services. S&T jointly with the Contracts Office should explore revisions in RFP's which would notify competitors from the beginning of a virtually unlimited buy-in provision limited only by a non-amendable termination date of the contract.

I. INTRODUCTION

A. Purpose, Scope, and Methodology of the Evaluation

The present mid-term evaluation is a standard component of AID-financed multi-year projects. Such evaluations are usually intended to determine several factors:

- o The appropriateness of the original design of the project;
- o Its effectiveness thus far in achieving its outputs and goals;
- o The adequacy of the project budget;
- o The quality of contractor management and administration;
- o The quality of AID management of the project;
- o The degree of coordination with AID and other related institutions;
- o Specific modifications proposed in the form of "course corrections" to be made during the remainder of the project; and
- o Suggestions related to the nature and magnitude of follow-on activities, if any.

To address these problems, AID through the Public Health Service and its contractor Devres, Inc., assembled a five-person team combining skills in immunization and primary health care technologies; in economics and health care financing; and in program design, implementation, and sustainability to work together for three weeks to evaluate the REACH effort. Basic program material was prepared in advance by REACH, and interviews were held with REACH staff, with AID staff in all bureaus related to the project, with subcontractor personnel, with Technical Advisory Group (TAG) members, and with specialists in collaborating institutions (i.e. UNICEF, CDC, and the World Bank). All members of the evaluation team travelled to countries of major REACH activity to assess impact from a field perspective. In addition, questions were cabled to several Missions asking their comments on the REACH project, and telephone interviews were held with others. (A full list of individuals interviewed is shown in Annex 1).

The evaluation was carried out during the three-week period of September 12 through September 30, 1988 including one week of travel covering Kenya, Zaire, Indonesia, and Bolivia to review in-country experience. The conclusions of the evaluation represented a high degree of unanimity among the team.

B. Summary of Project Goals, Objectives, and Scope

The REACH project was initiated in September, 1985 when it became clear that AID's growing interest in and demand for services related to child survival could not be met through a single PRITECH contract as originally foreseen. The stated goal of the REACH project was very general: "to lower infant, child, and maternal morbidity and mortality by introduction of key disease control technologies (especially immunization) through primary health care (PHC). "More specifically the stated purpose of the contract was to "strengthen PHC through these technologies, by innovations in health care financing, and by improved management and training." The contractor was to accomplish this "by the introduction, promotion, and improved delivery of key disease control technologies and technical assistance and limited commodities for selected countries; and by the provision of technical assistance in financing, management, training, and program and project design and evaluation."

Although these overlapping goals and objectives were somewhat unclear, AID's original contract with REACH clearly outlined two primary components: Key Disease Control Technologies and Systems Support, and one secondary component, Information Systems.

Under the Key Disease Control Technologies component, which was described to mean primarily immunization, the contractor was to conduct preliminary assessments, develop strategies, and carry out country interventions in approximately 15 countries (later amended to 8-10 countries). These were to be of a longer term nature.

The Systems Support component was defined as short-term assistance to approximately 20-30 countries in the the following fields: health financing, management, personnel training and development, and design and evaluation. Although health care financing was one of several activities under this component, the contract made clear that HCF should be "an area of particular emphasis" and would include long-term involvement in approximately five countries and short-term assistance in approximately 25-30 countries.

In addition,, the contract made provision for an Information Systems component which, although it ruled out an "informational unit" of the PRITECH type, did instruct the contractor to "collect,, organize, and disseminate literature on sector financing and related management issues" and on "lessons learned".

Expected results of the project were given in terms of number of countries with improved immunization programs, number of countries to use short-term technical assistance to improve PHC, number of countries in which financial analyses were to be undertaken, etc. In addition, greater private sector involvement in health service management and delivery as well as increased government support for and capability in management and delivery of PHC programs was expected.

It was clear from the beginning that AID perceived this project as both a service project to Missions, providing assistance in the design, preparation, implementation, and evaluation of projects, as well as a vehicle for the introduction of new technologies particularly in EPI. Both short and long-term interventions were foreseen. Health Care Financing was a distinctly secondary component under "Systems Support" and was combined with assistance in management and training. However, as the project evolved and country need and Mission demand became clearer, AID increasingly conceived the project as having two primary substantive components, EPI and HCF with both long-term interventions and short-term (Systems Support) activities under each. Short-term "Systems Support" in fields other than EPI and HCF, while still possible, were of distinctly lower priority. That evolution was not, however, reflected in changes in the scope of work in the contract.

C. Summary of Existing Project Status

As of August 31, 1988 a total of \$15.3 million had been contacted between AID and the REACH project of which \$10.7 million represented Science and Technology Bureau funds and \$4.6 million represented Mission and other Bureau buy-ins. Of this total REACH had committed \$5.0 million in S&T funds and \$4.6 million in buy-in authority, excluding core costs, to short and long-term activities. Expenditures to date as of August 31, 1988, including core costs, equalled \$7 million, or 72% of the \$9.7 million committed as activity specific. Core costs, therefore, must be considered in assessing level of effort necessary for performance of Project activities.

Activity of the Project is categorized under four headings: the two major foci, EPI and health care financing; both (EPI and health care financing); and primary health care. The tables below summarize the distribution of REACH's efforts thus far under the project. No activities were undertaken without the approval of the S & T Bureau of AID, which established sub-totals of level of effort by region and by field of activity which the contractor followed. As EPI and health care financing are the major mandates of the Project, emphasis in this report will be directed to these two disciplines.

TABLE 1

EPI Activities

AID Bureau	No. of Countries	S&T Funds (\$000)	Buy-in Funds (\$000)	Person Days
Africa Bureau				
Long-term	2	200.5	213.5	1,240
Short-term	6	97.4	0	174
Asia/Near East Bureau				
Long-term	4	872.1	1,912.9	4,930
Short-term	5	189.0	44.6	465
Latin American/Caribbean				
Long-term	3	230.3	593.4	1,684
Short-term	2	24.3	0	75
Science & Technology				
Long-term	NA	200.0	0	469
Short-term	NA	177.4	0	376
Food for Peace/VA Bureau				
Long-term	NA	112	50.0	260
Short-term	6	41	30.0	127

TABLE 2

HCF Activities

AID Bureau	No. of Countries	S&T Funds (\$000)	Buy-in Funds (\$000)	Person Days
Africa Bureau				
<u>Intensive</u>	2	574.0	667.6	3,263
<u>Short-term</u>	12+	258.8	293.8	817
Asia/Near East Bureau				
<u>Intensive</u>	1	249.3	21.2	797
<u>Short-term</u>	5+	86.6	142.0	446
Latin American/Caribbean				
<u>Intensive</u>	5	217.1	360	1,291
<u>Short-term</u>	6+	113.6	168.6	448
Science & Technology				
<u>Intensive</u>	NA	0	0	0
<u>Short-term</u>	NA	205	0	562
Food for Peace/VA Bureau				
<u>Intensive</u>	NA	0	0	0
<u>Short-term</u>	NA	11.9	0	20

TABLE 3

Other Systems Support Activities

<u>A. EPI & HCF Cooperative Activities</u>	<u>No. of Countries</u>	<u>S&T Funds (\$000)</u>	<u>Buy-in Funds (\$000)</u>	<u>Person Days</u>
Africa Bureau	2	16.9	35.0	62
Asia/Near East Bureau	2	143.6	0	200
Latin American/Caribbean	3+	85.5	11.0	186
Science & Technology Bureau	3+	83.5	26.6	237
<u>B. PHC and Child Survival Activities</u>				
Africa Bureau	4	67.8	0	114
Asia/Near East Bureau	4	60.9	30.0	166
Latin American/Caribbean	2	8.9	41.0	130
Science & Technology Bureau	4	61.3	0	307
Food for Peace/VA Bureau	6+	46.5	96.8	331
<u>C. Conferences</u>				
Science & Technology Bureau	NA	595.3	0	617

II. EXPANDED PROGRAM OF IMMUNIZATION (EPI)

A. Present Project Status

REACH has provided approximately 900 person months of services, and \$4.9 million of EPI assistance has been obligated by the REACH to date through short-term and long-term activities.

Activities have been undertaken in 20 countries, and there are currently ten long-term resident advisors in six countries, and regional advisors for Africa and Asia. A detailed list of long-term and Systems Support activities by geographic region is given in Annex 2.

B. Major Issues and Conclusions

1. Role of AID in the world immunization effort

AID's Immunization strategy recognizes the important roles of WHO, UNICEF and other bilateral donors in the global immunization effort and concentrates on those areas where AID has a clear comparative advantage. These include planning, surveillance and evaluation, financial analysis, communications and marketing, training and research. The strategy also emphasizes the importance for policy dialogue, the constant search for most cost-effective delivery systems, and the encouragement of private sector participation.

In fact, REACH has been concentrating in these areas, is recognized by other donors as playing a key role in the EPI effort, and has been the principal mechanism in establishing AID as a major contributor to progress towards achieving and sustaining Universal Child Immunization. Its effectiveness is evidenced not only by the consistent testimony of host country, other donor and AID personnel, but most clearly by the demand for its services by Missions and Regional Bureaus with the buy-in ceiling already having been reached more than two years prior to the end of the project.

Specific areas related to EPI in which the project has made innovative technical and managerial contributions include the following:

Surveillance and Evaluation:

- o Helping in developing methodology for measuring coverage

levels of tetanus toxoid in women of child-bearing age. REACH support was mentioned by WHO as being especially useful in planning and implementing the Zimbabwe neonatal tetanus workshop;

- o Establishing computerized information systems in several countries in collaboration with WHO (e.g. Bangladesh, India, Indonesia, and Nepal). REACH involvement is recognized by WHO as playing a critical role in refining this monitoring and evaluation tool in South-East Asia Region; and
- o Providing inputs to improve COSAS (coverage evaluation survey analysis software), to more fully understand timeliness and source of immunization through surveys. REACH has been in the forefront of actually using such software under field conditions.

Financial analysis:

- o Conducting cost-effectiveness studies of EPI in several countries and developing the methodology for costing of alternative strategies for the prevention of neonatal tetanus. REACH is recognized as a major resource of expertise in costing and cost-effectiveness study methodologies by WHO and UNICEF.

Communications and marketing:

- o Developing strategies for and assisting in implementation of urban EPI programs (Bangladesh; Philippines) with emphasis on communications and marketing components. REACH placement of long term advisors is helping accelerate urban EPIs; and
- o Strengthening the capacity of private voluntary organizations (PVO's) to carry out EPI activities (Haiti, Bolivia, and with the Food for Peace and Voluntary Assistance Bureau). REACH is proving to be a significant resource to help communicate with and coordinate PVO activities and strengthen PVO capacities in the EPI.

Training and Information Dissemination:

- o Developing new training materials on the logistics and management of EPI and on neonatal tetanus for use in Africa. REACH is recognized by WHO for developing quality materials that are timely for the evolving needs of the EPI;
- o Disseminating information and developing appropriate, information, education, and communication tools: e.g. EPI field guide; PVO directory, regional profiles, assisting ISTI in establishing child survival indicators, occasional technical papers, contributions at international scientific

meetings, OUTREACH, immunization insert on Dialogue on Diarrhea, maintaining reference library; and

- o Developing an internship and associate expert program to provide opportunities for young professionals to gain experience international health activities.

Operations Research:

- o Assisting in the development of technologies for ensuring sterile injections using non-reusable plastic syringes.

Policy Dialogue:

- o Influencing policy through dialogue with host countries and with UNICEF and WHO, through workshops (e.g in Zimbabwe on neonatal tetanus), through computerized information systems that give priority to disease surveillance and program monitoring, through participation in formal EPI reviews (Bangladesh, Turkey, Senegal, Cameroon, Haiti, Madagascar), through costing and sustainability studies, and through the development of PID's and PP's; and
- o Coordinating the use of PL-480 funds for immunization and other PHC activities in Madagascar and Bolivia.

CONCLUSION: AID, through REACH, is playing an important and unique role in the global immunization effort, and the fact that many other donors are involved (and therefore the direct relationship of REACH's efforts to reduced infant and child mortality and morbidity difficult to measure) should not diminish the importance of REACH's contribution. That role should be continued as a major AID contribution to the Child Survival effort.

2. Adequacy of project design

The project design does not set out explicit objectively verifiable indicators. This is due to the fact that even in countries where REACH has a long-term involvement, it is not possible to measure the project's impact in terms of infant, child, and maternal mortality. All that can be done is to measure the effect over time of the collaborative effort by the host country, WHO, UNICEF, other donors, and AID/REACH as a whole.

In fact, the relatively broad goal, purpose, and outputs of the project design provide for essential flexibility in project activities where so many donors are active. A particular activity of REACH may not always appear, in isolation, to be of high impact. When taken within the context of the entire EPI effort within a country and within the context of complementarity with other donors and technical agencies,

however, it fulfills a distinct need and is an important link to overall EPI success. Examples are the collaboration with WHO SEARO in developing computerized EPI information systems in the region which help in program monitoring, and in the conducting of an EPI/ARI workshop in Bolivia with the joint participation of the Ministry of Health and PVO's which led to agreed-upon norms and greater coordination.

Precisely because it is part of a global and long-term effort, AID and other donors must design and view such projects with a long range vision (at least 10 years) to provide developing countries a demonstrated commitment to help achieve, and sustain, universal child immunization.

The mix of long-term interventions and short-term systems support activities appears to be appropriate. This mix and the geographic areas of activity reflect the reality of AID funding, country profiles, the presence of other donors, and the absorptive capacity of host countries.

The rationale of the project to provide S&T Health with a strong technical resource in EPI so that AID could better define and pursue its comparative advantage and participate in the global EPI effort was, and continues to be, appropriate.

CONCLUSION: The design of the REACH project as a highly flexible instrument to pursue AID's comparative advantage in individual country, regional and global contexts as well as to serve as a technical resource for AID in EPI was, and remains, appropriate. These are functions which are being carried out by REACH with a very high degree of recognized leadership, skill, and effectiveness.

