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70697

Mid-Term Evaluation

The Center for International
Health Information

Project No. 936-5951.13

January 1991

Contract No. DPE-5951-Z-00-8004-00

by

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January 1991

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GLOSSARY

ACSI	Activity Codes/Special Interest
A.I.D.	Agency for International Development
A.I.D./W	Agency for International Development, Washington D.C. based offices
AIDS/HIV	S&T/H Division of Acquired Immunodeficiency Syndrome - Human Immunodeficiency Virus
AIDSTECH	Technical Support for AIDS Project
AFR	Africa
AR	Applied Research Division (of S&T/H)
CA	Cooperating Agencies
CCCD	Control of Communicable Childhood Disease Project
CDC	Centers for Disease Control
CDIE	Center for Development Information and Evaluation
CIHI	Center for International Health Information
CS	Child Survival
CTO	Cognizant Technical Officer
DHS	Demographic and Health Surveys
Front Office	Senior S&T/H management staff: Director, Deputy Director, Program Unit Staff and, Special Projects Unit Staff
FVA	Bureau for Food and Voluntary Assistance
FY	Fiscal Year
HCSP	Health and Child Survival Projects Questionnaire
HIS	Health Information System
HP	Hewlett Packard

HPD	Health Projects Database
HSD	Health Statistics Database
ISTI	International Science and Technology Institute, Inc.
LAC	Latin America and Caribbean
LAN	Local Area Network
LOP	Life of Project
MAC	MacIntosh computer
MIS	Management Information System
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PDPR	Office of Program Development and Policy Review
PRB	Population Review Board
PRITECH	Technology for Primary Health Care Project
PPC	Bureau for Program and Policy Coordination (A.I.D.)
PVO	Private Voluntary Organization
S&T/H	Bureau for Science and Technology, Office of Health
S&T/Pop	Bureau for Science and Technology, Office of Population
TAACS	Technical Assistance in AIDS and Child Survival
TAC	Technical Advisory Committee
U.N.	United Nations
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Overview

During the two and one-half years of the Center for International Health Information (CIHI) project, a quality program of health information has been established. This $6 million, five-year project is a follow-on to the Health Information System (HIS) project and is being carried out by the International Science and Technology Institute, Inc (ISTI). The project has been supported by $2.6 million in funding from the Agency for International Development's (A.I.D.) Bureau for Science and Technology, Office of Health (S&T/H), and additional funding has been provided through 15 buy-ins totalling nearly $725,000 from Regional Bureaus, several offices in Central Bureaus, and one USAID Mission.

The project covers a number of related, but diverse activities including maintaining and expanding two large, complex databases (on health projects and health statistics) and carrying out a program of analysis and dissemination with a much used information service and the highly praised Child Survival Report to Congress.

Project Accomplishments

CIHI has developed and expanded the Health Projects Database (HPD). Most users have found the information contained in the database to be of high quality and comprehensive for health and child survival accounts.

The annual Health and Child Survival Projects Questionnaire (HCSP) has been developed and administered by the project for three years. The contractor has demonstrated great flexibility and care in responding to the many demands on the questionnaire. Consequently, the current design satisfies a wide range of needs for health projects and statistical data. At the same time, the questionnaire has expanded considerably.

CIHI has also been very responsive in providing assistance to A.I.D.'s Bureau for Planning and Policy Coordination (PPC) in the setting up the Agency's Activity Codes/Special Interest (ACSI) system. This system should eventually satisfy the need for most of the obligation data on health and child survival programs.

In addition to the HPD, CIHI has expanded and maintains the Health Statistics Database (HSD). This database includes an extensive array of indicators on health, child survival, nutrition, infant feeding and breastfeeding, AIDS/HIV, demography, and socioeconomic status.

Both the HPD and HSD are maintained as computerized databases which has enabled CIHI to respond to a large number of requests for information.

Of eight case studies, three have been completed and two others are in progress. Two of these five have been supported through buy-ins.

By all accounts, CIHI provides an extremely useful, quality information service to many A.I.D. as well as non-A.I.D. users.

An extensive number of standard reports on trends in funding as well as health and child survival indicators has been prepared. These have been distributed widely within A.I.D. and among S&T/Health Cooperating Agencies (CAs).

A Child Survival Report to Congress has been prepared for each year of the past three years (1988, 1989 and 1990), in addition to two others produced under the prior contract. This report is the centerpiece of CIHI's dissemination program. The report is widely distributed and broadly praised.

CIHI also prepared the AIDS/HIV Report to Congress in 1990. While another contractor will prepare the report in the future, the high quality of the report has been cited by many within and outside A.I.D.

A series of diverse, pilot activities have been carried out in the first half of the project. Through these activities, assistance has been provided to USAID missions and a variety of offices in AID/W

In summary, the contractor has performed very well in carrying out the contract's scope of work. In addition, the project has been extremely responsive to the diverse and increasing demands placed on it by A.I.D. However, the contractor's very responsive performance was not accompanied by adequate reporting to A.I.D. on the impact of the increasing demands. Beginning in FY 1990, the contractor faced a reduction in core funding, while still trying to carry out the original scope of work plus responding to various other demands. Without a restoration of core funding, the contract's scope of work will need to be modified substantially. Given the strong performance during the first half of the contract, the Evaluation Team recommends that S&T/Health restore core funding to the original level to enable the project to fulfill its original mandate and provide a much needed service to A.I.D. and the health community more generally.

Principal Recommendations

Health Projects Database: CIHI should continue to administer the annual Health and Child Survival Projects questionnaire for S&T/Health. However, every effort should be made to systematically review the data currently being collected to determine what information is used and what might be dropped in the future.

As soon as possible an analysis should be made of differences in the 1990 questionnaire and data from PPC's ACSI system to determine if some obligation data can be dropped from the HCSP questionnaire. In addition, S&T/Health should consider substituting expenditure for obligation data which might enhance the use of the financial information for management and evaluation of projects and activities.

Health Statistics Database: CIHI and S&T/Health should review jointly the desirability of the project's becoming a key data repository for the health field beyond A.I.D.'s needs. CIHI should constitute a Technical Advisory Committee (TAC) for the project which could advise on a series of critical issues such as: 1) the feasibility of an A.I.D. contractor's serving as a data repository and watchdog on international health information and 2) topics for expert meetings and policy tools.

CIHI should also complete its systematic review of data sources to determine if there are major improvements needed in the HSD.

Hardware/Software Needs: Instead of designing the databases to be more accessible to non-CIHI personnel, more effort should be made in fostering closer working relationships with users. CIHI and S&T/Health should also assess the need for a LAN to improve the efficiency of the project.

General: CIHI needs to train several of its personnel so that more than one individual has total knowledge of either database.

A.I.D. and CIHI should decide on the disposition of the databases before the end of the project. If the database is to be transferred to another institution it should be in a form that is easy to access and utilize.

Analysis and Dissemination:

Case Studies: Topics for the remaining case studies should be reviewed to select the most important. A report on the 1990 vaccination meeting could be used as one of the topics.

The project CTO and CIHI should provide formal documentation to the contracts office (and perhaps initiate a contract amendment) confirming the decision to make four of the eight case studies contingent on buy-ins.

Information Service: CIHI should hold several briefings each year on the HIS for A.I.D. and non-A.I.D. staff to inform users about what is available. Similarly, a cable should be sent to the field to keep USAID Missions apprised of CIHI's program. CIHI should also track staff time spent on responding to ad hoc requests.

Standard Reports: Topics and formats for all standard reports should be reviewed prior to their preparation in 1991 to ensure that each is needed and useful. CIHI should continue to be very discriminating in the distribution of these reports, but also consider ways to enhance the distribution.

Child Survival Report: CIHI and S&T/Health staff should work together to streamline the preparation and review of the report without sacrificing quality.

Pilot Activities: CIHI and S&T/Health should consider applying several tasks to the contract requirements in this area. CIHI should search for lessons learned from the diverse activities which could be used in other settings. If at all possible, CIHI staff should be given adequate time to pursue other interesting pilot activities.

Policy Dialogue Tools: CIHI and A.I.D. should review the policy tools suggested in the evaluation report and select one or two of highest priority for completion during the second half of the project.

General: CIHI and S&T/Health staff should hold a retreat to consider what more can be done with the available funding and indicator data to improve planning, management and evaluation of health projects and activities.

Expansion of dissemination activities to improve the utility of the available information and to raise the visibility of the HIS is recommended. Activities such as widening the distribution of standard reports or preparing high quality presentation materials can be expensive and would require sufficient line-item funds to cover expenses.

Planning and Budgeting: ISTI should formally present its revised management strategy to S&T/Health. The presentation should be based on a May 1990 draft strategy but should also incorporate the additional analysis prepared in November 1990 for the evaluation. The presentation should include a revised budget that shows what tasks would have to be reduced or dropped if additional core or buy-in funds are not received.

The contractor should increase staff time on certain functions or activities in the contract such as for the position of an associate project director, additional analytical work, preparation of policy tools, etc.

S&T/Health should consider adding more core funds, restoring the original levels of core support, to the project.

Organization and Management: CIHI should consider dropping the Communications Unit and distributing its functions to other parts

of the project. The current Development Unit should be renamed the Analysis and Dissemination Unit with a reformulation of its functions to include more emphasis on analytic work.

An associate project director should be hired. S&T/Health should consider placing a Child Survival Fellow at CIHI to assist in the analysis of the health information.

CIHI should draft memoranda of record on major tasks changes or disruptions to the scheduled activities (e.g. those resulting from extensive information requests), and these should be distributed to the Cognizant Technical Officer (CTO) and other key S&T/Health staff.

All CIHI and S&T/Health staff should coordinate work on the project through the CTO who should be a conduit, the primary source for coordinating and communicating decisions, for the project.

S&T/Health should review its management structure to establish a clearer line of communications regarding project activities.

CIHI and S&T/Health should establish formal arrangements with the various data sources. CIHI should also set up a Technical Advisory Committee to guide the remaining two and one-half years of the project.

If a larger role for CIHI as a data repository and watch dog on health information is desirable, A.I.D. should promote the project's leadership role in organizing and implementing substantive meetings on health indicators and information.

I. BACKGROUND AND INTRODUCTION

The Agency for International Development (A.I.D.) established a major health program in child survival in developing countries beginning in 1985. Since that time the program has grown enormously to over $1 billion provided for programs in 60 countries across the globe. The major foci of A.I.D. efforts have included programs in such areas as vaccination, diarrheal disease/oral rehydration therapy, nutrition, and reduction of high risk births. A.I.D.'s Child Survival Action Program was developed to guide the expansion of these efforts. One small, but critical part of this major assistance effort has involved tracking A.I.D.'s financial contribution to the many country programs and monitoring changes in the health status of these populations.

In 1984, The Office of Health (S&T/Health) awarded a contract to the International Science and Technology Institute, Inc. (ISTI) to develop a health information system. ISTI set up a Health Information System (HIS) which served as a centralized, computer-based point of information to support policy, management and evaluation of A.I.D.'s health and child survival program. Under the first phase (1984-1985), a health projects database was established. From 1985-1986, additional data sets were created to accommodate specific project monitoring and information requirements, i.e., child survival activities and health statistics. Phase three was initiated in 1986 to expand the detail of statistical data, initiate an annual questionnaire for all A.I.D.-funded health and child survival projects, and establish links with other data sources including WHO/EPI and CDD, DHS, the UN, and PPC/CDIE.

By April 1988, the HIS database had evolved into two separate, but related databases. The first was the Health Projects Database (HPD) which included financial and programmatic information on all U.S. health and child survival projects, including bilaterally, regionally and centrally A.I.D.-funded activities. The second was the Health Statistics Database (HSD) which incorporated population-based country statistics related to health and child survival interventions in A.I.D.-assisted countries.

This HIS had three levels of users. The primary users were S&T/Health, the A.I.D. Child Survival Task Force, and the Office of Program Development and Policy Review in the Bureau of Program and Policy Coordination (PPC/PDPR). The database enabled these users to respond to Congressional, Agency and external inquiries about the programs. It provided much of the information used in the first two Child Survival Reports to Congress (1986 and 1987). The second level of users was PPC's Center for Development Information and Evaluation (CDIE), the Africa Bureau, the Bureau for Food and Voluntary Assistance, and the UN Water and Sanitation System. The third level of users was other A.I.D./ Washington offices and field missions, and A.I.D. contractors. Since the managers of A.I.D.-

funded health and child survival projects were responsible for providing the primary data to the database, it was hoped that these users would receive maximum utility from the databases.

In December 1987, an evaluation was conducted of the contract which provided recommendations for a follow-on project. The evaluation team concluded that the HIS had become a useful and relevant information system for A.I.D., and it should continue to be supported and strengthened. The team recommended that a follow-on activity:

- Focus on data compilation,
- Place greater emphasis on data quality,
- Focus on priority audiences and data users,
- Work with the A.I.D. project managers and missions to make the system responsive to their data needs,
- Upgrade professional and technical skills of staff personnel,
- Increase staff interface with data sources and users,
- Increase emphasis on health and population-based data and on project activity data,
- Work with PPC to ensure that the Agency had adequate budgetary data to track child survival and health programs at the sub-category level,
- Expand the types of data included in the HIS in response to the needs of the regional and other bureaus,
- Encourage buy-ins,
- Increase hardware and software and data presentation capacity, and
- Place greater emphasis on dissemination and analysis of data.

In April 1988, A.I.D. signed a new contract with ISTI for the follow-on project thus creating the Center for International Health Information (CIHI) and allowing them to build on the efforts of the initial project. The five-year project extends until April 1993 with a Life-of-Project budget of $5,999,989. The main goal of the project is to "raise the awareness of policy leaders and program managers both in the donor community as well as in developing countries about the trends in mortality, health status, and delivery of key health and child survival services and to contribute to the needs of policy makers and project managers in A.I.D., developing countries and counterpart institutions for health and child survival data."

The purpose of the project is to support planning, management and evaluation of A.I.D.'s health and child survival activities. The project represents a tiny portion of A.I.D.'s overall child survival program, less than one percent. The primary objectives of the project are to:

- "develop in a systematic way the health and child survival databases,

- improve the quality and availability of key indicators and programmatic information for health and child survival programs, and;

- provide useful, relevant information about A.I.D.'s health and child survival projects and trends in A.I.D.-assisted countries to A.I.D. program managers and secondarily to their counterparts and colleagues in order to support planning, management, and dissemination of technical information and evaluation."

The contract scope of work calls for specific tasks to be undertaken in collaboration with A.I.D./W, missions, other contractors and grantees, international institutions, and developing country governments and institutions. The central focus of these tasks is to develop further the health information system. This would include:

- A systematic effort to upgrade the quality of data.

- Continued collection of key information on projects and activities using an annual health questionnaire.

- Continued compilation and analysis of financial data in cooperation with PPC.

In addition, following from the recommendations of the evaluation of the previous project, the new project was to:

- Place greater emphasis on the development of health and population-based statistics reflecting A.I.D. policies and priorities (including a core set of indicators used to track child survival programs);

- Systematically analyze user requirements; and

- Embark on a program of information dissemination.

What follows in this evaluation report is an assessment of the contractor's performance on all tasks specified in the contract. Section II of the report looks at: 1) the development and maintenance of the Health Information System; and 2) the analysis and dissemination of data. Section III examines planning and budgeting under the project. The discussion of the budget is particularly important because the project is underfunded. Section IV reviews the organization and management of the project. Finally Section V includes conclusions and recommendations on the preceding sections.

Evaluation Methodology

A mid-term evaluation of the Center for International Health Information project took placed from November 5, 1990 to January 11, 1991. The Evaluation Team was composed of the following four external reviewers and a Johns Hopkins Fellow working in S&T/Health:

Judith R. Seltzer, Ph.D. (Team Leader)
Consultant/ Population Specialist
Former Chief A.I.D. S&T/POP/P&E

Gordon B. Ramsey, MS
Consultant. Management Training Specialist
Former A.I.D. Official

Kevin M. Sullivan, Ph.D.
Statistician
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Ellyn W. Ogden, M.P.H.
Project Director
Statistica, Inc.

Shelley Smith, M.P.H.
Johns Hopkins Health and Child Survival Fellow
A.I.D. S&T/H/AR

The team spent the first month collecting information on the project and interviewing A.I.D. and contractor staff as well as talking to groups outside of A.I.D. that were familiar with the project's work. The remaining time was used for writing and reviewing the team's report. The evaluation was guided by the scope of work prepared by A.I.D. and Statistica, Inc. staff (see Attachment 1). Attachment 2 lists all offices and persons interviewed in the course of the evaluation.

All team members reviewed the background documents listed in section III A of the scope of work. During the week of November 5-9, 1990, the team, with the exception of Gordon Ramsey, met under the leadership of Judith Seltzer. The team initially reviewed in detail the scope of work and tentative report outline with A.I.D. staff including the Cognizant Technical Officer (CTO) Petra Reyes, Connie Carrino and James Heiby. Petra Reyes provided the team with a summary of the background of the project and pointed out specific concerns given her role as the CTO. The team was also briefed by senior staff of the Office of Health (S&T/Health), Ann Van Dusen, Nancy Pielemeier, and Pamela Johnson on the role that the current evaluation would play in assessing: 1) the project's progress and accomplishments, 2) the vision and expectations of S&T/Health for the project, and 3) the need to modify the project's design or funding.

During the week of November 12-16, Gordon Ramsey, Ellyn Ogden and Shelley Smith met with A.I.D. and CIHI staff to review funding and organization and management of the project. The team met again on November 26, 1990 to review the findings and recommendations. (These were reviewed by telephone with Kevin Sullivan.)

The evaluation took place exclusively in Arlington, Virginia and the team had access to many users and sources of data in the HIS. Members of the team either met with or interviewed by telephone representatives of PPC, Africa Bureau, LAC Bureau, Asia and Europe/Near East Bureau, FVA, S&T/Health, S&T/POP, S&T/N, CDIE, U.S. Bureau of the Census, WHO (EPI, GPA, CDD), UNICEF, CDC, PAHO, and other A.I.D. contractors.

Lengthy meetings between the team and the ISTI/CIHI staff were conducted throughout the evaluation period. Roy Miller, the newly appointed project director, was candid and cooperative in responding to the team's many questions about the project. The team met with each of CIHI's organizational units to discuss their particular responsibilities and progress toward project goals. The former project director, Bart Burkhalter, and senior advisor, Jean Pease, were also very available to the team. CIHI staff responded quickly to ad hoc requests from the team for tables and documentation of various aspects of the project.

II. CONTRACTOR'S PERFORMANCE

1. Development and Maintenance of the Health Information System (HIS)

As described above, the contractor carried over two databases; the Health Projects Database (HPD) and the Health Statistics Database (HSD) from the previous project. As called for in the contract and in order to improve the quality and usefulness of these databases, the contractor performed several studies over the first two years of the project. These included a user needs study and an analysis of the quality of the databases. In addition, the contractor prepared an analysis of hardware and software requirements of the information system within the first nine months of the project. While the first two reports were prepared considerably behind schedule, the content of both appears to have been useful for the project's implementation. The computer hardware and software assessment, carried out in a timely fashion, enabled procurement of equipment within the project's first year.

1.a Health Projects Database (HPD)

The HPD provides programmatic information on A.I.D.'s health and child survival activities covering a wide range of functions. The source of information for the HPD is the annual USAID Health and Child Survival Project Questionnaire (HCSP), all A.I.D. budget documents, and other relevant information. CIHI staff devote considerable effort and resources (about 18 percent in the project's second year) to administering the questionnaire and maintaining the HPD.

The **HCSP questionnaire**, which is sent out each October, has three versions for bilateral projects (8 schedules, 19 pages), PVO grants (8 schedules, 19 pages) and central and regional projects (2 schedules, 10 pages). Information is collected on projects and sub-projects and includes the involvement of PVOs, the private sector, as well as the amount and types of training, technical assistance, and research. Financial information is based on obligations, although for the first time in 1990, expenditure data are being collected on central and regional projects by type of technical assistance (short-term or long-term) and by source of funds (core or buy-in). Data are collected on 21 functional categories (13 health functions such as diarrheal disease/oral rehydration and health care financing, 7 nutrition functions such as breastfeeding and Vitamin A) to determine attribution by program function.

In addition to the main or core questionnaire, there are seven other schedules: demographic, diarrheal disease control, immunization, nutrition, high risk births, AIDS/HIV, and other health and child survival data. Information from these other schedules describes characteristics of the activities being

supported in a given fiscal year, e.g. how many ORS packets were purchased or how many children were vaccinated. Indicator data are also collected such as the rate of malnutrition and vaccination coverage rate in a given project area.

The questionnaire has been administered in a timely fashion each year of the project. Each year substantial revisions have been made, and CIHI staff has been very responsive to changing priorities and the need to improve the design as well as the content of the questionnaire. (See Attachment 3 for a description of changes in the questionnaire.) The questionnaire has been translated into Spanish and French, which is necessary and should continue.

The amount of information being collected and tracked by CIHI has increased considerably over the life of the project. One reason for the growth is the overall number of questionnaires processed which cover projects, sub-projects and sub-sub-projects. The number of questionnaires increased from 294 in 1987, to 380 in 1988 and to 476 in 1989. This represents an increase of 25 percent or more each year. The jump in the number of sub-sub-projects between 1988 and 1989 was quite impressive -- more than a five-fold increase from 33 to 178. CIHI and S&T/Health should consider whether information on sub-sub activities is really needed. Further, given the large amount of information collected, CIHI, A.I.D. staff, and appropriate members of the Child Survival Task Force, should review the data available to determine what items are being used and which might be dropped in the future. This would be important not only for the various schedules on specific programs and services, but also for the funding data.

While the questionnaire is long and onerous to complete, USAID missions and PVOs voiced no specific complaints about completing the questionnaires. CIHI staff has provided training to a number of USAID missions and AID/W offices in completing the forms and similar assistance to PVOs. Such training has undoubtedly lessened problems in completing the questionnaire and improved the quality of information provided. In fact, CIHI efforts have been especially appreciated by the PVOs since a special PVO questionnaire was designed. The PVOs have found the questionnaire a useful way to monitor and manage their own projects, and were less concerned with how the information was used by A.I.D. In each of the project's three years, CIHI staff has also attended an annual PVO/FVA conference and guided PVOs in completing the forms.

Staff from several S&T/Health contractors appreciated the assessment value of the data collected in the questionnaires, but understood less well how important the information was to A.I.D. and how it was used. These Cooperating Agency (CA) representatives also asked that more advance warning be given of planned changes in the questionnaire (i.e. prior to the actual mailing of the questionnaire). This would give more time to set up procedures to

collect data for new items. A number of USAID Missions requested more feedback from the questionnaire beyond what they received in the mailing of subsequent year's questionnaires, such as a description of regional trends or other analysis linked to the review of the questionnaire.

HPD data for two program areas have been problematic. A.I.D. staff from S&T/H/AIDS and S&T/Nutrition programs indicated that in the past, the reporting on their respective activities did not accurately capture A.I.D.'s efforts. Some problems are not wholly a function of the questionnaire, but rather about the policy guidance given CIHI regarding the method of forecasting annual obligation levels. The sections of the questionnaire covering these two areas have been revised substantially which will presumably provide better data in the future. Nevertheless, the AIDS program will have AIDSTECH review the reported data and prepare a report to Congress in the future. (The FY 1989 report to Congress on HIV Infections and AIDS which CIHI staff prepared is discussed in the section on analysis and dissemination, page 24-25.) Given the already full work load of CIHI staff on other health topics and the special data problems and needs of the AIDS Division, this appears to be a satisfactory solution. CIHI should continue to work closely with A.I.D.'s AIDS staff and AIDSTECH to ensure that the annual questionnaire addresses key concerns and does not collect unnecessary data.[1] S&T/Nutrition believes CIHI's methods over-estimate the amount of resources devoted to S&T/Nutrition. This arises because so many "health " projects not directly linked to S&T/Nutrition are, in fact, doing nutrition work. CIHI plans to continue to work closely with the Office of Nutrition to overcome these problems and refinements in the FY 1991 questionnaire reflect this spirit.

In sum, there is general satisfaction in AID/W with the current format and content. While it is likely that much less time will be spent in the future on its design, the contractor's staff should continue to work with A.I.D. for ways to reduce the data collection and to ensure that all the data collected are useful.

<u>HPD and PPC'S ACSI System.</u> A principal use of the HPD is for tracking A.I.D.'s health and child survival activities and for reporting to Congress. Over the past two years, PPC has developed its own system (Activity Code Special Interest (ACSI)) for tracking A.I.D. obligations. CIHI has provided considerable assistance to PPC in the development of this system. Apparently the level of assistance provided greatly exceeded what was originally

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[1] For example, the current Schedule 6 on AIDS/HIV activities asks for information on indicators including reported AIDS cases and HIV seroprevalence rates. Since WHO already collects this information, CIHI need only obtain these data from WHO as it does other Health Statistics.

anticipated by CIHI or the Office of Health. Presumably, the assistance has benefitted the PPC system.

Outside of PPC, most A.I.D. staff believe that the PPC system will eventually be used by all parts of the Agency as the system for tracking obligations. However, there is not yet sufficient confidence in the ACSI system to abandon CIHI's work in this area. Further there is a level of detail in the HPD which S&T/Health deems critical and which will never be included in PPC's system. In addition, staffing constraints in PPC are likely to limit PPC's ability to respond to requests for data and special tabulations. Eventually all A.I.D. staff will apparently have on-line access PPC's ACSI data, but for the foreseeable future this will not be the case.

FY 90 is the second year that PPC is collecting obligation data under the ACSI system. A comparison of the HPD and ACSI data will be essential when both data sets are available (probably in early 1991). If the project-level obligation data are of sufficient quality, CIHI may no longer need to collect these data. Before dropping these elements from the HPD however, S&T/Health should try out the ACSI system to see if the information is sufficiently accessible.

HPD data are theoretically used for evaluating A.I.D.'s activities. A frequently cited limitation of the HPD is that only obligation data are collected which tell nothing about actual expenditures. The 1990 questionnaire does query central and regional projects about expenditures. If CIHI is able to drop the collection of data now being collected by PPC, S&T/Health and the project staff should consider changing expenditure data for obligation data for all sub-projects. By including in the questionnaire a table similar to the table used to record obligations by intervention (function), project managers will be able to allocate their annual expenditures across interventions.

