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Evaluation of Resources Support
Services Agreement (RSSA) between
AID and DHHS/OIH
(1981 - 1988)

by

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This report was prepared for the Office of Nutrition, AID under
Contract Number PDC-0262-I-00-7150-00.



JOHN SNOW, Inc.

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Table of Contents

	<u>Page</u>
Glossary	
Executive Summary	
I. Introduction	2
II. Background	4
1. History	4
2. Objectives	5
III. Effectiveness	9
1. Management	9
2. Inputs	10
3. Outputs	12
4. Outcomes	16
5. Impact	20
6. Process	22
IV. Conclusions and Recommendations	26
1. Conclusion	26
2. Recommendations	27

Attachments

- I. Scope of Work
- II. Protocol
- III. RSSA Agreement
- IV. List of People Interviewed
- V. List of INU Publications
- VI. ITS Contract Obligations
- VII. Estimated Non-S&T/N Funds Generated
- VIII. Quarterly Report Form

Glossary

AID	- Agency for International Development
APHA	- American Public Health Association
CRS	- Catholic Relief Service
CS	- Chief Survival
DHHS	- Department of Health and Human Service
DMD	- Dietary Management of Diarrhea
GM/P	- Growth Monitoring/Promotion
GOBI	- Growth Monitoring, Oral Rehydration Therapy, Breast Feeding, Immunization
INPF	- International Nutrition Planners Forum
INU	- International Nutrition Unit
IUNS	- International Union of Nutritional Scientists
LTS	- Logical Technical Services
MFM	- Meals for Millions
MIS	- Management Information Systems
MOH	- Ministry of Health
NCIH	- National Council of International Health
NGO	- Non-Governmental Organization
NSS	- Nutritional Surveillance System
OIH	- Office of International Health
OR	- Operations Research
ORT	- Oral Rehydration Therapy
PHC	- Primary Health Care
PHS	- Public Health Service
PVO	- Private Voluntary Organization
RSSA	- Resources Support Services Agreement
S&T/H	- Science and Technology/Health
S&T/N	- Science and Technology/Nutrition
TA	- Technical Assistance
UNDP	- United Nations Development Program
UNICEF	- United Nations International Child Emergency Fund
WHO	- World Health Organization

EXECUTIVE SUMMARY

This evaluation reviews the performance of the Resources Support Services Agreement (RSSA) between the Agency for International Development (AID) and the Department of Health and Human Services (DHHS), Office of International Health (OIH). The RSSA was in effect from September 1981 to February 1988. AID's primary objective for the RSSA was to promote nutrition issues and provide services to regional bureaus and country missions, specifically on nutrition surveillance, nutrition education, nutritional supplements and the control of infections that adversely affect nutritional status. In order to accomplish this the RSSA was to:

- collect, analyze, publish and disseminate informational and training materials,
- prepare resource handbooks,
- conduct workshops,
- provide technical assistance, and
- conduct operations research.

The OIH played a strong supportive role in the early stages of the RSSA being evaluated, providing considerable management support throughout the six and a half years being reviewed. By mutual agreement between the OIH and S&T/N, the RSSA services were provided by a contractor, Logical Technical Services(LTS), a private consulting firm.

LTS received core central funding of slightly over \$2.3 million from S&T/N. This was augmented by an additional approximately \$1.6 million from regional offices (REDSO/WCA) and bureaus (ANE and Africa), AID missions, WHO, UNICEF and UNDP. Most of the personnel involved were regular LTS staff; only a few outside consultants were utilized, primarily because of resource limitations.

In determining the overall effectiveness of the RSSA, performance must be measured against the agreement's purpose as stated in the original document. Generally, in the six and a half years the RSSA was on effect, it did, as the RSSA proposed, reinforce and expand AID's capability to provide leadership and supporting role in nutrition components in PHC projects. Its greatest achievements were its catalytic and advocacy activities, its systemization of Growth Monitoring/Promotion (GM/P), and its development and promotion of a simple/immediate feedback management information systems (MIS).

In terms of outputs, the RSSA produced a large volume of publications (78), provided technical assistance in 20 countries and carried out operations research (OR) activities in eight countries. The RSSA also organized and managed two major global conferences plus one regional workshop and 15 country meetings in eight countries on nutrition programming issues.

The RSSA began with a broad approach to adding nutrition to primary health care programs but increasingly focused on GM/P and Nutrition Surveillance Systems (NSS) and, to a lesser extent, on Dietary Management of Diarrhea (DMD) as part of Child Survival and GOBI efforts. Despite this narrow focus on technical activities, the RSSA was effective in promoting nutrition activities within AID missions. The RSSA generated guidelines for GM/P and DMD that were considered useful. The RSSA served as a catalyst by promoting coordination which led to standardized nutrition activities among PVOs and the MOH in several countries, developed indigenous skills and institutional capacity and reoriented GM/P projects from curative to preventative/promotive.

On the qualitative side, the point was raised that the RSSA activities were too narrowly focused on GM/P at the exclusion of other activities mentioned in the RSSA (eg. nutrition education, supplementary feeding, control of infection, child spacing, infant weaning/breastfeeding, vitamin A and iron). In addition, in several countries where OR activities were carried out, they met with little local interest and lacked evidence of how the activities would fit into larger programs. In several cases the RSSA staff had a tendency to take control of local research efforts, thus reducing local participation. There was concern expressed that a RSSA consultant was too directive. In some field activities GM/P (education and management objectives) and NSS (policy making) were intermingled. The limitation of bureaucracies to implement large-scale, community-based programs was not accorded sufficient attention, raising concern about the sustainability of some of the RSSA activities. The RSSA tended to concentrate on technical details at the expense of larger process issues (eg., on-going data collection and processing in the Dominican Republic at the detriment of other important elements such as nutrition education).

Though the LTS core consultants had limited capability in French which adversely affected their field work in Francophone, West Africa, their fluency in Spanish was a benefit in Latin America. The RSSA was responsive to bureaus and missions and typically provided the same consultant or team over time to a project effort; continuity was mentioned as a strength of the RSSA. In addition, the RSSA was viewed by the bureaus and missions as an inexpensive, easily accessible mechanism to get good quality technical assistance. It proved to be a cost-effective means of providing technical support to missions.

The RSSA was not directly involved in service delivery, and, therefore, impact upon nutrition status is impossible to evaluate. But positive effects on service delivery programs (supported through the RSSA), were noted, particularly in the Dominican Republic.

The OIH did not act as a service provider but did act as an important facilitator. S&T/N in most cases dealt directly with the contractor. The RSSA did not, therefore, fully satisfy AID's desire to broaden its support or reduce its administrative load. The OIH provided considerable support to the RSSA contractor (eg., communications, publications, library) and kept the project going for extended periods when the RSSA had officially lapsed. It also monitored RSSA "deliverables" and did most of the RSSA budget analysis and projections.

The evaluation team recommends that S&T/N design a new project in which the goals and implementation mechanism are more clearly defined. The project should be a direct relationship between S&T/N and a contractor. The new project should take the form of a nutrition-in-health service delivery/support project having a broad focus, maintaining the primary goal of promoting nutrition in other health efforts. As with the RSSA, services should be easy to procure, and the maximum continuity of TA personnel for each task should be encouraged. The project should have central funding to begin work and be designed in such a way that local missions and regional bureaus, as well as UN organizations, other governments and PVOs, could buy into the project. From the experience of this project, OR might be left to existing projects such as PRICOR, but in general, missions and bureaus can be expected to be specific about their requests for help.

I. Introduction

The Office of Nutrition requested JSI to conduct an evaluation of the Resources Support Services Agreement (RSSA) between the Agency for International Development (AID) and the Department of Health and Human Services (DHHS), Office of International Health (OIH). The period covered in this review is from September 1981 when RSSA No. BTS-0249-R-H1-2254 was signed until 29 February 1988 when the last extension came to an end. The Scope of Work for the evaluation can be found in Attachment I.

The evaluation was carried out by a team of individuals who followed a protocol developed for the exercise (Attachment II) and included:

- o the review of documents including the original RSSA (Attachment III), amendments, contract modifications and publications/reports produced under the RSSA.[1]
- o interviews with AID and country officials who had received support from and/or interacted with the RSSA contractor (See list of people interviewed, Attachment IV).
- o site visits to several of the countries/projects which had received support under the RSSA, including Thailand (John Comings), Togo and Sierra Leone with a visit to REDSO/West and Central Africa in Abidjan (Phyllis Gestrin), the Dominican Republic (Richard Lockwood) and Ecuador (David Nelson)[2]. Each consultant submitted a report reviewing RSSA activities in the country, their quality and relevance. Their findings are integrated into the body of the evaluation as the basis and/or supporting evidence for comments made.

The body of this report consists of three sections. The first of these provides the background, detailing how the RSSA was developed, the rationale for it, its objectives and the establishment of the contractual arrangement with the firm which carried out the activities of the RSSA over its six and a half year history. The next section addresses the effectiveness of the RSSA; that is, were the objectives of the Office of Nutrition of AID realized? The section is divided into several parts which look at management, inputs, outputs, outcomes, impact and process. The

[1] Because the technical services carried out under the RSSA were in all cases provided by the contractor, the terms RSSA and LTS are used synonymously. A study of low birth weight babies in India was requested by the Office of Nutrition, AID and is being carried out by the PHS under the OIH, paid for under the AID/ANE and specific PASAs.

[2] The Philippines was also mentioned in the Terms of Reference for the RSSA Evaluation, but because LTS has not had any nutrition-related activities there, it was agreed that there was no point in making a site-visit.

final section is devoted to conclusions regarding the value of the RSSA arrangement, a discussion of future needs, and several recommendations on how these needs might be met.

The team collectively felt that the formative aspect of this exercise was as important as the summative part. That is, how the needs identified during the last 6.5 years of the RSSA and during our discussions with experts in the field will be addressed in the years to come is as important as what has taken place over the life of the RSSA. The recommendations are the result of a rare opportunity to discuss nutrition programming with a lot of people who are interested in and committed to the role of nutrition programs as a vital part of Primary Health Care (PHC).

II. Background

1. History - In the mid-1960s, there was a general agreement between AID and the DHHS's predecessor (Department of Health, Education and Welfare - HEW) in which the latter would support AID's health and nutrition activities in the developing world. In 1977, a RSSA was established between the OIH and AID's Office of Nutrition (referred to as Participating Agency Agreement No. OIH 1-77).

The 1977 version of the OIH RSSA assisted AID and its overseas missions to incorporate nutrition components more effectively into low-cost health delivery systems. Under this agreement, AID's health sector programs were analyzed by region and the findings published. In addition, state-of-the-art publications on integrated health service delivery in the developing world by such groups as WHO and APHA were reviewed and abstracted. Consultants were sent to Bangladesh, Guatemala, Malawi and Swaziland to advise on nutrition interventions in health programs. Finally, bibliographies on breast-feeding and Oral Rehydration Therapy (ORT) were prepared and widely distributed. Approximately \$570,000 of AID central funds managed by the Office of Nutrition was budgeted to cover costs of carrying out RSSA-related activities between October 1977 and the end of June 1981.

As the early RSSA came to an end, the Office of Nutrition met with all four regions and organized, with the OIH and the committee on International Nutrition Programs/National Academy of Sciences, a workshop on "The Nutritional Component of PHC Services." After several years of operations all agreed that AID should increase funding for nutrition program support in PHC in the early 1980s. AID wanted the support of the DHHS and the Public Health Service (e.g. Centers for Disease Control, National Institutes of Health, Food and Drug Administration). The Director of the Science and Technology/Nutrition (S&T/N in AID) envisioned, among other things, a document/resource center. On the other side, the Health Resources and Service Agency of DHHS saw an opportunity for more involvement in international field work.

The renewal of the RSSA in 1981 coincided with the new administration's freeze on hiring. After a wide-ranging search for an experienced, well qualified and respected international nutritionist, the chosen candidate could not be hired as an employee of the DHHS. So that the resources received by the OIH under the AID RSSA (more than \$500,000) did not lapse, the DHHS, with the full concurrence of AID, made a contractual arrangement with Logical Technical Services (LTS) Corporation with which the Department had considerable favorable experience.[3]

[3] LTS had a contractual arrangement with OIH to provide technical assistance to the Office of Health in AID. The activities focused primarily on health needs assessments, program planning and evaluation. LTS also carried out most of the technical assistance provided during the 1977-81 phase of the Nutrition RSSA.

Because LTS was an 8A (minority owned) firm, the OIH was able to make a sole source (noncompetitive) contract with the firm. LTS, in turn, hired the same candidate whom the OIH had previously selected to head the effort.

In the early 1980s, the ability of the technical branches of AID to procure technical assistance (TA) was considerably different than today. None of the large, centrally-funded TA projects (e.g., PRITECH, REACH, and HealthCom) existed. Thus, there was a need for a flexible mechanism which would be responsive to a wide variety of demands emanating from the Office of Nutrition, the regional bureaus and AID missions around the globe. The RSSA mechanism fit these requirements.

In addition, the RSSA mechanism appealed to the Office of Nutrition because it broadened support for their activities. The Office of Nutrition thought it would be helpful to have the backing of the DHHS in the promotion of international nutrition initiatives. S&T/N had several RSSAs in effect at the same time with the Department of Agriculture (one in food technology and another in nutrition economics). Moreover, with limited personnel in the Office of Nutrition, the RSSA was one way to acquire assistance without increasing their management responsibilities. The OIH was interested in the opportunity the RSSA presented to increase the involvement of its personnel in integrated nutrition efforts in the agencies for which they are responsible. The RSSA, therefore, was seen as an arrangement that would benefit both offices.