3. Areas of comparative advantage

The areas of comparative advantage for AID as stated in the strategy statement cited above are very general in nature. With the experience of the project and the continuous interaction of REACH with other donors and recipients in EPI, a more specific list of areas where REACH's capabilities are needed, used and appreciated is becoming recognized:

- o Emphasis on sustainability (including increasing efficiency of delivery of immunization services, determining actual costs of immunization delivery under alternative strategies, stimulating demand for EPI, and exploring innovative approaches to cost recovery). The REACH combination of HCF and EPI contributed to developing this early emphasis which is only now being picked up by WHO and others in the international donor community as being an essential part of EPI planning in the 1990's;

- o Promoting private sector involvement in the EPI (including the PVO community). The emphasis of the AID strategy of promoting the private sector involvement was reflected in REACH activities and it is increasingly being recognized in the international donor community that the active involvement of the private sector plays a major role in sustainability;
- o Developing management information systems to improve implementation and monitoring of EPI and other PHC-related programs. REACH has been involved in developing the prototype information systems that are now becoming the global standard adopted by WHO and UNICEF. These systems are based on the US IBM standard hardware;
- o Strengthening urban EPI strategies. REACH is in the process of gaining significant expertise through short and long term advisors for urban EPIs and will be in a strong position for dissemination of lessons learned;
- o Promoting wider use of tetanus toxoid and working in collaboration with national EPI's, WHO, UNICEF, and other donors to develop strategies that will ultimately ensure adequate immunization of all women of childbearing age. The materials developed by REACH for the Zimbabwe workshop are already being disseminated through other workshops being held in Africa and may well serve as a basis for similar workshops in other WHO regions;
- o Assisting in social science operational research in knowledge, attitudes, and practices towards immunization with emphasis on using such research to develop social marketing strategies and comprehensive communication plans to create demand for immunization services (this type of activity requires coordination by S&T/Health to ensure that it is complementary to HEALTHCOM activities). It is increasingly being recognized that such a social science approach becomes more and more important to reach the remaining persons who are not receiving immunizations through the routine approaches;
- o Developing new injection technologies such as non-reusable plastic syringes and the costing of their introduction. Costing and cost effectiveness methodology expertise is going to be increasingly needed as new technologies and strategies are introduced;
- o Assisting in the design of projects with EPI and other child survival components and participation in the evaluation of EPI programs. REACH has an important role in assisting AID Missions since it is familiar with both AID procedures and technical content; and

- o Providing technical assistance on a rapid basis as needed by host countries, Missions, PVO's, and international organizations. Often other mechanisms to supply consultants are very time-consuming, whereas the REACH project has been able to be responsive to needs on a short notice.
- o Development and dissemination of appropriate technical information (e.g., EPI directory, EPI field guide).

CONCLUSION: REACH has for the most part concentrated in key areas of the immunization program where other donors are not as active and yet ones which are essential to overall success. Its leadership in these areas and its valuable contribution is widely recognized.

4. Role of the technical advisory group

The role of the TAG in AID activities is generally to provide peer review of the technical quality and the appropriateness of program strategy to be followed by the contractor and AID under the project. In the case of the TAG for EPI under the REACH project, it had already been established by AID at the time of the initiation of the contract.

Experience has shown that there appears to be little contact by REACH with TAG members in their capacity as TAG members. At least one TAG member did not recognize that he was formally on the TAG, and the TAG members with whom the evaluation team consulted were not aware when the next meeting was to be held or even if any meeting would be held at all in 1988. Some TAG members expressed the view that the time allotted for meetings is simply too short for any meaningful interaction among members on agenda items. The TAG, however, has been helpful in the project as a means of disseminating "lessons learned"; providing another forum for coordination between REACH, WHO, and UNICEF; and ensuring AID that some peer review of REACH activities is achieved.

CONCLUSION: The TAG in the EPI component of the REACH project should be continued, but should be encouraged to provide more meaningful oversight in the planning and implementation of REACH activities. It should monitor on a sample basis the quality and timeliness of reports. Additional time should be allowed to the TAG for sufficient interaction of members and reaching consensus. The TAG should be more formally used during the current year for "mid-course" correction and advice on future project activities.

5. Quality of management and administration

The evaluation team concluded that the management and administration of the EPI component of the REACH project on the whole has been excellent. Mission and Regional Bureau clients uniformly rated the overall performance of REACH in immunization as outstanding. In

particular, a good EPI in-house and consultant team has been developed, providing high quality technical support to field personnel. The office is organized in such a way as to provide effective and for the most part timely resolution of administrative issues by the appropriate staff associates and of technical issues by the associate director and the technical officers. Occasionally reports have not been completed in a timely way, though this may not be representative of the project as a whole. (For example, the final version of the background report which was needed as the basis for the Community and Child Health project in Bolivia was delayed 9 months; other examples were noted by the team in Africa and Indonesia).

CONCLUSION: Technical performance, day-to-day management, and overall administration of the EPI program has been of high quality. However, management needs to enforce existing mechanisms to ensure that all reports are provided in a timely manner (draft reports left in-country with Mission and turn-around of final report within two months, including appropriate peer review).

6. Collaboration with other donors in related fields

As only one actor in the field of immunization, REACH has recognized how essential it is to collaborate effectively with WHO and other donors, particularly UNICEF. It has frequently participated in joint EPI reviews and has taken an active role in collaborative programs such as the WHO-coordinated project for strengthening EPI information systems in the South-east Asia Region. REACH has also participated in the ongoing dialogue of campaign approaches versus strengthening routine delivery systems for EPI by stressing issues of sustainability and by comparing costs and assessing achieved immunization coverage levels of various delivery strategies.

REACH, however, has not always informed PAHO of its activities in the region and may have not on occasion adequately briefed or debriefed WHO through individual consultants when appropriate. In some situations this has resulted in activities not always considered helpful by PAHO. This situation is improving. Team planning meetings and donor briefings are now being held by REACH for short-term TA teams of more than two members and for all long-term or intensive activities.

CONCLUSIONS: REACH should continue to ensure that coordination of activities occurs, especially with WHO and PAHO, and that all consultants when appropriate brief and debrief with WHO and other concerned agencies.

With respect to coordination with other AID-financed projects, S&T/Health should consider reinstating periodic meetings, organized by geographic region, with staff from S&T/Health, Regional Bureaus, PAHO (when LAC countries are discussed), REACH, PRITECH, HEALTHCOM, and any other relevant project. Such meetings are particularly important

for focussing on proposed interventions by two or more organizations in the same country. They would provide a mechanism for pre-intervention strategy development, coordination of ongoing projects, and provide a forum for the dissemination of "lessons learned".

7. Project financing

The funding ceiling has been reached on the project, yet demand for REACH project services by both host countries and Missions continues to grow. The Contracts Office in AID, however, is understandably concerned about the anti-competitive nature of raising the ceiling. This situation has resulted in the scaling down of the initial and programmatically sound requests from Bangladesh, Kenya, and Indonesia. Decisions on requests from Chad and Sudan are pending denial or scaledown. In addition, REACH has not been able to accept proposals for possible areas of additional work which build on success already achieved (for example, follow-on assistance related to the neonatal workshop).

CONCLUSION: After review of pending potential requests for REACH activities in EPI during the final two years of the project, the team believes that it would be very useful from a programmatic view to raise the buy-in ceiling to accommodate pending EPI-related requests and activities in Indonesia, Pakistan, and Turkey as well as in AFRO of WHO (detailed in Annex 3). This would also include \$150,000 in systems support funds to provide limited, short-term TA assistance in EPI as requested by Missions, Bureaus, and other organizations. If that proved impossible from a contracting point of view, the initiation of a follow-on project prior to the completion date of this project should be considered. If neither of these is done, there is real danger of losing important momentum in AID's involvement in EPI.

8. Project impact, effect and output

As stated earlier the project is having a major beneficial effect and impact, particularly related to the development of more efficient and cost-effective delivery of immunization. The REACH project has carried out its mandate with a high degree of technical skill, administrative leadership, and flexibility, and responsiveness to AID directions. It has made AID an important and effective participant in the global, regional and national EPI.

The output of the project has often been demand driven (by Missions with sufficient interest and/or funding to request and develop a project) rather than epidemiology-driven. In some places of great need Missions do not perceive health as an assistance priority, and even in those that do consider health as important, there is often reluctance to add another project.

CONCLUSION: There should continue to be efforts made to direct REACH activities to the countries of greatest need, but the reality of the involvement of other donors, the willingness of the host country to

agree to a role for AID, and the other determinants of the magnitude of foreign assistance in any given country will continue to have to be accepted.

9. Need for and focus of future activities

As stated above, the team believes that AID is filling through REACH an important and unique role in the many-faceted effort at global immunization. Furthermore, this is a long-term effort requiring not only energetic support during the remaining two years of the REACH project but well beyond.

In addition to the areas of comparative advantage previously listed, the following are potential areas for continuing investment by AID:

- o Developing methodologies, combined with appropriate training and supervision activities, to focus more on the quality of immunization services as the quantity (coverage levels) increases. This would include improved methods of monitoring the cold chain, sterile techniques for injection, and field evaluation of vaccine efficacy;
- o Establishing EPI components of child survival projects in future areas of AID presence (Tanzania, Burma, Afghanistan, etc.);
- o Contribute to the search for activities and strategies that support EPI sustainability, including strengthening management and maintenance capabilities, methodologies for estimating recurrent costs, good accounting practices, improving efficiency of delivery of immunization services, and social marketing strategies to create demand for immunization;
- o Conducting operations research on missed opportunities for immunization;
- o Perhaps working with refugee populations (in countries such as Sudan, Afghanistan, etc.) to help prevent and control outbreaks of vaccine-preventable diseases in collaboration with the UNHCR. It is recognized that U.S. involvement in this activity falls under the responsibility of the State Department, but it may be appropriate to consider the possibility of the State Department's developing a fund of money to be used by S&T/Health projects to provide short-term Technical assistance to UNHCR (which would be responsible for long-term involvement) in their respective fields of expertise; and
- o Using WHO's poliomyelitis eradication initiative as a means of strengthening the EPI as a whole (including the disease

surveillance systems) within the context of improving primary health care services in general. It should be noted that this initiative may also result in a requirement for more long-term resident advisers in countries to work on a day-to-day basis in strengthening the surveillance, (not necessarily provided by AID/REACH), case investigation, laboratory services, and control activities that poliomyelitis eradication will necessitate.

III. HEALTH CARE FINANCING

A. Present Status of the Project

When the project began, Health Care Financing was regarded as a distinctly secondary component, but Mission demand for services in this field has resulted in its taking a significant share of project resources. In the area of HCF, REACH has committed, to date, 347 person months of services to 23 countries and to AID Bureaus, with a commitment of \$3.4 million. Of this commitment, \$1.7 million is from S&T/Health funds and \$1.7 million from buy-ins.

B. Major Issues and Conclusions

1. Need for and appropriateness of the HCF component

Helping developing countries increase their abilities to devote additional resources to health, particularly to sustainable child survival interventions is one of the most important technical contributions USAID can make to better health in developing countries. In creating the health financing component of REACH, S&T Health developed a program that could provide leadership in an area of increasing importance to mission health offices. The centrally funded contract with a buy-in component provided a mechanism to sensitize Missions to health financing issues, develop a body of operational knowledge on the topic, and simultaneously supply a mechanism through which Missions could purchase technical assistance in a market where they would not necessarily have the experience and capability to do so.

CONCLUSION: The S&T/Health approach to establish a centrally funded HCF activity with liberal buy-in authority for Missions has been a huge success. This is obvious from the high demand for REACH's services and unqualified delight among the regional offices and Missions in having access to this resource. The rationale and demand for supporting HCF activities now is stronger than when the project started.

2. The combining of EPI and HCF

The team was informed that the principal factor in combining the HCF and EPI components together was the lack of widespread appreciation within AID at that time of the importance and need for HCF and of the resultant necessity to attach it to the more widely supported child survival element of immunization. The team believes that while this may have been initially beneficial, the combination of the two elements has lost its usefulness.

The evaluation team found that within S&T/Health, the regional AID health offices, and in AID Missions a general feeling existed that

there was little direct overlap between the two areas, and that in dealing with REACH in EPI or HCF, they were dealing with virtually two separate projects. They also felt that the marriage of convenience between the two projects did not make sense for a future project before which there would be enough lead time to split them up contractually.

The REACH staff, in contrast, felt strongly that the combination of the two programs allowed for economies in administration, gave the EPI work a pragmatic financial focus, and created an atmosphere in which health people and finance people were forced to get to know each other and understand better the constraints and knowledge base in each area.

The evaluation team recognizes the potential for cost savings on administrative activities but notes that the combination has had disadvantages for both components. The EPI component of REACH has suffered from receiving a lower percentage of overall project financing than was originally foreseen while benefitting from having economists and financially aware public health professionals available. These have resulted in a number of highly useful EPI costing studies by REACH.

However, it is the evaluation team's impression that HCF has suffered from the marriage to EPI. Because the original core of the project, EPI, REACH is operated primarily by physicians and public health professionals. They are not health economists, and they have tended, along with S&T/Health, to view economic work as a secondary activity oriented more to costing out programs rather than having a separate contribution to make to the health sector. The initial disparity in REACH (now largely corrected), was clear from its organizational chart, in which the EPI side has been appropriately and completely staffed down to the country level, while the health finance side had only a small core of workers and subcontractors. The combination of the two areas has led to some specific problems that the evaluation team would like to note:

a. Difficulty in finding professional economists willing to work in this type of environment. REACH has had serious personnel problems on the health finance side. There have been three changes in leadership (including the temporary management of the project) in three years. Recruiting a new health finance director took nearly eight months.

b. REACH, supported by S & T/Health regarded the response to Mission requests as having highest priority with little felt need to develop a strategy on the health finance side that would better focus REACH's HCF activities. REACH had a clear agenda on the EPI side and sees itself as a technical leader in that area; however, on the finance side, it has not set a clear agenda and sees itself principally as a service organization to Missions. Yet on the finance side it could make a much more visible contribution to the world's understanding of the issues, since there is little real competition in the field.

c. Until the past year there has been little differentiation between health and economics personnel on the staff. Although no economists do technical EPI work, many of the technical staff in economics have been trained in public health, not primarily in economics. The evaluation commends the new HCF director for improving the staffing of the economics side of the organization.

d. To a degree, the focus on EPI limits the focus of HCF to child survival countries. Within those countries it tends to limit HCF to primary health activities. The needs are quite different but no less pressing in non-child-survival countries, and they are at widely varying levels of health infrastructure and health finance development. To focus only on primary health programs or rural services often misses important constraints that lie outside those areas (see our Zaire trip report for an example).