One further note to the discussion of CIHI and PPC is warranted. In interviews with PPC staff, it was clear that CIHI's assistance has generally been appreciated. However, attention to differences in reporting from the two systems is a subject between A.I.D. and CIHI and not for more public consumption, e.g. at Congressional hearings.

Quality of the Database

Given the size and complexity of CIHI's Health Information System, there are many different databases within the overall system. The size and scope of the HIS made it difficult to review in detail all aspects of the databases within the limited time available for the evaluation. Overall, however, the data system appears to be adequate and serves the needs of the various users. When the HIS

is measured in terms of responsiveness to simple tabular ad hoc requests, the response time is good. This is an indication that the data system is structured well for such uses.

Based on the Evaluation Team's interviews, the majority of those familiar with reports from the HIS thought the information was of high quality. This favorable evaluation results in large part because of the way in which the reported data are scrutinized. Ultimately however, the quality of the HPD data depends largely on those who complete the questionnaire. For example, in most instances attribution figures for certain activities and numbers of persons trained will be estimates and not hard and fast data. First, after receiving the questionnaires, the contractor's staff visually reviews all of the data for accuracy, based on what is known historically and from other project information. Data are then entered, and there are range checks of all variables. Data items that appear to be incorrect or inconsistent with previous years are verified with each Mission. Certain data items are then sent to each Mission for verification for the Child Survival report to Congress. The technical office in each regional bureau also reviews the data for correctness. Double data entry is not performed, although CIHI staff believe that the data are scrutinized closely enough that very few data entry errors would be detected. The costs of double data entry must be compared to the number of errors that would be changed. At this time, it does not appear that double data entry is needed given the data verification steps and the reported quality of the data output.

Another way to assess the quality of the data would be to perform an evaluation of the USAID missions and PVOs to determine how they complete the questionnaires. Where do they get their information? How accurate is it? At this time, such an assessment is not warranted given the overall satisfaction with the data output.

Updates to the files: When updated information is received, the data files are updated to reflect the change. In the HPD, there is a field for list changes to data items so that if the data are questioned for accuracy, the source of updated information (i.e., such as from a regional bureau or cable) can be identified.)

Completeness of the database: The categories of information currently collected from health and child survival projects (only) are relatively complete. Compliance with the HCSP questionnaire is very high. All Child Survival emphasis countries are included and data were provided by a total of 47 out of 51 Missions sent questionnaire in 1989. Questionnaires were also received from 24 PVO and numerous regional and central projects. Additional unexpected questionnaires are returned incorporating new projects or sub-projects. Viewing completeness as the degree to which the databases capture "all" health related activities in the Agency, including those

which are not funded by health or child survival accounts, the database is not complete. It would be worthwhile for A.I.D. to revisit this issue in light of comments by two bureaus that it would be desirable for CIHI to report all data, especially population data.

Data backup: Currently, the database information is backed up at the end of each day to floppy disks. Once a week, the data are backed up to tape. The current back-up system is adequate.

Data security: The only sensitive data collected by CIHI are obligation data used for the Annual Budget Submission and the Congressional Presentation. The security of the data is ensured by limiting access to the data to a very few CIHI staff. The computers have locks to prevent use of the computer by non-authorized personnel. Given the number of data checks, any major changes in the data would probably be detected. The data back-up system could also be used to recover from a breach in security. At this time the need for passwords to prevent access to the database is not necessary, however, if a LAN is installed tighter security would be required.

Maintenance of computer systems and data files: Each year the questionnaire changes, which results in a need to change the data file structures and data entry systems. While this results in considerable work for CIHI staff, this is common in health data systems where the system needs to be flexible and evolving.

In sum, the contractor has put in place good procedures for ensuring high quality information and adequate maintenance of the HIS.

Findings:

1. Most groups queried about the HPD praised the quality and comprehensive nature of the information collected. (The exceptions were the AIDS and Office of Nutrition staffs as discussed above.) These data, especially the financial data, are essential to the Office of Health for reporting to Congress on the health and child survival activities and for managing A.I.D.'s complex health and particularly the child survival programs.

2. USAID missions and S&T/H contractors find completing the questionnaires an essential, but onerous task. Compliance in completing the questionnaires is very good which indicates that the importance of the exercise is generally recognized. One complaint on the part of USAID missions is that they would prefer to see more feedback from the information collected. Cas do not have an adequate appreciation of the need for the data collected in the

HCSP questionnaire, and they would appreciate advance warning of changes in the questionnaire.

3. The contractor devotes nearly 20 percent of project's resources in a given year to the administration of the questionnaire and maintaining the HPD. Looking at this another way, of the $750,000 in S&T/H core funding for FY 90, one-third was used to support the HPD.

4. The questionnaire has been administered in a timely fashion each year. CIHI staff has been very responsive to the need for changes in the questionnaire. One consequence, it that the amount of information collected has increased by 25 percent or more each year.

5. The data system is adequate and serves the needs of the various users. The procedures for ensuring high quality information and good maintenance of the HIS are satisfactory.

6. While CIHI's HPD and PPC's ACSI are somewhat redundant, most AID/W users have considerably more confidence in the accuracy of the HPD compared to the ACSI data at this point in time. Further, much of the data in the HPD serves S&T/Health needs more appropriately because it was tailor made for their purposes. Obviously, an Agency-wide system cannot be that fine-tuned to any one program area.

1.b Health Statistics Database (HSD)

The HSD includes information on key health, child survival and demographic indicators. The database was to have been upgraded on the basis of a systematic review of data sources for key health and child survival indicators. The review is apparently now underway, although the contract anticipated that such a study would be completed early on leading to agreements with the various data sources to obtain data on a continuing basis. Even without this review, the data available in the HSD are extensive. These data are drawn from other sources and include the following:

- Demographic data: total population, children under age one, infant deaths, infant mortality rate, life expectancy. Sources: UN Population Division and U.S. Bureau of the Census.
- Immunization coverage rates for children and mothers. Source: WHO, Expanded Programme on Immunization.
- For diarrheal diseases, ORS access and ORT use rates. Source: WHO, Control of Diarrhoeal Diseases.
- Contraceptive prevalence, nutritional status, and infant feeding. Sources: Macrosystems for Demographic and Health Survey data and U.S. Bureau of the Census for earlier contraceptive prevalence rates.
- Nutritional status and infant feeding. Source: WHO.

- Vaccination coverage and ORT Source: CDC, CCCD.
- Socioeconomic data. Source: World Bank.

As mentioned in the discussion of the HPD, indicator data are also collected from bilateral projects and PVO grants through A.I.D.'s annual HCSP questionnaire. Such data provided by USAID missions are useful if other data are not available. For example, Missions sometimes receive WHO or other estimates prior to official publication. Further obtaining these estimates from USAID Mission has simplified the review of the Child Survival Report which occurs later in the fiscal year. PVOs find the exercise of providing indicator estimates useful in getting local project staff to consider the broader implications of their project activities.

Since the beginning of the contract, two additions have been made to the database. These are:

1. Anthropometric estimates of nutritional status. Sources: WHO, DHS and other surveys.

2. Infant feeding data including information on exclusive breastfeeding and the introduction of solid foods. Sources: DHS and WHO.

CIHI has also obtained copies of the machine readable databases containing: a) the "World Tables" and b) Social Indicators of Development from the World Bank. Since the World Bank databases have their own retrieval system, CIHI did not reenter these data into the HSD.

While the contract calls for the addition of five new areas of data, it refers to both the HPD and the HSD databases. If data from AIDS/HIV schedule are added to the above, four new types of data have been added to the databases. CIHI is exploring the possibility of adding another area: health care financing indicators. This addition would fully satisfy the contract.

According to CIHI, the primary change in the HSD over the past two and one-half years, has been its reorganization to enable rapid retrieval of trend data and/or current data from the files. This marks a change in concept behind the database. Originally, the HSD was seen as a device to capture all estimates of the various indicators without discriminating among them. In its new form, the HSD serves as an historical record of the values of the various indicators selected by USAID each year as well as a device to capture all other values reported for each indicator.

Data from the HSD are to be used to monitor changes in health and child survival and especially improvements in specific interventions or services. This information is a key component of the USAID Child Survival and Health Fact Sheet in the annual Child Survival Report to Congress and is used in country and regional

profiles on selected health and demographic statistics. During the project's second year, about five percent of the level of effort and about 7 percent of expenditures were devoted to maintaining the HSD.

For indicator data collected from the various other sources, there does not appear to be a systematic collection from these sources or verification of the data. In general, data are entered from published papers and reports when they become available. There are no formal **agreements with the various data sources**, although in some instances a formal relationship seems not to be needed to acquire the data. For example, WHO's EPI program publishes the results of the immunization surveys on a bi-annual basis, therefore these data are available to anyone without a formal agreement.

There are at least two drawbacks to not having formal agreements with data sources. One is related to CIHI's capacity to play a unique role in the international health field by being a repository, a "watch-dog" and a disseminator of health and child survival data. The contract did not explicitly state this as an objective, but clearly the **larger goal of the project or "vision"** as the Evaluation Team has called it was:

> "to raise the awareness of policy leaders and program managers both in the donor community as well as in developing countries about the trends in mortality, health status and delivery of key health and child survival services and to contribute to the needs ... for health and child survival data." (p. 9 Section C of CIHI contract)

To establish CIHI as such a repository requires formal arrangements with the various sources of health and child survival data. The contract called for the establishment of these agreements to obtain selected data on a continuing basis but such arrangements have not been made. This is an issue which should be considered by A.I.D. and could be an initial discussion point for a TAC.

A related issue concerns setting up a **Technical Advisory Committee** (TAC) to guide the overall direction of the project. (This is discussed also under Organization and Management.) Such a body would include representatives of organizations providing data (UN agencies, U.S. Bureau of the Census, Macrosystems), representatives from S&T/Health Cas and other data users, as well as technical advisors on health and child survival data. A TAC would help establish a consensus for CIHI to play a broader role as a central data repository and would enhance CIHI credibility. Again the contract called for the establishment of one or more advisory groups on an as-needed basis, but none has been set up. In truth, the contract itself is somewhat vague about the role of TAC given the "as needed" wording, but the Evaluation Team understood from A.I.D. that this was expected. Several consultants served on an <u>ad hoc</u> basis as advisors, and an expert meeting on vaccination

coverage was held, but these were for different purposes.

Based on interviews with CIHI staff, one reason for the contractor's not establishing TACs or formal arrangements with data sources is a different perception of the role of the HIS. CIHI staff have viewed themselves primarily as a service organization to the Office of Health and did not appreciate the project's larger goal. Furthermore, CIHI staff have apparently not had the time to go about fulfilling the larger purpose.

Another drawback to the informal approach is that there may be studies carried out by other organizations on indicators that do not get published. If CIHI is to be comprehensive in its compilation of indicator data then it should attempt to collect this information from all A.I.D.-funded projects (not just bilaterals and PVO grants). An additional problem is capturing data from non-A.I.D. sources. If it is desirable for the HSD to include indicator information from all sources, then links would need to be established with organizations in addition to those listed above. For example, other countries such as Canada and Belgium, are providing funds for the collection of anthropometry data. This information may not be known to USAID missions.

There are various ways to expand the database. As mentioned above, one way would be to collect indicator data from other sources. Another possibility would be to obtain information such as that published elsewhere (Update on the Nutrition Situation: Recent Trends in Nutrition in 33 Countries - AAC/SCN, United Nations, 1989) on economic indicators. With such information, comparisons could be made of A.I.D. funding and health indicators along side general economic indicators for the different countries.

The project is currently devoting a relatively small level of effort to maintaining the HSD. This may be appropriate given other demands of staff time. However, if fulfilling the larger vision of the project is still a desired goal, then more effort will be required to establish CIHI as a recognized, credible repository for health and child survival data. More effort would also be needed to expand the HSD and make it truly comprehensive. Whether there would be substantial improvements in the indicator data by trying to be more comprehensive is an open question, but one worth considering for each area of health and child survival activities.

UN vs U.S. Bureau of the Census Demographic Data

Early in the project, a decision was made to use UN data for demographic estimates rather than data from the U.S. Census Bureau. Differences in estimates of population size tend to be small between the two sources. Further, since numerators used for calculating rates were often provided by UN sources, it was felt that for consistency UN demographic data should be used.

The evaluation team recommends that this decision be reviewed ideally in consultation with the project's Technical Advisory Committee, assuming one is constituted. The reasons for reviewing the earlier decision are presented in Attachment 4.

Findings:

1. The contractor maintains an extensive database on health, child survival, demographic, and socioeconomic indicators. As called for in the contract, several additions have been made to the HSD although a systematic review of data sources, expected early in the contract, is only now underway.

2. Maintaining the HSD requires relatively small cost, around 5-7 percent of the project's resources. Given that the data are essential for preparing the annual Child Survival Report to Congress and the country and regional prcfiles as well as for CIHI's information service, it is an appropriate level of expenditure.

3. No formal agreements have been made with the various data sources, although required data are generally published and available without such agreements.

4. The contractor's staff has seen itself primarily as a service organization to S&T/Health and did not appreciate a larger role that it could play as a data repository, watch-dog and disseminator for the health field, and thus did not set up formal links with data sources or establish a Technical Advisory Committee. This is reflected in the cost for maintaining the HSD.

5. Five new types of data were to be added to the databases. At the mid-point of the contract, four have been added: nutrition status, infant feeding and breastfeeding, socioeconomic indicators, and AIDS/HIV.

6. The quality of the data in the HSD depends on the quality of data provided by the secondary sources. There do not appear to be problems with the quality.

7. United Nations rather than U.S. Census Bureau data are used for demographic estimates. The reasons for this selection need to be reviewed again to ensure that the most accurate data are being compiled given the uses of the HSD.

1.c Analysis of Hardware/Software Needs

Currently, the contractor has the following microcomputers:

5 IBM-compatible XT computers
8 IBM-compatible AT computers
2 IBM-compatible 386 computers (each with tape backups)
3 Toshiba T1000 portable computers with dual floppy drives
3 Macintosh computers

Other computer-related hardware includes:

One Bernoulli system (connected to an AT)
2 HP Series II LaserJet printers
1 Kyocera laser printer
1 Apple LaserWriter printer
10 dot matrix printers

In order for each of the IBM-compatible computers to access the HP laser printers, there are two printer sharing devices (each with one megabyte of memory.

The current hardware is adequate for the present work load. Should the HIS be expanded significantly, additional hardware may be required. However, efficiency could be improved through the addition of a LAN (Local Area Network). A LAN is a way to connect all of the computers so that information could be updated and shared by many users simultaneously. For example, currently the HIS system can only be updated on one computer at a time. When the data are updated, then the updated databases are copies to disks and distributed to two other microcomputers. With a LAN, the databases would be on one computer, and users could update the database from any computer. In addition, reports and ad hoc requests could be completed simultaneously. Although it is difficult to estimate the boost in productivity a LAN may provide, the boost may range from 10-25 percent. The cost of installing a LAN would include the cost of a server (a 386 computer), boards and cabling for each microcomputer to link them to the server, and LAN versions of the software. The total costs of a LAN would range from around $20,000 to $25,000. Currently, the contractor has an employee who would be able to implement and administer a LAN. Again, the current system is adequate, but the addition of a LAN would increase productivity. Should the HIS substantially expand, it may be necessary to acquire a LAN.

Depending on the types of services A.I.D. desires from the contractor, other possible hardware purchases would be a plotter for making color graphs/overheads (cost is around $2,000), and a more powerful computer. The existing portables are of limited use, primarily for word processing. If CIHI staff are needed for making presentations away from the Center's office, then a portable computer, such as a Compaq LTE or Toshiba 286 or 386 model would be useful.

Finding:

Given the current demands on the project, the current hardware configuration is adequate. Some efficiency would be gained by providing a LAN at a cost of $20,000 to $25,000.

1.d General observations common to both databases

While overall responsiveness to requests for information from either database have been excellent, there have been times when response time was delayed due to unavailability of key CIHI personnel. This points out a visible weak link in the operation of the CIHI database. The HPD and the HSD each have essentially one individual with the comprehensive expertise and knowledge to fully access the system. While the rest of the CIHI staff are familiar with various components of the databases, there is no true back-up person for either database.

Although this is the mid-point in the contract, some thought should be given by A.I.D. and CIHI regarding the disposition of the two databases on completion of the project. Any necessary modifications to the databases or the need to train others in the maintenance and use of the databases should be discussed and terms agreed upon in advance of the final evaluation.

Findings

1. CIHI places too much reliance on single individuals for comprehensive understanding of each database, limiting the projects' flexibility unnecessarily.

2. A.I.D. and CIHI should decide on the disposition of the databases before the end of the project. If the database is to be transferred to another institution it should be in a form that is easy to access and utilize.

2. Analysis and Dissemination of Data

This section reviews the implementation of a range of analysis and dissemination tasks including the following: case studies, information service, standard reports, Child Survival Report to Congress, pilot activities (including the AIDS Report), materials repository, and other dissemination. The contract mentions data analysis in conjunction with the operation of the databases, but the only specific output under the analysis section in the contract is the preparation of case studies on health and child survival topics. The discussion of dissemination is more specific with various deliverables cited.

2.a Case studies

The contract calls for case studies on health and child survival topics. At some point, A.I.D. and CIHI staff decided that four of the eight case studies would be conditional on the project's receiving buy-ins. This appears to have been a reasonable decision, but since these case studies are considered deliverables in the contract, some written documentation of this change should appear in the record if not as a contract amendment.

To date, three case studies have been completed and two are in process. Of these five, two are supported by buy-ins. The following lists the five plus three additional topics for case studies. A.I.D. staff was consulted in the selection of the topics and is presumably satisfied with the nature of the work.

1. ICORT III Supplement to the Third Report to Congress on the USAID Child Survival Program: Projects Supported by USAID for Diarrheal Disease Control. December 1988.
2. Analysis of age patterns on immunization. October 1988.
3. Central America Initiative, Trends in Selected Health and Nutrition Indicators: 1980-1987. February 1990. (This study was funded by a buy-in from LAC and will be one of a series, the others being country reports. See discussion of pilot activities.)
4. Africa Nutrition Strategy. Draft, June 1990. (This study is being supported by a buy-in from AFR/TR/HPN.)
5. Critical review of local health information systems. This study is in its early phase.

Other topics have been cited in the contractor's annual schedule of planned activities. These are:

6. Analysis of DHS nutrition data.
7. Relationship of obligations and indicator data.
8. Comparison of survey data vs. routine reporting.

2.b Information Service

As stipulated in the contract, CIHI provides an information service on health and child survival data drawing heavily on the information contained in the Health Project and Health Statistics databases. The service fills an important need in the Office of Health, but in other A.I.D. offices as well. Over the past two years, CIHI staff has responded to an average of 300 ad hoc requests per year. Most of the requests draw directly or indirectly on information contained in the databases. (See Attachment 5 on "Request Tracking System: Breakout of Requests by Type".) About 11 percent of staff time and expenditures (in the project's second year) were devoted to the information service. By all accounts, CIHI staff are extremely responsive to requests for information, and users expressed great confidence in the quality of

the information provided. The vast majority of requests are filled in two or fewer days.

Attachment 6 on "Request Tracking System: Information Distribution to Requesting Organization" shows the distribution of requests by the requesting office or institution. Not surprisingly, half the requests came from S&T/Health. PPC and the Regional Bureaus were the other main users in A.I.D. A rather small number of requests have come from A.I.D. Missions or regional field offices. Other organizations outside of A.I.D. accounted for about 25 percent of requests. These other institutions include cooperating agencies, universities, foundations, and international organizations (e.g. World Bank, UNICEF).

Just looking at requests from the Office of Health, not quite half were from the Applied Research Division and about 30 percent were from the Front Office. Many of these requests came from high-level AID/W personnel and merely were channeled through the Office to CIHI. The remaining requests came from three divisions: Health Services, AIDS and Communicable Diseases. While the information service is frequently used by the Applied Research Division and the Front Office, this analysis shows that there is a fairly large assortment of users. From the above description, it is also obvious that CIHI staff does a reasonable job of logging in and tracking information requests. However, the contractor's staff admits that as many as 15 percent of requests are never logged in for one reason or other. It is suggested that staff make an effort to record all requests and also that they keep a record of person-hours spent on each request so that CIHI management as well as the A.I.D. CTO can monitor the level of effort. This is very important so that CIHI can document its workload and be able to justify to A.I.D. lack of attention to other aspects of the contract. The information could also be used internally for periodic analysis of time spent as the means to determine what modifications in the structure and handling capability of the databases should receive emphasis. This will be especially important if the service is used more heavily in the future.

The relatively few requests from A.I.D. field staff suggests that their needs for health and child survival information are being filled elsewhere or that they don't need centrally supplied data or that they are not aware of CIHI's databases and information service. On the first possibility, CDIE's Research and Reference Service may be receiving most requests for health data. On occasion, CDIE has turned to CIHI for information. However, based on interviews with CDIE staff, it would be helpful to formalize the link between CDIE and CIHI. Such an arrangement may have been pursued early in the project, even so it is time to renew the link. Current CDIE staff need to learn about the overall content of the CIHI databases, get copies of reports, and know how to access easily CIHI's information. CDIE staff would also be interested in computer access to the data.

Closer collaboration between these two projects would probably increase and improve health information provided to USAID field offices. In addition to strengthening the ties between CDIE and CIHI, it would also be useful for CIHI to cable USAID missions with a description of its role as a center of health information (for example, some Missions aren't aware of CIHI since they see the HCSP questionnaire as coming from S&T/Health), what's in the databases and how Missions can access the information (either directly or through CDIE). The suggestion to cable Missions with this information is important since mailings to the field (especially with several publications) may not get the attention of field staff, but a cable will.

2.c Standard Reports

The contract calls for the preparation of a series of standard reports to disseminate health and child survival information to various audiences. The illustrative topics included funding summaries, child survival trends and projections, and a report to Congress on child survival. The contractor developed a standard report series based on an analysis of information requests received during the project's first eight months as well as the User Needs Study. The first series of 13 such reports were prepared in late 1989. In 1990, 15 standards reports were prepared.

There are two types of standard reports: those providing funding information drawn from the HPD and those on health statistics based on the HSD. In 1990, 12 of the 15 standards reports described funding trends for the various health and child survival activities. The remaining three reports were regional summaries (one for each A.I.D. region) of selected health and demographic statistics. (See Attachment 7 for a complete list of standard report available as of May 1990.)

The contractor has developed a third type of standard report which is the "country health profile". These profiles summarize USAID health projects in a given country along with health and demographic statistics. Twenty such profiles have been prepared (see Attachment 8 on Status of Population and Health Profiles, 11/7/90) Six profiles have been reviewed by both the Regional Bureaus and Missions and completed. The others await reviewers' comments before being completed.

The standard reports have been used to disseminate a range of funding and statistical data to AID/W and field staff as well as to other organizations. They are also helpful in responding to the more routine ad hoc requests. The cost of producing these reports is quite minimal (less than $10,000 for the 1990 standards reports, plus eight months of staff time). The number of funding reports appears rather daunting, but since each covers a different program function or functions, it is probably worth the small expense to

produce them. The contractor should nevertheless review the topics of the standard reports with A.I.D. staff prior to publication each year to ensure that each is needed. Some streamlining might be possible if no one seems to be using certain reports.

Given the large number of reports, the distribution procedure is important so as not to overwhelm potential users. The contractor produces a "List of Current CIHI Publications" which is updated at least annually. This listing is a good way to inform users of available reports. The listing also includes an order form which could be easier to use if designed as a check list and if it appeared more prominently in the publication.

Based on the Standard Report Distribution List for FY 1990 (see Attachment 9), the contractor has attempted to distribute reports according to the results of its user needs study. USAID Mission staff and Cooperating Agencies received a limited number of reports, but could request others. The one exception is that 34 AID/W staff received copies of all standard reports. Distribution of a thick stack of reports will not encourage most recipients to look at the materials. CIHI staff should review the method of distribution and perhaps precede such a distribution by general briefings for AID/W staff and/or send out only one or two reports with an order form for copies of the others. On the other hand, all technical staff in the Regional Bureaus may want to receive a full set of reports, and CIHI should make sure from time to time that these offices have a sufficient number of copies and understand what information is contained in them. This is particularly important given Regional Bureau staff turnover.

The regular distribution of reports also generates requests for more copies. Fifty such requests beyond the regular distribution were made in the first nine months of 1990. CIHI also received a sizeable number of requests for its publications at the NCIH annual meeting in 1990. This would appear to be an excellent way to disseminate further the standard reports, and a similar effort should be made at APHA each year. One footnote on these requests is that CIHI staff has apparently not yet filled these requests which it should do before more time has elapsed. The contractor should expand the distribution of some of the reports (such as the summary on funding trends for child survival activities as well as the statistical summaries) to international organizations, foundations, and perhaps to selected media representatives. Funding should be provided for purposes of expanding publication and distribution of reports as part of CIHI's dissemination activities. In addition, many opportunities for providing visual aids such as slides for briefings arise. This could be a visible means of raising awareness of what information CIHI has and their capability to present it well. If A.I.D. chooses to enlarge this aspect of CIHI's dissemination activities, additional funds would be necessary.

Users' or recipients' assessment of the standard report series is generally positive and that the materials are used as a basic reference. A number of AID/W staff maintain a notebook or folder with the various reports and can put their hands on the reports quickly when asked. Users especially appreciated the detail provided in the data and source notes. Members of the Evaluation Team did not spend much time if any reviewing the format of the reports, but no complaints were voiced by users. This assumes that either the formats are satisfactory or that few people pay much attention to the format or the reports. CIHI might want to expend a modest effort in reviewing the format of the reports. For example, Standard Report No 3-90 (USAID Funding for Child Survival in Emphasis Countries FY 1985-1991) includes separate tables of several pages each for each funding year. This makes comparisons of trends for a given country over time difficult, if such comparisons are important. If these comparisons aren't important, then one wonders why so much detail for the range of years is needed in one document.