The initial contract with LTS was signed in September of 1981, and this contract lasted until May of 1983. The first extension went from May, 1983 to December, 1984. The second extension was later extended to the end of February 1988.

2. Objectives - AID's primary interest in developing the RSSA with OIH was to promote nutrition activities in Primary Health Care (PHC) projects. In the latter half of the 1970s, a growing percentage of AID resources devoted to health were being programmed in PHC projects. In most of these efforts, nutrition played a minor role, if any, despite the fact that malnutrition was a serious problem and closely linked to the issue of infection and fertility in PHC projects. With strong justification, the Office of Nutrition desired a vehicle which would increase the role of nutrition and make it into a major component of PHC efforts funded by AID.

As described in the RSSA (Attachment III), the arrangement with OIH would assist the regional bureaus and individual country missions to determine the nature of their nutritional problems and the nature of the nutrition activities that would address them in the context of an integrated health system. Simultaneously, the RSSA effort would identify the tools that could be used to implement the nutrition interventions. The nutrition interventions identified in the original RSSA fell under four general headings:

- Surveillance - to facilitate the monitoring of the nutritional status of vulnerable groups (growth charts based on weight for age and simplified guidelines on how to use such tools would assist community health workers maintain nutritional surveillance more effectively.)
- Nutrition Education - to educate mothers on important nutritional concepts/messages (especially, breast-feeding, weaning practices and improvement in the basic diet).
- Nutritional Supplements - to supplement the diets of "at risk" groups (pregnant mothers and the under-fives) with nutrients such as iron/folic acid, vitamin A, and calories.
- Control of Infection - to control and manage infections (especially gastroenteritis) which adversely affect the nutritional status of the vulnerable populations.

The outputs of the original RSSA were envisaged to include five things. [4]

- Informational and Training Materials - the collection, analysis, publication and dissemination of information on nutritional components in community-based PHC programs in developing countries; the interventions include weaning foods, breast-feeding, supplementary feeding, nutrition training for community-based workers, oral rehydration and growth surveillance.
- Resources Handbooks - preparation and up-dating of guidelines on alternative approaches to improving the nutritional status of the vulnerable groups; these were to include curricula for training supervisors and community workers in nutrition and handbooks on growth surveillance, ORT, data collection, infant feeding, and home-based weaning foods.
- Workshops - conducted on regional and national levels to inform health policy and program makers about the role of nutrition, in PHC to update AID field staff and country personnel on the current state of knowledge on nutrition interventions.
- Technical Assistance - provision of short-term consultancies to AID missions and regional bureaus to respond to requests for nutritional needs assessment, development of training capacity, and support of nutrition interventions.

 [4] A more complete description of the outputs can be found in the RSSA (Attachment III).

- Operations Research - identification and support for studies on the effective implementation of nutrition interventions in PHC programs.

Among the initial activities identified under the RSSA were projects to be carried out in Asia, in the Philippines (determine the cost-effectiveness of a Nutrition/Health Interventions Project) and in India (design a low birth weight causality study). The Philippines and India projects were not carried out through the Nutrition RSSA. The latter Low Birth Weight study has been implemented by the Centers for Disease Control (CDC) and the National Institute of Allergy and Infectious Diseases under a PASA arrangement with the OIH although it first came to OIH's notice through the LTS and S&T/N. The early RSSA activities carried out by LTS concerned Africa with growing involvement in Latin America as the RSSA progressed.

The Scope of Work in the first extension of the RSSA and in LTS's Contract (May 1983) was to prepare analytical evaluative reviews and studies on the integration of nutrition interventions into PHC projects in six to eight countries. The issues to be considered included:

- Community participation and organization in nutrition program development;
- Optimum village health worker/team approach to malnutrition interventions;
- Nutrition sociology/anthropology at the village level and the affect on nutrition/health practices;
- Diarrheal disease control and treatment;
- Child spacing as a maternal and child health and nutrition intervention;
- Improved weaning and breast-feeding practices;
- Nutrition-related training and education;
- Nutrition surveillance and treatment targeting;
- Improved diagnosis and evaluation techniques as related to reducing malnutrition levels;
- Supplemental feeding and other prevention services integrated into low-cost primary health care projects; and
- Multisectoral nutrition planning as related to the overall delivery of nutrition services.

In addition, nutrition assessment data sheets were to be developed and data collected, initially on countries in Africa. Technical assistance on innovative public health nutrition projects was to be initiated with a

minimum of five AID missions. Finally, nutrition policy, program and project information and analysis, planning and evaluation activities were to be carried out, including distribution of nutrition training materials for PHC workers, publication of state-of-the-art guidelines on nutrition monitoring and surveillance, development of a resource handbook on micro-nutrients such as for iron and vitamin A, and preparation of a nutrition intervention matrix.

The Scopes of Work for the subsequent RSSA extensions remained similar. Work plans were developed on an annual basis in conjunction with the bureaus and S&T/N, focusing efforts on special needs and specific countries. Later amendments included support of the International Nutrition Planners Forum and the addition of dietary management of diarrhea (DMD). Geographically, the emphasis was increasingly shifted to sub-Saharan Africa and more work in Latin America. In Contract Amendment #9, dated 30 August 1985, for example, Nutrition Assessment Data Sheets were to be prepared for 21 Sub-Saharan African countries, and TA was to be provided to six of these countries.

III. Effectiveness

If we compare the achievements under the Nutrition RSSA with the stated RSSA purposes, the overall assessment is that the effort provided a useful service. In many ways it "reinforced and expanded AID's capability to provide leadership and supportive-role" in nutrition components in PHC projects as the RSSA dictated. Its greatest strengths included the playing of a catalytic advocacy role for nutrition, promoting a systematic approach to GM/P and developing simple MIS approaches which improved program performance.

This section will be divided into six sub-sections. First, the management of the RSSA is reviewed. Next, the inputs into the RSSA in terms of human and financial resources will be documented. The third subsection identifies the outputs resulting from the RSSA. Fourth, we look at outcomes which can be attributed to the AID/OIH RSSA. This is followed by a short discussion of the impact made by the Nutrition RSSA. Finally, the process of how the RSSA functioned will be discussed.

1. Management - The OIH was responsible for managing the RSSA. In the early years of the RSSA under review, the director of the office took considerable interest in the nutrition activities being carried out. His successor promoted work in the dietary management of diarrhea. Under the RSSA, the contractor interacted with the UN organizations (especially WHO and UNICEF), briefed US delegates to international bodies and reviewed position papers on nutrition-related issues; this access gave S&T/N broader access to the international organizations.

In addition to the technical facilitation role, the OIH provided essential administrative support which permitted the RSSA to function smoothly. To assist the underfunded contractor develop activities and carry out its responsibilities, the OIH provided support in the form of communications (long distance calls and telexes), publications (duplicating facilities for reports and monographs) and library use (searches and copies of relevant articles and publications). Very importantly, the OIH drafted and got approval for a series of RSSA amendments (12) and contract modifications (28). On several occasions, the OIH kept the RSSA functioning even though authorization had officially expired. Such cases took place in 1984 (Amendment #7 was to take affect 1 April but was not signed until 21 October - a six month gap) and in 1985 (Amendment #9 was to start 1 January but was not signed until 30 August - an eight month gap). [5] The OIH also monitored the production of contract "deliverables" on a regular basis throughout the RSSA. Moreover, the financial officer of the OIH devoted a portion of his time to developing RSSA budgets and carrying out budget analyses. With changes in budget allocations available to the Office of Nutrition, this exercise would often have to be repeated several times during the year. Finally, the OIH assistance to LTS Contract personnel was helpful. This included such things as the Surgeon General

[5] Funds were available to cover RSSA activities during the periods in question.

requesting a visa extension for an LTS consultant to salary calculations to ensure an LTS consultant received appropriate compensation for services rendered. For its role the OIH began to charge 10% overhead beginning in the fourth year of the RSSA. A portion of the money they earned under this arrangement was used to fund RSSA activities (e.g., international travel).

LTS consultants mentioned that they found their attachment to the PHS and the OIH helpful in their work in the Third World. The association gave them an apolitical, technical and professional standing which they might not have had if they were viewed only as consultants under the Office of Nutrition.

It was also mentioned that the lack of any involvement of S&T/H made LTS' job more difficult. Because the RSSA was to address nutrition in the context of PHC, it would have been appropriate that the health and nutrition offices work together. The director of the Office of Nutrition, committed to maintaining the discrete nutrition focus and concerned about nutrition being overshadowed, did not promote such collaboration.

The Office of Nutrition also had its own administrative responsibilities on behalf of the RSSA. Not only did they have to provide emergency support for the contractor in special circumstances (e.g., logistic support for the INPF Conference in Cairo), but it also had to issue travel orders and get mission clearance whenever the contractors made field visits.

LTS managed the limited funds under the nutrition RSSA efficiently. By reducing its personnel costs to a minimum (by maintaining staff as consultants rather than full-time employees) and by developing additional sources of support, LTS provided the Office of Nutrition with good value for the amount the latter invested. The arrangement must be described as being cost-effective. One concern, however, that did arise during this review regarded the determination of exactly how much in terms of additional resources had been generated by LTS and used to extend the activities under the Nutrition RSSA. While LTS provided the evaluation team with an estimate (Attachment VII) which gives an approximation, a more precise record keeping/accounting mechanism would have provided a more accurate picture of the additional support generated by LTS in support and extension of Nutrition RSSA activities.

2. Inputs - For approximately the first half of the RSSA arrangement, LTS operated with three nutrition professionals: a project manager - (Dr. Charles Teller), a Medical Nutritionist (Dr. Juan Aguilar) and a Program Assistant (Janet Wilcox followed by Virginia Yee). In 1984, Dr. Jose Mora replaced Dr. Aguilar and in 1986, the new position of Operations Research (OR) Specialist (Dr. Alfred Zervas) was added. There has been remarkable stability among the contractor's staff, and this continuity has added greatly to the effectiveness of the work in various countries and has facilitated the technical contribution made by the RSSA.

In addition to the core LTS team contracted under the RSSA, a Nutrition Advisor was also placed in the Africa Bureau.[6] The RSSA provided the mechanism to acquire nutrition expertise and support after two Nutritionist positions in the bureau were abolished. The position with LTS was supposed to be a temporary measure (a "bridge") since the position was fully expected to be sanctioned and the person filling in and supported under the RSSA would become a direct hire in a short time. In fact, the position was funded under the RSSA, hence through LTS, for almost three and a half years. Moreover, the current Medical Nutritionist used to spend a portion of his time in the Office of Nutrition providing technical guidance, especially on the dietary management of diarrhea.[7]

LTS used outside consultants very sparingly. The names of seven non-core LTS staff members appear as authors in the list of publications produced by the RSSA (Attachment V), and all but one of these are in the first several years LTS had the contract to carry out the work. One activity in which outside consultants were used that does not show up on the publications list is at the seminars and workshops. In these a number of experts took part as lecturers and facilitators (in Cairo, West Sussex, Abidjan and Monrovia). Many of these were local experts; the use of U.S. consultants was restricted due to funding limitations.

The fraction of central AID funding used to cover the activities of the RSSA contractor came out of the Office of Nutrition budget. Over the six and a half years that the LTS contract to carry out the Nutrition RSSA was in existence, the total amount of these funds that were appropriated was \$2,305,347 (see Attachment VI) in a total of 28 contract modifications. Although only slightly more than \$1.8 million was programmed under RSSA Amendments 1 through 12 and the Africa Bureau funds, another approximately \$500,000 was carried over from the S&T/N funds allocated to the RSSA prior to 1982.

The LTS funding included funds from the Africa Bureau to support the services of a nutrition advisor in the AID/Washington Office. Originally, the RSSA was to serve as a mechanism to provide interim support until the individual could be approved as a direct hire; however, this arrangement continued for several years (May 1984 to May 1986). When the person in question finally became a direct hire and was reassigned, his place as nutrition advisor was taken by another consultant who filled the position until the end of LTS's contract under the RSSA (February 1988).

[6] This was paid for by the Africa Bureau in a "cost-sharing" arrangement.

[7] He initially spent two days a week (40% of his time), but this was soon reduced to one day or 20% of his time when not enough work was generated as anticipated by the S&T/N Director and when responsibilities at LTS and under the RSSA required attention.

LTS documents and discussions about their activities since 1981 refer to a number of other funding sources. In addition to the Africa Bureau activity, LTS received "cost-sharing" funds from the Office of Food for Peace and the Asia Bureau. AID missions (Bolivia, Dominican Republic, Ecuador, Thailand) were also involved and provided travel and expenses for LTS consultants to respond to mission requests for TA. This allowed LTS to participate in national seminars and workshops. The consultant salaries were paid for out of the RSSA core funds. LTS also collaborated with PRICOR (in studies in Togo and Zaire and the production of the Thesaurus on GM/P); and PRITECH was mentioned as a partner in Ecuador. In addition, several activities such as the INPF in Cairo and West Sussex as well as the PHC Conference in Liberia and the Abidjan Conference were jointly sponsored with WHO and UNICEF. Finally, funds were received from UNDP for activities in several West African countries (Burkina Faso for example).