CONCLUSION: The health care financing component anticipated a need for technical assistance and leadership before many realized it was an issue. The demand for assistance in this area will only become greater and more complex in the future as developing countries and donors are increasingly faced with unmanageable health costs. The combination of HCF and EPI, while perhaps expedient at first and having some undoubted benefits to both sides, is increasingly becoming disadvantageous to both sides. A principal lesson learned is that any vertical intervention like EPI must have access to financial or economic expertise, but an HCF project should not be limited to any one health service function. The combination of the two components should not be continued following the completion of the REACH project.

3. Long-term versus short-term intervention

The contract identifies health financing under the "systems support" category of the contract. It states that technical assistance in this area should include short-term assistance of one week to three months in 25-30 countries (including 10 country "financial analyses") and long-term assistance longer than three months. The latter assistance was intended to implement "action-oriented interventions" in 5 countries. The contractor has made a good effort to better define the distinction between these two components. However, the distinguishing element of the long-term activities to date has been the cost and length of activity, as opposed to the content; in some cases it is difficult to see how the long-term interventions and choice of countries fit into a long-term HCF strategy.

The evaluation team observes that long-term interventions in health care finance should be more clearly delineated in the contract give clear priority to interventions related to cost-recovery and resource generation and with emphasis also given to disseminating information on lessons learned from such interventions. The general topics to be covered by these interventions should be more clearly specified in the contract. The team feels that the contractor has done

a reasonably good job in long-term intervention countries and topics (Kenya - supply side analysis, Zaire - strengthening health zones, El Salvador - demand survey, Dominican Republic - hospital costs, Indonesia - technical assistance with insurance focus, and Jamaica - overall technical assistance). But we believe that, had a more systematic operations research component been specified in the original contract, the long term interventions could have provided a better focus for the project, a springboard for short-term technical assistance, and a natural method for developing and organizing findings from the project.

CONCLUSION: In health care financing, where the body of operational knowledge on such issues as user fees, expenditure patterns, methods to target subsidies to the poor, insurance, the potential role for the private sector, and methods of better funding public health activities is so shallow, long-term interventions have an important role to play in creating a basic body of knowledge.

For the final two years of the contract, we encourage AID and REACH to focus the efforts of the project in its long-term interventions to synthesize its findings, to the extent possible putting them in an operational research context, to widely disseminate in an accessible manner the main findings of its work, and to try to fit those findings into an overall strategy for health care financing.

4. Project length

We note that the five year time horizon for the project contributes to several of the problems noted above, particularly problems recruiting economists and the character of long-term interventions. A longer project, maybe ten years divided into two phases of five years each, would reduce these problems by giving individuals and the contractor a longer planning horizon, although we are aware that it might create other difficulties for AID (especially competitive considerations over a long time horizon). However, improvements in HCF in the developing countries will only be realized over an extended period of time.

CONCLUSION: For any new project (and even for the remainder of this one) it is essential to have a long-term (10 year or so) strategy and to plan for such a project divided into two phases.

5. Quality of personnel and technical assistance

The foregoing discussion of personnel was put within the context of the EPI/HCF issue because we feel that combining the programs was a contributory factor (but not the only one) to the personnel problems. There are related problems that should be noted. On the S&T/Health side, there have been six Cognizant Technical Officers (CTO) back-stopping REACH in three years. With only one exception their area of specialty did not relate to health economics. For REACH, as soon as the CTO had become familiar with the project, he

or she left, and the result has been delays and discontinuity in guidance from the S&T/Health side. Moreover, S&T/Health does not have an economist on the staff; if it chooses to continue its work in the health care financing field, the evaluation team strongly suggests that either an economist should be added to S&T/Health's staff or management of the project be shared with an economics staff within S & T or with PPC.

Another problem is the relationship between REACH and its subcontractors. Three subcontractors were used heavily at the beginning of the project, but one, HIID, was dropped over concern for the quality of the work of the primary HIID consultant/manager. Later REACH came to depend primarily on two subcontractors, Abt Associates and the Urban Institute, for professional economic services. The two people primarily involved on the subcontractor side, Maureen Lewis and Marty Makinen, are highly respected and appreciated by the Missions. Yet REACH seems to have dealt with both subcontractors almost on a task-order basis. As a result, both subcontractors feel excluded from strategic planning in the health financial area and have come to consider themselves mainly as special relationship consultants.

The team strongly commends REACH for putting together in the last year an excellent technical support staff in HCF. Logan Brenzel, Denise Lionetti, Catherine Overholt, Matilde Pinto, Allison Percy, Andra Sawyer, Kodho Evlo are a knowledgeable, hard-working, thoughtful group that has demonstrated a high degree of administrative and organizational skills. We have reviewed many pieces of written work to which individuals in this group have contributed, and we have found it to be technically sound and generally well written. If REACH could complement this group with greater depth in health economics, it would have, in our view, an extraordinary combination of talent.

The quality of individual short-term consultant services has in most cases been judged to be excellent from Missions and host country clients.

CONCLUSIONS: With respect to S&T/Health, it is important to try to ensure a degree of continuity on the part of the CTO responsible for the project. More importantly, the S&T/Health office cannot adequately manage the HCF component of REACH without either having an economist on its staff to help develop and review strategy or alternatively sharing responsibility for managing the project with some other office in the bureau or agency that has economic talent.

REACH has responded more slowly than desirable in adjusting its staffing to the accelerating demand for HCF. It now has a capable staff, but should still add at least one health economist to its staff to help assure better project design and quality control.

The subcontractors represent an important addition to REACH's capacity for economic analysis. It is so viewed by REACH, although their expertise is currently being engaged less and less. REACH should

clarify its policy on the role of its subcontractors, if any, in the development and carrying out of an overall HCF strategy, and then follow through on its policy.

6. Relationship to Regional Bureaus and Missions

The Regional Bureaus and Missions are generally happy with the assistance provided by REACH in the HCF field. It has covered an extraordinary range of issues including all types of cost savings possibilities and related institutional reform. It has focussed much less (nor has it been asked to by S&T/Health, Regional Bureaus, and Missions) on revenue generation. That, in the team's view is the problem, for which AID/W as much or more than the contractor shares responsibility.

The Regional Bureaus and Missions have program design needs which dictate how they want to approach health care financing. We have two observations on this topic. First, the problem orientation has often been directed to cost and management issues that pervade government health systems. These questions are often tangentially related to health financing or are symptoms of larger problems that a health financing project would ideally solve. Second, from our experience with field visits and discussions with Regional Bureaus, AID health people and government health people are groping for guidance on health financing issues and tend to welcome assistance in sorting out the issues and prioritizing items on their own agendas. There is a great need not only to listen to the Bureaus and Missions but to provide guidance, training, and dissemination of material.

In the short-term, however, the competing needs of S&T/Health, the Regional Bureaus, Missions, and other audiences put the contractor in a difficult position. In our discussions with the contractor, we have emphasized the importance of a strategy in HCF to help distinguish among the demands placed on REACH and as a basis for guiding Missions down sensible routes of technical assistance. We have been particularly concerned that in responding to Mission requests REACH has by design or accident focused its resources on cost studies that we would suggest are tangential to the goal of increasing resources for health care. REACH managers have taken great exception to our views because they view their role in HCF primarily as a service organization to the Missions. REACH, though, in addition to responding to Mission requests, has an opportunity to contribute significantly to improving the quality of Mission dialogue with host countries on HCF issues.

Our central conclusion of this evaluation of the HCF component of the REACH project is that a better defined strategy in HCF is essential for the project to have an impact beyond the specific pieces of technical assistance that it provides. In our discussions with S&T/Health, the Bureaus, the Missions, and REACH, it was clear that everyone looked to REACH for guidance on an overall strategy but REACH seems to regard its primary function to respond to directives from S&T/Health, not to suggest alternatives for the nature of the demands

for its technical services. The evaluation team concludes, however, that while the responsibility lies with both sides, REACH should provide greater leadership in enunciating its strategy in this area in simple terms that would be clear to all of its clients. If nothing else, if REACH simply followed some of the major suggestions of the World Bank's health financing policy paper, they would have a far clearer framework within which to act.

CONCLUSION: REACH has been totally responsive to S&T/Health and to the Regional Bureaus, responding for the most part in a timely manner, with technical assistance of a high quality. However, REACH and S&T/Health together need a clearer strategy in the HCF area, not only to filter better the requests for REACH services, but also to provide a focus for its analytical work so that at the end of the project far more should be known about what specific interventions work in specific situations. It is never too late, and trying to define a strategy should not wait for a follow-on project. It is essential that S&T/Health seek support from economists in the agency to ensure that activities meet the new tighter selection criteria emerging from a refined HCF guidelines paper.

7. Project financing

The explosion of demand for health financing has drawn contract resources to it. Originally planned at \$1.5 million, the health care financing component (including buy-ins) will probably top \$8.0 million over the life of the project. The buy-in feature of the contract permitted flexibility in the allocation of resources within the project, but the high demand for both HCF and EPI has meant that the contract ceiling is fully committed half way through the project. This is disastrous for the regions and Missions. Just as they had started to put health financing in their own agendas and were willing to commit large chunks of Mission funds to the activities, the project may be forced to reject any newly proposed activities. Because it would take most of a year to transform buy-ins into bilateral projects (and in the process lose one of REACH's most valuable contributions-- knowledge of the market for health finance technical assistance), the Missions which depend on REACH are, for all practical purposes, out of the health financing business for a year.

In part the quick climb by REACH to its budgetary limit is a reflection of its failure to screen requests more carefully. But even if that had been the case, we suspect that the ceiling limit would have been a problem. At any rate, a decision must be made to raise the ceiling or leave it as it is. This problem is a contractual one that perhaps could be partially prevented in a follow-on project as discussed later in this report.

REACH has compiled a list of pending requests in HCF that cannot be accommodated under the current ceiling. We recommend that the ceiling be raised to accommodate the projects listed in Annex 6.

8. Overall project impact and effect

At the midpoint of the project, it is difficult and possibly not productive to try to assess the impact of the project, and we hope that our comments are taken as tentative. REACH has made several major contributions in HCF. It has helped to sensitize the development community to the importance of health finance activities, and it has given AID a voice in this area. It has been extremely responsive to Mission and Bureau requests for assistance. It has put together a core of people to work on health financing issues in developing countries, and the associate director for HCF activities is actively recruiting and providing experience to young people in the field. It has assembled a roster of consultants in this area, which is not a simple task because the supply of the necessary specialized talent is so small. It has contributed to the creation of an enormous demand for assistance. In some cases, such as its Zaire health zone study and its user fee studies in the LAC region, it has provided descriptive information of national experiments that have had enormous impact on people working in this area because they show what can be done and how people solve the problems implicit in user fee strategies. It has contributed to an awareness by EPI experts that sustainability requires an effort to cost out alternative interventions and to find continuing sources of funds to pay for them. It has collected data in several countries that could help to provide some facts about consumer demand patterns that are essential to help governments design their programs and make policy decisions in health financing. REACH has developed good internal procedures to brief and debrief consultants, and it has instituted good quality control procedures for consultant reports. REACH has begun to work with the World Bank's Economic Development Institute to organize seminars on HCF for policy makers; this effort makes good economic and strategic sense.

There are also areas where REACH could improve its efforts, but to some extent our observations in this area may be things REACH planned to do anyway during the final years of the project. In any event they should only be done with greater knowledge and support by AID/W.

It should be already clear that our main criticism of REACH has been a focus on supply side costing and management studies that can only help peripherally to reduce budget constraints for health care in developing countries. We have suggested that this focus might be partially the result of the marriage to EPI or because the project has been so strongly driven by mission requests. On the other hand, AID's Health Care Financing strategy paper itself gives no clear priority to resource generation issues such as user fees, insurance schemes, privatization and incentive structure for non-governmental providers of health services. Yet we would suggest that one of REACH's main tasks should be to disabuse the world of the notion that health financing problems can be solved simply or even largely by improving the management or cost efficiency of government services. Cost-side interventions may help, and they may provide the justification for projects to re-equip facilities, but they will not solve the revenue

problems that are the real constraint. Governments do not pay just unit costs, the reduction of which is the focus of cost studies; rather, they pay total costs. A reduction in unit costs is absolutely consistent with an expansion of the total budget, but it is the total budget that the government has been unable to finance in the first place. A more efficient public health service--one with a reliable supply of drugs, adequate personnel, and functioning diagnostic equipment and laboratories--will need more, not fewer, resources. The evaluation team has argued that a demand side or revenue focus should be given priority by the REACH project if it is to have a positive impact in health care financing. Unless there are direct efforts to get people to pay for health care, financial sustainability of health care systems will continue to be an elusive objective.

CONCLUSION: There is a great need for a more refined Health Care Financing strategy on the part of both AID and REACH giving greater priority to developing promising interventions for revenue generation.

9. Information dissemination

A related gap of the REACH approach again as much attributable to S&T/Health as to REACH, is a failure to publish results for an academic and development audience. The evaluation team realizes that AID is not subsidizing an operation for a university audience. But it is paying for an operation which should be engaged in original research--data collection, developing research techniques, and generating findings in a new areas. Publishing and disseminating information to a broader audience is an essential discipline that should be encouraged for REACH investigators; REACH would profit by presenting papers at academic conferences because those are also the primary recruiting grounds for professional people interested in this sort of work.

CONCLUSION: Dissemination of lessons learned in an easy to read form for Mission and country policy makers as well as health administrators and the relevant academic community can be an important device for extending understanding of health financing issues. The EDI forum is particularly valuable as an opportunity to target policy makers in a dialogue for health financing reform.

10. The role of the TAG

The evaluation team views the Technical Advisory Group meeting as a relatively expensive (\$15,000-\$25,000) public relations activity with little or no benefit to REACH. The concept of the TAG for a health finance project would make more sense if it were more of a paid "Technical Board of Directors" that met once or twice a year for working meetings in which REACH's main strategic decisions would be discussed and possibly even put up for a vote. The TAG would also be more valuable if members were compensated to review a few pieces of work a year or if they were called in to assist on some technical aspects of REACH's work. In REACH's recent activities, the technicians

who designed and administered the Nairobi Area Study, the Zaire health zone demand study, and the El Salvador household survey would have profited enormously from working meetings with TAG experts in demand surveys. At the analysis stage, similar consultations would be invaluable.

Finally, we suggest that REACH give more attention to publishing and widely distributing short, well illustrated, clearly written summaries of REACH's HCF experience. We assume that this activity, even to the extent of creating training materials from some of the work, will be a large component of REACH's core activities as they wind up the project.