2.d Child Survival Report to Congress

The centerpiece of CIHI publications is the annual Child Survival Report to Congress. This publication is uniformly lauded by A.I.D. staff and those from other organizations. The report serves three key purposes for A.I.D. First, it is the official (mandated) report to Congress. Because of the way it is prepared (see review process below) it represents a consensus report describing what A.I.D. is doing in child survival to a very wide audience. Second, it serves as a quality control check on the whole system of tracking and reporting on child survival activities. Third, the content of the report is used for various other materials such as country fact sheets, country profiles, and success stories. Although demanding of staff time and resources (for example, 10 percent in the project's second year), it is worth the cost by all accounts.

ISTI has produced five such annual reports, three during this contract period, for FY 1988, FY 1989 and FY 1990. Each year the report has been somewhat more complex and time consuming to complete. One simple comparison is the length. In 1988, the report was 70 pages. In 1989, it was 88 pages. In 1990, it was 116 pages or 30 percent longer than the previous year. In 1990, 10,000 copies of report were printed, and most have been distributed to a wide range of audiences. Given that the report is so well received, CIHI and A.I.D. staff should consider some special effort to inform the media of its existence. For example, A.I.D.'s External Affairs office could issue a press release on the report or conduct interviews for AIDNET.

The review process for the Child Survival Report appears indicative of the careful and thorough approach taken by CIHI staff in

producing publications. The process is very time consuming because it involves reviews by S&T/Health, Regional Bureau and USAID Mission staff as well as Cooperating Agencies that may have contributed to the report. Generally there are few mistakes made and thus high overall satisfaction with the content of the report. One exception is that a few CA staff apparently did not see drafts of the FY 1990 report for review. It may have been the A.I.D. CTOs for these projects reviewed the material in lieu of the Cas. In the future, CIHI should send relevant sections to CA staff for their review as well as to the CTO.

One final comment is needed on the review process. Some see the review as a formal clearance on aspects of the report. While use of the term "review" rather than "clearance" is one of semantics, CIHI and A.I.D. might ease the process without a loss of quality by having staff review rather than clear the text. At the very least, attempts should be made to reduce the number of "rounds" of either review or clearance. Thus if review deadlines aren't met, the contractor has greater liberty to proceed with completing the publication.

2.e Pilot Activities

The contract discusses pilot activities under a section on analyzing user requirements. However, given the purpose of such activities as described in the contract and the way this set of tasks has been carried out, it seems most appropriate to review their implementation under the heading of analysis and dissemination.

The contract calls for a number of pilot activities to improve the quality of the data, decrease the cost of data collection, and increase the usefulness of the health information system. As will be obvious with the activities listed below, both A.I.D. and the contractor have interpreted pilot activities rather broadly. Of the 2-3 such activities with AID/W offices required in the contract, at least two have been carried out.

1. Assistance was and continues to be provided to S&T/Health in setting up two management information systems - one for monitoring project funding and the other for key document control. This work is supported by a buy-in.

2. The FY 1990 HIV/AIDS report to Congress was prepared.[2]

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[2] AIDS Report The contractor was asked by S&T/Health to prepare the report to Congress on the AIDS program in FY 1990. This appears to be a one time only request to the CIHI staff (applied to pilot activities) and therefore does not merit great comment although some is needed. The report was funded by a buy-in

This work was supported by a buy-in.

In the spirit of liberal definition of pilot activities, the Evaluation Team suggests that two other activities undertaken by CIHI should be considered.

3. Assistance was provided for a CDIE Impact Evaluation of Child Survival activities in Nepal with buy-in funding.

4. Assistance was provided to PPC/PB on the development of the ACSI system.

The contract also calls for 3-6 pilot activities with USAID Missions. Visits were made to the Dominican Republic, Guatemala, Haiti, Peru, and Pakistan. From these trips, activities were or are being developed in at least 3 and possibly 6 countries.

1. Assistance was provided to the USAID Mission in Pakistan in the design of a system to monitor project and program performance. This work was supported by a buy-in. CIHI staff will follow-up this assignment to see how the system is being used and if there would be opportunities for application elsewhere.

2. Initial assistance has been provided to INCAP in Guatemala by hosting a visiting fellow. CIHI may be asked to provide more assistance to INCAP in the analysis and presentation of health and nutrition data for Central America. Such further assistance would be contingent on a buy-in from ROCAP.

3. CIHI staff is preparing a report on Trends on Selected Health and Nutrition Indicators in Haiti in collaboration with

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from the AIDS program. By all accounts (both from those at A.I.D. and those outside), it is one of the best reports on the AIDS problem globally, approaches to dealing with AIDS internationally and A.I.D.'s activities. There were apparently substantial delays in producing the report in part due to problems in its printing. These problems were related to an underestimate of the cost of producing the report; the priority or lack of priority given to completing the report because of competing work (specifically the Child Survival Report to Congress); and a lack of clear understanding over who way to supervise various aspects of the printing. The AIDS staff has decided to turn to one of its own projects, AIDSTECH for subsequent reports. Since CIHI staff has more than enough work to do on the various contract requirements, this would seem to be a wise decision. In the future, S&T/Health management should weigh carefully the advantages and disadvantages of asking CIHI staff to take on such a major task despite the contractor's capability given an already full agenda.

the Haitian Child Health Institute. LAC has provided funding for this. (The prototype report for this series is discussed under Case Studies, page 14.) The report will likely be used as a key document for a planned CDIE Impact Evaluation of the Child Survival Program.

4-6. CIHI is preparing other trend reports for Belize, Bolivia and Nicaragua. These also are funded by LAC and could be interpreted as pilot activities since they will in all likelihood involve collaboration with local health institutions in each country and presumably help improve the collection and use of health and child survival data.

In sum, given a broad interpretation, the contractor is already more than fulfilling the requirements of the contract for pilot activities. This broad interpretation has the advantage of giving great flexibility to the contract. At the same time, since CIHI staff are asked and do respond to a wide range of requests, they should be given sufficient credit for having delivered the required outputs. Since pilot activities are usually undertaken as an experiment or test of an approach, CIHI staff should draw from these disparate activities whatever general lessons can be learned and provide the findings to others in the health field at A.I.D. and among Cas.

2.f Materials Repository

CIHI maintains a repository of materials which includes a variety of documents such as:

a. A.I.D. project reports, including evaluations, annual reports, etc. filed by country.

b. Material describing the health situation in various countries.

c. Technical reports from other agencies working in the health area, especially UN agencies, filed by subject.

d. Policy and strategy papers for topics in health prepared by A.I.D.

e. Source data for the Health Statistics database filed by subject.

Most of the documents in the repository come through A.I.D. channels at no cost. Other documents are ordered on an ad hoc basis by the staff when the need is perceived. No more than $1,000 has been spent in any year on the acquisition of materials. Approximately one person-month is devoted to maintaining the repository each year. Due to a shortage of space, many of the

older documents are transferred to the A.I.D library maintained by CDIE.

CIHI staff is the main user of the materials repository. The materials are used as background for the country-specific Health and Population Profiles and to support the preparation of the Child Survival Report. Other users are those who request information through CIHI's information service. It would appear that the materials repository is a minor but important component of the CIHI information service.

2.g Other Dissemination Efforts

The contracts call for the preparation of a dissemination plan through the standard reports, analyses and information service described above. In addition, the contractor is asked to disseminate information through presentations at professional meetings, etc. CIHI staff prepared a "Plan for Data Dissemination and Information Reference Service" in January 1990. This plan and the work described above more than meet the requirements of the contract. The only area which as yet has not received any attention is the preparation of policy dialogue tools. Numerous possibilities exist for the project to benefit from if more effort and resources are devoted to this area.

Among the suggestions for policy tools suggested during the course of the Evaluation Team's interviews are the following:

- Short (4-page) reports on specific health and child survival topics. One topic might be a summary of results from the well-received expert meeting on vaccination coverage which was sponsored by CIHI in January 1990. The report on "Aging Trends: Thailand" prepared by the U.S. Bureau of the Census was noted as a model.

- Wall chart or data sheet on selected health and child survival indicators (a la the Population Reference Bureau's <u>World Population Data Sheet</u>). Care would have to be taken so as not to duplicate PRB's data sheet. Perhaps CIHI and PRB could collaborate on a special data sheet focusing on health or several special columns in the existing data sheet to be devoted to health or child survival indicators.

- World Health Profile (a la the <u>World Population Profile</u> of the U.S. Bureau of the Census.) This would be a major undertaking and would probably require more time and resources than will be available under the contract. Graphics used in such a publications could also be produced as slides if the need exists. The Census Bureau, for example, produces slides on the <u>World Population Profile</u> charts.

- Short booklets (16 pages or fewer) highlighting success stories in health and child survival. Models for this would be publications of the IMPACT project of the Population Reference Bureau. These booklets can include four-color photographs which increases the production cost, but can also be done attractively in two colors.

- Computer presentations of health and child survival trends a la the RAPID project of The Futures Group. This project has already produced a computer presentation of a child survival model using data from the Demographic and Health Survey.

If such policy tools are considered, CIHI should draw on its (to be constituted) TAC to advise on priority topics. CIHI should also ask members of the TAC to review and sign their names to the publications. Publications which cite an eminent review panel may carry more credibility and weight than those without. Further, if CIHI embarks on preparing any of the policy tools, it should also give more thought to the various audiences who need such materials and the appropriate distribution strategies. The IMPACT staff of the Population Reference Bureau might be a helpful source of pointers on the issues.

Another aspect to the production of materials is their translation into foreign languages. CIHI does translate the HCSP questionnaire into French and Spanish, but to date no effort has been made to translate its other reports. Translation is an expensive and often complicated business. Some thought might be given to translating a summary version of the Child Survival Report to Congress into French and Spanish, but the additional benefit would obviously have to outweigh the financial and staff costs. This idea might best be left to a follow-on project.

The project may or may not have the staff or financial resources to develop any of the above policy tools. The Evaluation Team nevertheless considers that a project such as CIHI should produce a few highly visible and polished products such as the Child Survival Report, and other considerably smaller endeavors during the remaining life of the project. Such materials would be a useful "test" of their need and value and might help to guide the direction of a future health information project.

The Evaluation Team heard quite frequently from various sources in A.I.D. and outside that there was not a clear idea of what information was included in the CIHI databases, who had access to the data and how best to access the information. Periodic and at least annual briefings (following the publication of the Child Survival Report for example) would be very helpful in this regard. Slides of graphics draw from the databases would obviously be helpful as well as descriptions of how the information is used. Audiences for such briefings or presentations should include S&T/Health staff (this particular briefing might help dispel the

sense that CIHI serves more or less exclusively S&T/H/AR), Regional Bureaus (separate briefings for each RB scheduled during the regular staff meeting is one way to ensure good attendance), CDIE staff, Cooperating Agencies (perhaps at the annual S&T/Health meeting of CAs) and other health organizations. Preparing for and giving such presentations are time consuming, but the increased visibility of the project would improve general understanding of its role and capabilities.

Among some S&T/Health staff was the expectation that more analysis would be forthcoming under the project. It appears that between the case studies, information service, and preparation of the Child Survival Report and the various standard reports, over one-third of all staff effort is expended. The evaluation team found this a reasonable level of effort for analysis and dissemination. Looking at the overall level of effort, it is not clear how staff could devote substantially more time to analysis and dissemination without cutting back on existing activities or increasing the resources and staff available to the project.

Related to the issue of analysis of CIHI's health and child survival information is the problem of defining what types of information can best serve the different needs. The contract speaks of the use of data for planning, managing and evaluating projects and programs. CIHI staff has given some thought to what data lend themselves to what types of uses. However, much more reflection is needed (and clearly CIHI staff has not had the luxury of time for reflection given the service orientation of the project) on this broad topic by both the A.I.D. health staff, CIHI and the other health CAs. It would be useful for A.I.D. and CIHI staff to organize a retreat on this topic and simply brainstorm about what more can be done with the available data and what other information needs to be gathered and by whom. Such a retreat might then be followed by another brainstorming session with selected CA staff who are practitioners in one or all of the areas of planning, management and evaluation.

In summary, the Evaluation Team was very impressed with the quality and magnitude of outputs. It would seem that the original contract did not anticipate the level of effort that would be required to accomplish the various tasks. Modest gains in efficiency of data entry, for example, have been more than out-paced by additional information requests. For some tasks, the level of effort has actually increased over the first three years of the project. The Child Survival Report is a case in point. More could be done with the available health and child survival information, but only if CIHI staff can cutback on some existing work or increase the resources available to the project.

Findings:

1. The contractor has completed three of eight case studies with a fourth in draft and a fifth in its early phase. A.I.D. and CIHI determined that four of the eight case studies would be supported by buy-ins. Two of the five have been so supported. The agreement to make four of the case studies contingent on buy-ins has never been formalized.

2. The Information Service is used extensively by A.I.D. staff in various offices and by other organizations. Users are very satisfied with the quality and output of the service. The information service absorbs about 11 percent of project resources or 18 percent of S&T/Health's FY 1990 obligation.

3. CIHI and CDIE have no formal link. Such a link might increase and improve health information provided to USAID field staff.

4. The contractor has prepared an extensive number of standard reports on trends in funding as well as health and child survival indicators. These reports are used to disseminate such information and are used by some AID/W staff as a basic reference. The contractor has also prepared many country health profiles which have been well received (although the majority are still in draft awaiting A.I.D. review). These reports are distributed widely (within A.I.D. and among CAs) and, on the whole, selectively, based on the Users Study. AID/W staff received a stack of FY 1990 reports in one mailing which may have limited their use.

6. CIHI has routinely attended meetings of APHA and NCIH as one way of increasing the project's visibility. At the 1990 NCIH meeting, information about the CIHI reports was also disseminated. At these meetings a sign-up sheet was provided allowing conference participants to request more information or standard reports from CIHI. To date, only a few of the requests have been filled to those CIHI felt were most likely to benefit from the information.

7. The Child Survival Report to Congress is the centerpiece of the contractor's dissemination work. It is widely distributed and broadly praised. Staff resources required to produce the report have increased each year reaching about 10 percent for the FY 1990 report. By all accounts, such an expenditure is warranted.

8. The review process for the Child Survival Report is thorough and time consuming and seemingly worth the effort. Some modest changes in the process may be feasible without sacrificing quality.

9. The AIDS Report was considered to be of very high quality, but because of competing demands on the contractor's time and a misunderstanding on the budget and responsibility for printing, the report was late. In the future, AIDSTECH will produce the report.

10. Pilot Activities have been defined broadly by A.I.D. and CIHI staff. Such activities for AID/W have more than met contract requirements. Depending upon interpretation, the contractor may have nearly fulfilled contract requirements for such work with USAID Missions. Given the diverse nature of these activities, no effort has been made, as yet, to look for lessons learned.

11. The Materials Repository is a very small, but useful element of the contract.

12. The contractor has yet to develop any policy dialogue tools. Various possibilities exist which could further disseminate the health and child survival information maintained by CIHI.

13. Not all users or potential users fully understand CIHI's role as a data repository of health and child survival information. Nor do they always understand what information is available, how it can be used, and how to gain access to it.

14. Insufficient time has been spent by A.I.D. and CIHI staff assessing or reflecting on the use of the funding and indicator data for the different purposes of planning, managing and evaluating projects and programs.

15. CIHI's preparation of visual presentation materials has been minimal, predominantly due to lack of time and funds.

III. PLANNING AND BUDGETING

1. Annual Workplans and Semi-Annual Progress Reports

The process of developing an acceptable workplan was long and arduous for the contractor. According to the records, a draft first-year workplan was submitted to S&T/Health in August 1988, four months after the contract was signed. (The contract called for an initial workplan to be submitted within 60 days of the contract's signing.) This first draft was unacceptable to A.I.D.'s Cognizant Technical Officer (CTO) for the project and was returned to be revised with more detail. In February 1989, the contractor presented a five-year workplan and a short-term (three and one-half months) plan to the CTO.

The February 1989 five-year and short-term plans consisted of a listing of specific activities called for in the scope of work of the contract. This listing was broken down into a task breakdown structure which is very useful for tracking and assessing project progress. Except for due dates for some reports, the plans did not specify any milestones or targets against which project progress could be tracked in a specific time frame.

The five-year plan, in tabular form, did show the task breakdowns by year in which the tasks were to be "worked on" and by what CIHI organizational unit. Again no specific targets or milestones were specified. This type of plan does give the project CTO a full compendium of detailed actions to be carried out, but no committed time frame when the contractor will accomplish specific tasks. The third version of a five-year and short-term plan simply updated the previous version.

By May 1990, CIHI had developed, in response to urging from the project CTO, a revised Life-of-Project work schedule in a format that is much more useable as a tracking instrument. It lays out in task breakdown structure the detailed tasks and places target dates for each task and sub-task listed. It also provides for comments and status remarks about progress toward those activity targets.

A new format was adopted for the fourth Semi-annual Report (October 19, 1989 - April 18, 1990) which combined the five-year timeline schedule with a summary in tabular form of the status of project progress by a specific date, compatible with the five-year work plan schedule. The semi-annual report is now comprised of the five-year work schedule, a tabular summary of progress related to the five-year schedule, a summary of expenditures over the report period, and a narrative which deals with the status of project staffing and "priority problems".

The missing aspect of such a report is a schedule projected over the next six months of what the contractor expects to accomplish by target dates for specific tasks. This addition to the semi-annual

report would help both CIHI's contract management and the A.I.D. CTO to monitor progress, problems and their solution over a more appropriate time frame (i.e. six months).

The contractor has been reluctant to produce a detailed workplan or semi-annual report partly because it believes any workplan will be obsolete before it is approved. CIHI also believes that by virtue of their close proximity to and nearly daily discussions with A.I.D., their CTO, and their clients, that detailed monitoring of progress on specific tasks through reporting is less necessary. The team recognizes and lauds this close relationship. However, as stated above, the need to produce these detailed reports is essential. The team feels it is very important that CIHI address the particulars of how and when it will complete all of the items listed and agreed upon in the contract. If the workplan does indeed become obsolete, as verified in the semi-annual report, then CIHI should refer to its request tracking system and other documentation of changes in workload to show A.I.D. and itself why the discrepancies occurred. Only then will CIHI and A.I.D. be able to review the contract deliverables and amend the contract as necessary to reflect the change in expectation and release ISTI from contract obligations it may not be in a position to fulfill at the end of the project.

Findings:

1. After a rather arduous process, the contractor developed a useful format for both the annual workplan and the semi-annual report.

2. While a useful format has been developed, the team is not sure if the contractor sees the value of using the reporting process for managerial control of the project or the importance of documenting the progress of contract deliverables.

2. Funding

2.a Contract Budget and Sources of Funding

The original contract for the CIHI project established a life-of-project budget of $5,999,989. Funds were to be obligated to the contract incrementally throughout the five-year life of the contract. The contract stated that a portion of the overall funding would be met through the "buy-in" mechanism from bilateral (USAID Missions) and non-bilateral (A.I.D. Central and Regional Bureau) sources. The original contract did not stipulate or estimate a breakdown between "core" funding from S&T/Health sources and "buy-in" funding from bilateral and non-bilateral sources.

The contract made a clear distinction between "bilateral" funds obligated to the contract through a discrete delivery order, and

"non-bilateral" funds which would normally be obligated to the contract by a contract modification. This distinction is particularly important because of the way these different sources of funds may be used and accounted for.

Although both bilateral and non-bilateral funds must be accounted for separately by source of funds obligated to the contract, i.e., PIO/T, bilateral funds obligated under a discrete delivery order may be used only for performance of the work order. At the conclusion of the contractor's performance under a delivery order, any remaining funds (in excess of those needed to perform the order) will revert to the original source and be deobligated from the contract. On the other hand, buy-in funds using non-bilateral sources from bureaus and offices other than S&T/Health, which are in excess of the costs of performance of the activity for which these funds were obligated, do not revert to their source, but rather remain available for expenditure as though they were provided as "core" funds by S&T/Health.

2.b Budget Performance

At the midpoint in the life-of-project (September 30, 1990), A.I.D. had obligated $3,322,727 to the contract ($2,598,988 in core funding and $723,739 in buy-ins). Core funding from S&T/Health has varied during the first three years of the project as follows:

FY 1988	$ 853,988
FY 1989	995,000
FY 1990	750,000
Total	$2,598,988

The contractor has been quite successful in generating a range of buy-ins from various sources. In fact, 22 percent of obligations have come from buy-ins.[3] Of the 15 buy-ins received, 9 came from Regional Bureaus, five from Central Bureaus, and only one came from a USAID Mission. (See Attachment 10 for a breakdown of buy-ins by source.)

Several of these buy-ins have helped to meet contract deliverables. Two of eight case studies were so applied, as were three of the

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[3] The main activities supported through buy-ins are:

1. Development of nutrition project databases (AFR and LAC);
2. Analysis of health indicators and preparation of regional and country-specific reports (LAC);
3. Assistance for evaluation and monitoring activities (PPC/CDIE, FVA/PVA, USAID/Pakistan);
4. Development and installation of management information systems (S&T/H);
5. Assistance in preparing a report to Congress on HIV/AIDS.

pilot activities. Buy-ins present opportunities as well as dilemmas for this contract as with most A.I.D. contracts. Even though the tasks fall within the scope of the contract, they invariably require a level of effort above and beyond the specific deliverables. (It is hoped that the newer contracting mode which involves separate contracts for core and buy-in funding under the same project lessens this dilemma.) The CIHI contract is no exception. While the contractor has been encouraged by A.I.D. to seek buy-ins and has more than succeeded in doing so, it may have trouble meeting deliverables or will find itself doing far in excess of what was originally envisioned or even required.

In terms of the overall level of expenditures, the contractor has demonstrated good performance. As of September 30, 1990 or the mid-term of the project, a total of $2,785,962 ($2,432,078 of core funds and $353,884 of buy-in funds) had been expended.

This amounts to an expenditure of 84 percent of funds obligated and 46 percent of the original LOP contract budget. (See Attachment 11, Table 2 on Expenditures by Source of Funds from CIHI Quarterly Financial Report No. 10) for a breakdown of all funds obligated, expended and remaining by source. The average burn rate over the project's first 30 months was $92,865. The burn rate for the most recent quarter was $125,988. Such a level of expenditure can not be sustained given present funding commitments.

Accompanying the most recent Quarterly Financial Report, the contractor prepared two budget scenarios: one based on full funding of the contract and the other based on $727,262 less in core funding yielding a LOP budget of $5,272,291. The reduced level is based on a March 1990 letter from S&T/Health to the contractor. In this letter, the contractor was advised that A.I.D. would provide only $750,000 per year for FY 1990, 1991 and 1992 in core funds. This amounts to nearly $245,000 less per year than had originally been planned.

The two budget scenarios show the difference in the monthly funds which would be available to the project: $107,134 assuming full funding and $82,892 assuming reduced funding. Both of these scenarios assume another $450,000 in buy-in funding will be obligated to the project. The level of future obligations will therefore have important implications for the contractor's performance in the second half of the project.

At the request of the Evaluation Team, the contractor prepared an analysis of expenditures and level of effort. This analysis covers the second year of the project from April 1989 through March 1990. (See Attachment 12 for Approximate CIHI Expenditures and Level of Effort by Unit and Task.) The table on the following page is drawn from that information.

The level of effort and expenditures are fairly well distributed among tasks. If work on the questionnaire and HPD is combined, nearly 20 percent of the contract was devoted to those tasks. Preparation of the Child Survival Report consumed 10 percent of the project's effort. Work on case studies and pilot activities together accounted for over 17 percent of effort. Given that these types of activities lend themselves more to buy-ins, it is likely that efforts on these areas would at least remain this high if not increase given the project's need for additional funding. Administration and management consumed a sizeable proportion of the budget, about one-quarter of the staff effort. Based on this breakdown, it is obvious that at least 75 percent of the effort and expenditures is devoted to core activities. This estimate does not include any work on case studies or pilot activities, a portion of which must be considered core as well. In sum, there isn't a great deal of flexibility for reducing core funding without reducing core activities.

Task	Percent Level of Effort	Expenditures
Questionnaire	10.0	10.2
HPD	8.3	7.6
combined	(18.3)	(17.8)
HSD	4.9	6.7
Case Studies[1]	7.5	8.4
Information Service	11.3	10.7
Standard Reports	4.3	4.8
Child Survival Report	10.0	10.1
Pilot Activities[2]	9.7	9.2
Other (LAC/Nut,AFR/AIDS,etc.)	8.6	9.6
Administration and management	25.4	22.7
Total	100.0	100.0

[1] Includes LAC indicator report and AFR Nutrition Strategy.
[2] Includes S&T/H MIS, HIV/AIDS report, USAID/Pakistan assistance.

2.c Future Funding

The contractor has produced two documents which can be used in determining the future funding and direction of the project. The first was prepared in response to an October 1989 letter from S&T/Health to ISTI. (See Attachment 13). The letter discussed the growth in the CIHI project, the expanded number of activities generated by buy-in funding, and the consolidation of core

activities. The letter expressed concern about the adequacy of the project's organizational structure and internal management systems to respond to increased complexity and demands being placed on the project. ISTI corporate management was asked to work with the project's management staff to develop: 1) a revised management strategy taking into account additional staffing needs created by buy-ins and the impact of these requirements on funding for the contract, and 2) a revised LOP work plan reflecting the revised management strategy and staffing needs.

ISTI responded favorably to the request and stated that an effort would begin almost immediately to develop a revised strategy and funding analysis. (See Attachment 14) To date, A.I.D. has not received the results of the internal management review. The Evaluation Team did receive a copy of a draft "Summary Findings and Recommendations of the USAID HIS Project which is dated May 1990. (See Attachment 15) The draft takes into account A.I.D.'s planned reduction in core funding for FY 90-92.

The reduced level of core funding forced the contractor to assess the implications on the project's ability to meet the original contract requirements. ISTI's draft response rightly points out that the contract does not stipulate what portion of the work scope is contingent on buy-in funding. An increase in buy-in funding also does not necessarily relieve the core funding problem since buy-ins usually require additional staff effort. The draft report also notes that since the beginning of the project, certain costs had increased (e.g., printing costs for the Child Survival Report which apparently had not been included in the contract budget and fringe and burden rates).