The Nutrition RSSA was limiting in that it did not permit those interested to utilize their own funds to have the project provide assistance in their country or region; that is, "buy-ins" were not allowed.[8] However, there were a number of "cost-sharing" arrangements in which bureaus, missions, private voluntary organizations and the OIH itself provided funds to LTS for project support. Attachment VII is a list provided by LTS which estimates the additional funds raised under the RSSA. According to this data, LTS was able to leverage the limited funding (primarily in the form of core staff support) received under the S&T/N-OIH RSSA, in the process generating an additional \$1.6 million for field activities; 85% of the funding came from REDSO/WCA. The ability of the RSSA to identify additional resources is an indication that a need existed in the field. The technical assistance and support available through the RSSA filled an existing need and encouraged "cost-sharing" arrangements. The flexibility of the RSSA as well as the cooperation of the involved parties (OIH, S&T/N and LTS) facilitated these arrangements and responsiveness to field requests.

3. Outputs - The RSSA produced a large volume of documents during the six and a half year period under review. In terms of quantity, a total of 78 publications were produced by LTS.[9] Table I breaks this number down into six categories.

[8] RSSAs by definition do not necessarily preclude buy-ins. For example, the OIH's current RSSA with S&T/Health for Child Survival permits buy-in arrangements.

[9] In LTS' List of Publications (Attachment V), the translated version of several documents appear as separate entries (ie., the English, Spanish and French editions are listed as three titles). In table I, such reports are listed as single publications.

Table I
Publications Produced by LTS Under RSSA
by Category

Year	Trip Reports	Evaluations	Workshops Seminars	TA/OR Reports	Papers	Guide-lines	Total
1982	4			1	2		17
1983	6		1	1	1	1	10
1984	6		2		1		9
1985	8		1		6	2	17
1986	15				2	1	18
1987	6	1	1	3	2		13
1988	1	2	1	1			5
Total	46	3	6	6	13	4	78

Much more difficult to quantify are the number of people trained under the RSSA. LTS worked with people in several countries and, according to those involved or knowledgeable about the activities, had considerable influence on their methods of operations. This is true in countries such as Thailand (Mahidol University and MOPH) and the Dominican Republic, Ecuador and Togo (PVOs, specifically on CRS). LTS worked closely with these groups and upgraded their understanding of nutrition interventions, especially GM/P, and their ability to implement nutrition projects more effectively.

Operations Research (OR) activities were conducted in eight countries. Actual studies were carried out in Thailand and Togo while OR methodologies for GM/P were tested in Zaire. OR techniques were used in Bolivia, Dominican Republic, Ecuador, Liberia and Sierra Leone. This is in accordance with the scope of work of the RSSA. Reports on these activities were completed and can be found in the list of publications.

The RSSA was also charged with carrying out conferences and workshops. It was assigned the additional responsibility by S&T/N to help plan and implement two global meetings of the International Nutrition Planners Forum (INPF) - in Cairo in January, 1984 and in West Sussex (England) in August, 1985. The INPF is a group of public health and nutrition experts from developing countries who are interested and involved in integrated programming who came together to discuss priority topics which they chose on how PHC/nutrition programs could be made more effective. The 1984 meeting discussed Nutrition in PHC and was attended by 90 experts from 34 developing countries. The topic of the 1985 meeting was Nutrition and Diarrheal Disease Control and had 27 participants from 21 countries. LTS

was also responsible for publication of the results of the two meetings. They produced widely circulated volumes in three languages on each of these forum meetings.

The RSSA scope of work mandated regional and country workshops. LTS organized and carried out a meeting for West African nutrition/health officials in Abidjan during the fall of 1984. Forty-two participants from 14 West and Central African countries attended. The following national-level meetings were held under the Nutrition RSSA (chronologically listed):

- Jamaica - December 1982
- Dominican Republic - August 1983 and May 1986
- Sierra Leone - February 1984 and October 1986
- Liberia - June 1985
- Thailand - February, August 1986 and August 1987
- Ecuador - September 1986 and June 1987
- Ivory Coast - December 1986 and March 1987
- Bolivia - September and December 1987

An example of one such national conference conducted under the Nutrition RSSA is the First Annual PHC Conference in Liberia which focused on integrating nutrition into PHC. Seventy national and international participants took part and developed national guidelines, outlining realistic approaches to address Liberian nutritional problems.[10] Other country-level workshops were carried out by LTS, e.g., Jamaica (December, 1982), Ecuador (September, 1986) and most recently in Bolivia (September and December 1987) focused on GM/P and were attended by PVOs (e.g., CRS and MFM) who were involved in nutrition programming. These workshops, as described, were really training sessions.

The greatest amount of work done by LTS under the RSSA was the provision of Technical Assistance (TA). As can be seen in Table I, almost 60% of all the reports were classified as trip reports and documentation of technical assistance efforts. From RSSA documents a total of 20 different countries were visited over the course of the six and a half year period.[11] To nine of these countries, single visits were made as part of project-related reconnaissance or evaluation activities. Prompted by mission requests, long-term assistance was carried out in six of these countries (Bolivia, Dominican Republic, Ecuador, Sierra Leone, Thailand, and Togo) and multiple visits were made to Colombia, Ivory Coast (REDSO/WCA), Jamaica, Peru, Senegal.

[10] The Abidjan and Liberia Conferences were also funded by WHO and UNICEF. This additional funding made it possible for the RSSA and USAID to achieve considerably more for their financial support than would otherwise have been possible.

[11] Belize, Burkina Faso, Bolivia, Colombia, Dominican Republic, Ecuador, Egypt, Honduras, India, Ivory Coast, Jamaica, Liberia, Peru, Senegal, Sierra Leone, Sudan, Tanzania, Thailand, Togo, Zaire.

The "deliverables" under the RSSA also included the production of state-of-the-art reviews or guidelines. The first one to be produced was the "Guidelines for Incorporating Nutrition into the Design of PHC and Related Development Projects" (May 1983). Others were "Making Primary Health Care Nutrition Work: Issues Raised in a Review of the Record" (January 1984), "The Guidelines for the Design and Organization of Health Sector Nutrition Surveillance" (May 1985), "Home Management of Acute Diarrhea" (July 1985), "Thesaurus on Growth Promotion Activities at Community Levels and at Clinic Level" (January 1986) and "Issues in Growth Monitoring and Promotion" (May 1987).

LTS also voluntarily wrote and presented a number of papers at professional conferences, including APHA, NCIH, Western Hemisphere Nutrition Congress, Panamerican Congress of Pediatricians, and IUNS (International Union of Nutrition Scientists). The OIH felt this was helpful in that it gave the office some visibility and publicity when its staff had been drastically reduced. The subjects most often dealt with were GM/P and Dietary Management of Diarrhea (DMD). LTS also participated in orientation sessions for AID health/nutrition/population officials (e.g., Gettysburg meeting for Africa Bureau officers in June, 1984) to orient them on nutrition interventions and their role in PHC programs. Finally, quarterly reports summarizing activities carried out by LTS were required and, according to the record, were issued on schedule and provided a succinct summary of work as well as copies of relevant documents produced during the period.

The list of "deliverables" which accompanied the scope of work on each new contract extension specified the number but left the delivery date open ("as agreed between Project Officers and AID Office of Nutrition"). In fact, the items to be delivered depended on discussions between the OIH and the Office of Nutrition; and if the requests for particular items were not forthcoming, the scope of work was changed through a contract modification. Thus, the type and number of reports produced did not always correspond with the scope of work. For example, more TA reports were published than specified. At the same time, although bibliographies were included in the three state-of-the-art papers produced under the RSSA, no bibliographic reviews of nutrition in PHC publications were forthcoming. The reason for this was lack of demand and changing emphasis within the Office of Nutrition; if the latter did not apply pressure for an item and the field did not demand it, it was not produced. Conversely, if a high demand existed (e.g., for TA), more than the specified number was produced. Responsiveness to need is to be applauded and neither the OIH, the Office of Nutrition nor LTS should be considered negligent for not producing reports for which little need existed. Flexibility was a positive feature of the RSSA.

In terms of content, the focus of LTS' work over the six and a half year period as mentioned was strongly in favor of GM/P and nutritional surveillance.[12] The list of reports includes 29 reports or papers on this subject. The second greatest number (16) relate to nutrition in PHC and Child Survival. Three reports address issues relating to DMD. One report each, all produced in the first two years of the RSSA, are devoted to family planning/child spacing, food supplementation and control of infection. The heavy concentration on GM/P reflects the focus of nutrition activities under the Nutrition RSSA. Very little attention was paid to aspects such as nutrition education, nutrition supplementation, control of infection, child spacing, infant weaning and breastfeeding, or specific nutrients (e.g., vitamin A and iron), all of which were mentioned in the original scope of work. The narrow focus under the RSSA was a result of several factors - the interests of S&T/N and its director, demands from the field and the background/expertise of the LTS staff and consultants.

4. Outcomes - The expectations in terms of outcomes were not spelled out in the original RSSA. No logframe providing indicators of outcomes or impact was included. Only outputs or products were specified. However, the quality and potential impact of RSSA activities are essential aspects of evaluation. As we focus on outcomes and address the quality of the activities carried out under the RSSA, it is not possible to measure results in quantitative terms as we did when reviewing project outputs. In this case, the measures are more qualitative in nature, addressing whether the activity was of a high technical quality, whether it was appropriate to the particular situation and whether it had a good chance of achieving improved health and nutritional status among the target population.

First, it must be noted that the nature of the work done under the RSSA changed as time passed. This, of course, is to be expected over a six and a half year period. As one can see in the list of activities in the original project description, the range of the activities was very broad. It included such things as community participation, child spacing, improved weaning/breast-feeding practices, supplementary feeding, and nutrition education.

In the early years as contractor for the RSSA, LTS promoted nutrition considerations in PHC. This was done by conducting needs assessments (especially in Sub-Saharan Africa) to determine nutrition-related needs and then design projects to address them. As time passed, more and more emphasis was placed on growth monitoring and nutritional surveillance. In the last three years, a second major topic was added, that of dietary management of diarrhea.

The idea of integrating nutrition into PHC activities became increasingly more difficult to practice as time passed. The reviewer of the RSSA-assisted activities in Togo noted that no efforts were being made

[12] The majority of trip reports to individual countries are not included in this count since they refer to a range of subjects.

to integrate nutrition efforts with PHC. This was the result of several factors. The Director of the Office of Nutrition came to see nutrition as a discrete entity, this was to and supported by the regional AID officers in Abidjan. Finally, emphasis on nutrition interventions found favor in the LTS core group since they were themselves highly competent in the activity being promoted, GM/P.

In the conferences, meetings, technical assistance missions, publications and in the regional bureaus, LTS served very much as an advocate for nutrition. In retrospect, informants now identify this as one of the most important roles of LTS. Following the difficulties faced in the Nutrition Planning era (the 1970s), nutrition had lost some of its support in the development community. In the meantime, PHC had gained momentum, and nutrition was seen as only one (often minor) component among many. Nutritional considerations were often neglected or excluded altogether. In the early 1980s, the health community did not give nutrition the attention it deserved and required. When the attention given to PHC was turned to Child Survival (CS), nutrition was still relegated to the background as the twin engines (ORT and EPI) captured everyone's attention and energy.

Despite the generally unfavorable climate, several nutrition interventions remained relevant. One of these was growth monitoring which was one of the four components of the GOBI[13] effort under UNICEF. It is also seen as the most tangible nutrition intervention in PHC and CS (after the "twin engines").

In support of this effort, LTS served an important advocacy as well as technical advisory role to those in the developing world who wanted to improve the nutritional status of their populations. The training role played by LTS in countries such as Belize, Ecuador, the Dominican Republic, Sierra Leone and Togo was important. It appeared that those who attempted to do growth monitoring, did it correctly. In terms of the guidelines (on GM/P and DMD) and the Thesaurus, informants judged them as useful and systematic and stated that they made it easier for those involved in training, planning, implementing, supervising, and evaluating these particular activities to be sure that all important aspects were covered. In addition, the joint OR activities (in countries such as the Dominican Republic, Zaire, Thailand, and Togo) were valuable in that they exposed local program officials and decision makers to new research methodologies (e.g., survey development and implementation and focus group techniques).

One of the most appropriate activities of LTS was the attempt to develop and institutionalize simple management information systems (MIS). The principles of focusing on participation, nutritional status and immediate feedback are to be supported. The quarterly report form (Attachment VIII) from the Sierra Leone Project may request a few too many

[13] GOBI - an acronym standing for Growth monitoring, Oral rehydration, Breastfeeding and Immunization.

numbers on it but the principle is correct. The more growth monitoring programs can focus on two numbers (% of target groups weighed and % not at risk), the more effectively they can be managed.

In addition to serving as the advocate for nutrition when little other support existed, LTS played an important role as a catalyst. In several countries (e.g., Bolivia and Sierra Leone) workshops and meetings sponsored under the Nutrition RSSA got PVO and public officials together and standardized approaches and procedures (e.g., scales and growth cards). The coordination was very important in initiating more effective nutrition programming.

The work of LTS in Dietary Management of Diarrhea (DMD) was regarded as superior from a technical perspective. It provided an important supplement to PRITECH's efforts to increase the knowledge and use of ORT which, in certain areas, did not give enough attention to nutritional aspects.

LTS is also to be commended for emphasizing the development of indigenous skills. They used the evaluation and planning process to help people rethink their objectives and activities. In Ecuador, LTS was said to have increased individual and institutional capacity to understand and deal with the nutrition problem. The RSSA-supported activity in the country was responsible for having GM/P included as a major component in the upcoming Child Survival Project now in preparation by AID.

In several countries (e.g., Dominican Republic and Sierra Leone) LTS was responsible for reorienting the nutrition program from curative (i.e., elimination of third degree malnutrition) to preventive and promotive (i.e., focusing more on monitoring growth and stressing education for the mothers of those children who are faltering or not gaining satisfactorily).