CONCLUSION: A more technical use of TAG members should evolve in the project particularly related to approval of a refined HCF strategy, quality control of major pieces of operations research, and dissemination of "lessons learned".

IV. SYSTEMS SUPPORT

The System Support component of the project, initially including all HCF and other activities outside the Key Disease Control Technologies, has evolved during the life of the project to be synonymous with all short-term activities including EPI, HCF, assistance to AID/W, and general Mission support in the preparation of PID's, PP's, evaluations, etc.

One of the most valuable assets of the REACH project has been its quick-response capability for short-term assistance. The S&T and FVA Bureaus, in addition to the Missions, have used REACH services extensively.

Since non-governmental organizations deliver significant amounts of quality care in many less-developed countries, AID's effort to mobilize and strengthen this PVO resource is essential to any complete strategy for delivering sustainable health services in LDC's. Many of these organizations are far ahead of the public health system in cost recovery and much can be learned from them about the ability of the poor to pay for health services and ways to deal with the equity issue and recurring costs.

CONCLUSION: REACH assistance has been of valuable use to PVO's and to the AID/W Bureaus. Its responsiveness to Mission requests for assistance in a great variety of skills has been outstanding.

V. GLOBAL PROJECT ISSUES AND CONCLUSIONS

A. Combination of EPI and HCF

The combination of EPI and HCF was useful at the time of project initiation primarily because EPI as a key element of Child Survival had considerable support throughout AID whereas the importance of HCF was not so widely appreciated. Furthermore, there is no doubt that the combination has had some beneficial impact on both; in the case of EPI, the fuller incorporation of economic and financial analysis into project design has been useful and the juxtaposition has given the HCF a ready practical "laboratory" for application.

However, in the judgement of the team the disadvantages far outweigh the benefits:

- o EPI, for which there is continuing need and demand is receiving a smaller share of the funds than originally intended under the project;
- o Studying cost-effectiveness issues related to one intervention, in this case EPI, is essential and must be done in any activity, but it is quite different from HCF in a generic, sector-wide sense which focusses primarily on overall revenue structure for a total body of related services. Putting the two together blurs an important distinction; and
- o Demand for HCF interventions is expanding rapidly and yet knowledge of what works where under what conditions is more limited than in the case of EPI. A separate HCF project needs to focus on a range of operational research issues totally different from EPI and needing different skills for management.

CONCLUSION: The EPI and HCF combination project should be broken into two separate follow-on S&T activities.

B. Buy-In Ceiling

One of the most useful contributions S&T has made is the initiation of projects with the buy-in provision. Successful projects like REACH are marked by great Mission demand for their services. It would be totally consistent with the objective of the project to remove the financial limitation of Mission buy-in but instead to limit use by any one Mission in the following ways:

- o The scope of work obviously would have to meet existing programmatic criteria; and

- o Assistance would have to be short-term in nature and not part of cumulative effort by any one Mission which takes a disproportionate share of an S&T project. At that point, a separate Mission project would be required.

To address the issue of competitiveness which is of concern to the Contracts Office while preserving the great advantage of the buy-in authority, S&T should explore with the Contracts Office and perhaps with the General Counsel the feasibility of revising RFP's to make very clear from the beginning that competitors were bidding on a piece of work which comprised an S&T-financial fixed level of effort plus a buy-in of similar activities (costed similarly in terms of person/months). The limitation would be provided only by the scopes of work acceptable, the limitation on cumulative activity for any one Mission and most importantly an unextendable termination date for the contract. Mission buy-ins would include not only the cost of the specific services they were requesting, but also a pro-rated share of contract administrative and overhead costs.

CONCLUSION: S&T should vigorously pursue the raising of the buy-in ceiling for the REACH project. It should also explore the possibility of revising future RFP's to inform competitors from the very beginning of buy-ins limited by scope and time rather than by level of financing.

ANNEX 1

List of Persons Interviewed

ANNEX 1

LIST OF PERSONS INTERVIEWED

AID/W - S & T/Health

Susan Abramson
Kenneth Bart
Robert Clay
Lloyd Feinberg
Pam Johnson
Allen Randlov
Anne Tinker

AID/W - Other Bureaus

Connie Carrino, PPC
Lois Godicksen, PPC
Charles Johnson, ANE
Julie Klement, LAC
Joseph Lieberson, PPC
Terri Lucas, ANE
Gary Merritt, AFR
Mary Anne Micka, AFR
Tricia Moser, LAC
Wendy Roseberry, AFR
James Shepperd, AFR
Keith Sherper, AFR
Barbara Spaid, LAC
Dory Storms, PVC
Nick Studzinski, ANE
Jake Van der Flugt, PVC

REACH

R. Arnold
L. Brenzel
Pierre Claquin
K. Evlo
Diane Hedgecock
Norbert Hirschorn
M. Kunz
D. Lionetti
C. Overholt
A. Percy
M. Pinto
Gerald Rosenthal
P. Steele
R. Steinglass
A. Wylie
A. Yanoshik

Other Organizations and Agencies

John Akin, TAG
Samir Basta, UNICEF
Ricardo Bitran, Abt Associates
Andrew Creese, WHO
Joseph Davis, CDC
Ann Diego, CDC
David Dunlop, World Bank
Raif Henderson, WHO
Susi Kessler, UNICEF
Maureen Lewis, Urban Institute
Marty Makinen, Abt Associates
David Parker, UNICEF
Ciro de Quadros, PAHO
Carl Stevens, TAG
John Tilney, Abt Associates

Field Visits

Kenya

Linda Lankenau, USAID
David Oot, USAID

Mr. Muriuki, KHN, Chairman of the Board
Mr. Noreh, KHN, Deputy of Planning Unit; worked on KHN study

Professor Ogada, MOH, Director of Health Services, and staff
Dr. Maneno, MOH, Director of Medical Services

Dr. Acholla, Nairobi City Commission, Medical Officer for Public Health

Peter Bjergaard, Kenya EPI, Division of Family Health

Dr. Wangombe, REACH
Mr. Ikiara, REACH
Ms. Kariuki, REACH
Dr. Germano Mwabu, REACH
Cathy Overholt, REACH

Michael Mills, IBRD
Dr. Sebina, IBRD

Zaire

Dennis Changler, USAID Mission Director
Rhonda Smith, USAID Project Officer for SANRU, REACH monitor
Lois Bradshaw, USAID Acting HPN Office Chief and Senior Population
Office

Dr. Duale Sambe, SANRU project director
Dr. Kalambay Kalula, GOZ Representative to SANRU
Dr. Frank Baer, SANRU project manager
Citoyen Munkatu Mpese, SANRU Chief of Operations Research
Citoyen Manunga Mapele, SANRU Accountant
Steve Brewster, SANRU Chief of Administration Division

Dr. Bill Bertrand, School of Public Health

Dr. Minuku, Medicin de Chef in Sona Bata Health Zone

Bolivia

Mr. Paul Hartenberger, USAID, Chief, Health & Human Resources
Mr. Rafael Indaburu, Project Manager, USAID

Dr. Andres Bartos, Ministry of Health, Chief, MCH
Lic. Enrique Lavadenz, Chief, EPI

Dr. Sanchez, PAHO, Counselor, Epidemiology
Dr. Daniel Girherrez, PAHO, Counselor, MCH

Dr. Oscar Castillo, UNICEF, Health Program Officer

Mr. Mario Telleria Rios, PVO/REC, Executive Secretary

Mr. Durval Martinex S., Foster-Parents PLAN, Director
Lic. Larry Wolf, Foster-Parents PLAN, Director in Altiplano La Paz

Indonesia

Dr. Manuel Voulgaropoulos, USAID
Ms. Joy Riggs Perla, USAID
Ms. Katie McDonald, USAID

Dr. Soekarjono, Indonesian Ministry of Health, Bureau of Planning
Mr. Azis Lasida, Indonesian Ministry of Health, Bureau of Planning
Dr. Kariti Binol, Indonesian Ministry of Health, Bureau of Planning
Dr. Paramita, Indonesian Ministry of Health, Bureau of Planning
Dr. Ridwan Malik, Indonesian Ministry of Health, Bureau of Planning

Dr. Gunawan, Indonesian Ministry of Health, Directorate of Health
Dr. Jones, (CDC), Indonesian Ministry of Health, Directorate of Health
Dr. Rosenberg, (CDC), Indonesian Ministry of Health, Directorate of Health

Mr. Rosmin Djaafar, Tugu Manderi, Private Sector

Dr. Roger Bernstein, WHO

Mr. Thomas D'Agnes, ISTI, Resources for Child Health, (REACH)

ANNEX 2

List of Active EPI Activities

EPI Activities

Africa Bureau

Long-term Activities

Country	Activity Title	S&T/H Pnds	Buy-in Pnds	Person Days	LT Advisor	Beg/End Dates
Kenya	Long-term EPI TA Planning	\$23,658	\$0	27		
	LT EPI Intervention	\$91,124	\$213,500	1040	To be identified	Oct 1988/Sep 1990
Madagascar	EPI and PL480 Programming	\$16,270	\$0	33		
	Long-term EPI TA	\$69,462	\$0	140	Consultants	Apr 1988/--

Systems Support Activities

Benin and Burkina Faso	OCCGE EPI Plan/Trng Module	\$19,307	\$0	2		
Chad	Long-term EPI TA Exploration	\$4,162	\$0	9		
Guinea	TA to CCCD	\$28,545	\$0	66		
Liberia	CCCD/Health Ed Assessment	\$10,661	\$0	20		
Niger	Long-term EPI TA Exploration	\$34,773	\$0	77		

Asia and Near East Bureau

Long-term Activities

Country	Activity Title	S&T/H Fnds	Buy-in Fnds	Person Days	LT Advisor	Beg/End Dates
Bangladesh	Municipal EPI Design	\$38,087	\$0	61		
	Urban EPI Design	\$85,773	\$0	168		
	Long-term EPI TA Planning	\$10,855	\$0	20		
	LT EPI Intervention	\$0	\$1,145,400	520	To be identified	Oct 1988/Sep 1989
Indonesia	Long-term EPI TA Exploration	\$3,865	\$0	5		
Philippines	EPI Manual and Newsletter	\$36,859	\$0	58		
	EPI Newsletter, CS Strategy	\$1,957	\$10,000	66		
	Urban EPI Assistance	\$15,398	\$0	22		
	Long-term EPI TA Planning	\$7,022	\$0	20		
Yemen	LT EPI Intervention	\$209,111	\$171,000	520	Alasdair Wylie	Mar 1988/Feb 1990
	Child Survival PID	\$20,000	\$0	40		
	Child Survival PP	\$21,190	\$0	63		
	Long-term EPI TA Planning	\$34,205	\$0	57		
	LT EPI Intervention	\$387,761	\$586,520	3,310	Dina Hammam Leslie Petry	Oct 1987/Sep 1990

Systems Support Activities

Bangladesh	EPI Review	\$14,469	\$0	24		
Indonesia	EPI Amendment & ESICP	\$17,906	\$0	24		
	TA to the CHIPPS Project	\$7,228	\$0	9		
	CHIPPS Infant M&M Survey	\$2,694	\$25,230	56		
	CHIPPS Survey Workshop	\$2,202	\$0	6		
	EPIS Training	\$1,916	\$0	8		
Nepal	SCF EPI Evaluation	\$10,353	\$0	12		
Pakistan	EPI Review, IT Assessment	\$30,151	\$0	48		
	Springe Field Test	\$55,653	\$0	75		
Philippines	EPI Evaluation	\$28,166	\$0	90		
	PID and PP Development	\$14,035	\$0	21		
	Child TB Manual	\$4,207	\$10,000	22		
	EPI Assistance, CS Strat Paper	\$0	\$9,351	50		

Food for Peace and Voluntary Assistance Bureau

Long-term Activities

Country	Activity Title	S&T/H Fnds	Buy-in Fnds	Person Days	LT Advisor	Beg/End Dates
USA	PVC/EPI Coordinator Planning	\$1,000	\$0	0		
	PVO Coordinator	\$110,000	\$50,000	260	Mary Harvey	Dec 1987/Nov 1988

Systems Support Activities

Bolivia	PVO Workshop	\$2,164	\$3,246	10		
Haiti	PLAN Evaluation	\$0	\$206	2		
	PLAN EPI Assessment	\$2,333	\$3,500	15		
Indonesia	CARE and PCI EPI TA	\$6,350	\$9,280	22		
Malawi	TA to IEF in Child Survival	\$15,363	\$0	20		
Uganda	CARE Mid-term Evaluation	\$4,978	\$7,468	23		
USA	PVO EPI Interventions Evaluatn	\$4,394	\$0	10		
	PVO Conference Design	\$1,284	\$0	3		
	PVO Headquarters Workshop	\$1,200	\$1,800	5		
Zimbabwe	PVO Child Survival Workshop	\$2,977	\$4,465	17		

Latin America and Caribbean Bureau

Long-term Activities

Country	Activity Title	S&T/H Fnds	Buy-in Fnds	Person Days	LT Advisor	Beg/End Dates
Bolivia	Epidemiology TA	\$47,832	\$0	133		
	EPI Review and TA	\$11,453	\$0	20		
	NT Anthropological Study	\$25,807	\$0	88		
	ARI/EPI PVO Workshop	\$10,153	\$0	15		
Ecuador	Long-term EPI TA Planning	\$3,145	\$0	6		
	LT EPI Intervention	\$60,000	\$0	390	Jose Barzola	Oct 1988/Mar 1990
Haiti	EPI Technical Assistance	\$11,492	\$0	17		
	NOVA Technical Assistance	\$0	\$2,712	4		
	Long-term EPI TA Planning	\$60,441	\$0	121		
	LT EPI Intervention	\$0	\$590,668	520	Serge Toureau	Nov 1987/Oct 1989
				370	Lucas Spinelli	Jun 1988/Oct 1989

Systems Support Activities

Ecuador	KAP Survey and Cold Chain	\$4,226	\$0	9		
	EPI Data Analysis	\$11,639	\$0	50		
Peru	EPI Evaluation Survey	\$8,436	\$0	16		

Science and Technology Bureau

Long-term Intervention

Country	Activity Title	S&T/H Pnds	Buy-in Pnds	Person Days	LT Advisor	Beg/End Dates
	EPIIS	\$199,795	\$0	469	Dinesh Gupta	Nov 1987/Jan 1989

Systems Support Activities

USA	EPI Field Guide	\$54,070	\$0	69		
	EPI Roster	\$1,774	\$0	0		
	EPI w/weak Infrastructure	\$301	\$0	3		
	LAC EPI Profiles	\$3,247	\$0	7		
	EPI Candidates for AID	\$1,617	\$0	3		
	EPI Coverage in AID Countries	\$311	\$0	3		
	Review EPI Guide w/AID	\$578	\$0	1		
	EPI Training Module/BU	\$5,148	\$0	21		
	Neonatal Tetanus Analysis	\$1,681	\$0	10		
	Vaccine Symposium	\$933	\$0	4		
	EPI Technical Consultant	\$15,813	\$0	65		
	APHA Annual Meeting	\$8,412	\$0	13		
	EPI Directory	\$8,554	\$0	10		
	Social Marketing Paper	\$10,477	\$0	38		
	EPI Supplement to Dial on Diar	\$17,430	\$0	8		
	Immunization Issues Papers	\$7,752	\$0	22		
	EPI Technical Summaries	\$4,128	\$0	25		
	EPI MIS	\$8,102	\$0	18		
	Urban EPI Concept Paper	\$2,716	\$0	10		
	Behavioral Aspects of NT	\$6,831	\$0	19		
WHO	Review WHO EPI Files	\$3,180	\$0	6		
	1986 EPI Global Adv Group Mtg	\$2,000	\$0	6		
	1987 EPI Global Adv Group Mtg	\$7,711	\$0	8		
	Review Polio Manual - PAHO	\$4,321	\$0	7		

ANNEX 3

Pending Activities of EPI Meriting Future Funding

ANNEX 3

Pending Activities of EPI Meriting Future Funding

I. Pakistan Syringe Study \$70,000

Testing of an autodestruct injection device in Pakistan work has already been started by REACH at the request of the Child Survival Office in coordination with PATH and WHO. A protocol for the first field experimentation has been finalized. Pakistan has been identified for testing and field work will start as soon as the devices are produced in sufficient number.