The draft analysis prepared by ISTI makes the following recommendations for accommodating to a reduced level of core support:

1. Identify certain tasks in the scope of work that can be made contingent upon receiving adequate buy-in funding, e.g., Mission and AID/W pilot projects; four of eight case studies; an innovative policy dialogue tool; and the major collaboration with PPC.

2. Terminate the demographer position in the core staff and cover this expertise with consultants when needed, and adjust all required core staff person-months to reflect and be contingent on actual funding levels.

3. Reduce the time that key personnel charge to the project (by charging time to other projects), but ensure that CIHI receives absolute first priority for use of their time.

The Evaluation Team considers that the draft analysis prepared by ISTI identified the key issues needing resolution and that the

recommendations address those issues. It is clear that the reduction in core funding will mean dropping or cutting back on some tasks in the contract's scope of work. Even though the contractor has proposed in the May 1990 draft a way to reduce costs, the revised management strategy has never been presented formally to S&T/Health.

A second analysis of the project's activities and funding was prepared by the new project director to inform the Evaluation Team. (See Attachment 16 for "An Analysis of CIHI Activities," December 5, 1990.) The analysis reviews essential tasks, staff time and funding required for a one-year period from November 1, 1990 through October 31, 1991. The analysis is very helpful, but needs to be compared to contract deliverables such as case studies and pilot activities. Further, the analysis should take advantage of estimates on the level of effort and expenditures by task which CIHI prepared for the evaluation. These estimates could be used to estimates future levels of effort for such tasks as the information service. The analysis also has an anti-consultant bias which seems unnecessary since some of the work, such as pilot activities, could very nicely be assisted by consultants.

Under this analysis the 12-month budget is $802,420 or $66,868 per month. The budget does not include the cost of an associate director for the project. Without restoring core funds and assuming additional buy-in funding, it would seem that this position is affordable and is warranted on both management and technical grounds. This analysis should be another key document in the discussions between the contractor and A.I.D. on future directions and funding.

Findings:

1. The original contract contained a scope of work that did not differentiate what tasks would be funded by core vs. buy-in support. This ambiguity in the specifics of the contract budget did not constrain the use of funds so long as the contractor could treat non-bilateral buy-ins as fungible with core funds. However, as is typical with many such buy-ins, there were specific sets of tasks and additional effort was required on the part of the contractor. Thus the non-bilateral buy-in funds didn't serve as additional core funding.

2. At the mid-way point of the contract, the rate of expenditure is good. The average monthly burn rate has been $92,865, although it was much higher in the most recent financial report.

3. With the reduced core support in FY 90-92 and assuming $450,000 in future buy-ins, the LOP funding estimate is $5,272,291. At this reduced level, the average monthly burn rate should not exceed $82,892 for the rest of the project.

4. Based on the contractor's estimates, the Evaluation Team concluded that well over 75 percent of the major project tasks are devoted to core activities including the annual questionnaire, maintaining both the HPD and the HSD, standard reports, and the Child Survival Report. This leaves little room for cutting core funding without cutting back on core tasks.

5. The contractor prepared a draft revised management strategy, taking into account funding cuts, which identifies the key issues and suggests recommendations. This strategy has not been finalized or presented officially to A.I.D.

6. For the evaluation, the contractor prepared another analysis of activities and funding in November 1990. The analysis describes which core activities should and can be maintained given reduced funding.

7. The Evaluation Team believes that A.I.D. staff recognize that the project has increased in complexity and has more demand for its services. At the same time, S&T/Health is reducing the budgetary resources available for the second half of the contract.

IV. ORGANIZATION AND MANAGEMENT

1. Organizational and Staff Structure

CIHI has been organized since July 1, 1989 as shown on the first chart of Attachment 17. This structure parcels out responsibilities for direction, administration and three line units: Operations Unit (database development and maintenance); Development Unit (data interpretation, statistical analysis, quality standards, resource for technical reports, linkage to data sources, special studies and reports to Congress); and a Communications Unit (distribution of standard reports and special reports to Congress, mailing and logging in annual questionnaires, data and information presentation). For the first two years of the contract, this organizational structure and its management has served the project well judging by the response from users of CIHI's output who consistently gave high praise for the quality and speed with which health information (regular and special reports) has been provided.

The second organizational chart (Attachment 17) in effect as of November 1990, maintains the same organizational structure but shows a reduction in direct project staff of two positions and a reduction of two consultants. As indicated in the project director's cover memorandum (Attachment ..), this reduction and reconfiguration of staff responsibilities was done to accommodate reduced funding levels.

The contractor complied fully with the contract's Key Personnel clause requirement to inform and acquire AID/CTO written consent on any changes and replacements for key personnel. Attachment 18 has copies of the exchange of correspondence between ISTI and A.I.D. documenting the staff changes and reassignments.

Finding:

The Evaluation Team considers the current organizational and staffing arrangement as an interim measure in response to a reduction in expected funding. A decision on the organizational structure and staffing for the remaining years of the contract will need to be made in conjunction with the review of the project's revised management strategy. (See Recommendation 2 on Section III.)

2. Internal Monitoring, Review and Reporting

2.a Internal Monitoring and Reporting

CIHI is one of a number of contracts that ISTI has in the health, population and nutrition areas. The Director of CIHI reports to Jean Shaikh, Head of the Health, Population and Nutrition Group at

ISTI headquarters. The division of responsibilities between CIHI and ISTI headquarters is generally on administrative and technical functions. ISTI headquarters provides administrative policy and support to CIHI, e.g., accounting, payroll, payments to vendors, filing vouchers with A.I.D., issuing corporate policy on salary rates, fringe benefits, recruitment of staff and consultants, and periodic management reviews of CIHI. CIHI, however is allowed full independence on technical matters regarding the development, maintenance and use of the HIS.

There is close daily collaboration between CIHI and ISTI headquarters on administrative and policy matters. ISTI headquarters, on the basis of detailed information provided from CIHI, prepares quarterly financial reports; and recently -- in connection with its internal management review of CIHI -- has helped CIHI revise its semi-annual progress report format and workplan.

Although CIHI has the basic responsibility for marketing its capabilities and resources, ISTI is now, according to Jean Shaikh, devoting more effort to marketing CIHI, particularly in overseas A.I.D. Missions.

In a previous section of the report, the breakdown of expenditures and level of effort by task and by unit (Attachment 12) was discussed. The Evaluation Team found this a reliable aid to understanding the distribution of LOE application to the several tasks called for in the contract scope of work. Of particular interest was the fact that the spreadsheet showed that the information service consumed the largest amount of staff time for any single task identified. The service has grown as more parts of the Agency have found what CIHI has in its databases and how effectively it can provide pertinent health and health program information to individual users. The Evaluation Team believes that the demand for this information service will continue to expand. CIHI would be well-served if it expanded its current internal monitoring system to keep track on a regular basis of the person-loading and budgetary use on a scope of work task basis, using a format similar to the one developed and shown in Attachment 12.

Findings:

1. The internal monitoring and review procedures involving the project staff of CIHI and headquarters staff of ISTI appear to be adequate and working smoothly, although as the project nears conclusion closer monitoring of contract deliverables may be necessary. ISTI is available to the project on a regular basis and as specific needs arise.

2. The contractor prepared an analysis for the evaluation which estimated expenditures and level of effort by contract task and organizational unit. This breakdown was very useful in seeing

where most of the contract's effort in that one year period was focused.

2.b Reporting Requirements

The contract has specific reporting requirements that must be met. The five-year workplan and the semi-annual report have been addressed in section III.A above. The on-going management reports specified in the contract have in general been well-received and are considered to be of good quality by the AID/CTO. These include the Annual Response to the Health and Child Survival Questionnaire and all trip reports. The frequency and detail of the financial reporting has been very good.

It is clear that both S&T/Health and the contractor expected changing priorities over time which would have the potential to disrupt on-going or planned CIHI activities. Thus the contract calls for the contractor to "immediately notify the AID/CTO in writing in the event that circumstances arise that have or may have an adverse impact on the timely performance of the contract or the incurrence of costs under this contract." Apparently this kind of notification has been done occasionally, but not consistently. It has also been noted that follow-up memoranda documenting verbal agreements about type or date of deliverables have not been consistently prepared and distributed.

Experience during the first two and one-half years of the contract shows that disrupting, but important, assignments do arise. In the future, the contractor should consistently discuss with the AID/CTO by phone or in a brief meeting the consequences of responding to extraordinary requests. Such a discussion is particularly important because these requests can be made by individuals in many parts of the Agency. As a follow-up, a short memorandum of record must be prepared and distributed to key A.I.D. staff, including the CTO, laying out the impact of "unexpected" tasks on the regular work of the contract. Such memoranda would provide a paper trail of the discussions and could be used by the contractor and the CTO to revise the timetable for deliverables.

Excessive formalization can harm good working relationships. The team's goal is not to damage the excellent informal daily relationship between CIHI and the CTO. However, the team saw instances where the informal relationship did not work to the benefit of the project and the lack of formal documentation on project activities was detrimental. Documenting what has happened, if written judiciously, need not be adversarial; often it is the only way to clarify events or explain the rationale for decisions.

Such follow-up memoranda is important with other parties as well. For example, decisions made with offices buying-in to the project need to be documented. Some of the problems with the HIV/AIDS

report might have been avoided if memoranda of understanding on the content and process of the report had been prepared.

One final concern on reporting is that reports and documents frequently were not clearly dated. While the contractor's staff was easily able to identify the right dates, care should be taken in the future to date clearly all reports or documents.

Findings:

1. In general, the reporting has been adequate. The Annual workplan and progress reports have progressed and will be more useful if the recommendations suggested above are taken.

2. The contractor has not consistently informed the AID/CTO about the impact of various demands on the project's work scope. This coupled with the very responsive nature of the project's staff may have adverse consequences for timely performance on some contract deliverables.

3. The front office of S&T/Health seems not to appreciate how busy the project staff is or to understand delays in completing activities (e.g., S&T/H MIS or more analysis).

3. Relationship between CIHI and A.I.D.

The CIHI project was designed and has been managed by staff currently in S&T/H/AR. In fact, the now chief of the Applied Research Division designed the project when she was a member of the Front Office staff. When the AR Division was created in 1988, management of the project was transferred to that Division. In 1989, another staff member (who is currently a TAACS/IPA at Johns Hopkins and not a direct hire) became the project's CTO.

In general, both CIHI and S&T/Health have very favorable opinions about each other regarding the project's performance and management. However, there are aspects of this relationship which have complicated the project's implementation. The following describes the findings in several problem areas.

Findings:

1. Within S&T/Health and its contacts, there is a perception that the project belongs to the Applied Research Division. Given the number and range of information requests, it is clear that CIHI serves a wide audience. A good many demands on CIHI staff time do come from AR as well as the Front Office although AR also serves as the conduit for many requests from other parts of A.I.D.

2. CIHI staff is very responsive to requests for information and assistance. This is desirable and to be expected since the project

depends in part on buy-in funding. However, a greater measure of coordination or control over what and how much CIHI responds to would be beneficial.

3. S&T/Health (including the Front Office staff) and other A.I.D. staff must be sure either to go through the CTO for important or time consuming assignments or at a minimum inform the CTO as soon as possible. This is particularly important for the now chief of AR given her past role with CIHI. On the other hand, CIHI staff should always confer with the CTO if a request comes from another individual on the A.I.D. staff. (CIHI has a detailed procedure for screening ad hoc requests, and this has generally served the project well.) Given that the CTO is not a direct hire, it may be that other staff do not pay sufficient heed to her critical role.

4. As was mentioned in an earlier section of the report, there is a perception on the part of key S&T/Health staff that CIHI should be more "proactive" in conducting analysis of data and pointing out to S&T/Health interesting trends or anomalies in the data. Coupled with this perception is a lack of understanding (the CTO excepted) of how complex the project has become, how certain aspects of the work have increased, and how busy the CIHI staff are.

5. One specific incident reflects a problem in A.I.D.'s dealing with the contractor's staff. The contractor arranged a meeting to discuss infant mortality rates for the Child Survival Report to Congress. The meeting was called on short notice because of the availability of a technical expert on the subject. Both S&T/Health and Regional Bureau staff were invited. Due to travel and other commitments, only one member of the S&T/Health staff attended while many staff from the Regional Bureaus did so. Given that CIHI is a central project, some individuals in S&T/Health were concerned because they were not leading the effort. At a subsequent technical meeting, S&T/Health played a more prominent role. Unfortunately, the perception on the part of the contractor is that initiative is not always appreciated. One further repercussion of such an incident is that CIHI may be perceived as too dependent on A.I.D. and that information is not very accessible. These are not desirable perceptions if CIHI is to serve the larger community as a data repository.

4. Coordination with Other Agencies

As has been discussed in previous sections, contributors to and audiences for the project's work are varied. One such group is the Cooperating Agencies of S&T/Health. These organizations provide information on their projects in the annual HCSP questionnaire. The CAs also are users of CIHI's information service. Unfortunately, among some CAs is the impression that CIHI is not in existence to serve their information needs, but rather to collect data from them and report to Congress. There is also the perception that access

to the databases is limited because the information is confidential.

Other agencies with whom the contractor works are those institutions from whom statistical data are collected. These are primarily WHO, the United Nations and the U.S. Bureau of the Census. Individuals from these institutions confirmed that there were no formal agreements on sharing data with CIHI. None of them felt a formal arrangement was necessary. In general these institutions publish information on a regular basis, and CIHI can use data from these reports. These same individuals said they would be willing to participate in an advisory capacity to the project.

5. Technical Advisory Committees

The contract calls for one or more advisory panel(s) on an as-needed basis to review technical and scientific issues and to foster the improvement of data quality. The contractor did hire several consultants on an ad hoc basis as advisors and held one expert meeting on vaccination coverage; no technical advisory committee (TAC) was set up. In fact, the contract is somewhat vague about the role of a TAC given the "as needed" wording. However, the Evaluation Team understood from A.I.D. that this was expected.

One reason for appointing a TAC is to improve the quality of the indicators used for health and child survival programs. Separate committees or subcommittees would need to be appointed to address the different areas such as immunization, nutrition, diarrheal disease/oral rehydration, water and sanitation, AIDS, etc. Committee members should consist of A.I.D. personnel and individuals from other organizations (A.I.D. contractors, international organizations such as WHO, the UN, etc.). Among the questions which TACs could address are the following:

> Which indicators should we measure?
> What are the most appropriate methods to measure the indicators?
> How should the indicators be interpreted?
> Who should be the lead agency to maintain a database of the indicators?
> How should the information on the indicators be shared?

The decisions made by a TAC would affect the annual HCSP questionnaire. These TACs would need to meet on a periodic basis to determine if there is a need to update the indicator information. CIHI and A.I.D. sponsored a meeting on immunization indicators in January 1990 which many of the participants thought was useful. This meeting could serve as a model for other topics. For some areas, there are already existing expert groups (e.g.,

PRITECH with diarrheal diseases) that A.I.D. and CIHI should work with closely.

At the mid-point in the contract, the decision to appoint a TAC depends on the role that S&T/Health and the contractor agree the project should play in its second half. The Evaluation Team concluded that a TAC would help establish a consensus for CIHI to play a broader role as a central repository and would enhance CIHI's credibility.

V. CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The Evaluation Team concludes that the contractor has performed very well in carrying out the contract's scope of work. In addition, the project has been extremely responsive to the diverse and increasing demands placed on it by various offices at A.I.D. However, the contractor's very responsive performance was not accompanied by adequate reporting to A.I.D. on the impact of the increasing demands. For its part, A.I.D. has not recognized the increased and often competing demands on staff time and has not provided clear guidance in setting priorities or adjusting the contract's workscope.

Beginning in FY 1990, the contractor faced a reduction in core funding, while still trying to carry out the original scope of work plus responding to various other demands. Without a restoration of core funding, the contract's scope of work will need to be modified substantially. Given the strong performance during the first half of the contract, the Evaluation Team recommends that S&T/Health restore core funding to the original, planned level to enable the project to fulfill its mandate and provide a much needed service to A.I.D. and the international health community more generally.

Recommendations on the Contractor's Performance

1. Development and Maintenance of the Health Information System (HIS)

1.a Health Projects Database (HPD)

1. Given the critical nature of these data to the Office of Health, CIHI should continue to collect funding information in the annual Health and Child Survival Project Questionnaire, and other sources. Every effort should be made, however, by S&T/Health to reduce the level of effort needed by CIHI staff to carry out this task by keeping the information collected to a minimum and limiting last minute changes which greatly increase the production costs.

2. CIHI, the appropriate Child Survival Task Force representatives and A.I.D. staff[4] should systematically review the data collected in the 1990 questionnaire to determine what information is actually used (of both funding and indicators data from the various schedules) and what might be dropped in the future. As part of

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[4] The use of A.I.D. staff vs S&T/Health is intentional. A.I.D. refers to the larger group of interested parties including Regional Bureau staff.

this review, the need for sub-sub-project data should be reconsidered.

3. S&T/Health should consider the collection of expenditure data in place of obligation data for sub-projects (whether bilateral, PVO, central or regional).

4. An analysis of differences in the results of the 1990 questionnaire and PPC's ACSI system should be conducted by CIHI as soon as possible to determine if some obligation data can be dropped from the CIHI questionnaire.

5. S&T/Health should monitor closely further assistance by CIHI to PPC to keep to a minimum the demands on the contractor.

6. CIHI should acquire from WHO relevant AIDS/HIV data for the HSD and in consultation with S&T/H/AIDS consider dropping some items on Schedule 6 such as the number of reported AIDS cases and HIV seroprevalence rates.

7. CIHI should prepare a short graphic summary of funding trends (à la Standard Report No. 2) by country for each region from the 1990 questionnaire and send this to the USAID Missions to give them feedback as soon as possible.

8. S&T/Health Cooperating Agencies should be informed as early as possible of changes to be made in future questionnaires to give them more time to collect the information.

9. CIHI should continue to follow the careful procedures used in scrutinizing data provided to the HPD and tracking changes made to the databases.

10. S&T/H should consider expanding the database to include all A.I.D. "health" related activities regardless of funding source, especially population information.

1.b Health Statistics Database (HSD)

1. CIHI should complete its systematic review of data sources to determine if there are major improvements needed on the database.

2. S&T/Health and CIHI together should consider establishing formal links with the data sources to ensure that regular procedures are in place to obtain data on a continuing basis. At the same time, it would be desirable to constitute a Technical Advisory Committee (TAC) for the project which would necessarily include representatives from the data sources.

3. CIHI and S&T/Health should review jointly the desirability of CIHI's devoting more effort to becoming a key data repository for

health information. This could be a topic for consideration for a first meeting of a TAC.

4. CIHI should work closely with the S&T/H/AIDS staff to establish an arrangement with WHO to obtain the needed AIDS/HIV data and make sure that the various AIDS projects have easy access to these data.

5. CIHI and S&T/Health should review the decision to use UN demographic data in the HSD and preferably confer with the TAC prior to making a decision. (Presumably staff from the U.S. Census Bureau as well as UN agencies and users of the data would be party to such discussions.)

1.c Analysis of Hardware/Software Needs

1. It would not be cost-effective at this time to design the databases to be more accessible to non-CIHI personnel. Fostering closer working relationships with these other groups may be the most efficient way to make the data more accessible at the least cost.

2. CIHI and S&T/Health should assess the need for a LAN to improve the efficiency of the project. If a LAN is installed, tighter security for restricting access to information is required.

3. The contractor should also check out the possibility of exchange one or more of the MAC computers for a more efficient lap top or other computer.

4. The contractor should also monitor more closely the performance of the computer maintenance subcontract.

1.d General

1. CIHI places too much reliance on single individuals for comprehensive understanding of each database. CIHI should provide more training to personnel in the use of the databases.

2. A.I.D. and CIHI should decide on the disposition of the databases before the end of the project. If the database is to be transferred to another institution it should be in a form that is easy to access and utilize.

2. Analysis and Dissemination of Data

2.a Case Studies

1. CIHI should review with A.I.D. proposed topics for the remaining case studies and determine if these are still high priority. An alternative topic, which could count as a case study,

might involve CIHI's producing a short report or booklet on the vaccination meeting. Holding additional expert meetings (such as the one on vaccination coverage) might be useful alternatives as well.

2. The project CTO and CIHI should provide formal documentation to the contracts office (and perhaps initiate a contract amendment) confirming the decision to make four of the eight case studies contingent on buy-ins.

2.b Information Service

1. CIHI should maintain a record of person-hours spent on completing each ad hoc request to monitor better the level of effort on the Information Service.

2. CIHI should hold several briefings each year on the HIS for A.I.D. staff (all S&T/Health staff, CDIE, Regional Bureaus, etc.) and staff of the CAs and the PVOs. These users need to know what information is included in the HIS, how it is used, how the data can be accessed, what reports are available and how to get more copies. In a similar vein, S&T/Health should cable USAID Missions on CIHI's behalf describing the role of the HIS and how Missions can access the information, either directly or indirectly through CDIE.

2.c Standard Reports

1. CIHI and A.I.D. staff should review the topics for standard reports prior to their preparation in 1991, to ensure that each is needed. Similarly, the formats for the reports should be reviewed with users to facilitate use of the data.

2. S&T/Health and CIHI staff should urge faster review by the Regional Bureaus of the country health profiles so that those currently in the pipeline can be completed and distributed.

3. The order form in the "List of Current CIHI Publications" should be changed to a check list and placed at the front of the listing.

4. CIHI should continue to be discriminating in its distribution of reports including to AID/W staff, but should also consider whether groups beyond the A.I.D. and CA audience might be interested in receiving some of the reports.

5. More extensive dissemination activities (including responding to all requests for information gathered at NCIH and APHA) will increase publication, mailing, translation and other costs. High quality visual presentation materials can also be expensive. If

A.I.D. chooses to expand these activities, which would heighten awareness of the project, additional line-item funds should be found to provide this service.

2.d Child Survival Report to Congress

1. With the publication of future reports, CIHI and S&T/Health should approach the media (including staff from A.I.D.'s External Affairs office) about publicizing the report.

2. S&T/Health staff should work with CIHI to see if the "review" of the report can be less time consuming and costly. In the review process, CIHI should be sure to give draft copies of relevant sections to CA staff as well as to the various project CTOs.

2.e Pilot Activities

1. S&T/Health and CIHI should consider applying several tasks performed under the contract (e.g. assistance to PPC/PB and to PPC/CDIE for an evaluation in Nepal) to contract requirements for pilot activities.

2. Despite the diversity in pilot activities, CIHI should search for lessons learned (à la the Pakistan assistance) that might be useful in other settings.

3. CIHI and S&T/Health should work together to ensure that sufficient time is available to complete the various pilot activities underway or pursue other interesting possibilities in lieu of reports on trends in health indicators if these are not applied to fulfilling the contract requirements.

2.f Other Dissemination Efforts

1. CIHI and A.I.D. should review the policy tools suggested in the evaluation report and select one or two of highest priority for the remainder of the contract. These could be used to fulfill requirements for case studies and/or pilot activities if need be.

2. CIHI and S&T/Health staff should organize a retreat (perhaps with other CA staff) to brainstorm about what more can be done with available funding and indicator data and how this information can best be used for planning.

Recommendations on Planning and Budgeting

1. Workplans, Progress Reports, and Funding

1. The contractor should continue to use the most recent format for the semi-annual report but should add an element. A six-month projection of targets for specific activities should be made. In the subsequent semi-annual report, the contractor should report on progress as a comparison against the six-month projected targets. It is also recommended that the problems section of the report separate "administrative" from "technical" problems and prepare specific actions for the next reporting period (with target dates) to address the separate problems.

2. ISTI should formally present its revised management strategy to S&T/Health for consideration. The presentation should be based on the May 16, 1990 draft given to the Evaluation Team, except that circumstances have probably negated the possibility that collaboration with PPC will be financed through a buy-in from PPC. If the assistance to PPC will continue, the task will have to be treated as a core activity and budgeted as such. S&T/Health may require a fuller exposition of details backing up the May 16, 1990 one-page summary. This presentation should also incorporate the additional analysis prepared in November 1990 by the project director. Finally, the presentation should specify the staffing requirements for the balance of the contract -- core positions, descriptions, names, percentage of time for each to be used on the project, and projected consultant time.

3. The contractor should present for A.I.D. review and approval, a revised budget based on the management strategy that it presents (from No. 2 above). The budget should clearly show what tasks included in the contract scope of work will have to be reduced or dropped if additional fungible buy-in as well as other buy-in funds are not received.

4. The contractor should increase staff time on certain activities in the scope of work, e.g., hire an associate director for the project, internal tracking of level of effort for ad hoc requests, further development and expansion of the semi-annual work plan, additional analytic work, preparation of policy tools, etc. All of these activities and staffing will require additional funds to implement. The Evaluation Team therefore recommends that A.I.D. carefully consider adding more funds (hopefully to fully fund the contract if at all possible).

5. Any decisions made to change the number and scope of the contract deliverables, as a result of the new management plan or budget should be followed-up with the appropriate contract modification. The contractor should monitor closely the progress of project deliverables by using the workplans described above.

Recommendations on Organization and Management

1. Organization and Staff Structure

1. The contractor should consider dropping the Communications Unit (currently non-functioning), continue to redistribute its more routine functions to the Operations Unit and cover any additional "creative" responsibilities (e.g. presentation and marketing, etc.) by the project director, associate director and newly configured Development Unit.

2. The current Development Unit should be renamed the Analysis and Dissemination Unit with a reformulation of its function to include any residual functions from the Communications Unit and with additional emphasis on analytic work.

3. An associate director should be hired who has management qualifications and strong technical expertise in public health. This individual would assume overall duties in quality control, presentation development and marketing of buy-ins, as well as sharing overall administration of the project with the director.

4. With the promotion of Roy Miller to the position of director, the ISTI corporation should provide him with appropriate management and executive training. The ideal time is now, or as soon as possible, since he has recently assumed his new responsibilities.

5. A.I.D. should consider placing a Child Survival Fellow at CIHI to assist in the analysis of the health project and statistics information. In addition, there is some interest at present in having fellows work overseas. Perhaps a fellow could work on assignments for CIHI in the field as well as in Washington, D.C.

6. There is apparently a lack of name recognition with CIHI and at the same time confusion over ISTI's name on the annual questionnaire. These might be resolved by choosing a new name with a good acronym for the project.