Despite a generally positive view of the RSSA's advocacy, catalytic, coordination, and TA functions, some adverse opinion was voiced about the overall value of some of the activities undertaken by LTS. Of particular concern is the operations research projects which focused on the mechanics of growth monitoring and nutrition surveillance. While the design and methodologies used are considered appropriate, several concerns about the efforts were raised. In some cases the OR exercise was not requested or desired by the local Health and Nutrition agencies, but LTS was not always responsible for this. For example, in Togo the impetus came from REDSO/WCA.

In other cases (e.g., Togo and Dominican Republic), the OR effort began as highly participatory but soon came under the control and direction of LTS. CRS in Togo is described as being only minimally involved and having no real commitment to the OR study. The CRS Director left and his successor became disenchanted. CRS goals differed from that of LTS/PRICOR

with the former less interested in research.[14] LTS also had a dominant role in the Dominican Republic, designing and helping institutionalize OR techniques in the form of a new MIS. As shall be mentioned, the emphasis on the data collection became a concern.

One member of the evaluation team pointed out that the GM and NSS approaches were occasionally confused in the field. While the distribution is very clear in Yee and Zerfas' paper ("Review of Growth Monitoring - Issues Paper", September, 1986), some aspects of NSS crept into GM/P activities. The separation of collection of data for program management as opposed to policy making purposes was not always maintained in practice.

There was also concern voiced about the relevance of the OR activities. The Thai exercise has run for several years, and it is clear the research effort has helped to improve Thailand's already strong nutrition program. Though participation in the OR activity led to program changes, people are uncertain where the RSSA assisted research fits in and what long-lasting impact it might have.

Finally, sustainability was mentioned in the original RSSA as being necessary if the project were to be effective (p. 5), and was found by the evaluation team to be important and not given proper attention in the OR exercises carried out under the RSSA. While several relatively small PVOs like Meals for Millions (MFM) were assisted and the effectiveness of their nutrition programs improved, the benefits to larger segments of the population suffering from malnutrition were not as clear. One concern is the dependence of several of the PVO programs on PL-480 donated food commodities. The success of their GM/P activities depends on the food which serves as the incentive to get mothers to bring their children for weighing. As larger PVOs like CRS withdraw from feeding programs, the chances of GM/P programs continuing to function are reduced. LTS is not optimistic about efforts to replace donated commodities with production from community or family plots.

Despite LTS' acknowledgment that large-scale public GM/P programs have not been effective[15], they placed relatively less emphasis on the development of alternative strategies. While LTS did suggest other approaches (e.g., periodic screening, periodic surveillance, sample surveys), the greatest portion of their work was concentrated on one form of GM/P or another. Other possibilities might include expansion of PVO

[14] LTS mentions that because the activity was funded under another project (ie., PRICOR), it should not be considered a RSSA activity. However, since core staff received core funding out of the central RSSA allocation, it is appropriate to evaluate it as part of the RSSA activity.

[15] "For reasons of feasibility, resources and misunderstanding of its applications and implementation, GM/P has not yet satisfied expectations, especially in large-scale programs" from ("Issues in Growth Monitoring and Promotion" by V. Yee and F. Zerfas, May 1987).

activities, development of contractual mechanisms between public and private entities which would have given the latter a larger role. Such attention to broader implementation strategies could have led to more effective GM/P programs in the future. In Sierra Leone, for instance, it might have been wise to encourage MFM to develop local NGO capability to succeed them rather than becoming a service facilitator for the MOH. There are inherent limitations in bureaucracies that preclude their effective management of community-based social sector programs; the materials produced under the RSSA did not reflect a sensitivity to this difficulty.

An analysis of the content of the OR and TA activities under the RSSA, makes it clear that a great percentage of the work was devoted to technical details involving such aspects of GM/P as scales and weight charts and dealing with anthropometric data generated in GM/P projects. While LTS changed the overall orientation of GM/P efforts in several countries from curative to preventive, important aspects such as supervision were given less attention. No large-scale programs can hope to have an impact without this critical and frequently neglected element. The aspects LTS focused on were necessary but not sufficient for program success.

Concerns were also raised over the technical orientation of some of the TA provided under the RSSA. In the Dominican Republic project, for example, the on-going data collection exercise became an end in itself. The workers neither understood the objective of the monitoring component nor how it fits into the implementation of the Applied Nutrition Education Project (ANEP). The collection and processing of the data became the dominant activity, overshadowing and eventually diminishing the nutrition education activities. This bias on the technical and scientific aspects at the expense of the broader implementation issues that will be faced in a larger-scale program reduced the long-term potential for success of the LTS activities.

5. Impact - The activities carried out under the OIH RSSA are primarily in the area of capacity building. The contractor was never in the position to deliver services, and, as such, it is very difficult to discuss specific impacts that resulted directly from LTS' work. Nonetheless, there is evidence that LTS was able to raise the effectiveness of nutrition activities which should, in turn, improve the nutritional status of the target population.

It is virtually impossible to determine the extent of LTS' contribution to a particular project's impact. However, LTS has provided guidance and technical assistance to at least one project that reportedly has had remarkable success. This is the CRS/CARITAS effort in the Dominican Republic. Despite the problem mentioned above of the data collection/processing activities becoming all-consuming and, therefore, distracting from the nutrition education efforts, the project has been able

to achieve remarkable impact. The External Evaluation[16] of the ANEP (September 1987) represented some very impressive figures in regard to the CRS/CARITAS project:

- a 60% decline in II and III degree malnutrition in ANEP communities which had been in the project for three years;
- a 40% differential in malnutrition between project and non-project communities;
- 96% of the children who entered the program with normal nutritional status did not become malnourished (preventive index);
- 63% recuperation rate for malnourished children without utilizing a supplementary food component.

In the case of Sierra Leone, the evaluation of the MFM effort could not demonstrate any evidence of overall improvement in nutritional status among program participants. All that was said about the nutritional status of those who had taken part in the program is that it had not worsened.

It is the view of the evaluation team that the MIS approach advocated by LTS for nutrition programs is not only an appropriate one but the one most likely to improve project performance. The built-in monitoring and evaluation system focusing on a few key indicators informs all those involved with a project (from community members and community workers to the local manager, project director and donor) how well the activity is going at any given point in time. Moreover, it allows managers to practice "management by exception", identifying the communities or zones not performing well so that extra attention (e.g., training, supervision, and support) can be provided. The principle that the nature of implementation problems cannot be identified on an MIS seems to be well understood. Rather, LTS has advocated and encourages the nutrition projects it has advised that once problems are identified (e.g., low participation rates or high levels of nutritionally "at risk"), then the supervisor or manager must visit the site in question and identify the cause of the problem. Thus, the MIS espoused by LTS is a problem-identification/problem-solving approach which can greatly improve performance. The evaluators believe that simple well designed management information systems of the variety LTS has advocated "drive" projects and contribute significantly to their effectiveness. Thus, even though LTS has not been directly responsible for impact, they have contributed necessary elements to the process.

[16] This was referred to as an external evaluation although Dr. Jose Mora, an LTS employee, served as team leader of the evaluation team. It should be noted, however, that Dr. Mora had had no previous technical involvement with the D.R. project.

6. Process - The RSSA arrangement was not a totally satisfactory one for either the OIH/DHHS or S&T/N of AID. The former did not derive much out of the arrangement. Originally it was expected that OIH/DHHS experts would be utilized in responding to AID needs around the world. That, however, never materialized during the 1981-88 period, and the contractors or their consultants provided the technical assistance requested. The OIH points out that this is the result of the limited resources available under the RSSA which provided for very little funds over and above what was required to support core staff salaries and travel. Although the LTS project director kept the responsible OIH officials informed of RSSA activities, OIH felt like nothing more than an intermediary between the Office of Nutrition/AID and LTS; this, in fact, is an accurate description of their status.

The original rationale for the Office of Nutrition wanting to develop a RSSA with OIH were not fully satisfied either. As mentioned, the AID Office expected that they would generate broader support by involving the DHHS in their programming. Since OIH/PHS personnel were not involved [17] and OIH had only a limited knowledge of activities taking place within the Office of Nutrition, this objective was never realized. The second qualification of the RSSA was to reduce management obligations of S&T/N. While the OIH devoted considerable time and resources to the administration of the RSSA, the fact that the Director of S&T/N maintained tight technical and functional control over the actions of the RSSA contractor and treated them more like a part of the Office of Nutrition, resulted in the Office of Nutrition also having management responsibilities (e.g., preparing documentation and cutting travel orders). LTS assisted the Office of Nutrition by drafting memos, cables and concept papers.

The Director of the Office of Nutrition saw and treated LTS as an extension of S&T/N despite the fact that LTS was a contractor for OIH/DHHS. By mutual consent, the official chain of command in many cases was abridged for purposes of expediency. S&T/N communicated directly with LTS. An LTS representative attended the bi-weekly staff meetings of the Office of Nutrition. While the value of this cannot be denied, it does indicate the extent to which the official relationships and chain of command were modified. LTS, for its part, realized that their best interests were represented by maintaining close cooperation with and serving the needs of the Director of S&T/N.

Having a project officer in the Office of Nutrition who had a technical background and capability reportedly improved the effectiveness and smooth operation of the RSSA. During the first several years of the LTS contract, a public health specialist backstopped the RSSA and everything was said to operate with a minimum of disruption. Over the last four years of the LTS contract the project officer was not expected to

[17] It must be noted that at the beginning of the LTS contract under the RSSA coincided with a sharp reduction in staffing levels at the OIH. They went from a strength of over 50 to only 10 within a very short period.

provide technical guidance. The director of the Office of Nutrition took a more active role and used the arrangement for his particular priority activities.

The de facto management structure of the RSSA led to certain difficulties. One involved the running of and logistic support for the INPF conferences. For example, LTS was made responsible for the Cairo meeting. LTS had little experience of such matters as arranging for travel and hotel accommodations for a large number of participants; this is not what LTS was hired to do. But the contractor was eager to please the Office of Nutrition and its director, and, therefore, accepted a modification (extra appropriation) to the contract and responsibility for logistic details in Cairo. Several informants complained that LTS did less than a satisfactory job in this case and required outside assistance to complete the job. While their shortcoming was unfortunate, questions remain as to whether LTS should have undertaken such work. The contractors were hired for their technical expertise, not their conference management skills.

At the project level, LTS had to work closely with local counterparts to be successful. In some cases, people interviewed in the field commented on how cooperative and responsive the LTS consultants had been. One LTS consultant in particular was complemented for his participatory style of working and his "non-directive, consultative and collaborative" manner. However, in several cases (Ecuador and the Dominican Republic), informants complained about the "directive" approach taken by another senior LTS consultant. There were concerns raised about forcing pre-conceived assistance and pre-packaged approaches on the program. While the techniques and methodologies of the two consultants were virtually the same, the style and manner of one was found more appealing and effective.

Concern was also mentioned about the ability of local experts to carry on the research once the technical assistance received under the RSSA was no longer available. This particularly pertained to the operations research activities in Thailand, Togo, and the Dominican Republic. Carrying out OR is obviously appropriate and in accordance with the RSSA and LTS' mandate. However, utilizing inappropriate methodologies and techniques or requiring data processing much beyond local capabilities has little value in the long run. The case of the Dominican Republic, where the computer hardware was too sophisticated and where an LTS consultant with considerable experience in data processing had to analyze the information, is not the most effective way to institutionalize operations research capabilities that might survive long after the LTS association comes to an end. A simpler, more appropriate research component would permit this to take place and increase local capacity to undertake OR studies in the future.

The Spanish language fluency of LTS consultants in Latin America was a big advantage and a particular strength. LTS not only communicated with high levels of fluency but published reports in Spanish. This obviously helped gain cooperation from local counterparts. In contrast, LTS core

consultants were deficient in French in West Africa (in Togo for example).[18] One of the LTS consultants had limited French, another had none. This detracted from their effectiveness in Francophone Africa.

The aspect of the RSSA which appealed to the regional bureaus and missions was the responsiveness and ease of programming. Having a centrally funded source of technical support was appreciated by those in need of assistance in identifying, designing, managing and/or evaluating nutrition activities. Moreover, procuring the services of LTS was very easy since the reservoir of technical expertise existed and only had to be requested. There was no bureaucratic impediments such as the PIO/T that is required for an Indefinite Quantity Contract (IQC) delivery order to be activated.

The fact that the technical experts were already funded under the RSSA increased the attractiveness of the RSSA services. Informants stressed the point that having a centrally funded pool of technical expertise is particularly important in a discipline like nutrition which has limited support in the field. The number of AID officers having knowledge of nutrition was low. To get nutrition activities included in PHC programs, therefore, outside expertise was required. With little appreciation for the role of nutrition, missions were unlikely to allocate any of their own scarce resources to initiate nutrition components in projects. However, they would be receptive to requesting advice if it did not cost them anything. Once oriented to the need and the importance of nutrition had been documented, the mission was much more willing to invest its own money to carry out nutrition activities. This is in fact what happened in the RSSA in the case of Thailand and several African countries.

Finally, the Africa Bureau found the support they received through the RSSA to be especially helpful. As described, a Nutrition Advisor was assigned to the Africa Bureau under the RSSA and LTS. Not only was this person a constant presence in the office representing the nutrition perspective and attending nutrition meetings, conferences and workshops, but the Advisor served as an advocate for nutrition when mission health officers visited Washington. The Nutrition Advisor [19] was strengthened by having a pool of technical resources in the form of LTS consultants. If interest was demonstrated by a particular country and technical assistance requested, the Nutrition Advisor could and did turn to LTS and support was provided. The advocacy by itself would not have been as effective; the RSSA arrangement provided the follow-up capacity which turned talk into action.