II. Africa EPPIS in Africa \$150,000

WHO has identified the EPI in Africa as a priority area for disease surveillance and implementation monitoring. Unfortunately, progress has been very slow. However, WHO has been requesting REACH to bring their expertise in the field of EPIIS to Africa.

III. Indonesia Implementation of 4 specific technical areas to strengthen national EPI \$500,000

Indonesia has identified 4 areas of work where they want REACH to assist the national EPI (urban development, design and carry-out supplementary research, field assistance to districts, and development of computer capability). The Mission is ready to buy-in up to \$800,000. REACH believes that \$500,000 would probably allow for a decent amount of the initial scope of work to be implemented within the next 18 months.

IV. SEARO Workshop on lessons learned from EPIIS in 5 countries \$80,000

Three days of workshop before the annual EPI managers meetings will allow to keep costs to a minimum. The presence of other WHO regions and other users will be useful. The Workshop proceedings will be a milestone in EPI information systems worldwide. The system could also be a model for polio control monitoring (example of Vellore).

V. Turkey EPIIS TA \$40,000

The unique situation of Turkey will provide a good model for what an EPIIS could be in a country with high coverage but still significant problems. REACH has provided equipment and would like to install the EPIIS there and keep building the national capability to sustain the initial effort.

ANNEX 4

List of Active HCF Activities

HCF Activities

Africa Bureau

Intensive Activities

Country	Activity Title	S&T/H Fnds	Buy-in Fnds	Person Days
Kenya	LT HCF TA Planning	\$55,613	\$0	72
	KNH Study	\$156,167	\$165,000	879
	Nairobi Area Study	\$97,381	\$296,165	1,422
	HCF Workshops and Seminars	\$0	\$22,909	22
	Prov/District Hospital Study	\$0	\$68,545	264
Zaire	HCF Study Design	\$9,896	\$0	10
	Hlth Zones Financing Study	\$87,779	\$0	145
	LT HCF TA Planning	\$41,300	\$0	46
	Long-term HCF Intervention	\$125,904	\$115,000	403

Systems Support Activities

AFR Sub-sahara	Eight Country Study	\$30,324	\$0	91
Burundi	Recurrent Cost Study	\$0	\$11,988	20
CAR	Auto-financing Study	\$14,704	\$0	30
	Auto-financing TA II	\$0	\$34,673	57
	HCF Discussions	\$0	\$9,975	16
Gambia	Hlth Sector Financing Anal	\$25,402	\$0	36
Guinea	Fee-for-service Study	\$39,477	\$0	65
Kenya	World Bank Conference	\$26,381	\$0	14
Liberia	CCCD Financial Review	\$14,626	\$0	21
Malawi	Economist for PID Team	\$24,322	\$0	40
Niger	LT HCF TA Exploration	\$17,708	\$0	30
Rwanda	CCCD/HCF Study	\$34,849	\$0	69
Senegal	Community Finance Study	\$4,318	\$0	5
	LT HCF Workplan Development	\$10,609	\$19,847	50
Sudan	CS Plan Development	\$13,700	\$0	23
	Costing of EPI	\$0	\$175,000	193
Togo	Financing Section of PID	\$2,328	\$13,993	20
USA	CCCD Comparative Study	\$0	\$28,302	37

Asia and Near East Bureau

Intensive Activities

Country	Activity Title	S&T/H Fnds	Buy-in Fnds	Person Days
Indonesia	Private Sector Health/Fam Plan	\$44,908	\$0	119
	HMO Pre-feasibility Study	\$0	\$21,176	39
	HMO Business Plan	\$110,204	\$0	248
	Social Financing Analysis	\$19,669	\$0	34
	Economic Analysis for PP	\$12,533	\$0	21
	Hlth Financing Assistance	\$54,179	\$0	308
	HCF Overview	\$7,769	\$0	28

Systems Support Activities

Indonesia	HMO Mobile Seminar in US	\$17,505	\$0	25
Jordan	Hospital Study	\$1,527	\$15,926	21
Morocco	Indicative HCF Study	\$28,206	\$0	61
	HCF TA	\$3,151	\$0	5
	HCF Workshop	\$0	\$9,074	12
Pakistan and Philippines	ANE Guidance Field Test	\$0	\$6,369	9
Philippines	PHCF Evaluation	\$0	\$23,081	40
	HMO Mobile Seminar in US	\$6,170	\$0	9
	Economic Anal for CS Proj	\$0	\$5,344	27
	Medicare Evaluation	\$13,547	\$0	23
	HCF TA Exploration	\$5,454	\$0	10
ANE	Cntr for Mid-East Hlth Mtg	\$2,727	\$0	3
USA	CMEH Plan Development	\$0	\$25,000	34
	ANE Costing Guidance	\$8,332	\$33,000	102
	ANE Financing Model Devel	\$0	\$24,164	65

Latin American and Caribbean Bureau

Intensive Activities

Country	Activity Title	S&T/H Funds	Buy-in Fnds	Person Days
Dom Republic	Hospital Cost Study	\$144,835	\$60,000	452
El Salvador	Comm Hlth Services Survey	\$0	\$240,000	594
LAC: Dom Rep	User Fee and Comparative	\$72,290	\$60,000	245
Honduras	Studies			
Jamaica				

Systems Support Activities

Antigua	Hospital Study	\$0	\$31,630	36
Belize	TA to Banana Control Board	\$0	\$13,984	32
Bolivia	Self-financing Proj Eval	\$24,164	\$0	62
	Economic Analysis for PP	\$16,497	\$0	37
El Salvador	Hlth Serv Reconstruction	\$0	\$12,271	31
Jamaica	Hlth Sector Analysis	\$31,271	\$0	49
	PID Development	\$7,127	\$0	7
	Soc Adjustment Paper	\$24,471	\$0	67
	Hlth Sector Initiatives PP	\$0	\$17,731	24
LAC	Cross Cutting Studies	\$0	\$93,000	80
Mexico	Explore HCF Activities	\$2,666	\$0	3
	Cost-eff Anal/CAAPS	\$4,914	\$0	14
USA	LAC HCF Project Meeting	\$2,511	\$0	6

ANNEX 5

Pending Activities in HCF Meriting Future Funding

ANNEX 5

Pending Activities in HCF Meriting Future Funding

I. Zaire HCF Long Term Advisor \$200,000

Role of long term advisor is:

- to facilitate the implementation of FMIS developed to date;
- to support the application of the policy analysis model to health zone costing and planning;
- to assist the Mission in the further development of their HCF effort.

II. Kenya HCF Sectoral Adjustment \$500,000

REACH activities in Kenya were initiated to support the development of new policy and program directions which emphasize improved efficiency, private sector development, and greater cost-sharing through user fees in the health sector. This proposed activity builds on that experience by undertaking additional analyses and training as part of the health care financing component of the Mission's overall Program for Economic Stabilization and Sectorial Adjustment.

III. Systems Support \$150,000

The ceiling constraint has discouraged formal request for initiation of a number of activities. Examples include analysis of transfer of PHC funding responsibilities from MOH to Social Security in Peru, revenue generation for recurrent costs in new hospital in Zaire, and expansion of medicare insurance coverage in the Philippines. The need to balance our activity in REACH and the needs of the field make additional systems support high priority.

IV. Jordan National Medical Institute \$200,000

REACH has supported the initial phase of planning for the integration of the three public hospital systems and the restructuring of the MOH. The proposed activity will support the design of improved revenue generation and resource management.

ANNEX 6

Bolivia Trip Report

Robert Kim-Farley, MD, MPH

ANNEX 6

Bolivia Trip Report

Trip Report of Dr. Robert Kim-Farley to La Paz, Bolivia
September 22-24, 1988

Purpose: To meet with staff of USAID mission, PAHO, Foster-Parents PLAN, PVO Rotating Executive Committee (PVO-REC), and Ministry of Health regarding the mid-term evaluation of the REACH project.

Persons met:

USAID: Mr. Paul Hartenberger, Chief, Health & Human Resources
Mr. Rafael Indaburu, Project Manager

Ministry of Health: Dr. Andres Bartos, Chief, MCH
Lic. Enrique Lavadenz, Chief, EPI

PAHO: Dr. Sanchez, Counselor, Epidemiology
Dr. Daniel Girherrez, Counselor, MCH

UNICEF: Dr. Oscar Castillo, Health Program Officer

PVO/REC: Mr. Mario Telleria Rios, Executive Secretary

Foster-Parents PLAN: Mr. Durval Martinez S., Director
Lic. Larry Wolf, Director in Altiplano La Paz

Findings and Observations:

A. Areas of Technical Assistance:

1) A summary of the major areas of technical assistance in EPI and other child survival related activities provided by REACH is shown in Annex I. REACH has also been of assistance in the evaluation of the PROSALUD self-financing PHC project in the private sector.

2) The REACH project has had multiple contacts with the mission in La Paz. The mission considers this ongoing relationship as "long-term" assistance. The mission has, in general, been pleased with the scope of technical assistance available from, and provided by, REACH.

3) To date there has been no request from the mission that has been turned down by REACH.

B. Quality of Technical Assistance:

1) The quality of technical assistance provided by REACH has been appreciated by the mission, government, PVO's, and UNICEF. PAHO has, in general, been pleased but was concerned about the anthropological neonatal tetanus survey which they felt did not adequately define neonatal tetanus. This led to conclusions that neonatal tetanus was a health problem in the Altiplano and PAHO has technical disagreement on this conclusion.

2) The consultants identified by REACH, including Mr. Robert Steinglass and Dr. Nils Daulaire, were felt to be especially appropriate for the Bolivian context because of their experience in countries, such as Nepal, which also have widely dispersed mountainous populations.

3) The only negative concern mentioned by the mission was regarding the November 1987 four-person team assembled by REACH to analyze the current status and priorities for action for child survival in Bolivia, which served as the basis for a project paper. The final Spanish and English versions were only provided to the mission nine months later. The mission was concerned that this delay affected program planning and implementation.

C. Project Impact:

1) REACH has been instrumental in helping coordinate the activities of PVOs in the country, facilitating training activities to ensure better coordination between PVOs and the Ministry of Health, and assisting in reaching agreement on the technical norms of the program.

2) REACH has been helpful in identifying Ministry of Health officials that have been useful contacts for the mission (for example, Dr. Jorge Mariscal, National Director of Epidemiology, who assisted in developing some of the project paper documents for the Community and Child Health project).

3) Although there was concern that some of the workshops may have been more costly than necessary, it was also recognized that by having the higher-quality accommodations, it was possible to have higher ranking government officials present.

D. Future Needs:

1) Future needs for REACH would include: helping to establish or strengthen norms for program implementation, developing communication materials, assisting in operations research and conducting training workshops. It is especially felt that there is a need for additional training of PVO members because the workshops were restricted as to the number of participants per PVO.

2) Although they have not had a request turned down, the mission is concerned that the buy-in availability is being compromised because of the ceiling. The mission feels that REACH activity is critical because they have now established a good rapport with the Ministry of Health and PVOs.

E. Recommendations:

1) REACH should continue to work with PVOs and Ministry of Health to improve coordination and uniformity of norms and health messages.

2) It would be beneficial for REACH consultants visiting the country to brief and debrief at both the country and regional level of PAHO. The draft conclusions of studies should be discussed with PAHO to ensure that PAHO's input and interpretation is included in final reports.

3) REACH is considered to be an important technical assistance arm of the mission and has, in general, established a good reputation and has developed a rapport with the major partners with government in health. This mid-term evaluation confirms the usefulness of the REACH project and that, in general, its technical assistance is needed, appreciated, of high quality and should continue.

Historical Synopsis of REACH Activities in Bolivia
1987-1988

Summary

REACH has been engaged in a series of short-term technical assistance assignments since early 1987. These assignments have been instrumental in guiding USAID/La Paz in its involvement in and long-term commitment to the national EPI for the years 1987-1991. REACH consultants have been involved in each step of the planning process in the development of a new bilateral US\$15 million Community and Child Health Project, including an initial epidemiological assessment, PID development, and preparation of the project paper.

USAID has begun to call upon REACH to provide technical assistance for some of those activities which USAID agreed to support during the regular Interagency Coordinating Committee meetings. In addition, REACH has provided on-going technical assistance to PVO's during two workshops and as part of other broad TDY's.

Given the consistent focus and purposeful pattern of these short-term technical assignments, REACH believes that its past, present, and projected involvement in Bolivia constitutes, and should be recognized as, a long-term intervention.