2. Internal Monitoring, Review and Reporting

2.a Internal Monitoring and Reporting

1. CIHI should set up and maintain on a continuing basis a systematic collection of expenditures and level of effort by contract task and organizational unit. Such a system would provide the contractor with an excellent internal monitoring and management tool and a very good monitoring instrument for the AID/CTO.

2.b Reporting Requirements

1. The contractor should keep the AID/CTO informed verbally and followed by memoranda of any request that has an adverse impact on

the project.

2. Memoranda of record should also be drafted defining any major task changes (in time for delivery or substance) in the work scope and these should be distributed to the AID/CTO and other key staff.

3. Concurrence memoranda should be prepared to clarify content and process of major tasks that have no scope of work, but have been discussed verbally. Copies of such should of course be given to the CTO.

4. All official reports should clearly indicate: a) dates of the reporting period, and, b) date of report preparation.

3. Relationship between CIHI and A.I.D.

1. Both the CIHI and S&T/Health staff should coordinate work related to the project through the AID/CTO. It is the responsibility of all parties to keep the CTO aware of any activities going on, but it is the primary responsibility of the project director to make sure that this is adhered to.

2. The S&T/Health staff should review its own management structure for the project. There needs to be a clearer line of communication between the CTO and the Front Office and the Chief of the Applied Research Division so that all parties are fully aware of the activities of the project. In addition, the CTO should be the primary conduit for communication and coordination on the project.

3. CIHI should conduct periodic briefings with other Bureaus, CAs, etc.. As the project expands, it is essential that the staff conduct these briefings so that others can have a better understanding of the essence of the project.

4/5. Coordination with Other Agencies/Technical Advisory Committees

1. The contractor should hold periodic and at least annual briefings for the CAs on the project to ensure that these organizations understand the purpose of CIHI, what information is available and how the information can be accessed.

2. Assuming a larger role for CIHI as a data repository is desirable from both A.I.D.'s and CIHI's perspectives, formal arrangements should be established with the data sources and a TAC should be established.

3. If a larger role is anticipated, A.I.D. should promote CIHI's leadership role in organizing and implementing substantive meetings on health indicators and information.

ATTACHMENT 1

SCOPE OF WORK
FOR MID-CONTRACT EVALUATION
CENTER FOR INTERNATIONAL HEALTH INFORMATION PROJECT

SCOPE OF WORK
FOR
MID-CONTRACT EVALUATION

HEALTH INFORMATION SYSTEM CONTRACT
DPE-5951-Z-00-8004-00

I. SUMMARY PROJECT INFORMATION

Name/Number:	Health Information System Subproject (936-5951.13)
Country Entity:	Worldwide
Contract Effectiveness:	April 19, 1988 - April 18, 1993
Contract	The purpose of the Health Information System (as defined in the contract) is to support the planning, management and evaluation of USAID's health and child survival activities. The primary objectives are to: - Develop in a systematic way the Health and Child Survival Database; - Improve the quality and availability of key indicators and programmatic information for health and child survival programs; and - Provide useful, relevant information about USAID health and child survival projects and trends in USAID-assisted countries to AID program managers and secondarily to their counterparts and colleagues in order to support planning, management and dissemination of technical information and evaluation.
Contract Context:	This contract is a subproject of the Child Survival Action Program (CSAP) - Support Project (936-5951) first obligated on August 30, 1985 and with a PACD of August 29, 1995. The goal of CSAP-Support is to reduce mortality among infants and children under five years of age and the purpose is to improve the use and effectiveness of child survival technologies and methods in A.I.D. assisted developing countries. This contract

	is a follow-on to previous contract also funded in part by CSAP-Support.
Implementing Agent and Mechanism	Center for International Health Information International Science and Technology Institute STI) - Through contract DPE-5951-Z-00-8004-00
Contract Amount:	$5,999,989 (Est. $3,854,000 core funding and $2,145,989 from "Buy-ins")

II. EVALUATION OBJECTIVES

The subject contract has been in effect for just over 24 months and is scheduled to terminate in approximately three years. This evaluation will be used primarily by S&T/H to assess:

A. progress made under the contract and buy-ins; assess the contribution of the buy-ins to the implementation of the contract;

B. the efficiency and effectiveness of overall contract implementation, with emphasis on the role of this project as AID's health and child survival information system;

C. the efficiency of the project's organizational structure and management for achieving the SOWs;

D. the adequacy of external advice and project relationships to the information and its dissemination;

E. the appropriateness, responsiveness and progress of the data bases;

F. the adaptation/collaboration of the project level data base to other Agency data systems;

F. Recommend modifications to the techncial direction of the contract and/or to the organization/management of the project which may be required in order to maximize the potential for meeting contract objectives.

III. DETAILED SCOPE OF WORK

A. Document Review

Review pertinent project documents and correspondence including but not limited to:

-- Child Survival Action Program - Support (936-5951), Project Paper Supplement;

-- Final Report of Contract No. DPE-5920-C-00-4008-00 (previous contract);

-- Contract evaluation dated (December 1987? - evaluation of previous contract);

-- Technical Proposal (with revisions) date 3/29/88;

-- Contract No. DPE-5951-Z-00-8004-00 dated 4/19/89;

-- Amendments to the contract;

-- The Five Year Work Plans and the Annual Project Work Plans prepared by ISTI;

-- Semi-Annual Progress Reports and Quarterly Financial Reports; and

-- Information collection tools (questionnaires)

-- Selected systems procedures and evaluative reports

-- Standard Reports and Information Feedback packages

-- Selected technical and trip reports and other relevant materials.

B. Review of the Original Contract Scope of Work and Subsequent Contract Amendments

1. Reconstruct the contract deliverables in as detailed, specific and quantitative a way as possible (the list developed in the Five Year Work Plan should be compared to the contract as a point of departure).

2. Identify and describe any significant subsequent modifications (additions or deletions) to B.1. To the extent possible, note the tasks clearly designated as of high priority.

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3. Discuss the adequacy of the project work plans for establishing priorities and strategies to accomplish deliverables. Assess the SOW and the workplans in terms of fulfilling the deliverables and the buy-ins to the project: in term of objectives, hunman and other resources, noting problem areas, if any.

C. Contract Progress

Describe the progress towards meeting contract deliverables and the overall contract objectives. In as quantitative a way as possible, compare the progress to date with the total contract targets and progress projected in the work plans. Note areas substantially above or below the targets and explain the discrepancies.

D. Overall Contract Implementation

Examine the efficiency and effectiveness with which the above deliverables have (have not) been provided.

1. Project Data Bases - Review both the Health Statistics Data Base and the Health Projects Data Base and analyze in terms of:

   a. Types of information available on and regular/special data reports prepared by the system? Is the handling of confidential or sensitive data appropriate?

   b. Discuss the quality and timeliness of the information provided: how is the information collected, analyzed and synthesized? Are quality control mechanfms adequate? What agreements have been reached or relationships forged with external data sources? What steps have been taken to ensure that the data reliable, duplicative/consistent with other similar data sources such as the Population Reference Bureau and the UN Population Office?

   c. What efforts have been undertaken to develop new or improve/expand existing sources of data? Results? Do such efforts reflect AID priorities? Are they cost effective?

2. Data Users/Data Reference Service

   a. To what extent are potential users aware of what is available to them from the different data

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bases? Describe the type, quantity and source of demand for information (various AID/W offices, missions, contractors, other donor agencies, host countries, policy and decision makers, other)? How does the project identify and target additional users? What efforts are now underway/planned to stimulate demand? What projections can be made regarding future demand during the life of the contract? Are the requests regular or sporadic/ad hoc, or in response to specific requirements for information?

b. Is the information available responsive to the above demands and in a format readily useable? How are the data being used? What efforts have been initiated under the contract to analyze the data users and their requirements and to modify the system based on those priorities? Results? What additional types of information should be tracked, and /or added to the data bases?

c. an assessment of the Annual Health and Child Survival Questionnaire (ease and time of completion, USAID cooperation, relationship to normal project information such as Project Implementation Reports, etc.)

3. Discuss the type, magnitude and appropriatenesss of technical assistance provided to information users and sources. Analyze in terms of quality, timeliness and utility.

4. Data Access and Dissemination - Describe the regular and special reports and other means by which the data is accessed by and/or disseminated to the above users. Analyze in terms of timeliness, ease of use and understandability. Is distribution appropriate?

5. Hardware and Software - Review the contractor's response to the hardware and software requirements of the system. Analyze in terms of technical appropriateness, speed, ease of use and cost.

6. Project Management Reporting - Review the management information requirements for the project including Annual Work Plans, Annual Progress Reports and semi-annual updates, trip reports and other reports. Have they been prepared and submitted in timely fashion? Has distribution been appropriate? Briefly describe form and content used. Is that form/content an appropriate planning/management tool? Have they been

used as such by ISTI and AID? Is the required frequency appropriate? What changes might improve their utility?

7. Financial Reporting - Examine expenditures to date in terms of the estimated budget contained in the Contract. Compare to originally planned expenditures and rate of disbursement and analyze the differences. Estimate total five year expenditures based on current work plans and alternative assumptions. Have quarterly project reports been filed and budgets been updated on a regular basis? Has the separate accounting for bilateral and non-bilateral funds and the segregation of each funding increment been as provided for in Section 4. of the contract?

8. Levels of Effort - Estimate to the extent possible the levels of effort and costs going into the major contract components. How do they compare to the projected levels of effort at the time of contract signature? Are they appropriate to the use and priorities assigned to the various components?

9. Examine the level and style of management provided by AID/ST/H. Discuss the relationship to and involvement of the Cognizant Technical Office. Is the involvement appropriate, cordial, helpful? Do AID and ISTI have adequate access to each other?

10. Provide a general assessment of the recipient's innovativeness, organizational, administrative and managerial performance and ability to plan and implement the contract in an effective, timely and efficient manner. The assessment may be broken down to reflect performance on the principal project activities and include such things as: appropriateness of staff numbers and skills mix; mix of full-time employees and part-time consultants; structure for information and data flow including bottlenecks if any.

E. Conclusions and Recommendations

This section should explore such subjects as:

The contract's relevance to A.I.D.'s overall health and child survival portfolio.

Cost effectiveness of the system and structures for collection, analysis and dissemination.

Modifications to current contract (deliverables or other).

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Modifications to overall contract design.

Appropriateness of data and information services being provided by a contractor rather than directly by AID.

IV. METHODOLOGY

The evaluation will be based primarily upon reviews of project files and interviews with contract staff people, subcontractors and consultants, S&T/H, information users and sources, individuals of selected host country organizations or institutions, other donors and/or international organizations. To the extent possible, interviews in Washington will be in person while interviews with people overseas will be by phone. If phone interviews are not practicable, responses to key questions will be solicited by cable, telex or FAX. Specific individuals to be contacted will be determined during the first week of the contract.

V. SCHEDULE

The evaluation is expected to require three people for approximately 7, 10 and 25 person-days each.

WEEK	ACTION
1	Review of project documents, briefing by A.I.D., preparation of individual scopes of work, detailed plan and schedule for carrying out the evaluation, list of interviews, preparation of interview guidelines, list reconstruction of contract deliverables and preparation of evaluation outline.
1-2	Visits to ISTI, examination of files, interviews.
3	Follow-up interviews, preparation of draft report. AID comments
4	Finalization of report.

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VI. TEAM COMPOSITION

The team should be composed of three-four people, depending on the combination of skills:

a Management Specialist, experienced in assessing project organization, management, and financing issues, and who has hands-on experience in managing an AID contract will:

a) assess the efficiency and suitablility of project structure and staffing for fulfilling the contract SOW and the SOWs under the buy-ins;

b) compare the contract SOW listing of personnel requirements wnd assess the continuing appropriateness of the original identification of personnel requirements with current project needs;

c) assess the adequacy of the financial and other management systems for the timely completion of the contract deliverables;

d) determine the management requirements added to the project by the buy-ins and assess the status of the most critical management concerns for timely and effective completion of project SOW;

- Generalist with health program experience, with direct experience of AID organization, the health and child survival program issues, related project/program information systems, reporting and monitoring requirements. This person will concentrate on the data bases, their content and the overall information system's responsiveness to AID; this person will:

a) compare the contract SOW with the CIHI information system to assess the design, the appropriateness and responsiveness of the CIHI data bases and information system to AID's requirements;

b) assess progress in and the adequacy of the process followed in developing tools for collecting, validating project-level information, and for providing feedback- this should include the user perpective;

c) assess the coordination of the CIHI information system with other AID data bases;

d) review the appropriateness and completeness of the dissemination plan and review progress in dissemination activities;

e) assess planned additions/expanion of information to the health information data base and make recommendations for these future directions;

- Information System Specialist, with knowledge/experience in the monitoring of health program/child survival indicators; manipulation of periodic and fluctuating health statistics data sets; knowledgeable about hardware and software questions;

a) review the timeliness, completeness and presentation of indicators and other health statistics;

b) review the status of analyses conducted of the information system- i.e., type of information, utility, validity; and review the adequacy of systems procedures established for assurance of data quality;

c) examine the data base work flow, the utilization of personnel for data base maintainance and output;

d) review the linkages with other other health data bases;

e) assess the status of software systems development, and its application in the project level and health statistics data bases;

VI. REPORTING REQUIREMENTS

A completed draft, together with a verbal presentation will be submitted within four weeks of beginning work and ten copies of the final report will be submitted within five days of receipt of A.I.D.'s comments on the draft. The document shall include a table of contents, an executive summary, the body (not to exceed 40 pages), and annexes including the scope of work, documents consulted, people/agencies contacted, and additional detailed information on technical matters.

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ATTACHMENT 2

LIST OF CONTACTS FOR EVALUATION

LIST OF PEOPLE CONTACTED BY EVALUATION TEAM

AGENCY FOR INTERNATIONAL DEVELOPMENT

A.I.D./W
Brad Langmaid

S&T/H:
Ann Van Dusen, Acting Director
Nancy Pielemeier, Deputy Director
Pamela Johnson, Chief Applied Research
Petra Reyes, Project CTO
Jim Heiby, Medical Officer
Connie Carrino, Health Services Division (on last evaluation team)
Jeff Harris, Chief AIDS Division
Holly Flutie, HSD
Dennis Long, CDD
Celeste Carr, AIDS
Genease Pettigrew, Program Officer

LAC:
Carol Dabbs

AFR:
Gary Merritt
Hope Sukin
John Coury

ANE:
Mike Jordan
Len Rogers

FVA:
Sallie Jones

PPC:
Peter Thiel
George Hill

CDIE:
Gary Hansen

S&T/N:
Norge Jerome
Nina Schlossman

MISSIONS:
Maryanne Micka, Senegal (fax)
Lynn Gorton, Guatemala
Heather Goldman, Pakistan (fax)
Charles Lewellyn, Bolivia
Edward Scholl, Peru

CONTRACTORS:
Robert Steinglass, REACH
Martita Marx, PRITECH
Dory Storm, JHU
Dan Campbell, WASH
Mary Harvey, REACH
Craig Haeffner, WASH
Caroline Rush, AED/CDIE
Kaaren Christopherson, AED/CDIE
Ann Langhang, AED/CDIE

U.S. BUREAU OF THE CENSUS:
Barbara Torrey
Frank Hobb
John Matt Reid

DONOR AGENCIES
WHO:
Dr. Robert Kim-Farley, Director, Expanded Program on Immunizations
Dr. James Tullock, Director, Diarrheal Diseases
Dr. Michael Merson, Director, AIDS
Jonathan Gorstein, formally with the Nutrition Unit, currently with the University of Michigan

UNICEF:
Dr. Gareth Jones, Senior Advisor, Statistics

CDC:
Dr. Ronald Waldman, Director, Division of Technical Support, International Health Program Office
Dr. Stanley Foster, Director, Division of Field Services, International Health Program Office
Dr. Andrew Vernon, , International Health Program Office

ISTI/CIHI STAFF
Jean Shaik, Vice President, Health Population and Nutrition
Roy Miller, Project Director
Jean Pease, Head and Senior Health Advisor
Beth Plowman, Nominee, Head of Development Unit
Steve Waugh, Head, Operations Unit
Tara Lewing, Acting Database Manager
Johnathan Mosely, Information Analyst
Gary Pollard, Research Assistant
Heidi Sawyer-Cann, Research Analyst
Stan Lehman, Health Consultant
Yvette Robinson, Secretary/Data Entry
Elizabeth Mahara, Secretary
Bart Burkhalter, Former Director

ATTACHMENT 3

DESCRIPTION OF CHANGES IN THE
HEALTH AND CHILD SURVIVAL QUESTIONNAIRE

CHANGES IN THE QUESTIONNAIRE

MAJOR CONCEPTUAL CHANGE

In FY 90, a fundamental change was made in the questionnaire design to accommodate centrally funded and regional projects. The questionnaire used in previous years was designed to capture information from service-oriented field projects. As the USAID portfolio of centrally funded technical assistance and research projects has expanded, the need for a questionnaire to deal specifically with this type of project has been felt more deeply.

Central and regional projects without a well-defined geographical focus, or with many such foci, no longer complete the schedules pertaining to the individual interventions. Instead, a new schedule, known as schedule 10, has been added to ascertain the quantity of long and short term work done under central and regional projects and to identify in what countries those projects are working. Central and regional projects continue to fill out the main schedule pertaining to funding attributions. They have also been asked to provide annual reports or other progress reports to provide other background for the Child Survival Report to Congress and other reports prepared with CIHI assistance.

MAIN SCHEDULE

The question regarding contractors/implementors has been modified to enable respondents to list and differentiate sub-contractors as distinct from either implementors or host country counterparts.

A question has been added to ascertain who from the project staff should receive technical materials when they become available.

The question regarding the attribution of life-of-project attribution of funds to interventions (functions) and to child survival has been modified each year to maintain the parallel between the CIHI system and the PPC AC/SI system. One aspect of these changes worthy of note relates to the fact that in FY 88 (and before) all attributions for the 4 major child survival interventions were automatically assigned a 100% attribution to child survival. In both FY 89 and FY 90, the decision was left to the respondent (although CIHI continues to force those attributions to 100% according to the guidance given CIHI by the Child Survival Task Force).

The series of questions regarding other sources of funding (e.g. from other donors and P.L. 480) have been modified in the FY 90 questionnaire to request actual contribution during the last year rather than estimated over life-of-project. (The

rationale for this change is that other donors and even P.L. 480 funds are not linked to the A.I.D. project cycle and, therefore, it is not possible for a project manager to estimate contributions over the life of the USAID project.) Also, the wording of these questions has been improved by eliminating Washington D.C. jargon not always understood by respondents.

In FY 90, an open-ended question was asked to ascertain how P.L. 480 funds were used during the year (question 13, bilateral questionnaire).

In FY 90, an explicit request (question 15, bilateral questionnaire) for percentage of the funds for FY 90 passed through PVOs was added (to facilitate the preparation of the Standard Report on PVO involvement).

In FY 90, the question regarding private sector activity was modified to focus attention on the host country private sector as distinct from PVOs in the U.S. private sector (the PVO question mentioned above dealt with U.S. and local PVO involvement.)

In both FY 89 and FY 90, a list of descriptive research titles was requested to enable CIHI to provide feedback on the nature of research (defined quite broadly) funded through the health and child survival portfolio.

In FY 88, a question regarding the numbers of people trained was asked on each of the separate schedules. In FY 89 and FY 90, one question regarding the numbers of people changed in all sectors was added to the main schedule and the requests for "counts" of people trained on all other schedules was eliminated. (Feedback from the field has been that the most difficult questions to answer are those asking for direct counts of items which require a detailed review of records which may be scattered in a number of different places.)

The wording of the "highlights" question asking for prose descriptions of the most noteworthy events in the project over the last year has been improved.

THE DEMOGRAPHIC SCHEDULE

The Demographic Schedule was designed, in part, to cater to a specific need expressed by PVOs for a stimulus and a guide to the collection of data on the population served. In response to negative feedback from non-PVOs regarding the difficulty of answering these questions, the more detailed of them were eliminated from the demographic schedule in FY 89 and again in FY 90. At the same time, a special schedule is added to the questionnaires distributed through the umbrellas PVO project managed by Johns Hopkins for FVA containing the request for a more detailed demographic breakdown of the project catchment

area.

THE DIARRHEAL DISEASE CONTROL AND IMMUNIZATION SCHEDULES

In FY 90, the question regarding the quantity of packets of ORS purchased has been restricted to address only those purchased with USAID money under the assumption that knowledge of the quantities purchased by other donors may not be available to A.I.D. project managers (for example, PVOs working in sub-national projects who might be using UNICEF packets provided through the government system). Similarly, the question regarding the purchase of vaccines was restricted to those purchased with USAID funds.

The questions regarding strategies employed to address diarrheal disease control and vaccination have been expanded each year. (It was assumed that any project manager could answer the strategy questions quite easily and that the added richness of knowing just what projects are trying to do would enhance the usefulness of the questionnaire.)

In both FY 89 and FY 90, the attempt to differentiate type of Technical Assistance given (management, research etc.) was eliminated because it had never proved useful.

In each schedule for both FY 89 and 90, a question asking for "Tier 2" data (ORT Use Rate and vaccination coverage rates) was added even though this questionnaire had been perceived as the "Tier 1" questionnaire. CIHI assumed that after several years of project implementation under the Child Survival banner, many projects would be collecting this information and that it would prove useful.

In each schedule in FY 90, the number of categories of people trained was reduced because, in previous years, whenever the data were used the aggregation to the smaller number of categories was effectuated.

THE NUTRITION SCHEDULE

As with the first two functional schedules, the inquiry regarding strategies has been modified substantially in the nutrition schedule. Also, in ways parallel to the other schedules, the training and technical assistance questions have been simplified and a question regarding the nutrition "Tier 2" indicator (nutritional status as measured by anthropometry) has been added.

THE HIGH RISK BIRTHS SCHEDULE

In FY 90, the question regarding quantities of commodities purchased was eliminated because, in somewhat more aggregated

terms, the information exists elsewhere in the organization and no requests for the data by project have been received.

Modifications regarding the training question, the technical assistance question and the strategies questions were similar in nature to those of the other schedules.

In FY 89, a single question was added to ascertain the contraceptive prevalence in the project area. In FY 90, another question was added requesting an estimate of the number of high risk births in the project area. (This question reinforces the notion that the portion of family planning expressly considered to be child survival is that pertaining to high risk births.)

THE HIV/AIDS SCHEDULE

In FY 89, an HIV/AIDS schedule was added to the questionnaire. This schedule was designed to parallel the schedules used for the other interventions. The S&T/H/AIDS division found the information provided of marginal use only. One reason for this lack of usefulness was that the HIV/AIDS initiative, still rather new, was highly centralized and largely under the control of S&T/H/AIDS. As with other centrally funded questionnaires, the field oriented schedules were of marginal use only.

In FY 90, a completely different HIV/AIDS schedule, designed jointly by CIHI and S&T/H/AIDS was substituted for the old one. This questionnaire is calculated to retrieve information on individual activities within an HIV/AIDS initiative; that is, it is far more disaggregated than any of the other schedules. The need for this greater disaggregation grows out of the unique reporting requirements of the HIV/AIDS program.

THE OTHER HEALTH AND CHILD SURVIVAL SCHEDULE

This schedule continue to grow, allowing more detail for the interventions experiencing growing importance within the USAID child survival strategy. In FY 89, a set of malaria questions were added as well as one health care financing question. In FY 90, the inquiry regarding strategies of approaching health care financing was also expanded.

ATTACHMENT 4

UN vs. U.S. BUREAU OF THE CENSUS DEMOGRAPHIC DATA:
REASON FOR REVIEWING THE DECISION TO USE UN DATA

Attachment 4

United Nations vs. U.S. Bureau of the Census
Demographic Data:
Reasons for Reviewing the Decision to
Use UN Data

1. U.S. Census Bureau revises its population estimates as soon as new data on mortality (especialy infant mortality) and fertility are available or at least annually. Given dramatic changes that have occurred in some of these rates and anticipated changes (for example, in infant mortality from AIDS in some African countries), estimates from the U.S. Census Bureau will be more current and thus more accurate.

2. Many of the health and child survival indicator data are percentages and not numbers of cases, so having a consistent source for the denominator of a rate isn't important.

3. A.I.D. reports to Congress annually using population estimates prepared by the U.S. Census Bureau (through CDIE) while CIHI reports to Missions (through their Selected Health and Demographic Statistics reports) using UN data. It would be desirable to use consistent sources for demographic data within the Agency. CIHI's own use of demographic data is not consistent, since the source for most population estimates in the Child Survival Report to Congress are from the the U.S. Census Bureau's World Population Profile.

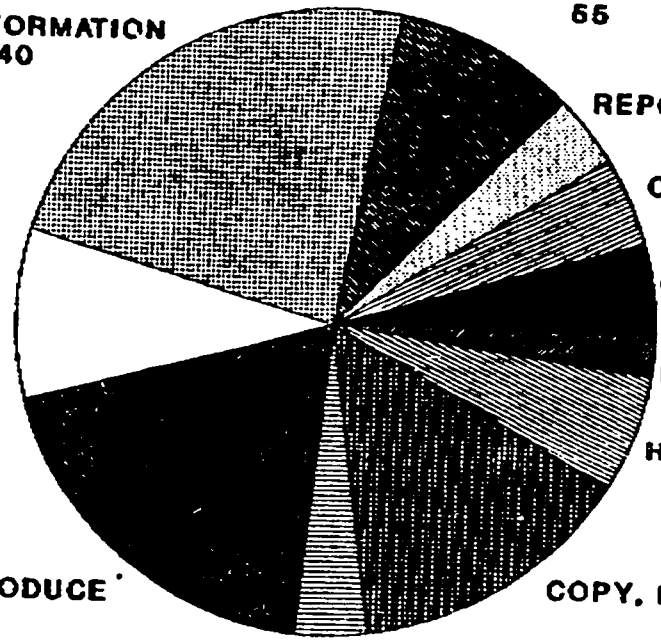
4. UN population estimates are based on five-year averages and are published every several years. While U.S. Census Bureau's data are annual and prepared annually.