[18] The LTS-contracted employees in the Africa Bureau were proficient in French.

[19] There were two that held the post and were LTS contractors under the RSSA. The first was David Eckerson who was followed by Neen Alrutz.

From the field, the continuity of technical assistance was mentioned as a strength of the RSSA. The services of the same group (and usually the same consultant(s)) were available on a continuous basis. Because of the low level of turnover among the contractor's professional staff in the course of the six and a half year arrangement, only six LTS consultants were involved. Primarily because of the limited amount of funding available under the RSSA, few outside consultants were utilized by LTS after the first few years of the contract. Missions saw this as an advantage and one that they could not have had under alternative contracting mechanisms in which they would have to accept whomever was offered. In addition, being a long-term arrangement, the RSSA could provide technical assistance and support over extended periods in contrast to options like the IQC which is limited to 120 days.

IV. Conclusions and Recommendations

1. Conclusions - With considerable administrative support from the OIH, the Nutrition RSSA was carried out by LTS, a contractor with experience working in the nutrition field and with the OIH/DHHS. In general, the six and a half year RSSA fulfilled the stated purpose of the RSSA which was to "reinforce and expand AID's capability to provide leadership and supportive role" in nutrition components in PHC projects.

The greatest strengths of the RSSA include the catalytic/advocacy role it played for nutrition. Of note are the large volume of publications produced and technical assistance provided. Consultants visited twenty countries during the course of the RSSA; more than half of these received multiple visits. Fifteen national workshops on a variety of nutrition strategy and programming issues were held as well as a regional meeting and two international conferences. Technical assistance in Latin America was made more effective by virtue of the Spanish capability among the consultants; on the other hand, support in Francophone Africa suffered because of limited French speaking ability among the core staff.

The RSSA mechanism was found to be highly favored among the regional bureaus and missions of AID. The Africa Bureau in particular benefited in the form of a Nutrition Advisor to develop and support nutrition activities in the region. The continuity of the core staff was considered a benefit in that the same consultants were available on a continuing basis for follow-up. The RSSA was also centrally funded making support available at little or no cost to the missions, although the level of funding was limited. Moreover, the RSSA services were easily accessible and flexible. Although no "buy-ins" were officially permitted by the RSSA, a number of "cost-sharing" arrangements were developed. In this way, the \$2.3 million allocation to the contractor was expanded by another 70% (estimated at \$1.6 million), allowing broader coverage. The leveraging of the S&T/N funds made the RSSA a particularly cost-effective means of providing support for nutrition in PHC for the Office of Nutrition.

While the original RSSA did not specify any indicators for project outcomes or impact, the evaluation attempted to review the effectiveness of the RSSA activities. The guidelines on GM/P and the dietary management of diarrhea were considered useful contributions. Particular strengths include the promotion of a systematic approach to GM/P and the development of simple management information systems (MIS) to improve the performance of GM/P projects. Under the RSSA indigenous skills in nutrition programming and research techniques were developed. In several cases GM/P projects were reoriented from curative to preventive/promotive.

Concerns were raised by several informants about some of the activities carried out under the RSSA. For one, in a few cases (e.g., Togo and the Dominican Republic) there was limited support for the operations research techniques that were introduced. Complaints were heard in several countries where RSSA activities were carried out (Ecuador and the Dominican Republic) that the consultant was too "directive", promoting pre-conceived assistance and pre-packaged approaches.

With the great majority of the RSSA publications and technical assistance being involved with GM/P, concerns were raised about the RSSA being too narrowly focussed. While this was partially a function of the evolution of the Child Survival approach and a reflection of field interest, it did result in the exclusion of other activities as specified in the original RSSA (nutrition education, supplementary feeding, control of infection, child spacing, infant weaning and breastfeeding, specific nutrients - vitamin A and iron).

The focus on the technical aspects and mechanics of GM/P, and to a lesser extent DMD, included attention to training and supervision issues. However, a general lack of awareness on the limitations of bureaucracies to manage community-based nutrition programs (especially GM/P) was noted in RSSA reports and monographs. This raises concerns for the long-term sustainability of community-based GM/P activities as supported by the RSSA.

Complaints were made about the contractor's performance in the management of the two international conferences which the Office of Nutrition requested LTS to support in terms of preparation and logistics. While difficulties were identified, the appropriateness of having technical experts such as the LTS consultants performing such a function and the fact that such a request can be considered beyond the RSSA's Scope of Work relieve the contractor of full responsibility for the breakdown that occurred.

2. Recommendations - Neither the OIH nor the Office of Nutrition want to renew the RSSA. As mentioned, neither was fully satisfied with the way it evolved or how it functioned in the latter stages. The PHS considered it time for AID to assume full and direct control of the nutrition support activity. At this point, two questions must be answered: first, is there a desire for the type of support provided under the RSSA?; second, if the answer is yes, what contractual form should it take?

The answer to the first question is a qualified affirmative. The most utilized and highly valued aspect of the RSSA was TA. A number of entities within AID expressed interest in having a pool of technical resources to call upon when the need arises or to simulate nutrition-related activities in the field. Those expressing an interest included the Office of FVA/PVC, Office of Nutrition, the regional bureaus and a number of the AID missions overseas. The need for the type of broad-based TA that might or should have been available under the RSSA is of increasing interest to AID missions particularly as the nutrition capabilities within the agency shrink. No mission has a nutrition officer and promotion and support of nutrition activities fall on the one nutrition advisor assigned to each regional bureau at AID Headquarters in Washington. This is hardly sufficient.

Less support was voiced for OR activities. It is felt that centrally funded projects such as PRICOR can respond more appropriately to these needs.

In determining what form the central nutrition TA support should take, programming needs in the field must be considered. First, it should be broad-ranging. Second, it should be easy to procure. Third, the maximum continuity of TA should be encouraged. Fourth, at least a portion of the support should be centrally funded. In addition, bureau and/or mission "buy-ins" should be possible so that once nutrition needs assessment has been conducted and plans/strategies developed, the local office can utilize its own resources to carry out the effort.

The IQC is not really right since no central funds are available and there is no assurance of continuity in TA. The recently awarded Nutrition Education and Social Marketing Project is too narrow to respond to the range of needs of the bureaus and missions.

What is called for is a centrally funded project for Nutrition Program Support. It should be distinguished by being operational in nature and concentrate on the provision of technical assistance (e.g., needs assessments, planning, strategy development, implementation, MIS development, social marketing, curriculum development, and evaluation).

It is suggested that a Project Identification Document be developed for such a Nutrition Support Project under the Office of Nutrition utilizing the approximately \$2 million that was not programmed for the Nutrition Education and Social Marketing Project. If this were done, the other clients (FVA/PVC, regional bureaus, and missions) would have open access to its services. Without this, it would be of little use. The central funding would be used to initiate nutrition activities. Once started, the client would be expected to "buy-in" to procure additional TA.

An alternative is for the regional bureaus to develop their own nutrition support projects. The regional bureau most in need of such a project in Africa. Several models from the LAC region might serve as the basis for such a project. One is the recently developed project in support of vocational education. The contractor developed guidelines for a variety of services which could be called upon through the project. Each mission in the region received a worksheet with all areas of TA listed and the level of effort desired. Anything from setting up tours, doing literature searches carrying out training to searching for personnel was included. Once all the requests were received, the contractor allocated a dollar amount for each AID country program which the missions could draw upon over the three-year life of the project to meet their particular needs. The flexibility and responsiveness of this particular project made it popular with the missions. In addition to the central resource pool for short-term TA, buy-ins from the mission were also possible.

A second possible model, again from the LAC Bureau, is the Health Technical Services Support Project being developed which depends heavily on buy-ins while providing a mechanism to be more responsive to requests for TA. A Nutrition Technical Services Support Project, possibly for the Africa Bureau, might be appropriate. This could be funded out of a central appropriation and allow for the maximum level of buy-ins. The

latter might be facilitated by the recent increase in mission funding as a result of the Development Fund for Africa which Congress recently established.

The RSSA activity has provided AID with the basis for design of a project that could effectively serve to promote the inclusion of nutrition in PHC, CS and other program activities and then ensure that basic services existed to program and implement nutrition efforts. With this as the key focus of the project, rather than the institutional needs that began the RSSA, some of the negative aspects of this effort can be avoided while the positive elements are retained.

ATTACHMENT I

Scope of Work

A. Objectives

1. To evaluate the procedures and achievements completed under the OIH RSSA with the Office of Nutrition (RSSA No. BST-0249-R-HI-2254) to assist A.I.D. in the promotion of Agency nutrition objectives through health systems in developing countries. The evaluation will assess the following:

(a) Compliance with the objectives stated in the RSSA agreement;

(b) Tangible and intangible final results achieved, including (1) reductions in the problems addressed, and (2) observable impacts on A.I.D. field missions and on host country institutions and programs;

(c) Managerial and technical effectiveness of the entities involved in providing oversight and guidance, technical assistance, research, training, state-of-the-art development, analysis and reporting, and other undertakings under the terms of the RSSA. The analysis will focus and report on, in turn,

-- technical assistance (in subjects such as nutrition planning, monitoring and evaluation; project design and monitoring; growth monitoring and promotion; nutrition education; policy analysis, survey design and analysis, data handling; and other topics as provided for in project documents);

-- research (including relevance of problem identification to the overall A.I.D. Strategy, and USAID and host country bilateral strategies; the rigor and relevance of the design and methodology development; the extent of collaboration with host country experts; and reporting);

-- training (including curriculum and materials development, testing, and dissemination, participant selection, involvement and follow-up);

-- state-of-the-art development, analysis and reporting (of methodological and other advancements derived from these projects and the relevant work of others);

-- other undertakings of the projects (noted in their objectives and procedures, plus ad hoc services and consultancies in response to requests);

-- management (including effectiveness and efficiency of staffing, funding and financial management, internal controls, networking and communications); and

-- major external constraints (affecting resources, timing, geographical scope, access to A.I.D. and host country information and influence).

In summary, the basic questions which the evaluation should answer are:

-- Has this RSSA been designed, implemented and managed effectively by S&T/N and HHS/OIH to achieve the stated project objectives as indicated in relevant project documents? and

-- Is this approach, focusing on the promotion of A.I.D. nutrition objectives through health systems, the most effective way for AID/W to influence health sector activities for the simultaneous achievement of the Agency's nutrition objectives?

2. To prepare recommendations for inclusion in the design of a possible follow-on project attuned to current needs for equivalent services that deal with persistent or emergent problems relevant to the attack on malnutrition through health sector undertakings.

B. Statement of Work

The evaluators will complete the following activities in the general sequence of the listing below:

1. Prepare a detailed draft evaluation protocol for review and approval by A.I.D.;

2. Review project documentation, such as

RSSA agreements	project work plans
relevant A.I.D. cables	RSSA reports
trip reports	training plans
methodological guidelines	state-of-the-art reports
research reports	other technical reports
other publications	correspondence;

3. Conduct interviews with relevant staff in S&T/N, HHS/OIH, and other contractor, cooperator, and grantee organizations in the United States that have been involved in the project;

1/2

4. Undertake one or two overseas field trips to review documentation and conduct interviews with representative program cooperators and participants (A.I.D. staff, host government agencies, private voluntary organizations, scientific organizations, and multilateral organizations) in one or more of the following countries, as concurred in by appropriate A.I.D. units: Thailand, Philippines, Ecuador, Dominican Republic, Togo, and Sierra Leone;

5. Prepare recommendations for the future planning of cost-effective, feasible approaches to implementing A.I.D.'s nutrition objectives through health sector undertakings in a possible follow-on project;

6. Prepare and submit an evaluation report that includes the matters listed above; and

7. Discuss the evaluation findings and recommendations with the A.I.D. Office of Nutrition, and with the HHS/OIH RSSA management office.

C. Reporting Requirements

1. Prior to departure from each overseas project site country (see item B.4., above), the evaluator will prepare a draft country site visit report for review and discussion with appropriate USAID staff, host country counterparts and other relevant institutions. The draft country site visit report will include the following information:

(a) A summary of the in-country project activities, including purpose, objectives, accomplishments, places visited, constraints, conclusions and preliminary recommendations;

(b) Names, titles and addresses of persons contracted during the evaluation visit; and

(c) List of documents reviewed.

2. Within one calendar month of completing the last project site country visit, the evaluator will complete the overall evaluation report covering in a clear organized manner all the information mentioned in the previous portions of this Scope of Work, and submit the report in final form to A.I.D.

3. Twenty copies of the final evaluation report and recommendations will be submitted to the A.I.D. Office of Nutrition (S&T/N) Project Manager, Nick Luykx, Room 320, SA-18, A.I.D., Washington, D.C. 20523.

D. Relationships and Responsibilities

The consultant(s) will work under the general supervision of Nick Luykx in the Office of Nutrition (S&T/N).

E. Term of Performance

Maximum of 85 paid working days for the evaluation team,
beginning o/a Dec. 1, 1987.
A six day work week is authorized.