History of REACH Activities to Date

REACH began providing technical assistance to Bolivia in February 1987 following the suggestion of Dr. C. de Quadros, PAHO Regional EPI Advisor, in October 1986, during the first REACH Technical Advisory Group Meeting. In response to a request from USAID/Bolivia, REACH provided two consultants to assist in evaluating epidemiological, organizational and financial aspects of a proposed acceleration of the Expanded Program on Immunization (EPI) in Bolivia. The two REACH consultants, Immunization Specialist Dr. Ernesto Guerrero and Health Services Financing Specialist Dr. Judith Williams reviewed the Bolivian National Plan of Action and assessed the feasibility of its implementation, gathered and evaluated costs data, and made recommendations to USAID/Bolivia. The consultants also attended the annual meeting of the EPI Interagency Coordinating Committee (Bolivia), which brought together GOB, PAHO, UNICEF, Rotary and USAID to review the Plan of Action for 1987-1991. The consultancy resulted in the development of a revised and detailed plan of action of 1987, and the development of more general plans for 1988 through 1991. The MOH also made a commitment to complete a comprehensive, revised Plan of Action for 1988-1991 by April 1987 and to survey its capital resources.

REACH continued its assistance to the EPI/Bolivia following a request from the FVA/PVC Bureau to send an EPI specialist to serve as a resource person at a PVO Child Survival Bolivia Country Workshop, hosted by USAID with the cooperation of Planning Assistance (Bolivia). This workshop was held September 15-18, 1987 at Lake Titicaca, Bolivia. REACH Senior Technical Officer Mr. Robert Steinglass gave presentations at the plenary and special interest session on monitoring and evaluation of immunization activities at the community level. In addition to presenting technical discussions at the workshop, Mr. Steinglass also participated in pre-workshop planning and lesson preparation in La Paz from September 10-14 and a post-workshop evaluation on September 19 in La Paz.

Following the workshop, USAID/Bolivia requested LAC Bureau and S&T/H to extend Mr. Steinglass' TDY in Bolivia for five working days to prepare the groundwork for an epidemiological situation analysis as part of the Mission's formulation of the Child Survival Country Strategy (CSCS). Mr. Steinglass also explored with Ministry of Health officials possible implementation of a neonatal tetanus mortality survey and coverage evaluation surveys, and catalyzed action by all donors towards signing a Memorandum of Understanding in support of the Government's EPI National Plan of Action, 1987-1991.

A detailed epidemiological assessment of Bolivia was conducted by a four-person REACH team from October 1, 1987 through November 4, 1987. This assessment was done in anticipation of a new bilateral Community and Child Health (CCH) Project, which was to have a strong EPI component. Two of the team members, Dr. Jorge Mariscal and Dr. Javier Torres Goitia C., are Bolivian nationals and may serve as resources to both the MOH and USAID/B during the implementation of the child

survival activities framed by the study. Other team members included Dr. Duncan Pedersen, team leader, and Dr. Claude Betts. The purpose of the team consultancy was to: 1) establish general guidelines for the development of a child survival project appropriate for the country's epidemiological, socio-economical and cultural reality; 2) identify major health issues related to child survival from the review of available secondary data sources and field visits to selected sites; 3) analyze and identify priorities for action, utilizing an epidemiological and social approach; and 4) provide input for a plan of action, in order to facilitate the development process for child survival projects. The resulting document entitled, "Child Survival in Bolivia: Current Status and Priorities for Action" was distributed in Spanish and English. It was a useful analysis for health planners of the new CCH Project and will be an important resource for years to come.

REACH further assisted with the development of this Community and Child Health Project in a consultancy performed in November 1987. In response to a request from USAID/Bolivia, REACH provided a health educated/PHC specialist, Rose Schneider, to participate in a Bolivian national and USAID team effort in preparing a PID for the CCH project. The PID supports and seeks to develop the Bolivian MOH regional health system's capacity to implement child survival interventions; specifically immunizations, diarrheal disease control, acute respiratory infection, nutrition and high-risk pregnancy and delivery programs, and health management strengthening. The immunization intervention is the only selected intervention planned to have nationwide coverage. All other interventions will focus on selected regions. The CCH project will be funded by a US\$15 million, five-year grant to the GOB.

On February 17-19, 1988, REACH Senior Technical Officer Mr. Robert Steinglass and consultant Dr. Claude Betts represented USAID health staff at the 1988 meeting of the EPI Interagency Coordinating Committee. GOB, PAHO, UNICEF, Rotary and USAID reviewed the most recent progress of the EPI National Plan of Action for 1987-1991 and identified specific activities and funding arrangements for 1988. It was agreed that USAID will be involved more broadly in all areas of EPI rather than solely in the provision of commodities for the cold chain and supervision, as previously planned. USAID's support to the EPI National Plan of Action will come from US\$3.3 million of the US\$15 million CCH Project. According to the Plan of Action, USAID will support the development of neonatal tetanus mortality surveys and a medical-anthropological study on cultural perceptions and practices concerning neonatal tetanus. During their TDY, Mr. Steinglass and Dr. Betts also reviewed MOH EPI coverage evaluation survey data, which were collected in 25 urban districts in October and November 1987. These surveys were funded by AID PL 480 and the Bolivian government, based on recommendations during Mr. Steinglass' earlier visit in September 1987. The consultants also worked with MOH to draft a SOW for the long-term CDC Technical Advisor for Child Survival to be posted in La Paz by AID. They provided cold-chain technical assistance to SCF (USA) in order to expand their immunization service delivery. Finally, discussions were

held with the PVO Rotating Executive Committee to determine PVO technical assistance needs in the field of immunization.

As a continuation of REACH's support to the development of a project paper (PP) for the new CCH project, a REACH economic/financial analyst consultant, Dr. Robert Robertson, joined the international PP team and assisted in the preparation of the economic and financial elements. Dr. Robertson also drafted recommendations to the team concerning information needs under the Project and research and evaluation ideas, especially of an economic nature (e.g., a proposed study of certain financing sources, including revolving drug funds and cash payments for certain services.)

In accordance with USAID's commitment, made at the aforementioned EPI Interagency Coordinating Committee Meeting, to conduct a medical-anthropological study on neonatal tetanus, REACH provided a three-person team, headed by a medical anthropologist, to study the cultural perceptions of neonatal tetanus in Bolivia and the programming implications in Aymara, Quechua, and Spanish-speaking communities. This study was conducted August 2-27, 1988. The study will be of practical use to inform the MOH, USAID and other donors in the acceleration of neonatal tetanus control activities through immunization. Having identified cultural obstacles to tetanus toxoid immunization acceptability, the findings will be used to develop social communication strategies, design appropriate health messages, and refine delivery approaches.

In August 1988, REACH Senior Technical Officer Robert Steinglass continued his involvement with PVOs by conducting a joint EPI/ARI Workshop for a group of PVO and MOH staff members. The workshop objectives for EPI were to develop a consensus about the indicators to be included in the basic health information system, define basic health messages, oversee the early development of standard educational materials, and foster sharing of plans, policies and strategies.

Pending a formal request from the MOH, projected activities include conducting two neonatal tetanus mortality surveys in different ecological regions to alert senior decision-makers to the presumed high magnitude of neonatal tetanus. This would be a first step in catalyzing the MOH in support of accelerated neonatal tetanus control.

ANNEX 7

Kenya Trip Report

Charles Griffin
Alfred White

October 1988

ANNEX 7

Kenya Trip Report

A. Projects

REACH has completed one study in Kenya, the Kenyatta National Hospital Study, and is on the verge of completing a second, the Nairobi Area Study. A third project is planned which will study financing issues at the provincial and district levels if it can be accommodated within the budget ceiling for the REACH project.

B. Process And Administration

On all sides of the Kenyatta National Hospital and Nairobi Area Study projects, REACH was strongly applauded for the process it used in conducting the work. REACH assembled mixed teams of Americans and Kenyans, with Kenyans playing a prominent role. The research team and steering committee repeatedly met to define the scope of work for each project and to keep the steering committee informed of the research activities. Neither the clients nor the Kenyan researchers had seen this consultative approach in Kenya. They appreciated it, and they intend to use it in the future. Everyone was pleased with REACH's effort to bring Kenyans into the work, leaving behind not only a report but also the human resources to do this type of work locally.

C. Quality, Appropriateness, Timing

On the products, both the mission and the Kenyatta National Hospital were pleased with the work done for Kenyatta National Hospital. Everyone we talked to felt that the quality of the work was high, that it met the need of the Board of Directors of Kenyatta National Hospital to better define its problems and ways to proceed in solving the problems. The natural question is whether the Kenyatta National Hospital Board would have undertaken the management study if REACH had not been involved, but the hospital officials stated that they had neither the capacity nor the financial resources to undertake the work. By all accounts, REACH's involvement considerably speeded up the time frame of solving the hospital's problems, and the timing of the assistance is viewed as a godsend. On the negative side, there was a four month delay (from June to September 1988) in receiving the final "blueprint for action," which put a halt to the Kenyatta National Hospital Board's momentum.

D. Health Care Financing Strategy

The evaluation team arrived in Kenya with some misgivings about such a large commitment of REACH's contractual resources (nearly

\$800,000) to a hospital management study and a facility inventory for Nairobi designed to assess whether Nairobi facilities could absorb patients turned away from the hospital. It was clear from our conversations with both Kenyan health officials and Kenyan members of the research team that the pressing need in Kenya was for information on how to justify and proceed with cost recovery. Some "how to" and "why should we do it" information consists of the following: information from consumers on how much they spend for health care, where they get it, what role the availability of free government services plays in their decisions, and the subsidy patterns implicit in the government's delivery of free services. Knowing about demand and expenditure patterns would allow government officials to understand better the intended beneficiaries' evaluation of the value of their efforts. A second set of issues is addressed by user fee experiments - methods of charging, collecting fees and accounting for them, methods of exempting the poor, and methods of repeatedly adjusting charges to meet costs. Although the Nairobi Area Study will begin to address some of these issues, its main purpose was to assess the ability of the Nairobi area health system to accommodate the closing down of the Kenyatta National Hospital outpatient ward.

After a year of effort and nearly \$800,000, REACH has not provided information necessary to upgrade and reequip Kenyatta National Hospital and the Nairobi area government health system (the likely content of a World Bank loan), but we remain concerned that as a long term REACH intervention, an opportunity to help the government move forward politically and practically with cost sharing has not been exploited to its fullest. In practical terms, health planners will decide how to invest project resources against standards for a perfect hospital or health center, but that does not assure that the facilities will be used, that the equipment will be maintained, that subsidies will be better targeted to the poor, that people might be better served by investing in NGO or private sector facilities, and so on. We understand that our impressions will (and should!) be discounted somewhat because of the brevity of our contact with the project, but given the amount of resources consumed by this activity, we hope our concerns will be carefully considered.

E. Kenyatta National Hospital Study

Looking at the Kenyatta National Hospital Study by itself, there were both management and economic issues that required analysis. The study provided an even-handed analysis of most of the issues, but we would like to point out some of the economic components of the study that have general applicability in the generic policy problem of privatizing or "parastatalizing" public hospitals.

1. How to get the hospital off the Ministry of Health budget

The future relationship between Kenyatta National Hospital and the national treasury in both the annual budget process and in making investment decisions is unclear. Little thought has been given to what that relationship should look like and the period over which Kenyatta National Hospital is to be weaned from dependence on the Treasury. Hospital officials do not view themselves as restricted in any way from government funds, which is presumably the main point of making the hospital a state corporation. They expect the budget process to remain the same as it is now. They will be able to receive investment funds directly from donors as well as from the development budget, and they will collect user fees. In the near future, it is likely that Kenyatta National Hospital will absorb even more funds than ever before, so the issue of its relationship with the central government requires immediate attention. This is a general problem in health care financing in developing countries because the intention is to limit the ability of hospitals to absorb Ministry of Health funds, not to open new avenues for them to supplement their budgets.

2. Greater efficiency versus cost recovery

The relative importance of cost reduction and revenue enhancement in making Kenyatta National Hospital work is not well understood. Understanding this issue is vital for the Kenyatta National Hospital board, the government, and the donors. Most people we met in Kenya argued that cost reduction was more important to the system than revenue generation. As the argument goes, if the system could be made more efficient, charges would not have to be introduced or could be kept very low. Michael Mills at the World Bank Resident Mission said directly that he felt much more money could be saved through cost reductions/greater efficiency than could be collected through user charges. There is an essential fallacy in this argument, and it should ideally have been pointed out in the Kenyatta National Hospital report. In that hospital, average length of stay approaches 25 days, and the bed occupancy rate is over 100 percent. Suppose the length of stay were reduced by half (thus cutting unit costs, say, by half). Given certain cost assumptions, if bed occupancy rates do not fall to 50 percent, the hospital's total costs must rise even as unit costs fall. There will be upward pressure on the government's subsidy due to the lower unit costs! As long as hospital services are free, as the hospital becomes more efficient and provides a higher quality of care, total costs will rise because more patients will use it. In short, there is no way to get around the paramount importance of raising additional revenue, and we believe that REACH should have boldly made the point in the Kenyatta National Hospital study. It is impossible to overemphasize this point for Kenya because there is such broad agreement that greater internal efficiency will save the government from making difficult revenue-side decisions. It will not.

3. Closing the outpatient clinic

One element of the Kenyatta National Hospital "parastatalization" strategy was the so-called closing of the adult outpatient department, which previously served over 2,000 people a day. Managers -- and REACH's analysts -- concurred that the outpatient service was an inappropriate function for this tertiary facility, and it is now barred to anyone without a referral from a lower level facility. In economic jargon, the management attempted to ration a service that was already in excess demand. An economist would expect that people would make an enormous effort to circumvent the closing. That seems to be the case. The Kenyatta National Hospital found it impossible to close the child outpatient department, they still accept emergency cases (so patients try to redefine their problems as emergencies), and a market is apparently developing for letters of referral. Referrals are not hard to get under any circumstances because lower level public facilities often cannot adequately treat their patients. The result of the "closing" has therefore been to add another hurdle for patients seeking care, with no reallocation of money and personnel to lower level facilities.

An obvious alternative is to charge a relatively high price for outpatient services at Kenyatta National Hospital. Under that strategy people retain the option of using Kenyatta National Hospital, the hospital gets revenue, and those who do not want to pay retain the option of using free services from other sources. While we are advised that the Board considered and rejected the possibility of cost sharing as an alternative to restricting access to the outpatient department, we believe that the hospital study should have contained a clear analysis of the economic consequences of that option/decision.