There are at least two drawbacks to using U.S. Census Bureau data. UN agencies providing health data such as WHO may prefer using UN demographic estimates for consistency with their practices. If CIHI is to serve as a repository for international health data for the health community generally and not just for A.I.D., this could be an important consideration. Second, estimates of the U.S. Census Bureau don't have the official sanction of host-country governments as UN data do.

ATTACHMENT 5

REQUEST TRACKING SYSTEM: BREAKOUT OF REQUESTS BY TYPE

REQUEST TRACKING SYSTEM
BREAKOUT OF REQUESTS BY TYPE



TOTAL REQUESTS: 536
CIHI, 11/15/90

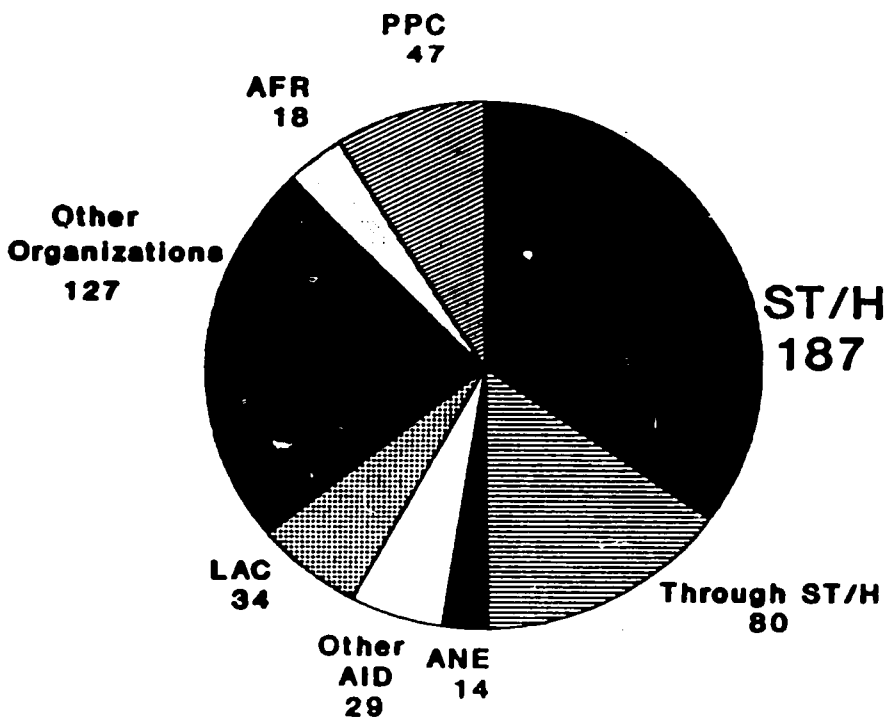
DEMOGRAPHIC DATA, CHARTS, GRAPHS

TOTAL TASKS (DEPICTED ABOVE): 599
DUE TO MULTIPLE TASKS PER REQUEST

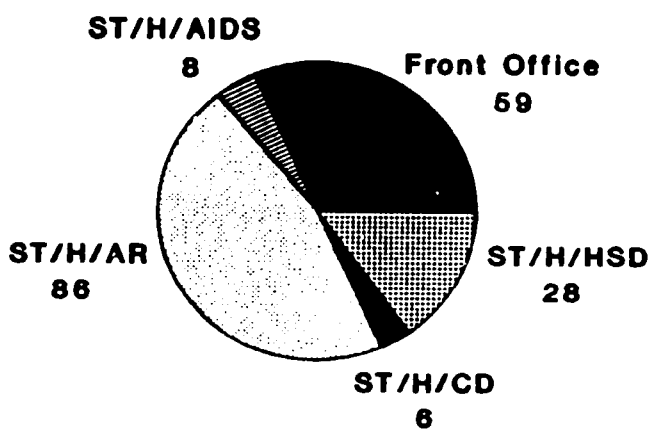
ATTACHMENT 6

REQUEST TRACKING SYSTEM: INFORMATION DISTRIBUTION TO REQUESTING ORGANIZATION

REQUEST TRACKING SYSTEM
INFORMATION DISTRIBUTION TO REQUESTING ORGANIZATIONS



Breakout of ST/H



Requests funded through the back-stop officers not specifically for ST/H

Total Requests: 536
Timespan: Feb. 1989 - Oct. 1990
Source: RTS Database, CIHI 11/13/90

ATTACHMENT 7

LIST OF CURRENT CIHI PUBLICATIONS, MAY 1990

List of
Current CIHI Publications
(with a description of Standard Reports)

May 1990

Center for International Health Information
USAID Health Information System
1601 N. Kent Street
Suite 1001
Arlington, Virginia 22209
(703) 524-5225

List of Publications
May 1990

Standard Reports

Information regarding project funding and activities for USAID's child survival portfolio as well as reports on selected demographic and health statistics for USAID-assisted countries, is available through a series of 15 standard reports updated annually by the Center. Funding and project activity information is culled from the Agency's financial reporting system, the Center's databases and USAID's Annual Health and Child Survival Questionnaire. A description of each report is attached.

Report to Congress on USAID's Child Survival Program

Published annually by the Agency since the Child Survival Program began in 1985, these two-color reports present an overview of the Agency's bilateral, regional and centrally funded activities in child survival on a year-by-year basis. Through informative narrative, graphs and photographs, the reports discuss the need for child survival programs and the Agency's strategy in combatting infant and childhood diseases. Project activities and lessons learned are highlighted for USAID-assisted countries worldwide as well as their accomplishments in improving the health of their young generations. Fact sheets highlight the project activities and accomplishments in USAID's 22 emphasis countries. Fiscal year obligations by region, country and project are supplied in an appendix. This year's report which discusses project activities during FY89, pays special tribute to the increasingly important role of the private sector in extending and sustaining the reach of the Agency's program. The Center for International Health Information assists in the preparation and distribution of the reports.

USAID Population and Health Country Profile

Selected health and demographic statistics are brought together from multiple sources to provide an overview of a country's current and historical child health status. Data are presented in tables and graphs and include: infant and child mortality, vaccination coverage rates, ORS access and ORT use rates and prevalence of HIV/AIDS. The profiles also include timelines of USAID-funded health, child survival and population projects since 1980 as well as obligation figures for projects receiving funds in the most recent fiscal year. Data notes and sources are supplied with all reports. Profiles are currently in draft form for most of the Agency's 22 child survival emphasis countries and will be available in final form at various points throughout this year.

Special Reports

On occasion, the Center for International Health Information prepares special reports for meetings, conferences and program planning sessions, and analyses of information contained in its databases. The **ICORT III Supplement**, prepared for the ICORT conference held in Washington in December 1989, outlines USAID's diarrheal disease control strategies and growing financial commitment to combatting the number one killer of children in the developing world. The supplement describes the activities of each of the Agency's projects worldwide, organized by region and country. **A Synthesis of Lessons from Health and Health-related Project Evaluations for Child Survival Projects** provides lessons learned from health and health-related project evaluations conducted between 1980 and September 1987, the date of the report. The report contains three sections: an introduction, a brief summary and discussion of the most frequently encountered lessons and a synthesis of country-specific and child survival-related lessons, the largest section of the report. **The Nutrition Intervention Action Plan – Latin America and the Caribbean**, prepared in January 1988, provides a plan of action to support nutrition activities in LAC. The report is available in two parts: Part I contains only the 34-page nutrition intervention action plan; Part II contains the action plan along with a discussion of the nature and magnitude of malnutrition in LAC and implications for USAID assistance, as well as a current portfolio of USAID's nutrition activities in LAC.

Center for International Health Information
USAID Health Information System
1601 N. Kent Street - Suite 1001
Arlington, Virginia 22209
(703) 524-5225

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Standard Reports

May 1990

Standard Report No. 1-90

SUMMARY OF USAID FUNDING FOR CHILD SURVIVAL FY 85-FY 91, April 1990. This report includes two tables and two graphs summarizing USAID funding for all child survival activities and funding accounts. The tables and graphs show trends in funding from FY 1985 to FY 1991 and provide breakdowns by USAID bureau, by funding account and by type of intervention. Funding figures are estimated using data from the FY 1991 Congressional Presentation (CP) and the 1989 USAID Health and Child Survival Questionnaire. Project listings supporting all summary figures in this report are available in CIHI standard reports 15-85/Final, 15-86/Final, 15-87/Final, 15-88/Final, 15-89/Final, 15-90/91CP and 15-91/91CP.

Standard Report No. 2-90

SUMMARY OF USAID FUNDING FOR HEALTH, INCLUDING CHILD SURVIVAL AND AIDS FY 85-FY 91, April 1990. This table summarizes USAID funding for all health activities, including child survival and AIDS, from FY 1985 to FY 1991. The data show trends in funding for health, child survival and AIDS activities, by USAID bureau and by funding account. Funding figures are estimated using data from the FY 1991 Congressional Presentation (CP) and the 1989 USAID Health and Child Survival Questionnaire. Project listings supporting all summary figures in this report are available in CIHI standard reports 15-85/Final, 15-86/Final, 15-87/Final, 15-88/Final, 15-90/91CP and 15-91/91CP.

Standard Report No. 3-90

USAID FUNDING FOR CHILD SURVIVAL IN EMPHASIS COUNTRIES (with project listing), FY 85-FY 91, April 1990. The three tables in this report provide information on child survival funding for the 22 USAID child survival emphasis countries only. The funding information is presented by region, by country, by funding account and by type of child survival intervention. This report also contains project specific listings with annual funding for child survival activities by fiscal year, region, country, funding account and type of intervention. Funding figures are estimated using data from the FY 1991 Congressional Presentation (CP) and the 1989 USAID Health and Child Survival Questionnaire.

Standard Report No. 4-90

SUMMARY OF USAID FUNDING TO PRIVATE VOLUNTARY ORGANIZATIONS (PVOs) FOR HEALTH, INCLUDING CHILD SURVIVAL AND AIDS FY 85-FY 89, May 1990. The four tables in this report summarize USAID funding to PVOs for health and child survival activities during the period FY 1985 through FY 1988 (and in one table through FY 1990). The information is presented by funding account, by region, by year, by U.S. vs host country PVO, and by source (FVA Bureau vs other USAID bureaus). Funding figures are estimated using data from the FY 1991 Congressional Presentation (CP) and the 1989 USAID Health and Child Survival Questionnaire.

Standard Report No. 5-90

SUMMARY OF USAID SHORT-TERM TECHNICAL ASSISTANCE THROUGH CENTRALLY FUNDED PROJECTS (AS REPORTED IN THE USAID HEALTH AND CHILD SURVIVAL QUESTIONNAIRE) FY 86-FY 89, May 1990. The six tables in this report summarize short-term technical assistance (T.A.) activities provided by USAID centrally funded health projects to other USAID supported projects in FY 1986, FY 1987, FY 1988 and FY 1989. Data is provided on estimated number of days of short-term T.A., and estimated expenditures for short-term T.A. (from project core funds and from Buy-In funds), by region and country, and by central project. These data are taken directly from the USAID Annual Health and Child Survival Questionnaires.

Standard Report No. 6-90

USAID FUNDING FOR HEALTH RESEARCH FY 85-FY 91 (with project listing), April 1990. This table summarizes USAID funding for health and child survival research activities from FY 1985 to FY 1991. The funding data are presented by region and by funding account. Project specific listings with annual funding for research by fiscal year, region, country and funding account are included in this report. Funding figures are estimated using data from the FY 1991 Congressional Presentation (CP) and the 1989 USAID Health and Child Survival Questionnaire.

Standard Report No. 7-90

USAID FUNDED PROJECTS IN FY 1989 REPORTING NUTRITION ACTIVITIES, April 1990. This report contains a listing of all USAID projects that reported nutrition activity in the USAID FY 1988 Health and Child Survival Questionnaire, along with ten tables that show the number of projects reporting breastfeeding, growth monitoring, vitamin A or infant feeding approaches.

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USAID Health Information System

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Standard Reports

May 1990

Standard Report No. 8-90

USAID FUNDING FOR ACUTE RESPIRATORY INFECTION (ARI) FY 89-FY 91 (with project listing), May 1990. This report includes two tables and a project listing documenting USAID funding for acute respiratory infection (ARI) activities in fiscal years (FY) 1989, 1990 and 1991. The first table summarizes USAID funding for all USAID ARI activities from FY 1989 to FY 1991, by region and by funding account. The second table documents the amount of this activity which is attributed specifically to the USAID child survival program. The project listing contains the amount of funding in each project with ARI activity by fiscal year, region, country and funding account.

Standard Report No. 9-90

USAID FUNDING FOR MALARIA FY 85-FY 91 (with project listing), April 1990. This report includes two tables, one graph and a project listing documenting USAID funding for malaria activities by region and funding account. The first table and the graph show trends in funding of the total USAID malaria program from fiscal year (FY) 1985 to FY 1991. Table 2 presents data which was collected for the first time in 1989. It shows the portion of this malaria activity which directly supports USAID's child survival program. Projects reporting malaria as part of "Other Child Survival" activities between FY 1985 and FY 1988 are not included in this table, as the breakdown of activity was not available for these years. The project listing contains the amount of malaria funding for each project with malaria activity by fiscal year, region, country and funding account.

Standard Report No. 10-90

USAID FUNDING FOR WATER AND SANITATION FY 85-FY 91, May 1990. This table summarizes USAID funding for water supply and sanitation activities related to human use from FY 1985 to FY 1991 as recorded in the Water Database. The funding data are presented by region and by funding account. Project specific listings with annual funding for water supply and sanitation are included in this report.

Standard Report No. 11-90

AFRICA: SELECTED HEALTH AND DEMOGRAPHIC STATISTICS IN USAID ASSISTED COUNTRIES, April 1990. Trends in demographic and child survival indicators are presented in country-specific tables and graphs for USAID-assisted countries in Africa (USAID AFR Bureau). Some of the sources for these data include the United Nations Population Division, World Health Organization, the Demographic and Health Surveys (DHS) and assorted studies reported by USAID missions.

Standard Report No. 12-90

ASIA/NEAR EAST: SELECTED HEALTH AND DEMOGRAPHIC STATISTICS IN USAID ASSISTED COUNTRIES, April 1990. Trends in demographic and child survival indicators are presented in country-specific tables and graphs for USAID-assisted countries in Asia/Near East (USAID ANE Bureau). Some of the sources for these data include the United Nations Population Division, World Health Organization, the Demographic and Health Surveys (DHS) and assorted studies reported by USAID missions.

Standard Report No. 13-90

LATIN AMERICA AND THE CARIBBEAN: SELECTED HEALTH AND DEMOGRAPHIC STATISTICS IN USAID ASSISTED COUNTRIES, April 1990. Trends in demographic and child survival indicators are presented in country-specific tables and graphs for USAID-assisted countries in Latin America/Caribbean (USAID LAC Bureau). Some of the sources for these data include the United Nations Population Division, World Health Organization, the Demographic and Health Surveys (DHS) and assorted studies reported by USAID missions.

Standard Report No. 14-89

USAID FUNDED PROJECTS IN FY 1988 REPORTING COMMUNICATIONS, SOCIAL MARKETING OR TRAINING ACTIVITIES RELATED TO HEALTH OR CHILD SURVIVAL, April 1989. This is a listing of every project, ordered by region and country, that reported communications, social marketing or training activity related to health or child survival in the USAID FY 1988 Health and Child Survival Questionnaire. It includes project title, implementing agent, time frame and type of communications activity. The report does not include funding data.

Standard Report No. 15-85/Final

LIST OF USAID PROJECTS WITH A HEALTH, CHILD SURVIVAL OR AIDS COMPONENT, FINAL FY 1985 OBLIGATIONS, May 1990. This is a list of all USAID projects that received funding for health, child survival or AIDS in FY 1985, by region and country. New obligations in FY 1985 for each project are provided by funding account and type of intervention.

Standard Reports

May 1990

Standard Report No. 15-86/Final

LIST OF USAID PROJECTS WITH A HEALTH, CHILD SURVIVAL OR AIDS COMPONENT, FINAL FY 1986 OBLIGATIONS, May 1990. This is a list of all USAID projects that received funding for health, child survival or AIDS in FY 1986, by region and country. New obligations in FY 1986 for each project are provided by funding account and type of intervention.

Standard Report No. 15-87/Final

LIST OF USAID PROJECTS WITH A HEALTH, CHILD SURVIVAL OR AIDS COMPONENT, FINAL FY 1987 OBLIGATIONS, May 1990. This is a list of all USAID projects that received funding for health, child survival or AIDS in FY 1987, by region and country. New obligations in FY 1987 for each project are provided by funding account and type of intervention.

Standard Report No. 15-88/Final

LIST OF USAID PROJECTS WITH A HEALTH, CHILD SURVIVAL OR AIDS COMPONENT, FINAL FY 1988 OBLIGATIONS, May 1990. This is a list of all USAID projects that received funding for health, child survival or AIDS in FY 1988, by region and country. New obligations in FY 1988 for each project are provided by funding account and type of intervention.

Standard Report No. 15-89/Final

LIST OF USAID PROJECTS WITH A HEALTH, CHILD SURVIVAL OR AIDS COMPONENT, FINAL FY 1989 OBLIGATIONS, May 1990. This is a list of all USAID projects that received funding for health, child survival or AIDS in FY 1989, by region and country. New obligations in FY 1989 for each project are provided by funding account and type of intervention.

Standard Report No. 15-90/91CP

LIST OF USAID PROJECTS WITH A HEALTH, CHILD SURVIVAL OR AIDS COMPONENT, FY 1990 (1991 CONGRESSIONAL PRESENTATION LEVEL), May 1990. This is a list of all USAID projects, active or proposed, that are proposed to receive funding for health, child survival or AIDS in FY 1990, by region and country. Proposed obligations in FY 1990 for each project are provided by funding account and type of intervention.

Standard Report No. 15-91/91CP

LIST OF USAID PROJECTS WITH A HEALTH, CHILD SURVIVAL OR AIDS COMPONENT, FY 1991 (1991 CONGRESSIONAL PRESENTATION LEVEL), May 1990. This is a list of all USAID projects, active or proposed, that are proposed to receive funding for health, child survival or AIDS in FY 1991, by region and country. Proposed obligations in FY 1991 for each project are provided by funding account and type of intervention.

CIHI Publications Order Form

May 1990

CIHI publications are available free of charge to USAID offices and to USAID contractors, grantees and cooperating agencies. Please specify the publications you wish to receive by Title and Publication Number. (Multiple copies of single reports are available by special request.) We invite your comments after your review.

TITLE	PUBLICATION NUMBER

Address to which CIHI's publications should be sent:

Please Print Clearly

NAME:

ORGANIZATION:

ADDRESS:

Date _____

Please return this form to:

Center for International Health Information/ISTI
Attn: Publications
1601 N. Kent Street
Suite 1001
Arlington, VA 22209
U.S.A.

ATTACHMENT 8

STATUS OF POPULATION AND HEALTH PROFILES, 11/7/90

Status of Population and Health Profiles
(Formerly "Country Health Profiles")

Country	Country Profile (date)	Population & Health Profile (date)	Draft to Regional Bur. (Name)	Comments from Reg.Bur. Revisions Req. (date received)	Regional Bur. Clearance (date)	Draft to Mission (date)	Mission resp. Revisions Req. (date received)	Mission Final Clearance (date)
Senegal	Jun-89		N/A			Nov-89	1/11/90	1/11/90
Uganda	Feb-89		N/A			Nov-89	12/27/89	12/27/89
Mozambique	Feb-89		N/A			Nov-89	6/11/90	6/11/90
Kenya	May-89		N/A			Nov-89	12/15/89	
Zaire	May-89	Jun-90	Merritt/AFR			Nov-89	3/1/1990**	
Egypt	Sep-89	near completion	N/A			Nov-89	1/30/90	1/30/90
Thailand	Apr-89		N/A			Nov-89		
Indonesia	Jul-89		N/A			Nov-89		
Guatemala	Oct-89	Apr-90	Dabbs/LAC	no changes	5/31/90	Apr-90	5/15/90	6/11/90
Morocco		May-90*	Hansen/CDIE		N/A			
Nepal		Feb-90*	Hansen/CDIE		N/A			
Cameroon		May-90*	Merritt/AFR					
Honduras		May-90	Dabbs/LAC	(10/24/90)		May-90		
Nigeria		May-90	Merritt/AFR					
Peru		Jul-90	Dabbs/LAC	(10/24/90)		Jul-90	8/15/90	9/24/90
Haiti		Jul-90	Tanamly/LAC			Jul-90		
Ecuador		Aug-90	Tanamly/LAC	(10/24/90)		Aug-90		
Bolivia		Sep-90	Tanamly/LAC	(10/24/90)		Sep-90		
El Salvador		Aug-90	Tanamly/LAC	(10/24/90)		Aug-90		
Dom Republic		Sep-90	Tanamly/LAC			Sep-90		

Revisions have not been made on all original Country Health Profiles. As profiles are reformatted, revisions are incorporated.
* Selected data only. Population and Health Profile for Morocco is near completion.
**Mission comments were made regarding the original Country Health Profile.
This office is waiting Bureau clearance before sending the new profile to the mission, as per procedure.
11/7/90

ATTACHMENT 9

STANDARD REPORT DISTRIBUTION LIST FOR FY 1990

7/11/90

STANDARD REPORT DISTRIBUTIONS LIST
FY90

STAND. REPORT LIST	OVERSEAS HPN OFFICERS	AID/W/HPN OFFICERS	*AID/W OFFICERS	COOP. AGENCYS	NCIH REQUESTS	CIHI/ISTI SHELF COPIES	TOTAL REPORTS ORDERED	NO. PAGES	TOTAL PAGES FOR REPRODUCTION	*TOTAL NO.# BOUND REPORTS
SR-1 Child Survival FY85-91	104	63	34	38	13	48	300	8	2400	266
SR-2 Health,CS & AIDS FY85-91			34		13	53	100	6	600	66
SR-3 CS in Emph. Countries FY85-91			34		19	47	100	55	5500	66
SR-4 PVOs for Hlth,CS & AIDS FY85-89			34		18	48	100	8	800	66
SR-6 Health Research FY85-91			34		8	58	100	24	2400	66
SR-7 Projects in FY89 Rep. Nutrition Activities			34		11	55	100	23	2300	66
SR-8 ARI FY89-91 (with proj. listing)			34		4	12	50	10	500	16
SR-9 Malaria FY85-91			34		10	31	75	16	1200	41
SR-10 Water and Sanitation FY85-91			34		6	10	50	9	450	16
SR-11 AFR Demographic Statistics	34	10	30	0	38	50	162	106	17172	166
SR-12 ANE Demographic Statistics	38	10	30	0	31	50	159	56	8904	166
SR-13 LAC Demographic Statistics	32	57	30	38	19	50	226	43	9718	216
SR15-85/Final Hlth,CS or AIDS Comp. 85			34		0	16	50	18	900	16
SR-15-86/Final Hlth,CS or AIDS Comp.86			34		0	16	50	17	850	16
SR-15-87/Final Hlth,CS or AIDS Comp.87			34		0	16	50	19	950	16
SR-15-88/Final Hlth,CS or AIDS Comp.88			34		0	16	50	21	1050	16
SR-15-89/Final Hlth,CS or AIDS Comp.89			34		12	29	75	25	1875	41
SR-15-90/91CP Hlth,CS or AIDS Comp. 91CP			34	38	0	28	100	20	2000	66
SR-15-91/91CP Hlth,CS or AIDS Comp. 91CP			34	0	0	16	50	21	1050	16
Guatemala Country Profile	104	63	34	0	0	24	225	23	5175	191
CIHI Publication List	104	63	34	38	69	42	350	8	2800	316
Subtotal	**416**	**266**	**702**	**152**	**271**	**2522**	**2522**	**536**	**68594** 1/	**1911** 2/

8.04
8.04
8.90

1/ Reproduction Cost $2,743.76
2/ Bounding Cost $1,719.90
Total Cost $4,463.66

*AID/W Officers reports are not BOUND
Total AID/W Officers reports are included in total reports orderded

ATTACHMENT 10

SUMMARY OF BUY-INS TO CIHI PROJECT BY SOURCE

TABLE 1

OFFICE	NUMBER OF BUY-INS	$ AMOUNT	DESCRIPTIONS
LAC/DR/HPN	6	327,670	Nutrition Database, Health Indicators
AFT/TR/HPN	3	197,968	Nutrition Databases, AIDS Database
S&T/H	3	130,965	M.I.S., AIDS Report to Congress
USAID/Pakistan	1	23,683	Mission M.I.S
PPC/CDIE	1	22,967	Nepal Evaluation
FVA/PVA	1	20,486	PVO Evalutaiton
	15	723,739	

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ATTACHMENT 11

TABLE 2 ON EXPENDITURES BY SOURCE OF FUNDS
FROM CIHI QUARTERLY FINANCIAL REPORT NUMBER 10

CIHI Quarterly Financial Report No 10

2. Expenditures by Source of Funds

T.O. No.	PIO/T No.	Source	Obligated Amount	Expenditures at Start of Quarter	Expended This Quarter	Cumulative Expenditures End of Quarter	Remaining Balance
185-00	8361169	S&T/H (Core)	$853,988.00	$853,988.00	$0.00	$853,988.00	$0.00
185-04	9361043	S&T/H (Core)	750,000.00	749,999.99	0.00	749,999.99	0.01
185-08	9361043.A1	S&T/H (Core)	245,000.00	245,000.00		245,000.00	0.00
185-17	0361148	S&T/H (Core)	159,000.00	159,000.00		159,000.00	0.00
185-18	0361149	S&T/H (Core)	591,000.00	98,776.91	325,313.14	424,090.05	166,909.95
		CORE SUBTOTAL	$2,598,988.00	$2,106,764.90	$325,313.14	$2,432,078.04	$166,909.96
185-01	8653052A1	LAC/DR/HN	$7,670.00	$5,822.41	$0.00	$5,822.41	$1,847.59
185-02	8616119	AFR/NUT	92,000.00	89,603.17	0.00	89,603.17	2,396.83
185-03	9385000	FVA/PVA	20,486.00	20,734.13	0.00	20,734.13	(248.13)
185-05	9616123	AFR/NUT	55,000.00	25,738.88	18.61	25,757.49	29,242.51
185-06	9653201	LAC/CA REG	25,000.00	24,990.79	0.00	24,990.79	9.21
185-07	9611708	AFR/TR/HPN	50,968.00	28,154.88	0.00	28,154.88	22,813.12
185-09	9361538	S&T/H	50,000.00	35,547.32	7,878.29	43,425.61	6,574.39
185-10	9653301	LAC/CA REG	80,000.00	18,076.06	13,742.20	31,818.26	48,181.74
185-11	9653350	LAC/CA REG	38,000.00	2,628.50	11,603.62	14,232.12	23,767.88
185-12	9653401	LAC/DR/HPN	120,000.00	16,441.42	8,396.73	24,838.15	95,161.85
185-13	9653450	LAC/DR/HPN	57,000.00	2,655.00	2,353.00	5,008.00	51,992.00
185-14	9365972 31	S&T BUREAU	31,000.00	12,188.56	0.00	12,188.56	18,811.44
185-15	391-0470-3-90051	USAID/PAKISTAN	23,683.00	18,652.45	5,025.43	23,677.88	5.12
185-16	930-0085-03020	AID/W	22,967.00	0.00	3,433.12	3,433.12	19,533.88
185-19	0361501	S&T/H	49,965.00	0.00	199.67	199.67	49,765.33
						353,881.	
		BUYIN SUBTOTAL	$723,739.00	$301,233.57	$52,550.57	~~$3,169,958.15~~	$369,854.76
		GRAND TOTAL	$3,322,727.00	$2,407,998.47	$377,963.71	~~$5,601,036.20~~	$536,764.72

2,785,962.21

ATTACHMENT 12

APPROXIMATE CIHI EXPENDITURES AND LEVEL OF EFFORT
BY UNIT AND TASK,
APRIL 1, 1989 - MARCH 31, 1990

APPROXIMATE CIHI EXPENDITURES AND LEVEL OF EFFORT BY UNIT AND TASK

April 1, 1989 - March 31, 1990

UNIT	TASK										
	CS R2C	Question	Info Serv	STd Rpts	HPD	HSD	Booth	DQ Study	Other	LAC-Ind	LAC-Nut
Admin									*		
Person Days	31	40	75	24	35	5	5	1	757.23	50	9
Expenses	$ 7,200	$ 19,800	$ 33,100	$ 12,300	$ 17,300	$ 3,200	$ 2,300	$ 600	$232,500	$ 22,500	$ 3,000
Development						*		*		*	*
Person Days	51	60	98	25	0	166.5	0	1	67	67	85
Expenses	$ 15,500	$ 23,100	$ 36,900	$ 14,200	0	$ 79,200	0	$ 24,700	$ 19,600	$ 22,300	$ 27,100
Operations			*								
Person Days	59.5	115	230	65	291	20	0	0	73.5	0	0
Expenses	$ 10,400	$ 23,200	$ 56,600	$ 14,900	$ 78,300	$ 3,600	0	0	$ 11,700	0	0
Communications	*	*		*							
Person Days	251	179.13	40	55	0	0	14.44	0	98	0	0
Expenses	$ 95,900	$ 53,900	$ 9,700	$ 20,900	0	0	$ 17,300	0	$ 23,400	0	0
Total											
Person Days	392.5	394.13	443	169	326	191.5	19.44	2	995.73	117	94
Expenses	$129,000	$120,200	$136,400	$ 62,400	$ 95,700	$ 86,100	$ 19,600	$ 25,400	$287,400	$ 44,900	$ 30,100

NOTE:

* Responsible Unit

Columns and rows do not always add due to rounding errors.
Expenses are fully burdened.