ATTACHMENT II

ATTACHMENT II

PROTOCOL

Evaluation of OIH RSSA with the Office of Nutrition, AID

I. Approach

The review of relevant RSSA documents, interviews with officials and technicians who have knowledge of the RSSA activities and observation of field activities will provide information on the following issues:

- technical assistance
- research
- training
- state-of-the-art developments
- other relevant activities

The project will be evaluated against the objectives for which the RSSA was established. Project management will also be evaluated to determine if the activities undertaken were managed in the most effective, efficient and expeditious manner. Constraints arising during the seven-year RSSA will be identified. Based on interviews and from the information collected, recommendations on how RSSA objectives can best be achieved in the future will be included.

II. Methodology

RSSA performance will be evaluated from both quantitative and qualitative perspectives. Quantitatively, project outputs will be measured. Services provided during the life of the RSSA will be measured in the five program areas:

- preparation and distribution of informational and training materials
- development of a series of Resource Handbooks on nutrition interventions and training
- convening of regional and national workshops
- provision of technical assistance to USAID missions and LDCs
- completion of operations research exercises to identify critical nutrition tasks and minimum data requirements.

It is important to determine whether the studies carried out and the advice given under the RSSA were technically sound and whether the methodologies followed and statistical methods employed were scientifically correct.

Qualitatively, activities carried out under the RSSA will be reviewed to determine if they have fulfilled project assumptions that developing countries' resources can be utilized to improve their nutritional situation and that community beliefs and practices affect its nutrition and health status. Criteria that will be utilized to determine the effectiveness of RSSA activities include:

- integration with over-all health/community development effort
- appropriateness and feasibility in terms of local institutions, technology and resources
- consistency with community sociocultural beliefs and context
- ability to become self-sustaining

The quantitative and qualitative analysis of RSSA activities will be measured against project goal and objectives.

III. Interviews

As many officials and technicians who have been involved directly or indirectly in RSSA activities will be interviewed. These will include:

- LTS staff
- Office of Nutrition, AID
- Office of Health, AID
- Regional Offices (ANE, Africa, LAC), AID
- Bureau of Program and Policy Coordination, AID
- Bureau of Food for Peace and Voluntary Assistance, AID
- Voluntary agencies
- Persons involved in overseas activities
- USAID missions

IV. Schedule

A tentative schedule for the RSSA evaluation is as follows:

<u>Activity</u>	<u>Time</u>
Document Review	March
Interviews in U.S.	March/April
Field Site Visits -	
Thailand (Comings)	April
Togo/Sierra Leone (?)	April
Dom. Republic (Lamstein or Pyle)	April
Management Review of LTS (Lamstein)	May
Report Writing	May
Draft Report Submission	early June
Revisioand Final Submission	mid-June

ATTACHMENT III

APPENDIX B

RESA CONTINUATION
INSERT

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
Department of Health & Human Services
Office of International Health

 ORIGINAL
 AMEND NO. 4

RESA NO.

RHW/OIH-1-77

FISCAL YEAR

1981/82/83

1 of 11 PAGES

B. BACKGROUND

1. Introduction

Of the estimated 1.5 billion children in the world today, 80% live in developing countries, most in an environment of malnutrition, infection, poor housing, lack of safe water, and inadequate health care. Mortality is high among infants and young children in developing countries. Infant mortality ranges from 60 to 200 deaths per thousand live births per year. The risk of mortality begins before birth with the highest risk in the perinatal period from the seventh month of pregnancy to the seventh day of life.

Many risk factors which determine perinatal mortality also affect maternal mortality. Maternal mortality, as low as 5 deaths per 100,000 births in developed countries may be as high as 1,000 per 100,000 in some developing countries - a 200 fold difference. Early childhood (age 1 to 4 years) is also a dangerous period with rates as high as the infant mortality in some developing countries. Because 1-4 year old mortality has been reduced to very low levels in most developed countries, the differences between countries with the lowest and the highest levels may be as much as 50 times or more. In some regions, as many as one-third to one-half of the children do not live to the age of five.

One of the principle obstacles to supplying integrated health services to the poor majority in developing countries is a lack of effective integrated health networks that reach out to the community level, particularly in rural areas. Early in the 1970's, the importance of a realignment of health services with integrated planning, improved coverage and increased emphasis on participation at the community level was recognized. The importance of nutrition in these primary-health care systems was emphasized at a WHO-UNICEF Conference on Primary Health Care in Alma Ata, USSR, in 1978. Representatives from 140 nations endorsed the concept of including nutrition components in primary health care systems.

Recent research has shown that health, nutrition, and family planning services can be more effective if they are integrated at the village level. The Narangwal study showed that increased food for children without improved sanitation, deworming programs, and immunizations resulted in little impact.¹ In Central America, Mata reported that improving diets without alleviating infectious diseases in high risk children produced no improvement in their nutritional status.²

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
Department of Health & Human Services
Office of International Health

 ORIGINAL
 AMENDMENT NO. 4

RBSA NO.

HEW/OIH-1-77

FISCAL YEAR

1981/82/83

On the other hand, health activities such as immunization are relatively ineffective in children as preventive measures when malnutrition has undermined the body's immune response.³ Infectious diseases and malnutrition are so intimately related, particularly in children, that any attempt to address one problem without addressing the other is likely to produce little impact.

Increasing evidence shows that nutrition considerations play an important role in the acceptance of family planning on the part of the rural poor in developing countries. The perception of increased child survival is probably a key precondition to the success of family planning programs. Conversely, increased child spacing is important to the success of nutrition and health improvement programs. In Colombia, Wray and Aguirre⁴ found that when birth intervals exceed three years, there was a decline in the incidence of malnutrition. The amount spent per person on food declines as the number of living children in a family increases. For these reasons, integration of health, nutrition, and family planning services at the community level can be most effective.

2. Optimum Nutrition Activities in a Primary Health Care System

A.I.D. pioneered early initiatives in low cost health delivery systems and primary health care with such projects as the Lampang Province Project in Thailand (1972) and the Integrated Health Delivery System Project in Brazil (1973). As of FY 1979, about \$70 million, over one-third of A.I.D.'s health budget, was spent on primary health care projects which integrate health, nutrition and family planning activities in 36 developing countries. This figure is nearly three times the amount A.I.D. allocated for these projects in FY 1976.

~~Under ideal circumstances,~~ community health workers in a primary care system would undertake all nutrition activities which have an impact on malnutrition. The proposed project will assist Bureau and Missions in determining the nature of the nutrition component(s) to be included in integrated health systems, and will provide a means for identifying the tools that can be used to implement the desired nutrition activities. Optimum nutrition activities fall under four general headings: a) surveillance, b) education, c) supplements, and d) control of infection.

a. Surveillance

Identifying nutrition problems is an important first step for health workers. Simplified guidebooks on diagnosing nutrition problems for health workers can be developed and distributed. Growth charts are an important tool in community diagnosis.

In particular, charts based on body weight for age. The chart not only indicates the nutritional status of the child but also serves as a device to ensure continued contact between mothers and health workers.

b. Nutrition Education

Properly planned and executed nutrition education of the mother can be of great value in nutrition promotion, especially for infants and children. For most developing countries, the following three messages, properly conveyed, will produce significant impact on the nutritional status.

- 1) Breastfeeding - The objective of education should be protection of breast feeding. Where the practice is declining, breast feeding should be promoted. After six months of age, breast feeding should be supplemented with appropriate weaning foods.
- 2) Weaning Practices - This area is of great importance in child nutrition. An important step in this direction would be to identify successful weaning practices and weaning foods in a country or region and then disseminate this information to the mothers through the community level health workers.
- 3) Improvement of Basic Diet - The consumption of a theoretically balanced diet is not possible in a large majority of cases due to financial constraints. Health workers should give suggestions for the improvement of the basic diet commonly eaten in the area. Desirable local foods and practices should be endorsed and promoted.

c. Nutritional Supplements

Maternal nutritional supplements (iron, folate and calories) were the most effective means of reducing mortality found in the Narangwal study. In Guatemala, 200 calories per day added to the diet of pregnant women in their last trimester of pregnancy, apparently reduced the incidence of low birth weight babies.

The community health worker can undertake the task of distributing nutrient supplements in areas where certain types of nutrition deficiencies are widespread, e.g., xerophthalmia, caused by vitamin A deficiency and nutritional anemia, caused by iron and/or folate deficiency. Supplements should be targeted as much as possible to "at risk" groups.

d. Control of Infection

Infections and malnutrition go hand in hand. Without the control and management of infections in children, food supplementation will have little impact. Control and management of infections, especially gastroenteritis, should therefore be included in the armament of the primary health care workers.

Realistically, however, only some of these activities are possible in the health systems of many developing countries due to the lack of resources. The nutritional status of the population, together with demographic factors and health infrastructure, will determine which activity is feasible in a particular setting.

c. NATURE OF THE PROBLEM

Typically, health care systems are three tiered, pyramid shaped structures administered by physicians or other health professionals. Mid-level workers and village level workers are trained to extend scarce professional services by treating simple illnesses and referring more serious cases to central health posts or hospitals. The tasks of these health workers usually include the promotion of proper nutrition.

In general, nutrition activities are nominal and limited to vaguely defined nutrition education activities. Major deficiencies in these programs can be summarized as follows:

1. Lack of adequate skills at the village/community level to properly carry out nutrition activities.
2. Lack of sufficient logistic and management support to enable good field-level nutrition components to be designed and/or implemented.
3. --Lack-of-sufficient awareness and skills and commitment within the health sector to provide the needed resources or to design good nutrition outreach services.
4. Lack of basic information not only to design the nutrition components of integrated programs but to estimate costs or evaluate impact of nutrition inputs.

d. PROJECT ASSUMPTIONS

Typical descriptions of nutrition and health in developing countries include high infant and maternal mortality, a high incidence of parasitic and infectious disease, inadequate diet, high birthrates and fetal wastage, traumatic weaning experience and inadequate attention to diets

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
Department of Health & Human Services
Office of International Health

<input type="checkbox"/> ORIGINAL	<input checked="" type="checkbox"/> AMEND 4 NO.
RBSA NO.	
HEW/OIH-1-77	
FISCAL YEAR	
1981/82/83	

of recently weaned children. These are the result of poverty, unhygienic living conditions, and lack of basic information. Poor nutrition status appears to be predicated to a great degree on these factors rather than solely on food shortage.

Because poor nutrition, poor health, high birthrates and lack of sanitation are all related, any effort to affect one of these factors should go hand in hand with efforts to affect the others. Because of limited resources and because ideally the developing countries should become self-sustaining in providing basic needs, efforts to improve nutrition should focus on upgrading under-utilized but potentially effective local resources.

The proposed project is based on the following assumptions:

- that industrial countries cannot nor should they supply all of the resources and technologies necessary for improving nutrition.
- that there are untapped resources in LDCs that can be utilized for the improvement of nutrition.
- that the people of the community have beliefs and practices which affect, for better or worse, nutrition and health.

To be effective, the proposed project should:

- be part of an over-all health/community development effort.
- be feasible in terms of local institutions, technology and resources.
- be developed within the sociocultural beliefs of the community.
- be designed in such a manner that it can become self-sustaining.

B. DESCRIPTION OF THE PROJECT

1. Project Goal

To promote the well-being of malnourished populations by incorporating appropriate nutrition activities into integrated health/nutrition/family planning programs.

2. Project Purpose

To reinforce and expand A.I.D.'s capability to provide a leadership and supportive role in developing appropriate nutrition components for integrated health/nutrition/family planning programs in LDCs. Specifically, the following will be accomplished during the next three years as a result of this project.

<p>APPENDIX B RSSA CONTINUATION SHEET 6 of 11 pages</p>	<p>RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND Department of Health & Human Services Office of International Health</p>	<p><input type="checkbox"/> ORIGINAL <input checked="" type="checkbox"/> AMENDMENT 4 RSSA NO. HEW/OIH-1-77 FISCAL YEAR 1981/82/83</p>
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- Missions and key personnel responsible for integrated health delivery systems will receive information through publications and workshops concerning the evolving state-of-the-art regarding nutrition inputs into such systems.
- Technical assistance will be provided to Missions in all Regions and the RSSA will be recognized as a valuable resource for assisting in the development/incorporation of nutrition considerations into integrated health delivery systems.
- The nutrition content of integrated health delivery systems will be materially advanced and integrated health delivery systems will more effectively meet the needs of the LDCs.

3. Progress to Date

A Resource Service Support Agreement (RSSA) was established with the Office of International Health, OIH/HEW, in 1978, to assist DS/N and Missions to better incorporate nutrition components into low cost health delivery systems. In accordance with the initial work plan, the following was accomplished.

- (a) A.I.D. health sector programs were reviewed by Regions and a description and an analysis of these programs was published and made available to Bureaus and Missions.
- (b) WHO, APHA and Overseas Development Council publications on the state-of-the-art in integrated health service delivery in LDCs were reviewed and abstracted.
- (c) Site visits in 1979 to consult on Nutrition Interventions in Health Programs were made to Guatemala, Malawi, Swaziland, and Bangladesh.
- (d) Bibliographies on Breast Feeding and Oral Rehydration were prepared and widely distributed.

Prior to moving ahead with this request for the renewal of the OIH/RSSA, meetings were held with the Regional Bureau Nutrition and Health Advisors. This was followed by a workshop on "The Nutritional Component of Primary Health Care Services" sponsored by A.I.D., O.I.H., and the Committee on International Nutrition Programs/National Academy of Sciences. All four Regional Bureaus participated in the discussions. The "Scope of Work" for the new OIH/RSSA incorporates the needs and views of the Regional Bureaus.