F. Nairobi Area Study

The follow-on project, the Nairobi Area Study, was precipitated by the Kenyatta National Hospital outpatient department closing (which should never have happened). Its intention, as stated earlier, was to discover whether other facilities could absorb the outpatients previously seen at Kenyatta National Hospital. We asked the director of city medical services whether his system could absorb the patients. He said they could absorb another 1,000 clients a day with little problem. His concern was that Kenyatta National Hospital was giving him the clients but not any of its outpatient budget or personnel. The \$400,000 Nairobi Area Study apparently confirms his point -- there is plenty of capacity in the Nairobi area to absorb the patients in the public, private, and non-government organization sectors. Of course many of those patients will not materialize because they have found ways to continue to use Kenyatta National Hospital. The extremely short time frame and narrow scope of work for the Nairobi Area Study was dictated by the pressing problem of answering this question.

The study design was limited to the supply side -- inventorying facilities and interviewing patients at the facilities -- which provides a good (but not too useful) picture of the facilities and an inaccurate picture of the patients (the survey captures only patients who have chosen a particular provider, so the patient sample is not randomly drawn, and the "nonrandomness" is of unknown dimensions). Had REACH brought to the analysis a more strategic economic perspective, it is reasonable to expect that it would have succeeded in undertaking a demand-side or consumer-oriented piece of research rather than the supply-side strategy it chose. It is our impression from our discussions with the consumers of both the Kenyatta National Hospital and Nairobi Area Study research that they depended heavily on REACH to advise them on these technical issues, but it is equally clear that REACH was hesitant to direct the research away from the narrow supply-side focus dictated by the World Bank's information needs for re-equipping the government's health facilities. As should be obvious, we believe the movement toward cost sharing in Kenya requires a strong baseline of demand-side information.

G. REACH's Future Involvement

The provincial and district study poses exactly the same issues once again. Its purpose is to find the scope for making secondary hospitals independent and to understand better the provider network in rural areas. The work could easily become the Kenyatta National Hospital and Nairobi Area Study activities writ national although the AID mission has already taken steps to broaden the scope. The budget and scope of work provided by the AID mission are adequate to support the collection of supply-side data but also the demand-type information the evaluation team sees as required in Kenya. But it will require strong technical leadership from a REACH team that understands the underlying policy problems that should be addressed by the study. Yet we are still not clear as to the purpose of the study. A facility survey is appropriate as the analytical base for re-equipping public hospitals. If the focus is on developing an informational base for cost sharing and health financing, it would take a different form, focusing on demand rather than the supply of services. The purpose should be clarified prior to REACH involvement.

H. Insurance

REACH has not identified Kenya's national health insurance fund as a potential policy tool which the government could use as an element in a cost sharing program to ameliorate both the political and economic impact of the policy change. Currently the insurance system pays only for care in private facilities. The World Bank recently sponsored a visit of Kenyan officials to Mexico to study its social insurance system. Dr. Acholla of the Nairobi City Commission, one of the participants, was impressed by how much of Mexico's health costs were financed by the system.

I. Summary of Issues

In discussing these issues in such detail, it is easy to forget the general concerns that make them so important.

1. Kenya now realizes that its national health care system is not functioning well. It is under pressure because of its own budget constraints but also from the International Monetary Fund and the World Bank to solve its health financing problems.

2. Kenya has been encouraged by the World Bank to make Kenyatta National Hospital a parastatal, which is the source of its interest in the Kenyatta National Hospital management study. But the World Bank appears to be pushing a cost-efficiency strategy rather than a revenue-generating strategy as its contribution to health financing in Kenya. It is planning to re-equip and upgrade hospitals, which will provide a beautiful public system on paper that may or may not work and may or may not change existing demand patterns. Two things are certain: the strategy will create a more costly system and will mean huge investments in hospitals. We do not believe that AID and REACH should blindly follow this strategy and that they would serve everyone better if they help to open the policy discussion to include a broader set of issues.

J. Conclusion

The people who are thinking through these problems and options, both on the Kenyan and donor sides, are for the most part health administrators and politicians. It is a politically sensitive and difficult area. REACH is widely viewed as the main source of economic information. Yet REACH's guidance has been extremely narrow in scope and has primarily focused on supply-side or facility issues. Because the audience is new to these concerns, it does not have a clear understanding of the types of information it needs to know. When administrators are forced to act in setting economic policies (for Kenyatta National Hospital, setting its fee schedule, closing the outpatient department, or negotiating its budget with the Ministry of Health), they have proceeded without much economic guidance. While the providers may end up with fancy new equipment, it is problematic whether patients will be served better, and whether the resulting health system can be sustained, including the primary health component AID is most interested in.

People Visited In Kenya

Linda Lankenau, USAID
David Oot, USAID

Mr. Muriuki, KNH, Chairman of the Board
Mr. Noreh, KNH, Deputy of Planning Unit; worked on KNH study

Professor Ogada, MOH, Director of Health Services, and staff
Dr. Maneno, MOH, Director of Medical Services

Dr. Acholla, Nairobi City Commission, Medical Officer for Public Health

Peter Bjergaard, Kenya EPI, Division of Family Health

Dr. Wangombe, REACH
Mr. Ikiara, REACH
Ms. Kariuki, REACH
Dr. Germano Mwabu, REACH
Cathy Overholt, REACH

Michael Mills, IBRD
Dr. Sebina, IBRD

ANNEX 8

Zaire Trip Report

Charles Griffin
Alfred White

October 1988

ANNEX 8

Zaire Trip Report

A. Projects

REACH has done three studies in Kenya:

- o Z1: Descriptive study of cost recovery experience in ten health zones. This study was followed up in 1987 by "Z1.5," an update to show how zones were adjusting to runaway inflation;
- o Z2: Financial accounting system for health zones; and
- o Z3: Demand study with health zone planning/cost recovery model.

Z1 is finished; Z2 is finished but not implemented in any health zones yet; data collection and frequency tables for Z3 are finished; the Z3 health zone planning/cost recovery model will be presented in Zaire by the end of 1988. In Zaire, REACH is essentially ABT Associates, the subcontractor which has done all of the work. The people involved for ABT are Marty Makinen, Ricardo Bitran, and Taryn Vian.

B. Process and Administration

As in Kenya, REACH was praised by everyone in Zaire for the choice of consultants. In following Marty Makinen's trail through AID regional offices in Washington and now in Africa, it is clear that he does an excellent job of communication with nonspecialist audiences, and he is careful to leave a written record of his thoughts and activities before he leaves a country. Bitran and Vian are also well respected in Zaire.

C. Quality, Appropriateness, Timing

The health zone study (Z1) provided the eye-opening conclusion that clinics in operating health zones -- located both in urban and isolated rural areas -- could and did recover most of their recurrent costs. Up to that point, no one really knew on a systematic basis what the health zones were doing -- whether they were a success or failure in terms of delivering adequate services and how they were operating financially. In addition to recovering costs, in comparison to other countries as poor as Zaire and many that are much better off, the health zones studied were doing an extraordinary job of delivering these services. The health zone study showed the great value of simple descriptive studies of successful experiments; it had a huge effect on

both Zaire's health establishment and people in other countries who read it. The other activities (Z2 and Z3) are more difficult to appraise because only bits and pieces have been seen. For Z2, we read two pieces by Taryn Vian, one explaining the value of a management financial information system and another co-authored piece describing accounting systems in a sample of health zones. They are of unknown practical use, but the second paper concludes that an accounting manual should be developed for the health zones, but it seems that such a manual would be a likely output of this activity. Implementation of single entry accounting is underway by SANRU. For Z3 we saw the questionnaires, description of the sampling methods, frequency tables, and a short descriptive draft of some of the survey results. We saw no analysis, nor did we see a description of the health financing model; these items will be forthcoming. We question the survey design because only two health zones were chosen for sampling, so there will be almost no variation in the cross section on some of the important economic variables, especially prices and level of operation of the health zone.

The only criticism of these studies that we heard is the same one we heard in Kenya: difficulty in getting closure. The English version of the health zone study was presented to great acclaim and interest in Kinshasa, but the French translation was not received until nearly eight months later, long after the enthusiasm generated by the oral presentation had dissipated. Follow through on the accounting system has been spotty. Z3 appears to have had little local input; the data was taken back to the U.S., and the analysis will be done there.

D. Health Care Financing Strategy

The evaluation team arrived in Zaire with the hypothesis, derived from a close reading of the health zones study, that REACH's Z2 and Z3 studies were aimed at fairly low priority topics from a health financing standpoint. The reason for our doubts was that the health zone study (Z1) provided tantalizing bits of information suggesting the need for insurance (hospitals were accumulating bad debt and were least successful of the institutions in covering costs; two hospitals were experimenting with prepayment schemes on their own), totally unexpected success in getting people to pay for preventive services and in cross-subsidizing those services, extreme difficulty paying for central administrative support, many nicely exploited opportunities and many other unexploited opportunities for price discrimination to increase revenues, a big question about whether the lack of means testing criteria in many zones prevented poor people from receiving care, the role of parallel providers, and a very different expenditure mix (salary versus other recurrent costs) relative to that found in government health facilities in the developing world. Our feeling was that, given this long list of issues crucial to health care financing that could be examined in Zaire and nowhere else (because nowhere else is cost recovery practiced so completely in the government system, especially for primary health services), an accounting system and a financial planning model were low priorities. Furthermore, neither

would help zones raise more money, their pressing need, except in the most indirect way. Every zone in the study is by trial and error collecting money, paying bills, and somehow surviving; an accounting and management information system may improve their performance at the margin but will not assure their survival. For survival, other issues must be addressed. A few are listed below.

1. Inadequate support from the central government

In Zaire, the MOH has for all practical purposes stopped paying for its system of curative and preventive care. Budget allocations even for hospitals last at most two months, according to some of the people we talked to. Others told us of horror stories in which patients requiring surgery have to take everything necessary for the surgery with them to the hospital, including blades. The government barely pays salaries for its personnel, who must find ways to supplement them. The health zones receive some sporadic salary subsidies from the central government but little in the way of general support for administrative costs, vector control, or administrative services. On the other hand, Zaire has a law requiring all employers to provide health care for their employees and the employees' families. To provide this benefit for its own employees and those of state enterprises, it spends as much as it spends on health for the rest of the population. As a consequence we observe the perverse phenomenon that the government is providing free health care for its civil servants but -- for all practical purposes -- nothing for anyone else. In fact, the poorest people are required to pay full cost for everything; those in the formal sector get care for free¹. Note we are not arguing against user fees and the decentralization of the Zairian system. We are arguing that through neglect or design, this has been done only for the poorest segments of society, and the government has forsaken some essential aspects of its involvement in the health sector.

These essential pieces of involvement are the provision of public goods in health and regulatory quality control. The health zones have proved that people will pay for preventive services, but they still are characterized by some public goods aspects (or externalities) which have led to the realization by the zones that they must be subsidized. The method the zones have developed to subsidize preventive care is to tax curative care. In order to tax curative care, they must control price in the zones, and they try to do this by

¹ It could be argued that people in the formal sector pay for their health care because their wages are reduced by the amount of the benefit. Surely there is some cost shifting to employees by the employer even if it is not complete. However, this argument is beside the point that those who are best off in the society -- in general, government employees -- are provided with over half of the government's spending on health care.

driving out private (or parallel) providers. This effort is completely understandable, but the public finance question is whether sick people should be taxed (and in the process, the supply of health care available in the zones restricted) in order to raise money to subsidize a service that ought to be subsidized from central government funds. In order to subsidize preventive services, vector control, regulatory activities, and health education, the government must maintain an administrative presence in each zone. Because of inadequate contributions from general tax revenues for these administrative activities, SANRU and the health zones are for all practical purposes beating their organizational heads against a brick wall trying to find ways to finance them from their only source of revenue -- a tax on curative care. The result of these problems is that only the richest zones, those which can depend heavily on contracts with private firms, and those most successful in restricting parallel providers and taxing curative services are able to adequately provide these "public" functions. This is a classic public finance problem that must be solved above the level of the health zone; when solved it will improve both the equity and economic efficiency of their operations. In nontechnical language, it will make life much easier for SANRU and the health zones. REACH has not identified this over-arching problem. The accounting system and health finance model are intended to help central administrators get better control over the zones so they can solve the problems internally. Yet the problems are caused by factors external to the zones.

2. Self insurance by firms

The requirement of private firms to provide health care for their employees is problem in all of francophone Africa, and the reasons are clear in Zaire. No matter what the size of the firm, 1 employee or 10,000, the employer must provide health services to the employee and his/her family. Larger firms operate their own clinics or hospitals (which, by the way, must also serve anyone living in the area), but more generally, a single firm is much too small a risk pool to pay for the care. Bill Bertrand at the School of Public Health stated that fully half of his personnel costs are for employee health services, and he (unlike most employers) has ready access to university facilities. A small firm can handle health care costs not much better than an individual. Catastrophic costs for inpatient care that cannot be paid are simply not paid. We discovered two examples of this problem. At the Sona Bata health zone reference hospital, the *medecin de chef* told us that half of his bad debt, or 2 million Zaires², was owed by enterprises. He sees little hope of recovering it and is

² This amount is about US\$10,000, which is approximately the 1985 annual average budget for the reference hospitals in the ten zone study. Given that the hospital's bad debt is twice this amount, increasing its ability to recover the debt would make an enormous contribution to its (and the zone's) financial stability.

trapped by the firms because both he and they know that he cannot stop providing care to their employees. A team of insurance specialists working at AID on a financial plan for a new hospital had developed a benefit package to market to firms. This package was basically a prepaid contract for outpatient care; they felt that they could not include catastrophic inpatient coverage because the hospital was too small an entity to absorb the risk of such a plan. The consequence is that the firms and the hospitals cannot insure themselves for the problem most easily insured against -- catastrophic care -- and this is simply because risk pools are too small. The extraordinary element of this environment is that everything is in place for insurance: a requirement that employees be covered, an incentive for firms to share risk and buy something cheaper than is now available, and an obvious need for hospitals to eliminate bad debt. Again, here is a problem of health finance that lies well above the level of the health zones but is making their operation difficult. Resolving the risk-sharing problem can improve both the efficiency and equity of the system. REACH provided no advice to the SANRU staff on this issue, however.