APPROXIMATE CIHI EXPENDITURES AND LEVEL OF EFFORT BY UNIT AND TASK

April 1, 1989 - March 31, 1990

UNIT	TASK					
	AFR-Nut	AFR/AIDS	S&T/H-MIS	HIV/AIDS	AID/PAK	Totals
Admin						
Person Days	9	8	15	9	2	1075.23
Expenses	$ 3,000	$ 2,700	$ 6,300	$ 3,300	$ 300	$ 370,200
Development	*	*		*	*	
Person Days	169.3	211	0	226	23	1249.6
Expenses	$ 58,800	$ 44,200	0	$ 58,100	$ 13,100	$ 437,500
Operations						
Person Days	0	2	95	5	0	956
Expenses	0	$ 700	$ 31,700	$ 700	0	$ 232,200
Communications						
Person Days	0	0	0	5	0	642.57
Expenses	0	0	0	$ 1,200	0	$ 222,500
Total						
Person Days	178.3	221	110	245	25	3923.6
Expenses	$ 61,800	$ 47,700	$ 38,100	$ 65,300	$ 13,500	$1,262,600

NOTE:

* Responsible Unit

Columns and rows do not always add due to rounding errors.
Expenses are fully burdened.

ATTACHMENT 13

OCTOBER 1989 LETTER FROM S&T/HEALTH TO ISTI
ON CHANGES IN CIHI PROJECT

October 31, 1989

Mr. Nihal W.Goonawardene
President
International Science and
Technology Institute (ISTI)
1129 20th Street, N.W.
Washington, D.C. 20036

Dear Nihal:

During the past year we have seen the Center for International Health Information (CIHI) undergo noteworthy growth, expansion through buy-ins on one hand, and consolidation of established core activities on the other. Most significantly, the project is increasingly demonstrating its value to the Agency for International Development (A.I.D.). Now that the CIHI/ISTI has entered a mature phase, we would like to encourage its greater independence from A.I.D. directions, and with less intrusiveness into the daily management of the project.

At the same time, we are becoming increasingly concerned about the adequacy of the Project's current organizational structure and management systems to respond to the increased complexity and demands of the project. There also have been major personnel changes in the past year, and increasing amounts of unplanned short-term demands on the project. The additive burden of these demands on senior staff has to date left the project without an up-to-date management plan.

Two further concerns have prompted this letter. The imminent departure of Subhi Mehdi leaves the Project less one of its critical management resources, and, as you know, CIHI/ISTI is also scheduled for a mid-term evaluation beginning during June 1990.

In order to ensure continuing strong internal project management, with less involvement in daily activities by A.I.D., we request corporate assistance in the form of a senior health professional to work with the senior management of the Project on the following crucial tasks:

1. To identify the additional management requirements created through the buy-ins; and in light of these and the contract requirements, develop a revised management strategy for the project;

2. To provide assistance to senior management and to A.I.D by assessing the impact of changes in project financing through core support and buy-ins, and to develop a realistic project management plan to deal with the financial reality of core support and buy-ins.

3. To provide assistance to senior management for revision of the LOP work plan, that include strategies developed in steps 1 and 2 above. As this is a key contractual obligation and A.I.D.'s principal management tool for the project, we require its completion as soon as possible.

We have reviewed these concerns with senior management of the project, who welcome this assistance. We know that we can rely on your support to undertake this as soon as possible. This not only will help with immediate problems, but will also address the longer-range issues in preparation for the midterm evaluation.

Sincerely,

Pamela Johnson, Ph.D.
Acting Chief of Applied Research
Office of Health

cc: S&T/H/AR, Petra Reyes
ISTI, Bart Burkhalter

bcc. S&T/H, Ann Van Dusen

Drafter:S&T/H/AR:PReyes:sm:54705:10/25/89:4491j

ATTACHMENT 14

LETTER FROM ISTI TO A.I.D.
ON THE NEED TO WORK ON THE PROJECT'S MANAGEMENT

International Science and Technology Institute, Inc.
Headquarters: 1129 20th Street, N.W., Washington, D.C. 20036
202/785-0831 • Telex 272785 ISTI UR • FAX: 202/223-3865

Pamela Johnson, Ph.D.
Acting Chief of Applied Research
Office of Health
Bureau for Science and Technology
Agency for International Development
Washington, DC 20523

Dear Pam:

I am writing to respond to your letter of October 31, 1989 to Nihal Goonewardene concerning the internal management of the Center for Health Information.

We fully agree with the need for corporate assistance in the three areas that you listed: identifying the additional management requirements created through buy-ins; assessing the impact of changes in project financing; and revising the LOP work plan.

We have designated Jean Shaikh, the Head of our Health, Population and Nutrition Group, to take the lead in providing this assistance to the senior management of the project. I will personally work with Jean, and will devote whatever time is necessary to insure that these issues are dealt with completely. Jean and I will be available to begin this effort the week of November 20.

ISTI appreciates the positive manner in which you have raised these issues. We look forward to further strengthening what all recognize is a very successful project.

Sincerely,

William R. Thomas 3d
Vice President

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ATTACHMENT 15

SUMMARY FINDINGS AND RECOMMENDATIONS
OF THE USAID HIS PROJECT, MAY 1990

DRAFT

Summary Findings and Recommendations
ISTI Review of USAID HIS Project
May 16, 1990

1. So far the USAID HIS project has generally achieved its very challenging goals and has been well managed.

2. The decrease in core funding to the project (from $859,00 in year one to $750,000 in subsequent years) jeopardizes the ability of the project to meet its objectives:

a. While the contract allows buyin funding, none of the work scope is contingent on such buyin funding,

b. an increase in buyin funding to make up the drop in core funding would not necessarily relieve the problem because buyins require additional effort to obtain and to perform,

c. additional costs not budgeted in the contract have increased the problem (e.g., printing the C.S. Report to Congress and increases in ISTI fringe and burden rates),

d. therefore, in order to put in place a feasible work plan, we make the following recommendations.

3. *RECOMMENDATION:* Certain tasks identified in the contract scope of work should be made contingent upon receiving adequate buyin funding to do them, namely:

a. All mission pilot projects (3-6).

b. All Washington pilot projects (2-3).

c. Four (4) of the eight (8) analytic case studies.

d. The innovative pilot policy dialogue tool.

e. The major collaboration project with PPC (noted in Work Schedule).

4. *RECOMMENDATION:* The demographer position should be removed as a key staff position and not required beyond the first year of the contract. Instead demographer consultants should be used as needed. In addition, required person-months should be adjusted to reflect and be contingent on actual funding levels.

5. *RECOMMENDATION:* Key personnel should be allowed to charge time to other projects, subject to CIHI receiving absolute first priority, in order to achieve budget goals. (The Full LOP financial plan assumes that Burkhalter, Miller and Waugh will charge 10% of work time elsewhere, and the alternative Bare Bones plan assumes 25% of their work time is charged elsewhere, and that buyins fall short.)

Agency for International Development
Washington, D.C. 20523

Barton Burkhalter
Director
CIHI/ISTI
1601 North Kent, Suite 1001
Arlington, VA 22209

March 16, 1990

Dear Bart,

As you are aware, and we have discussed previously, this Office has shared your concern over the funding situation of the CIHI/ISTI project. We have made a concerted effort to maintain the current level of core funding and to encourage buy-ins. This letter is to advise you that we expect FY 1990 core funding to be $750,000 for the twelve month period. While we have been able to maintain the FY 1989 core support level of $750,000, we do not anticipate that this funding level will increase in FY 91 and 92.

This prompts us to ask you to review the various options you would propose for adjusting the project to this core funding level, and to advise us how you wish to proceed. We will be happy to assist you with developing an agressive marketing plan for buy-ins appropriate to the project's Scope of Work, and to discuss with you the options for meeting an otherwise reduced budget.

Sincerely,

Petra S. Reyes
Cognizant Technical Officer

Clearance:
L. Doheny

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ATTACHMENT 16

AN ANALYSIS OF CIHI ACTIVITIES, DECEMBER 5, 1990

December 5, 1990

AN ANALYSIS OF CIHI ACTIVITIES

BACKGROUND

The contract governing the Health Information System project managed by the Center For International Health Information makes no distinction between "core" activities and "buy-in" activities. At the time of the contract award, activities which asked for exceptional analysis and/or presentation of the data already stored within the Health Information System were envisioned as candidates for "buy-ins". As the project evolved and it became apparent that the "core" funds provided by S&T/H were sufficient only for the maintenance and development of the two primary databases (the Health Statistics Database and the Health Projects Database) and the development of the standard reports from those databases, a strategy emerged to fund the "pilot activities in 3 to 6 field missions and with 2 to 3 A.I.D./Washington project managers", as stated on page 12 of the contract, from buy-ins. Moreover, the pilot activities at mission level were deliberately postponed until the latter half of the project under the assumption that many of the developmental initiatives regarding the databases would have become routine by that time.

In practice, the project has received no "buy-ins"; only "incremental funding". As we have come to understand, the distinction is that a "buy-in" is accompanied by a separate and distinct contractual agreement and scope-of-work governing the work while "incremental funding" is merely a transfer of funds through contract amendment with no accompanying legal agreement or scope-of-work. It should be noted that each tranche of "incremental funding" received by the project has had an associated letter of agreement between the project and the source of funds. Thus, although incremental funds are, in theory, supposed to support the "core" activities of a project, in the case of the Health Information System project, each tranche has added a distinct and well-defined set of tasks to the core activities.

In what follows, no effort is made to distinguish core activities from buy-in activities as, according to the contract, there is no such distinction. Instead, an effort is made to distinguish the set of activities required to maintain the most essential functions of a Washington, D.C. based information system from those which would enable the system to expand its role in countries or into new dimensions of health information not currently perceived as part of the project mandate.

An estimate of the level of effort required for each major group of tasks is presented. Following the description of the "maintenance" activities, a budget is constructed based on

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current staff and salary levels. The cost of each "additional" possible tasks is also presented.

TASKS REQUIRED TO MAINTAIN THE H.I.S.

A. Maintain the "Health Projects Database (HPD)" - The Operations Unit

The nature of the task to maintain the HPD has changed markedly over the first half of the project due to the introduction of the AC/SI system by PPC and, as the relationship between the two system is further clarified, we can anticipate that this task will continue to evolve. As originally envisioned, the task included:

a. updating (data entry and verification) the database at the time of the ABS, the OYB, and the CP;

b. continuous updating of the database from mission documents, cables and other communications;

c. updating the database following the receipt of the annual health and child survival questionnaires;

d. development and distribution of standard reports to help reduce the need for individualized responses to ad hoc requests;

e. continuous documentation of the database;

f. iterative application of a clearance process with each major periodic update; and

g. responding to ad hoc requests for funding information or other information about project activities.

With the introduction of the AC/SI system by PPC, several additional tasks have been created:

a. updating the HPD based on information gathered in the AC/SI system; and

b. analyses of the differences between the AC/SI "numbers" and those generated through the HPD.

Finally, several tasks have been envisioned but not yet implemented:

a. restructuring of the database to enhance the efficiency of data storage and retrieval; and

b. the development of programs to facilitate on-line retrieval of the most common standard reports.

The maintenance of the HPD and its constituents parts has always been the province of the Operations Unit. This Unit has also been responsible for a number of other essential project tasks:

a. maintenance of the computer hardware and software; and

b. maintenance of the request tracking system.

Finally, the Operations Unit contributes to the annual Report to Congress on Child Survival, furnishing the financial information and generating many of the tables and listings appearing in the "back of the report" (the country fact sheets, appendices and project listings).

The current staffing of the unit, three professionals and two support persons has proven adequate to maintain these tasks. One of the support persons, Yvette Robinson, has been performing many of the functions originally envisioned for a Communications Unit. If that Unit is revitalized (see the discussion of the Associate Director's position), Yvette would be reassigned to that unit.

With this configuration, there are periods during the year in-between the major pulses of data entry and analysis where the pace of activity is more relaxed. <u>However, each of the major data entry pulses is followed by immediate demands for analysis and feedback by the primary system users. The staffing of the unit must be maintained at a sufficient level to enable it to function rapidly and efficiently during these periods.</u>

A summary of the level of effort required to maintain the Operations Unit is as follows:

Chief (Steve Waugh)	Full-Time
Database Manager (Tara Lewing)	Full-Time
Analyst (Jonathan Mosely)	Full-Time
Data Entry (Gary Pollard)	Full-Time
General Support (Yvette Robinson)	Full-Time

Though not officially a part of the Operations Unit, the Advisor to the Director, Jean Pease, devotes a substantial portion of her time to the maintenance of the database and the dissemination of the information contained therein.

Advisor to the Director (Jean Pease)	4 Months

B. Maintain the Health Statistics Database (HSD)

The task of maintaining the HSD consists primarily of integrating data received throughout the year from various sources (WHO, DHS, CDC, the U.N. Population Division, and other surveys and/or studies) into the database. In addition to entering all new data in the appropriate format, the task requires "judgement" regarding which of the available values for a given time period should be reported out by the Agency. Specific tasks include:

a. updating (data entry and verification) of the database;

b. organizing and carrying out of the clearance process for the health statistics at the time of the Report To Congress;

c. preparation of the standard report of health statistics indicators including trend graphs for all countries for those indicators where trend data is available.

Until October 1, 1990, these tasks were shared by the then Director of the Development Unit and the Epidemiologist on staff. With the exception of the "judgements" required to determine which data to report where alternatives exist, this task could be handled by an individual at the level of a research analyst with computer skills and some public health experience. Moreover, it is estimated that maintenance of the data base as defined above, independent of any efforts to expand it or enhance the retrieval system would require such a person half-time. No such person is on staff at present. (The function continues to be done by the new Project Director, formerly Director of the Development Unit.) In addition, one month of the Project Director would be needed to provide technical back-up regarding the "politics" of the selection of values to be reported out for the major indicators. Assuming an individual similar to Jonathan Mosely, currently in the Operations Unit were found to undertake the maintenance task, the level of effort would be:

Research Analyst	6 Months
Technical Back-up (Roy Miller)	1 Month

It is difficult to estimate the amount of time required to respond to ad hoc requests for data from the database. One known task which has been viewed as another ad hoc request has been the provision of data and analysis to support the Regional Bureaus in the preparation of their annual Reports to the Administrator on Child Survival. The project has undertaken this task at the request of the Child Survival Task Force in each of the past two years. This specific task occupies two months of staff time. In past years, this time has been provided by Roy Miller and Beth Plowman. Assuming an additional month will be required to respond to ad hoc requests, the level of effort required to

accomplish task B includes:

Chief, Development Unit (Beth Plowman) 3 Months

C. Annual Health and Child Survival Questionnaire

The Health Information System project manages the design, implementation and analysis of the annual USAID Health and Child Survival Questionnaire. The sub-tasks associated with the questionnaire include:

a. definition of the content of the questionnaire;

b. design of the layout of the questionnaire;

c. ascertain clearance of the questionnaire from the evaluation sub-committee of the Child Survival Task Force;

d. translation of the questionnaire into French and Spanish;

e. packaging and dissemination of the questionnaires;

f. logging in and pre-coding the questionnaires upon their return to CIHI (including the writing of a data entry program) followed by the data entry itself;

g. drafting of follow-up cables to seek clarification of unclear responses to key questions and/or to track down unreturned questionnaires;

h. an analysis of the questionnaires.

In each of the three years of the project, these tasks have been spread across all four CIHI units with the different units playing roles of varying importance depending on the availability of staff-time throughout the project. (Currently, due to the non-functioning Communications Unit, the Operations Unit has come forward to pick up the slack.)

The level of effort required for tasks "a", "b", "c", and "d" above is difficult to predict as it is a function of the level of changes to the questionnaire requested by the Agency. For the FY 90 questionnaire (currently being processed), the redesign, clearance and translation process required four to five man-months of effort due to the addition of a completely new schedule (Schedule 10) for centrally funded projects and the complete revamping of the HIV/AIDS schedule. Due to the magnitude of the changes, the clearance process proved to be overly time consuming as well.

The level of effort required to do tasks "e", "f" and "g" is, for the most part, independent of the actual form of the

questionnaire. The processing (packaging, logging in, pre-coding, data entry, and follow-up inquiry) consumes at least another six man-months and, perhaps, more depending on the level of diligence of pre-coding and follow-up undertaken to clarify questionable data.

An estimate of the staff time required to process the questionnaire -- up to the analysis phase (task "h") -- is as follows:

Senior level staff time for content redesign and clearance negotiation	5 Months
More junior professional staff time for formatting, and processing the questionnaire	7 Months

In this past year, the senior level staff time was provided by then Project Director, Bart Burkhalter, the current Project Director, Roy Miller, Head of the Operations Unit, Steve Waugh, and, for the HIV/AIDS schedule, epidemiologist Stan Lehman. As both Burkhalter and Lehman are no longer with the project, an alternative will have to be found next year. Given the current staffing pattern, the task would be shared by Roy Miller, Jean Pease and Beth Plowman with assistance from the Operations Unit as follows:

Project Director (Roy Miller)	2 Months
Advisor to the Director (Jean Pease)	2 Months
Chief, Development Unit (Beth Plowman)	1 Month
Research Analyst (Heidi Sawyer-Cann)	3 Months

Requirements to do task "h" properly, an analysis of the questionnaire, is more difficult to make as it has never been done properly. The questionnaire proves to be quite useful as a mechanism to provide information about individual projects; however, it is difficult to aggregate the technical information about projects to describe A.I.D.'s portfolio at country or regional level. (One problem contributing to the difficulties in generating meaningful analysis is the lack of direct information about level of activity or level of expenditures for a given project during the reporting period.) Thus, efforts to produce an analysis of the questionnaire for distribution each year have fallen short of expectations.

Last year, Beth Plowman spent about two-man months attempting an analysis of the questionnaire data base and produced a good first draft subject to the limitations of analyzing information derived from questionnaires of this type. However, time was unavailable to enable the next step in order to

complete the analysis. Accordingly, an estimate of the time available for doing a complete analysis is three months of a person at Beth's level. (At present, Beth is the only staff person available to undertake this task.) In addition, to promote proper interpretation of the statistical analysis, the Advisor to the Director, Jean Pease, will devote some of her time to this task.

Chief, Development Unit (Beth Plowman) or a Research Assistant	3 Months
Advisor to the Director (Jean Pease)	1 Month

D. The Child Survival Report To Congress

The Health Information System Project plays a major role in the preparation of the annual Report To Congress on Child Survival. While this activity could well be handled by the Agency through means other than the Health Information System project, the project considers the Report to be one of its most noteworthy contributions (and, certainly, it most visible) and, therefore, views preparation of the Report as one of its essential activities.

The demands on staff time each year have been different as the degree of dependency on consultants has changed. To the degree that the same consultants can be used from year to year, as has been done regarding the designer/graphic artist, the process is made easier. However, supervising and coordinating consultants new to the process can place demands on the staff which, for assignments of relatively short duration, approach the level of effort required to do the work itself.

It should be noted that many of the intermediate products developed under the umbrella task of the Report To Congress serve other functions within the project. Therefore, the demarcation line between the Report and other activities is not always clear. In what follows, the staffing estimates are limited to those tasks done expressly for the Report.

A complete list of tasks required to complete the Report To Congress would be overly long for this analysis. A list of broadly defined tasks is as follows:

a. Provide the factual information for the preparation of the text and either draft the text or coordinate with a writer hired to draft the text;

b. Design chart and graphs for the text and find suitable photos;

c. Develop the fact sheets on the child survival emphasis countries including project highlights and statistical indicators (the fact sheets are used in other CIHI products);

d. Draw up the project listings and matrices of central project support at country level;

e. Oversee the clearance process;

f. Oversee the design process (as noted above, the design is done by a consultant);

g. Arrange for the printing of the report; and

h. Handle the distribution of the Report.

Each year, as the Child Survival initiative has gained momentum, the length of the Report has increased. This year, expectations are that a new format will be used and that the length will be some thirty pages less than last year's. A writer has been hired (50 days anticipated) and the continued participation of the designer has been assured (time estimate under development). Beth Plowman, nominee for Director of the Development Unit, is serving as overall editor of the Report. It can be expected that she will devote four to five months on the effort. Jean Pease and Heidi Sawyer-Cann are working on country-level fact sheets. At least three man-months (including clearances) will be expended on the fact sheets. The matrices and project listings are done by the Operations Unit and are subsumed in the estimates made above. At least one research assistant, to be hired as a consultant, will be recruited to work approximately four months. In addition, at least two months of the Project Director's time will be devoted to the Report both as a technical overseer, as the verifier of Health Statistics and as the "problem solver" as they arise. A summary of the level of effort required follows:

Chief, Development Unit (Beth Plowman)	5 Months
Advisor to the Director (Jean Pease)	1.5 Months
Research Analyst (Heidi Sawyer-Cann)	1.5 Months
Project Director (Roy Miller)	2 Months
Writer (Jean Shirhall)	50 days
Designer (Mary Kaye Nilan)	30 days
Research Assistant (not currently on staff)	85 days

E. <u>Study of New Sources and New Indicators</u>

Mandated by the contract, the Development Unit, principally

Beth Plowman, has initiated a study of potential new indicators for the Health Statistics Database. In addition to identifying possible indicators, the study includes a review of possible sources of data, not only for the new indicators but also for the indicators already tracked in the Database. In order to complete the study, it is estimated that two more months of Beth Plowman's time and one of Roy Miller's time would be needed. The budget implications are:

Chief, Development Unit (Beth Plowman)	2 Months
Project Director (Roy Miller)	1 Month

F. Health and Population Profiles

During FY 90, the Health Information System Project developed a format for Health and Population Profiles for individual countries. Each document presents available data from the Health Statistics Database as well as textual and funding information describing A.I.D's portfolio in the country under review. Requests for new profiles have continued to mount as the profiles gain visibility. They have been used as briefing documents for consultants, for evaluation teams, for country reviews within the Regional Bureaus, and as general information documents. CIHI can anticipate continued demand for the profiles and, accordingly, view it as a "core" task which, due to the time required to prepare a profile, goes beyond the normal ad hoc responses to requests for information.

It can be anticipated that Heidi Sawyer-Cann, who has done most of the work in preparing the profiles would devote 1.5 months to any additional requests while, in support of Heidi, Jean Pease would devote 1 month. Costs implied are:

Research Analyst (Heidi Sawyer-Cann)	1.5 Months
Advisor to the Director (Jean Pease)	1 Month

Tasks A through F above constitute the essential "maintenance" functions required to retain the identity of the Health Information System project.

However, due to prior commitments under "incremental funding" awards given the project in the past, additional tasks must be undertaken in the next year.