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
Department of Health & Human Services
Office of International Health

<input type="checkbox"/> ORIGINAL	<input checked="" type="checkbox"/> AMEND NO. 4
RSSA NO. HEW/OIH-1-77	
FISCAL YEAR 1981/82 /83	

4. Outputs

The services to be made available under the new RSSA include: (a) the preparation and distribution of informational and training materials; (b) the development of a series of Resource Handbooks on nutrition

interventions and training; (c) the convening of regional and national workshops; (d) the provision of technical assistance to Missions and LDCs; (e) the identification of key nutrition issues, unanswered questions, and areas for operational research and manpower development which are practical and field-oriented in their nature.

(a) Informational and Training Materials

The collection, analysis, publication and dissemination of information concerning current development involving nutrition inputs into LDC community based integrated health delivery systems will be undertaken. Material will be gathered from ongoing activities sponsored by A.I.D., WHO, UNICEF, international development agencies, bilateral donors, PVOs, and other institutions working in LDCs. Examples of the types of information that could be provided include:

- composition, preparation and use of weaning foods in the home and at the community level.
- activities designed to promote breastfeeding.
- supplementary feeding practices.
- nutrition training components for mid-level and community-level primary health care workers.
- basics of oral rehydration.
- growth surveillance.

(b) Resource Handbooks

In addition to the compilation of information concerning the state-of-the-art of potential nutrition activities, a series of Resource Handbooks will be prepared. These handbooks will review alternate approaches to carrying out specific tasks; assess the utility of these approaches under a variety of country conditions; and discuss their respective cost/effectiveness. The Handbooks will be in "loose leaf" form and will be updated at appropriate intervals. Examples of Resource Handbooks that could be provided include:

APPENDIX B

RSSA CONTINUATION
SHEET

8 of 11 pages

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
Department of Health & Human Services
Office of International Health

<input type="checkbox"/> ORIGINAL	<input checked="" type="checkbox"/> AMENDMENT NO. 4
RSSA NO. HEW/OIH-1-77	
FISCAL YEAR 1981/82/83	

- curricula for training supervisors and community health workers in basic nutritional skills.
- handbooks for growth surveillance, oral rehydration, basic data collection, management of infant feeding and preparation of home weaning foods.

(c) Workshops

Seminars/workshops will be designed at regional and national levels to:

- inform health sector policymakers regarding the importance of nutrition in the health sector.
- update A.I.D. contractor field staffs and LDC personnel on current state of knowledge on nutrition outreach services. These workshops will provide an opportunity:
 - (a) to keep A.I.D. Missions informed of the kinds of technical advisory services and other resources available from AID/W through centrally funded contracts, IQCs and RSSAs; and
 - (b) for personnel activity engaged in the implementation of programs to exchange field experiences.

Topics and agenda for seminars/workshops will be developed jointly with Bureaus/Missions/LDCs.

(d) Technical Assistance

The RSSA will provide short-term technical assistance to A.I.D. Missions and A.I.D. regional programs upon request. This assistance can cover a wide range of activities including:

- assessment of long-term needs of nutrition oriented staff from policy planning down to primary health care workers--assessment of institutional capabilities for training personnel;
- development of training curricula for nutrition oriented health workers at all levels of responsibility;
- provisions of appropriate training materials;

- guidance in the procurement, storage, supply and maintenance of materials and equipment such as weighing scales, growth charts, oral rehydration packets, food supplements, vitamin/mineral supplements, etc.;
- guidance involving specific nutritional components of integrated health delivery systems (nutrition education, weaning foods, use of growth charts, etc.)

(e) Operations Research

Identify priority nutritional operational research areas and potential sites and institutions for implementing pilot programs under the RSSA guidance and leadership. For example, what is the minimal package of critical nutrition tasks to be carried out by primary health care workers; what are the limitations and risks associated with home and village level oral rehydration techniques; what is the minimum data set necessary for planning, programming and evaluating nutrition interventions. All tasks undertaken within the RSSA will have prior concurrence from DS/N.

5. Inputs

- The RSSA will be expected to call upon other HEW/PHS personnel to augment its own skills. If deemed necessary, the RSSA could sub-contract with appropriate individuals or institutions. All sub-contracts will be subject to DS/N approval.
- RSSA personnel should have LDC field experience and at a minimum represent expertise in: (a) maternal and child health care, (b) nutrition, (c) nutrition education and community organization. The RSSA Director will have overall responsibility for carrying out the task enumerated under "Outputs" and serve as principal liaison with DS/N on overall policy and decisions concerning implementation of the scope of work under the RSSA.
- The DS/N project manager and RSSA Director will draw extensively on the expertise in DS/HEA and DS/POP, as well as the Regional Bureaus, in order to assure coordination of all ongoing efforts in the health/nutrition/family planning arena.

APPENDIX B

RSSA CONTINUATION
SHEET

10 of 11 PAGES

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
Department of Health & Human Services
Office of International Health ORIGINAL AMEND
NO. 4

RSSA NO.

HEW/OIH-1-77

FISCAL YEAR

1981/82/83

- A Project Advisory Committee, consisting of representatives of the Regional Bureaus, DSB and consultants when required will be established to assist in: (a) formulating RSSA priorities and tasks; (b) reviewing the work accomplished; (c) obtaining feedback from the field; (d) identifying specific subject areas for future seminar/workshops.

F. Subcontracting

The Office of International Health is hereby authorized to enter into a non-personal service contract under OIH's own contracting authority with Logical Technical Service, not to exceed \$501,496, as stipulated in attached budget, Appendix A.

G. Other Requirements

No international travel originating in the U.S. should be undertaken without prior approval of DS/N and/or CM/SOD/IIA.

NOTE: This amendment does not require the procurement of new publications as restricted under the President's Moratorium on New Publications and Audiovisual Products.

APPENDIX B

RBSA CONTINUATION
SHEET

11 of 11 pages

RESOURCES SUPPORT SERVICES AGREEMENT BETWEEN
THE AGENCY FOR INTERNATIONAL DEVELOPMENT AND
Department of Health & Human Services
Office of International Health

<input type="checkbox"/> ORIGINAL	<input checked="" type="checkbox"/> AMEND NO. 4
RBSA NO. HEW/OIH-1-77	
FISCAL YEAR 1981/82 /83	

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ATTACHMENT IV

Others

Hal Rice Formerly, Nutrition Advisor in
Asia Bureau
Judy McGuire Formerly, PPC Nutrition

II. USAID Mission Overseas

- Belize
Mary Ellen Duffy General Program Officer
- Bolivia
Paul Hartenberger Director, Office of Health and
Nutrition
- Dominican Republic
Lee Hougan Chief Health Officer
Maria Castello Assistant to Chief Health Officer
- Ecuador
William Goldman Chief, Family Health Division
Kate Jones-Patron Asst. Chief, Family Health Division
- Haiti
David Eckerson Health IDI
- REDSO/WCA
Man-Ming Hung MCH/Family Planning Advisor
- Sierra Leone
James Habron Affairs Officer
Nance Webber Participant Training Specialist
- Thailand
Narintra Tima Program Specialist
- Togo
Ernie Popp

III. Collaborating Officials - U.S.

- Catholic Relief Services
Joy Delroso Formerly of CRS/DR
Scott Osborne West Africa Desk Officer
- Meals for Millions
James Becht Asst. Director, Planning and
Evaluation

IV. Collaborating Officials - Overseas

- Dominican Republic
Ana Ingrid Diaz Supervisor for Nutritional
Surveillance, CARITAS

Barbara Liedtke	Former Health & Nutrition Projects Manager, CRS
Juana Maria Mindez	Former Field Director of ANEP, CARITAS
Lynn Renner	Director, CRS
- <u>Ecuador</u>	
Lautaro Andrade	Director, MFM
José Avecillas	Field Coordinator, CARE - MOH
José Castro	Chief, Division of Community Devel.
Wilma Freire	Chief, Nutrition Section, CONADE
Connie Galant	Acting Field Director, PLAN International
Yolanda Grijahva	Director, PEMPAAMI Project, MOH/ ININMS
Mercedes Landy	Social Program Coordinator, Peace Corps
Susanna Larren	Head, Child Survival Project, CRS
Carol Munroe	Director, CRS
- <u>Sierra Leone</u>	
Fatu Contech	Assistant Nutritionist, PHC (MOH - Bamboli District)
Henry Morie Karimu	Training Coordinator, MFM
Renee O'Sullivan	Director, MFM & Manager Bombali PHC Program
Sylvetta Scott	Head, Nutrition Unit, MOH
Josie Vespa	Senior Nutritionist, MFM
- <u>Thailand</u>	
Vason Pinyowiwat	Medical Officer, Department of Communicable Disease Control, MOH
Kanjana Sri-Ngern-Yuang	Sanitation Division, MOPH
Chawalit Suntikitrungruang	Head, Malnutrition Control Section, Nutrition Division, MOPH
- <u>Togo</u>	
Maria Therese Adjanla	Regional Supervisor, CRS
Nancy Brown	Technical Associate, CRS
Michael Hastings	Director, CRS/Lome
Charlotte Johnson-Welch	LTS Consultant
Koffi Mensaui	Supervisor, Social Affairs Division Maritime Region
Nancy Michelson	Regional Coordinator, CRS
Afi Tsogabe	Director, OR Project, CRS
Karen Wilkins	Project Manager (Health & Nutrition), CRS

ATTACHMENT V

ATTACHMENT V

INTERNATIONAL NUTRITION UNIT PUBLICATIONS - 1982 to 1988

1988

1. Trip Report: National Child Survival Conference for PVOs. Lake Havasu City, Arizona.

Charles H. Teller (January 4-8, 1988)

2. Supporting Nutrition in Child Survival: A National Growth Monitoring Seminar and Related Activities. Lake Titikaka, Bolivia.

Charles H. Teller (January 13-26, 1988)

3. Mid-Term Process Evaluation, "Child Survival Applied Nutrition Project", Catholic Relief Services, Ecuador. Quito. January 26 - February 5, 1988.

Jose O. Mora, Helen Bratcher, Pablo Martinez and Charles H. Teller (January 26 - February 5, 1988)

4. Informe de Viaje: Sistema de Informacion, Programa de Nutricion Aplicada "Suspervivencia Infantil", 1986-1987. CRS, Ecuador.

Charles H. Teller, Jose O. Mora (February 1988)

5. Growth Monitoring and Nutrition Education: Impact Evaluation of an Effective Applied Nutrition Program in the Dominican Republic. CRS/Caritas, 1983-1986.

Jose O. Mora (February 1988)

INTERNATIONAL NUTRITION UNIT PUBLICATIONS - 1987

1987

1. Operations Research on Growth Monitoring and Promotion - Togo
Virginia Yee (April 6-22, 1987)
2. Integrating Growth Monitoring Promotion and Child Survival Operations Research: A Field Test in Zaire
Neen Alrutz, Charltes Teller and Alfred Zerfas (April 30, 1987)
3. Issues in Growth Monitoring and Promotion (Summary)
Virginia Yee and Alfred Zerfas (May 11, 1987)
4. Entrenamiento De Capacitadores En Monitoreo Y Promocion Del Crecimiento Y Desarrollo Infantil. Informe de Viage Al Ecuador - Spanish Ecuador Trip Report
Jose O. Mora (June 8-18, 1987)
5. Community Nutrition Assessment and Evaluation: Towards Model Building - Thailand Trip Report
Charles H. Teller (August 15-29, 1987)
6. A Simple Method for Estimating a Standardized Prevalence of Child Malnutrition from Anthropometric Indicators
Jose O. Mora (August 25, 1987)
7. External Evaluation of the Applied Nutrition Education Program (ANEP) of CRS/CARITAS in the Dominican Republic Final Report - English and Spanish (not for distribution)
Jose O. Mora, Team Leader (September 1987 revised)
8. Proyecto De Mejoramiento Infantil, Caritas Boliviana, Informe De Evaluacion De Progreso - Bolivia Trip Report
Jose O. Mora (Agosto 24 - Septiembre 4, 1987)
9. Revision Del Componente De Vigilancia, Del Crecimiento Dentro De Programs, De Sobrevivencia Infantil: Hacia Una Estrategia Coordinada en Bolivia. Informe de Viaje - Spanish Boliva Trip Report
Charles H. Teller (September 14 - October 2, 1987)

10. Strengthening Community-Based Growth Surveillance in Thailand: Phase II Analysis and Implications for Program Development - Thailand Trip Report
Alfred Zerfas (August 14 - September 4, 1987)
11. PYO Growth Monitoring/Promotion Workshop at Save the Children Federation (USA), Westport, Connecticut, November 23-24, 1987. Workshop Report
Irwin J. Shorr (November 23-24, 1987)
12. La Vigilancia Y Promocion Del Crecimiento (VPC): Apoyo Tecnico A Proyectos De Supervivencia Infantil De Meals for Millions Y CARE En Bolivia.
Charles H. Teller (November 30 - December 10, 1987)
13. Designing a National Nutrition and Child Survival Strategy for Ecuador - Trip Report.
Jose O. Mora (November 29 - December 11, 1987)

INTERNATIONAL NUTRITION UNIT PUBLICATIONS - 1986

1. Thesaurus For Operations Research: Community Health Worker Sub-System

Growth Promotion - Activities at Community Level and at Clinic Level

Mora, Teller and Yee (Second Draft January 10, 1986)
2. Strengthening Growth Monitoring And Nutritional Surveillance Within PHC: Operations Research Within The Nutrition Division Of The MOH - Thailand Trip Report

Charles H. Teller (January 31 - February 18, 1986)
3. Lima, Peru Trip Report (English and Spanish Versions)

Jose O. Mora (February 2-8, 1986)
4. Bogota, Colombia Trip Report (English and Spanish Versions)

Jose O. Mora (February 10-15, 1986)
5. West and Central Africa Regional Nutritional Surveillance Training Course - Abidjan Trip Report

Virginia S. Yee (March 3-14, 1986)
6. Informe De Viaje Iniciando El Proceso De Replicacion Del Programa De Educacion Nutricional Aplicada, CRS/CARITAS Dominicana: Un Taller De Orientacion - Spanish Dominican Republic Trip Report

Charles H. Teller (April 28 - May 16, 1986)
7. Application Of Operations Research In Growth Monitoring/Promotion - Presented at the Annual Conference of the NCIH, Washington, D.C.