3. Public goods provision

This is a particularly troublesome area. As is clear from the foregoing, the MOH has not only withdrawn from curative services, it has also retreated from vector control and other public health interventions. In Sona Bata, for example, about 30 percent of the patients this year have suffered from malaria. Most of the other illnesses seen at the hospital were typical of an LDC -- many infectious and parasitic diseases that are preventable. If the government provided effective vector control and public health education, it might eliminate some personal expenditures for curative care, as well as much of the suffering of the people seen by health zone facilities. Because malaria is primarily a killer of babies, effective vector control would have its main impact on the infant mortality rate. Beyond this issue, we wonder to what extent health zone operations are dependent on the sale of chloroquine and other anti-malarial drugs. The issue of who is paying for the curative system and how it is supported is thus closely intertwined with the provision of public health goods and is an important financing question.

We had no inkling before arriving in Zaire of these structural problems from reviewing the REACH documents. Given the magnitude of the problems, the fact that Zaire is so far ahead of the rest of the developing world in so many important ways (especially cost recovery and decentralization), it is surprising that in one of its long term intervention countries REACH could have chosen accounting and financial model issues for research under Z2 and Z3. That is not to say that REACH's involvement will not be useful -- there is clearly a need for better accounting systems -- but it does little to solve the main health economic (or finance) problems facing the health zones. Possibly more important, the REACH involvement could result in

increasing centralization within the zones, increasing planning, and possibly eliminating some private sector establishments, which would be a great tragedy in the sense that decentralization and multiple providers are a positive result of the Ministry of Health's retreat from the health sector.

E. REACH's Future Involvement

The need is clear for strategic analysis of the Zairian health sector above the level of the Health zones. Zaire needs facts about insurance and public finance options. The same issues are important at the zone level, and more operational assistance is needed on economic issues, not merely accounting and management problems.

F. Conclusion

REACH did lay out a number of options for long term follow-on activities after completing the initial survey of health financing systems in Zaire. The list was long and did not attempt to give a sense of priority. As the experts in health finance, it was appropriate for REACH to advise on what the most important next steps should be. A menu that prioritizes options for policy-makers is essential; cost or management options are usually the most obvious and direct needs for people in the field but they do not necessarily contribute to resolution of economic problems. REACH's assistance was highly valued by the mission and SANRU. We only wish that REACH had felt inclined to take more leadership in helping everyone to understand the technical economic issues.

People visited in Zaire

Dennis Chandler, USAID Mission Director
Rhonda Smith, USAID Project Officer for SANRU, REACH monitor
Lois Bradshaw, USAID Acting HPN Office Chief and Senior Population
Office

Dr. Duale Sambe, SANRU project director
Dr. Kalambay Kalula, GOZ Representative to SANRU
Dr. Frank Baer, SANRU project manager
Citoyen Munkatu Mpese, SANRU Chief of Operations Research
Citoyen Manunga Mapele, SANRU Accountant
Steve Brewster, SANRU Chief of Administration Division

Dr. Bill Bertrand, School of Public Health

Dr. Minuku, Medicin de Chef in Sona Bata Health Zone

ANNEX 9

Indonesia Trip Report

Glenn Patterson

September 19-24, 1988

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ANNEX 9

Indonesia Trip Report

Glenn Patterson
September 19-24, 1988

I. Introduction

As part of the evaluation of the REACH project, a field visit was made to Indonesia to review REACH activities in that country over the past two years. Discussions were held with officials of USAID, the Indonesian Ministry of Health, Indonesian and American private sector consultants aware of REACH activities, and WHO advisors in the country. (A list of persons interviewed is attached).

USAID Indonesia has one of the largest health programs of any AID Mission, comprising five active projects with an additional project planned for Child Survival in 1990. It is also a country in which the WHO, UNICEF, the World Bank and a variety of PVO's are active in the health field. The Ministry of Health has committed itself to an energetic immunization program, and has determined to initiate a variety of experimental activities to contain health care costs and to broaden responsibility for health care financing.

The Mission's involvement with REACH began in early 1986 with a request for consultants to work with the Bureau of Planning of the Ministry of Health on preparatory studies leading to a Mission Health Sector Financing Project Paper. In addition, the Mission requested that REACH assist the insurance company, Tugu Manderi, to prepare a business proposal for initiating an HMO scheme with the petroleum parastatal Pertamina. REACH short-term assistance was also provided in immunization in the 1987/1988 period to develop part of the Mission's Child Survival Initiative Paper, to assist PVO's involved in EPI and to conduct province-specific surveys requested by the Ministry of Health.

A list of REACH activities in both Immunization and Health Care Financing is as follows:

Health Care Financing:

- Health care financing issues in Indonesia (Dr. Binol, Dr. Hunter)
- An information component for the proposed USAID private sector Health and Family Planning Project (Dr. Berman)
- Current status and future prospect for health insurance and pre-paid delivery systems in Indonesia (Dr. Torrens)
- Increasing efficiency of health services in Indonesia (Dr. Doodoh, Dr. Stevens)
- Economic analysis for health sector financing project (Dr. Stevens)

- HMO Business Plan for Tugu Mandiri (REACH team)

Immunization Program:

- Neonatal tetanus mortality survey in Aceh (Dr. Arnold and Birch)
- Developing of infant mortality survey in South Sumatera (Dr. Pollock)
- Draft report of results of infant mortality survey in South Sumatera (Dr. Pollock)
- Development of EPI component of child survival paper
- Consultant services to CARE and Project Concern International in EPI activities.

II. Observations and Conclusions:

A. Immunization

- Although the Mission has an ongoing National Immunization project through which some technical assistance can be provided, the use of the REACH contracting mechanism is far more convenient for the Mission and GOI for providing short-term services to conduct surveys, provide evaluations, etc.

- Both Mission and Ministry were highly pleased with the quality of work of the consultants, and the Ministry stated that the results of their work had been put to immediate use in its ongoing EPI program. Separate review of Dr. Pollock's reports and Dr. Arnold's survey confirmed the technical quality of those activities. UNICEF and WHO, in addition to the Mission and Ministry, regard REACH's intervention as having been valuable in the development of provincial immunization strategies.

- Both Mission and Ministry stated that the Pollack and Arnold reports were left in preliminary form and that apparently the present ceiling on buy-ins prevented the financing of additional time necessary to remove some discrepancies in numbers (Pollack report) or to adequately discuss methodology used (Arnold report). REACH EPI consultants were particularly effective in working with Indonesian counterparts.

- REACH backstopping on the EPI side was regarded as excellent and the visit and responsiveness of Pierre Claquin was particularly appreciated.

- If additional assistance was available through REACH, the Mission and Ministry would be particularly interested in a buy-in of approximately \$1 million for short-term consultancies in the preparation of NNT strategies for each province, studies related to a more comprehensive urban strategy, help in computerization and information systems, and mass media campaigns and social marketing. The ceiling on buy-ins was particularly irksome to the GOI, which did

not understand its rationale.

- In summary, the REACH mechanism was considered an extremely convenient mechanism, and without it USAID involvement in the EPI program will, of necessity, be more limited. Some of the gap will be filled by drawing on GOI funds, the CHIPPS project, some UNICEF assistance, but these are considered an inadequate substitute for the REACH project. The quality and administration of REACH activities were highly rated by everyone with whom REACH was involved.

B. Health Care Financing

- Under this component the Mission proposed a series of 18 studies related to the development of a Mission Health Care Financing Project to lay out the strategic framework for a five-year program. These studies were to examine priority areas of intervention, the policy framework, possible programs related to specific geographical regions, etc. A particularly important study in the eyes of the Mission was the one related to Tugu Manderi to develop a business proposal for creating an insurance scheme for the petroleum parastatal, Pertamina.

- The quality and usefulness of most of these studies was excellent. This was particularly true of Dr. Hunters' initial review of project development. It was also true of the economic analysis of the project by Dr. Stevens, as well as his work on increasing efficiency in the Indonesian Health Services. They were instrumental in developing the Health Care Financing Project which has since been approved by AID and initiated. The individual consultants for the most part related well to their Indonesian counterpart.

- Far less satisfactory, according to the Mission, the Indonesian director of Tugu Manderi, and an individual consultant there at the time, was the work of the team related to Pertamina. According to the Mission, the team wanted to renegotiate the scope of work of the contract to promote the commercial interests of one of the consultants. The relationship soured on all sides and the final report is considered to be unresponsive by the Mission and the Indonesian firm with whom they were working.

- The Mission stated that they repeatedly requested a visit from the Director of REACH to help resolve the issue, but were refused. The newly-named CTO was sent along with the Deputy Director of REACH (and head of the Health Care Financing element of the project). According to the Mission, the latter, (since resigned from REACH), was also interested in promoting the commercial interests of one of the team members. The CTO, new to the job, tried to change the scope of work to one unacceptable either to the Mission or to the GOI.

- The Mission has since signed its Health Care Financing Project with the GOI and will finance all additional consultancies in this field through that mechanism, using an existing contract with

ISTI. No additional REACH assistance is desired, although the Mission regrets that the convenience of the REACH contracting mechanism for buy-in under their project is not available to them.

C. Conclusions:

1. Consistent with other observations, REACH leadership and performance has differed with respect to EPI and HCF. In the words of the Mission, it is sometimes like dealing with two different organizations. In EPI, the quality of REACH consultants and leadership have been outstanding. In the case of Health Care Financing REACH has also provided outstanding individual consultants, but has suffered seriously from inadequate leadership due partially to gaps in staffing.

2. The demand for REACH services in Health Care Financing is almost unlimited. Inadequate attention on the part of AID/W as well as REACH has been given to defining appropriate priorities and limitations (i.e., giving priority to cost recovery or to cost-containment interventions, which are likely to lead to additional activities in revenue generation), and to the dissemination of information on identifying the most promising interventions.

3. The buy-in ceiling as now applied in many ways serves to defeat the very purpose of the project. Discussions should be held with the Contracting Office and the General Counsel to determine the possibility of issuing an RFP in a form which foresees virtually unlimited buy-in for a specified period of time.

4. AID/W's frequent turnover of the CTO has not helped REACH effectiveness.

5. As a whole, REACH services have made a limited but very valuable contribution in Indonesia.

LIST OF PERSONS INTERVIEWED

A. USAID

Dr. Manuel Voulgaropoulos
Ms. Joy Riggs Perla
Ms. Katie McDonald

B. Indonesian Ministry of Health

Bureau of Planning

Dr. Soekarjono
Mr. Azis Lasida
Dr. Kartini Binol

Dr. Paramita
Dr. Ridwan Malik

Directorate of Health

Dr. Gunawan
Dr. Jones (CDC)
Dr. Rosenberg (CDC)

C. Private Sector

Mr. Rosmin Djaafar, Tugu Manderi

D. WHO

Dr. Robert Bernstein

E. Others

Mr. Thomas D'Agnes, ISTI

ANNEX 10

Indonesia Trip Report

Jim Mize

September 18-21, 1988

ANNEX 10

Indonesia Trip Report

Jim Mize

Dates of Visit: September 18-21, 1988

Persons contacted: Joy Riggs Perla, Katie McDonald, USAID; Drs. Soekerjono,, Paremita, Binol, and Malik, Indonesia Ministry of Health; Dr. Voulgaropoulos, USAID; Drs. Gunawan, Rosenberg and Warren Jones, Indonesia EPI; Dr. Berstein, WHO; and Tom D'Agnes, Indonesia Ministry of Health.

Components Reviewed:

A. EPI

1) REACH's main role has been in the neonatal tetanus surveys done by Richard Arnold, Donna Brisch and Marjorie Pollack. These individuals were highly qualified and well liked. There were some questions about the survey design, since it assessed NNT in Aceh and Sumatera Provinces using different cluster surveys and extrapolate the results to both following vaccination campaigns. The change in NNTMR was believed to have dropped from 32.1/1000 to 4.9/1000 because of this intervention and because of the training given to traditional birth attendants. Generally, the MOH was very satisfied with this project and among other things, found that involving religious leaders in the vaccination campaign increased public acceptance and demand. They are now convinced that mass campaigns for tetanus vaccination are more cost effective than trying to raise coverage through primary health care.

The results of this information have been used in other provinces within Indonesia and additional "crash" vaccination programs are planned. Pollack's work was extremely useful in convincing various provinces to follow this AID strategy for preventing neonatal tetanus.

Pollack's work is perceived as excellent but unfortunately is still in draft form. She was asked to attend a conference during the time allotted to finish the survey and was unable to complete the work. Requests for an extension of her contract to finish the survey were denied and the report remains in draft form. The information is being used but it is still referenced as "preliminary" because of the rough data.,

While generally acknowledged as excellent, Arnold's work is still in the form of a trip report and supposedly has never been submitted in final form.

2) A less obvious but vital benefit of the REACH project has been the transfer of knowledge from the technical advisors to the host country nationals. This has occurred during particular projects during which the nationals are exposed to the design, methodology and analysis of the data.

3) REACH's role as a supplement to the EPI program in Indonesia has been valuable because of the contracting mechanism for short term technical assistance otherwise available. There is limited internal capacity to draw from and the Ministry of Health has difficulty identifying and acquiring outside assistance without the REACH contract.

4) Indonesia would like a higher buy-in ceiling to develop an urban strategy for EPI and management information systems for the provinces. This is believed possible if the projects become separate, which was generally agreed to be desirable. Short term assistance may be necessary to develop the urban strategy for immunization and management information systems at the province level. Surveillance systems (in anticipation of the disease eradication goals) and an analysis of missed opportunities for immunization are also needed and are unmet needs. Indonesia was prepared for a \$1 million "buy-in" to address these needs but could not because of budget ceiling limitations.

5) REACH's assistance in the installation of EPI IIS has been important, since it provided the means to summarize doses administered data from all provinces into the standard report format for the yearly WHO report. The standard report form analyzed doses administered information by dose number, drop-out rate, etc., and provides the only rough estimates of coverage among the target population. Management information systems development is still needed at the province level.

6) REACH has not served as a bridge between WHO, UNICEF, and AID in Indonesia as generally believed. Collaboration between these organizations occurs only when problems arise but not on a systematic basis because of the REACH EPI contract.

B. HCF

Indonesia's experience with Health Care Financing under the REACH contract has ranged from good to awful. Initially, some of the consultants were negotiating privately with the Ministry of Health for their own personal contracts to assist with HCF. The nationals believe AID sides with the contractor more often than with them, given disputes or disagreements. Finally, there was general agreement that JSI was prepared to follow its own HCF agenda regardless of the information produced from 17 in-country feasibility studies that indicated other approaches were in order. The MOH does not believe REACH has anything else to contribute to HCF in Indonesia and will resolve their future needs internally.