G. Completion of the Africa Nutrition Policy Paper

Under task orders 185-02 and 185-05, the Health Information System project undertook the preparation of a Nutrition Strategy paper for the Africa Bureau as well as the development of a

nutrition activities database (patterned after the HPD). The Africa Bureau is still reviewing the draft Strategy Paper and the plan for continued maintenance of the database has yet to be worked out. Assuming the availability of the consultant who drafted the paper initially, Tina Sanghvi, the level of effort required to finish this task is as follows:

Consultant (Tina Sanghvi)	10 days
Project Director (Roy Miller)	1 Month

H. Maintenance of the LAC Nutrition Activities Database and completion of country specific indicator trends papers for three Latin American countries

The details of the work plan for the coming year with LAC are still to be worked out. However, we can anticipate three "Indicator Trends" papers, Haiti, Bolivia and Nicaragua. Work on the Haiti paper has already begun. This work is being supervised jointly by the acting Chief of the Development Unit and the Project Director while the work itself is being done by a long-term consultant to the project, Kevin Wayne. Current plans assign responsibility for the maintenance of the Nutrition Activities Database to the Operations Unit and, therefore, the following level of effort estimate is for the country specific papers only.

Consultant (Kevin Wayne)	120 Days
Chief, Development Unit (Beth Plowman)	1 Month
Project Director, Roy Miller	1 Month

I. Administration and Support

Finally, in developing any estimate of annual level of effort for the project, it is necessary to acknowledge the effort devoted to general management (work plan development, quarterly reports, semi-annual reports, dealing with personnel, etc.) as well as the general support needed to function (secretarial and administrative). These functions are handled primarily by the Project Director, the Advisor to the director and the support staff as follows:

Project Director (Roy Miller)	2 Months
Advisor to the Director (Jean Pease)	2 Months
Secretary/Receptionist (Eliz. Maharaj)	12 Months
Administrator (Kiki Longmire)	12 Months

J. The Budget

Treating tasks A through I constitute the basis of a work plan (without specific targets and dates), a budget can be constructed rather easily. The following matrix summarizes the level of effort called for from each staff member.

LEVEL OF EFFORT BY TASK

	A	B	C	D	E	F	G	H	I	TOT
Miller		1	2	2	1		1	1	2	10
Waugh	12									
Plowman		3	1	5	2			1		12
Unnamed Analyst		6								6
Pease	4		2	2		1			2	11
Lewing	12									12
Mosley	12									12
Pollard	12									12
Robinson	12									12
Sawyer-Cann			3	1.5		1.5				6
Longmire									12	12
Maharaj									12	12

Notably absent from the above task list is the development of new initiatives under the project. As currently outlined above, the only person-power available for development work is the 2 uncommitted months of the Director (Roy Miller) and the 1 uncommitted month of the Advisor to the Director (Jean Pease). (This task break-down suggests that the name of the Development Unit is a misnomer -- in practice, that Unit has taken on the development and maintenance of the Health Statistics Database.)

In order to fashion a budget from the above information, it is necessary to make certain assumptions about the Other Direct Costs involved in running the project. In past years, project funds have been used to print the Report To Congress ($28,000 last year). This is a major component of Other Direct Costs. The printing of the Standard Reports is also a major single expense (near $10,000 last year).

In addition to these lump sum direct costs, the Project has been spending close to $5,000 per month on items such as computer equipment, xerox, postage, travel, etc. Using this figure, a "maintenance" budget can be developed.

TWELVE MONTH BUDGET ESTIMATE
Nov 1, 1990 through Oct 31, 1991

SALARIES

	ANNUAL SALARY	MULT (1)	COST TO PROJECT	
Miller	70019.25	0.85	59516.36	(Assumes 5% increase as of 10/18
Waugh	48048.51	0.9	43243.66	(Assumes 5% increase as of 2/15)
Plowman	34000.00	0.9	30600.00	(Assumes contracts grants raise)
Unnamed Analyst	24000.00	0.5	12000.00	
Pease	57359.23	0.75	43019.42	(Assumes 5% increase as of 2/1)
Lewing	28377.94	0.9	25540.14	(Assumes 5% increase as of 3/8)
Mosley	24403.05	0.9	21962.75	(Assumes 5% increase as of 7/5)
Pollard	22430.10	0.9	20187.09	
Robinson	20472.11	0.9	18424.90	(Assumes 5% increase as of 12/5)
Sawyer-Cann	28940.63	0.45	13023.28	(Assumes 5% increase as of 6/1)
Longmire	23761.40	0.9	21385.26	(Assumes 5% increase as of 4/1)
Maharaj	21451.01	0.9	19305.91	(Assumes 5% increase as of 10/1)
SUB-TOTAL			328208.77	
Fringe @		29.65%	97313.90	
Overhead @		41.23%	175443.00	(% of Sal. + Fr.)
SALARY TOTAL			600965.67	

CONSULTANTS

Writer - Shirhall Rep. To Cong.	50 days @ 200	10000.00
Designer - Nilan Rep. To Cong.	30 days @ 285	8550.00
Res. Ass't - ?? Rep. To Cong.	80 days @ 110	8800.00
Analyst - Wayne LAC "Buy-in"	120 days @ 125	15000.00
Nutrit. - Sanghvi AFR "Buy-in"	10 days @ 275.50	2755.00
SUB-TOTAL		45105.00

OTHER DIRECT COSTS

Rep. To Congress		28000.00
Std. Reports		10000.00
Other		60000.00
SUB-TOTAL		98000.00
G&A	12.57%	93529.68 (Sal+Con+ODC)
Fee	7.50%	62820.03 (Sal+Con+ODC+G&A)
GRAND TOTAL		802420.38

(1) Since not all salaries are charged directly to the project, a multiplier is applied which covers normal holiday and vacation time.

POSSIBLE ADDITIONAL DIRECTIONS

Within the existing contract, there is considerable leeway for pursuing a number of new directions. In the interest of brevity, this document partitions those directions into four classes:

A. Expand the scope (content) of the Health Statistics Database;

B. Refine the presentation of data from the existing databases, automate the presentation, and make it available through computerized channels;

C. Provide technical assistance to missions and/or countries in the realm of health information systems; and

D. Expand the role of the project as the single source of health data for A.I.D. and, consequently, its role as spokesman for the Agency on health information. If this were done, the project could also extend its role as "watchdog" of the international organizations reporting on similar data.

In practice, the directions for the project will be established in conjunction with our colleagues in the Agency. From the project perspective (at least, from the Project Director's perspective), the order of priority is captured in the ordering of the tasks above.

A. <u>Expand the scope (content) of the Health Statistics Database</u>;

The new sources-new indicators study (task E) above is identifying new content areas for the Health Statistics Database. If we had to identify an area to pursue today, that area would be health care financing -- the definition of appropriate indicators, the collection of available data, the development of methodologies to collect the data not currently available, and the presentation of useful reports based on the data. Another area of interest today is the development of appropriate indicators of high risk births.

Clearly, this is an open ended task which could absorb almost any level of effort possible given available resources. For the purposes of this paper, we assume a competent data analyst would be added to the staff for half time and resources made available for consultants who are specialists in the areas chosen for further development.

Research Analyst	6 Months
Consultants	3 Months

B. Refine the presentation of data from the existing databases, automate the presentation, and make it available through computerized channels

The initial concept for the project called for the establishment of a Communications Unit. This Unit was to serve roughly two functions: the handling of routine dissemination functions such as the mailing and processing the annual Questionnaires, the distribution of the Report To Congress, and the mailing of the Standard Reports; and the design of better methods of presenting data to make it more accessible to the clients of the project. (As noted above, many of the routine dissemination functions have been assumed by the Operations Unit.)

The explosion of computer technology has added a new dimension to the dissemination of data. The possibility exists to share information over computer networks. While many of CIHI's clients will remain wedded to "hard copy", others have expressed interest in having the capacity to access our data bases electronically.

The pursuit of this task requires two skills: data presentation and communication through computers. Assuming an individual can be found with both skills, an estimate of the level of effort required might be:

Communications Specialist 12 Months

C. Provide technical assistance to missions and/or countries in the realm of health information systems

The initial contract called for pilot activities in field missions. The current project staff is quite interested in retaining contact with the field through these pilot activities. However, in practice, given current staffing levels and the essential functions which must be performed throughout the year by each staff member, the prospect of spending adequate time away from Washington D.C. to contribute at country level is not good. Thus, this task is relegated to third priority. (The alternative of using consultants rather than staff to do out-of-Washington work is not particularly attractive. The point of the pilot projects would be to integrate the Washington perspective and the CIHI methodology into mission and/or country information gathering ventures. Consultants achieve neither.)

The level of effort for this task would depend largely on demand generated from missions. Assuming three country visits of one-month each, the level of effort would be:

Information Specialist 3 Months

D. Expand the role of the project as the single source of health data for A.I.D. and, consequently, its role as spokesman for the Agency on health information. If this were done, the project could also extend its role as "watchdog" of the international organizations reporting on similar data.

This item is not so much a task as a redefinition of role. Despite the image the project projects as **THE** A.I.D. Health Information System, it is, in practice **AN** A.I.D. Health Information System. Many other groups within A.I.D. also maintain information systems and, at times, report out data which is contrary to that reported by the project. If A.I.D. decides to have a single system -- in either the area of project information (including funding) or health information (health statistics), the coordinating function performed to some degree by CIHI now would take on greater importance.

Again, estimates of level of effort for taking on such a task are difficult due to the lack of specificity in the definition of the task. In this case, since this is not a future direction which can be chosen by the project (but only by the Agency) no level of effort estimate is provided.

NOTE TO JUDITH SELTZER: I will work up budget estimates for these tasks later; however, I wanted you to have what I have already written today. It is relatively easy to multiply salary figures by time to make budgets, except for item "C" which requires travel money as well. I will send them tomorrow.

ASSOCIATE DIRECTOR'S POSITION

In the discussion of "Maintenance Task A", reference was made (page 3) to the possibility of adding a staff member in the capacity of Associate Director to revitalize the Communications Unit. Given the twelve month budget on page 12 and the anticipated revenues for the next year, it is not feasible to consider adding staff unless the project were totally restructured (and some current staff were released). Nevertheless, the project should have an Associate Director, if only to assume responsibility when the Director is not in the Office.

It would be possible to designate an existing staff member as Associate Director and to continue to operate the project with the current staff. Ultimately, this may be the only alternative available. It is the belief of the incumbent Project Director that this project needs a second senior level person with credentials in the domain of health (not only A.I.D. project/funding) information. It is the hope of the incumbent

Project Director that funding for such a person will be found through the return of core level funding for the project to levels anticipated when the project began or through "buy-ins". If the funding comes through "core", great freedom lies in the definition of the characteristics of such a person; if it comes through "buy-ins", the content of those "buy-ins" will define those characteristics.

ATTACHMENT 17

CIHI ORGANIZATION CHARTS
JULY 1990 AND NOVEMBER 1990

CENTER FOR
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HEALTH
INFORMATION

A USAID Resource
Managed by ISTI

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M E M O R A N D U M

DATE: November 14, 1990

TO: CIHI Evaluation Team

FROM: Roy I. Miller

SUBJECT: Project Organization Chart

Attached are two Organization Charts: the first depicts the structure as of July 1, 1989; the second, as of today. It should be noted that Ruth Harvey, consultant to the project since October, 1989 will terminate her relationship with the project on November 21, 1990. Also, Stan Lehman, listed as a current consultant to the Development Unit, was full-time staff through September, 1990. Currently working on a specific assignment under a purchase order while searching for another position, Stan is not expected to retain a long term relationship with the project.

The reduction in staff size portrayed by the two charts reflects the decision by S&T/H to reduce core funding from anticipated levels and the inability of the project to-date to increase buy-in funding to compensate for the decline in core funding. (In FY 90, the project expected to receive substantial buy-ins from four sources: PPC (to facilitate the transfer of CIHI skills in tracking funding for health projects to PPC), the Africa Bureau (to support the continued maintenance of the Africa Nutrition Activities Database and the assembly of health and population profiles for countries in Africa, S&T/H/AIDS for the third Report To Congress on HIV/AIDS including maintenance of an HIV/AIDS database, and S&T/N for expansion and maintenance of the Nutrition Activities Database across the Agency. None of the above buy-ins materialized in FY 90; however, discussions continue with both the Africa Bureau and S&T/N and the prospects for FY 91 remain promising.

The more routine functions performed by the Communications Unit -- distribution of standard reports and the Report to Congress, mailing and logging in of the annual Health and Child Survival Questionnaires, etc. have been assumed by the Operations Unit. The more creative aspects of data presentation, originally planned for the Communications Unit, are being addressed by the entire staff as opportunity presents itself.

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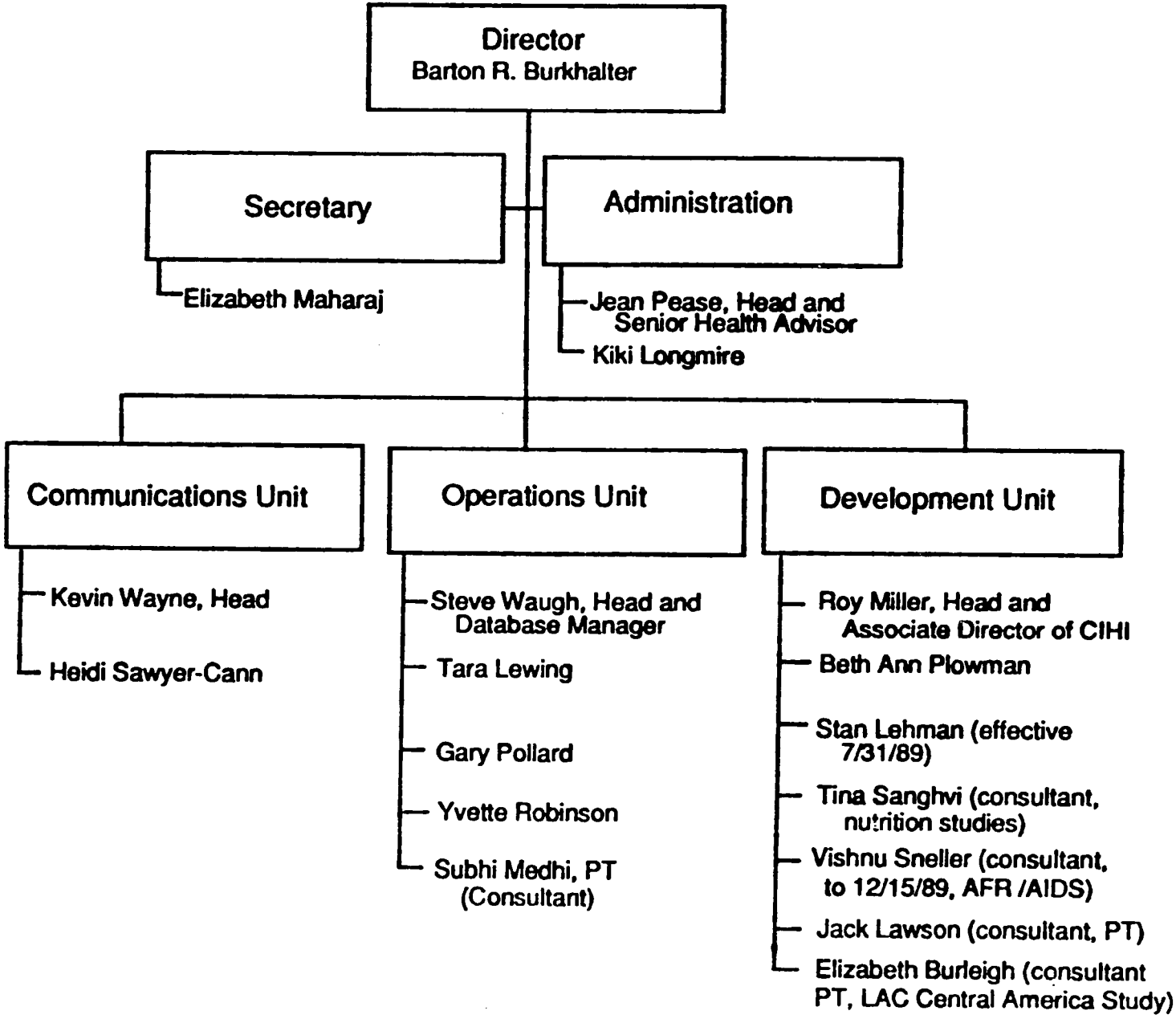
Page 27 of the contract agreement lists anticipated positions for the project and the approximate level of effort expected at each position. The functions of the writer/editor/librarian have been assigned to consultants on a need basis. The project has had a demographer and an epidemiologist on staff for part of the first two and one half years. At current funding levels, it is not possible to retain either of these posts as regular staff. In the future, consultants will be used as needed. Ms. Beth Ann Plowman, nominee for head of the Development Unit, though technically neither a demographer nor an epidemiologist, has increased her skills in these areas through studies undertaken in parallel with her work at ISTI.

The Organization Chart portraying the current configuration of the staff indicates the lack of an Associate Director for the Project. Should the financial situation improve, that post might be filled by an individual capable of revitalizing the Communications Unit in the manner envisioned in the original contractual agreement.

Center for International Health Information, ISTI

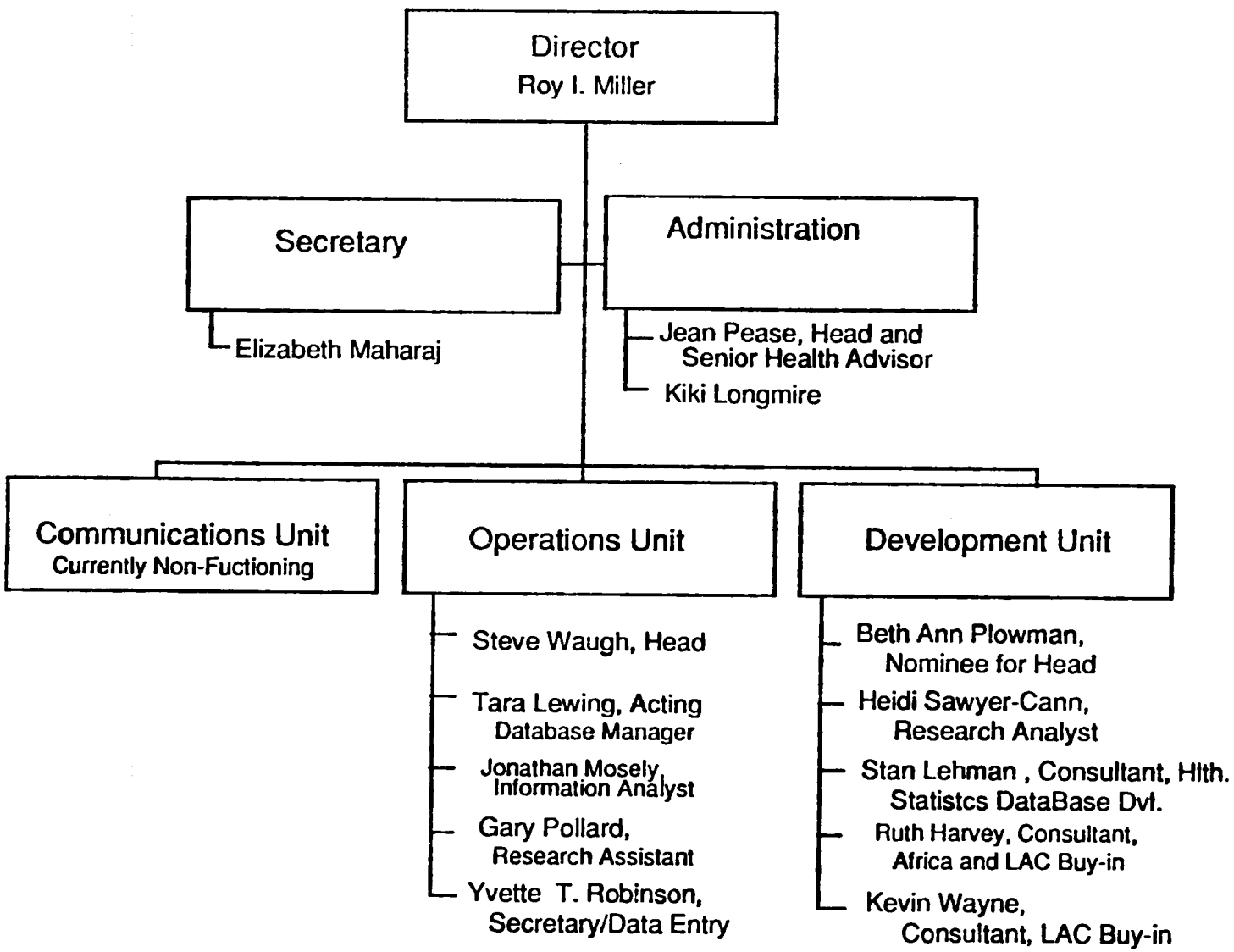
Organizational Chart

Effective, July 1, 1989



Center for International Health Information, ISTI
Organizational Chart

Effective, November 1990



ATTACHMENT 18

CORRESPONDENCE BETWEEN ISTI AND A.I.D.
ON CIHI STAFF CHANGES AND
REASSIGNMENT

ATTACHMENT II, A(2)

International Science and Technology Institute, Inc.

Headquarters 1429 20th Street, N.W., Washington, D.C. 20036
202/785-0831 • Telex 272785 ISTI UR • FAX 202/223-3865

October 2, 1990

Dr. Petra Reyes
Cognizant Technical Officer
S&T/H
Agency for International Development
Washington, DC 20520

RE: Contract No. DPE-5951-Z-00-8004-00

Dear Petra,

In my letter to you of September 13, 1990, I indicated that ISTI was proposing Dr. Barton Burkhalter as project director on a proposal to another office of A.I.D., and if the proposal was successful, we proposed to promote Dr. Roy Miller to replace Dr. Burkhalter as director of the Health Information System project and submit a project management plan for your approval.

The purpose of this letter is to inform you that ISTI has been successful in this offer and is presenting here its proposed project management staffing plan. Our plan is to promote Dr. Miller to be project director immediately, and further to promote Ms. Beth Ann Plowman to be Head of the Development Unit replacing Dr. Miller in that position. Ms. Plowman has been with the project and in the Development Unit for nearly two years and has performed excellently. A description of the Development Unit from the contract scope of work is attached. Her work on the past two Reports to Congress on Child Survival has been especially noteworthy.

We also propose that Ms. Plowman would replace Dr. Miller as Technical Editor overseeing the Sixth Report to Congress on Child Survival. As such, she would carry overall responsibility for that activity coordinating the work of the Writer/Editor (Jean Shirhall), Fact Sheets and Appendices (Jean Pease), Research Assistant, Logistics Manager and Designer (Mary Kaye Nilan). Over the next six months, this report will be the major activity of the Development Unit and we anticipate that Ms. Plowman will spend most of her time in this activity.

confirmed per telecon 10/5/9

Mary K

NO is ok the dog

In addition, ISTI is reviewing its overall staffing plan for the project in light of the budgetary conditions and work remaining to be accomplished by the project. Various issues are being considered in this review, including the appointment of an Associate Project Director (to replace Dr. Miller), alternatives for the logistics management function, and the ratio of consultant to staff time (in light of buy-in requirements). We believe that the upcoming project evaluation will contribute to this review. Therefore we propose to present a revised staffing and management plan that addresses these issues for your consideration within four weeks.

Sincerely,

Nihal W. Goonewardene
President

NWG/jhb

cc: Steve Dean, Contracting Office

DEVELOPMENT UNIT

This Unit will be staffed with senior health personnel possessing technical skills required to assure data quality, as well as maximum data use. Special studies and pilot activities will be developed and managed by the Development Unit team. The Unit will actively participate in establishing links throughout U.S.A.I.D. and with organizations that are sources of primary and secondary data. Statistical analysis of all data sets, including Tier I questionnaire data, will be the responsibility of the Unit. It will serve as a resource to the Database Operations Unit for setting data quality standards and for technical review of data entering the database. It will serve the Information Dissemination Unit as a resource for technical reports, including statistical indicators, trend analysis, and other presentations of database information. It will direct special studies and oversee pilot projects, develop appropriate tools for improving data collection, and strengthen linkages to primary and secondary sources of population-based data. It will manage the production of Technical Reports to Congress.

COPY FOR YOUR INFORMATION

AGENCY FOR INTERNATIONAL DEVELOPMENT
WASHINGTON, D.C. 20523

Nihal Goonewardene
President
International Science and Technology
Institute
1129 20th Street, N.W.
Washington, D.C. 20036

October 15, 1990

Dear Nihal:

Thank you for your October 2, 1990, letter informing us of ISTI's successful procurement and plans to implement related proposed personnel changes under Agreement NO. DPE-5951-Z-00-8004-00. The purpose of this letter is to express to you our agreement in principle with the key staff changes proposed in your letter.

We accept the proposed promotion of Dr. Miller as Director of the Health Information Systems project. We also agree in principle with the promotion of Ms. Beth Ann Plowman to the Head of the Development Unit, replacing Dr. Miller, on condition that her responsibility in relation to the Reports to Congress is redefined from Technical Editor to include overall management of the Report. Your letter proposes this overall responsibility for the Development Unit, we would want to see it made specific to the Head of th Development Unit. As you are aware, project financial constraints require reallocation of some responsibilities among project staff, and we feel it is unrealistic to maintain division of responsibilities for the Report which are no longer feasible with reduced staffing levels, as for example, a proposed logistics manager for the Report to Congress.

Further, given the increased technical scope of the FY91 Report to Congress, which will require increased collaboration with A.I.D. bureaus and cooperating agencies, we are particularly concerned that one person manages the entire process, from coordination of the technical meetings, oversight of the analytic work, its synthesis and technical editing; the complex clearance process, and finally, the coordination and supervision of other key logistics.

In our estimation, both Dr. Miller and Ms. Plowman have gained management experience during the past year in their respective areas of responsibility, and have demonstrated their capabilities to take on the increased responsibilities.

As per Pamela's September 12, 1990 letter to you, we are willing to work with you on the staffing approach you are developing, and would like to review a revised description of responsibilities for Ms. Plowman. We will give concurrence on the proposed staff changes in the context of a revised staffing and management plan with specific job descriptions.

Sincerely yours,

Petra

Petra S. Reyes, Sc.D.
Cognizant Technical Officer

cc: MS/OP/W/HP: Steve Dean
S&T/H/AR: Pamela Johnson