Charles H. Teller (June 10-13, 1986)
8. Hacia La Vigilancia Nutricional Comunitaria. Program De Nutricion Aplicada, Meals For Millions, Olancho, Honduras - Spanish Honduras Trip Report

Charles H. Teller (June 30 - July 4, 1986)
9. Informe De Viaje Bases Para Un Plan De Evaluacion Externa Del Programa De Educacion Nutricional - Aplicada (ANEP) De CRS/CARITAS Republica Dominicana - Spanish Dominican Republic Trip Report

Jose O. Mora (July 29 - August 12, 1986)

10. Operations Research On Growth Monitoring Within Primary Health Care: Methodological Advances And Preliminary Findings - Thailand Trip Report
Charles H. Teller (August 14-30, 1986)
11. Review Of Growth Monitoring - Issues Paper
Virginia Yee and Alfred Zerfas (September 18, 1986)
12. Informe De Viaje A Bogota, Colombia - Spanish & English Colombia Trip Report
Jose O. Mora (August 24 - September 6, 1986)
13. Training PVO Staff In Growth Monitoring For Child Survival - Ecuador Trip Report
Jose O. Mora (September 18-26, 1986)
14. Strenthening Community-Based Growth Surveillance In Thailand: Analysis of Phase I Operations Research And Preparations For Phase II - Thailand Trip Report
Alfred Zerfas (October 2-30, 1986 Long and Short Version)
15. Report on Child Survival Workshop - Belize Trip Report
Virginia Yee (October 15-17, 1986)
16. Resultados De La Evaluacion Continua, Programa De Nutricion, CRS/CARITAS Dominicana: Un Analisis Preliminar Spanish Dominican Trip Report
Charles H. Teller (October 18-22, 1986)
17. Upscaling An Applied Nutrition Program Through Government Primary Health Care: NGO's As Facilitators of Expansion in Sierra Leone - Sierra Leone Trip Report
Charles H. Teller (October 30-November 11, 1986)
18. DMD Project, Directing Council Meeting - Lima, Peru Trip Report
Jose O. Mora - (December 7-13, 1986)

INTERNATIONAL NUTRITION UNIT PUBLICATIONS - 1985

1. Home Management of Acute Diarrhea: An Integrated Approach to Preventing Malnutrition and Improving Health of Young Children

Jose O. Mora, M.D.
2. Nutrition in Primary Health Care in Liberia Planning a National Conference and Assessing the Present Situation - Liberia Trip Report

Charles H. Teller (February 4 - March 2, 1985)
3. Community Involvement in Primary Health Care Nutrition Program: Assessing Social Mechanisms in the Growth Monitoring Process - Thailand Trip Report

Charles H. Teller (April 23 - May 4, 1985)
4. Informe de Viaje, El proceso de monitoreo y evaluacion: Una apreciacion de su avance y la utilizacion de los datos - Spanish Dominican Republic Trip Report

Charles H. Teller (Mayo 12-18 de 1985)
5. Guidelines for the Design and Organization of Health Sector Nutritional Surveillance

Virginia S. Yee (May 22, 1985)
6. Integrating Nutrition in Primary Health Care: The First Annual Liberian PHC Conference June 3-7, 1985 - Liberia Trip Report

Charles H. Teller and Virginia S. Yee
(May 27 - June 13, 1985)
7. Growth Monitoring as a Useful Primary Health Care Management Tool - Paper presented at NCIH Conference, June 1985)

Charles Teller, Virginia Yee and Jose Mora (June 3-5, 1985)
8. Extension De Cobertura De Salud Primaria Integral, Enmienda De Nutricion, Peru - Spanish Peru Trip Report

Charles H. Teller (Junio 24-28, 1985)

9. International Nutrition Planners Forum, Nutrition and Diarrheal Disease Control:

Report Of A International Conference Held At
The West Dean Conference Center, United Kingdom

Jose O. Mora (August 12-16, 1985)
English, Spanish and French Versions
10. Pitfalls of Anthropometry

Presented at the Colloquim on Nutritional Status and Body Composition, XIII IUNS International Congress of Nutrition. Brighton, United Kingom

Jose O. Mora (August 18-23, 1985)
11. Control De Crecimiento Y Vigilancia Nutricional De PEMPAAMI (Ecuador): Grado De Avance Y Delineamiento De Reajustes - Spanish Ecuador Trip Report

Charles H. Teller (September 9-14, 1985)
12. 1985 World Food Day Address
Hunger in Africa - Understanding Micro-Level Causes & Public Health Efforts At Long Term Improvement

Presented by Dr. Charles H. Teller on October 18, 1985 at Beth Tikva Synagogue, Rockville, Maryland.
13. Concept Paper
Nutrition Support Project - Africa Region

Charles H. Teller (Draft November 6, 1985)
14. Growth Monitoring Within Primary Health Care: Main Constraints In Implementation And Recent Efforts To Overcome Them

Presented by Teller, Yee and Mora on November 17-21, 1985 in the International Health Section at the 113th Annual Meeting of the American Public Health Association, Washington, D.C. (Rough Draft - Do not quote)
15. Informe De Viaje Superando Las Metas De Cobertura Y De Reduccion De Desnutricion: Indicadores De Avance A Los Dos Anos

Programa De Educacion Nutricional Aplicada, CRS/CARITAS Dominicana - Spanish Dominican Republic Trip Report

Charles H. Teller (December 1-14, 1985)

16. USAID (REDSO/WCA) Nutritional Surveillance Strategy/
Training Course Planning Meeting - Abidjan Trip Report

Virginia S. Yee (December 4-8, 1985)

17. Nutrition Package of Child Survival "Some Thoughts on the
Nutrition Component of Child Survival"

Jose O. Mora (December 13, 1985)

INTERNATIONAL NUTRITION UNIT PUBLICATIONS - 1984

1. Cairo, Egypt Trip Report
Juan Aguilar (January 7-28, 1984)
2. Nutrition in Primary Health Care, Summary of an International Conference - Cosponsored by The Ministry of Health, Arab Republic of Egypt, and The International Nutrition Planners Forum
Cairo, Egypt (January 18-19, 1984)
3. Nutricion En Atencion Primaria De Salud, Resumen de una Conferencia Internacional - Patrocinada conjuntamente por el Ministerio de Salud, Republica Arabe de Egipto, y el Foro Internacional de Planificadores en Nutricion
El Cairo, Egipto - Enero 16-19, 1984
4. Nutrition ET Soins De Sante Primaires - Sous L'egide Du Ministere De La Sante De La Republique Arabe D'Egypte Et Le Forum International De Planificateurs Nutritionnels
Sommaire D'une Conference Internationale Le Caire, Egypte, 16-19 Janvier 1984
5. Designing a Nutrition Surveillance System within the Ministry of Health, Sierra Leone Trip Report
Charles H. Teller (January 27 - February 16, 1984)
6. Proposed Amendment to the USAID "Integrated Health and Family Planning" Project (527-0230) - Peru Trip Report
Juan R. Aguilar (February 25 - March 10, 1984)
7. International Conference on Nutrition in Primary Health Care (ICN/PHC), Making Primary Health Care Nutrition Work: Issues Raised in a Review of the Record
Janet R. Wilcox, Charles H. Teller and Abraham Horwitz (Revision - August, 1984)
8. Design of a Monitoring System for the Improved Nutrition Program ININMS/PAAMI - Ecuador Trip Report
Charles H. Teller (August 15 - September 1, 1984)

9. Circular Migration and Young Child Malnutrition in Guatemala
Charles H. Teller and William P. Butz (October, 1984)
10. Report on Visit to Ivory Coast
Virginia Yee (October 23- November 6, 1984)
11. Integrating Nutrition in Primary Health Care in Sierra Leone and Liberia: Followup to Proposals Developed at Abidjan Workshop - Abidjan Trip Report
Charles H. Teller (November 6-15, 1984)
12. Habana, Cuba Trip Report - XIV Panamerican Congress of Pediatrics
Jose O. Mora (November 11-17, 1984)

INTERNATIONAL NUTRITION UNIT PUBLICATIONS - 1983

1. Status Report on HMIP Health Information System Component
Charles H. Teller (February 16, 1983)
2. Senegal, Egypt & Casamance Trip Report
Juan R. Aguilar (January 27 - February 27, 1983)
3. Guidelines for Incorporating Nutrition Into the Design of
Primary Health Care and Related Development Projects
Janet R. Wilcox, Charles H. Teller and Juan R. Aguilar
(May, 1983)
4. Directives relatives a l incorporation de la nutrition
dans les projets de soins de sante primaires et les
projets de developpement sy rapportant
Janet R. Wilcox, Charles H. Teller and Juan R. Aguilar
(May, 1983)
5. The Rural Primary Health Project of the Sine Saloum,
Senegal: Proposed Nutrition Component of Project Redesign
Gretchen G. Berggren (May, 1983)
6. Nutrition in the Health Sector, A National Seminar and
Selected Projects - Ecuador Trip Report
Charles H. Teller (June 26 - July 7, 1983)
7. Community Nutrition Baseline Instruments: Stimulating
Initiatives Through Organized Groups, Applied Nutrition
Education Project (CRS/CARITAS) The Dominican Republic
Trip Report
Charles H. Teller (August 11-22, 1983)
8. Western Hemisphere Nutrition Congress VII, Miami Beach,
August 7-11, 1983
SINAPS Case Study, Guatemala, August 15-23, 1983
Juan R. Aguilar
9. Evaluation of the MOH Maternal and Child Supplementary
Feeding Program (PAAMI) in Ecuador Trip Report
Juan R. Aguilar (October 5-21, 1983)

Page two - 1983

10. Community Nutrition Surveillance: Combined Intervention and Planning/Evaluation Tool, Applied Nutrition Education Project (CRS/CARITAS) The Dominican Republic Trip Report

Charles H. Teller (October 18-28, 1983)

11. Jamaica Trip Report

Charles H. Teller (January 30 - February 22, 1983)

INTERNATIONAL NUTRITION UNIT PUBLICATIONS - 1982

1. Development of Nutrition Components for Baseline Study and Short-Run Plan for Improving On-going Nutrition Monitoring and Evaluation System - Jamaica Trip Report
Charles H. Teller (March 8-19, 1982)
2. Nutritional Problems in AID-Assisted Sub-Saharan African Countries: A Socio-Ecological Classification of Target Groups
Charles H. Teller (September, 1982)
3. Nutrition Components of AID-Supported Primary Health Care Projects in Sub-Saharan Africa: A Review
Phase I: Project Design Review and Recommendations
Janet R. Wilcox, Carol Corso and Charles H. Teller
(September, 1982)
4. Final Report on Consultation on Infection and Low Birth Weight Components of Integrated Maternal and Child Nutrition Project - India Trip Report
Russell Alexander and Richard A. Kaslow (September, 1982)
5. Phase II: Trip Report of Mission to: Senegal, Tanzania & Sudan
Charles H. Teller and Janet R. Wilcox
(October 3- November 8, 1982)
6. Nutrition Surveillance Workshop - Jamaica Trip Report
Charles H. Teller (December 5-11, 1982)
7. Toward Effective Nutrition Action in Primary Care: Findings from Sub-Saharan Africa. Presented at the 110th Annual Meeting of the APHA, Montreal, Canada.
Charles H. Teller and Janet Wilcox (November 14-18, 1982)

ATTACHMENT VI

ATTACHMENT VI
LTS CONTRACT OBLIGATIONS

HISTORY OF OBLIGATIONS TO THE NUTRITION LTS CONTRACT NO. 292-91-2075

PURPOSE	COST OF CONTRACT OR MODIFICATION	AMOUNT OBLIGATED INCREMENTALLY	
Original Contract (Signed 9-30-81)	935,000	935,000	
Modification 1-Authorize Foreign Travel (Signed 10-8-81)	0	0	
Modification 2-Add Incremental Funds to Contract (Signed 1-8-82)	0	381,869	
Modification 3-Extend Contract to March 31, 1983 (Signed 1-11-83)	0	0	
Modification 4-Extend Contract to April 30, 1983 (Signed 4-3-83)	0	0	
Modification 5-Extend Contract to May 8, 1983 (Signed 5-1-83)	0	0	
Modification 6-Extend Contract to 12-9-84 (Signed 5-9-83)	432,412	239,000	
Modification 7-Provide for Insurance-Defense Act (Signed 7-1-83)	0	0	
Modification 8-Phase II-Cairo Conf. (Signed 9-15-83)	68,451	68,451	
Modification 9-Phase II-Cairo Conf. (Signed 1-1-84)	83,678	83,678	
Modification 10-Correction of Error on Mod. 9 (Signed 1-1-84)	0	0	
Modification 11-Add Incremental Funds to Contract (Signed 6-25-84)	0	193,412	
Modification 12-(Provide for Translation & Printing of Summary Proceedings, Cairo Conf. & Services of B. Eckerson (Signed 9-26-84)	31,671	31,671	927,496 from Africa Bureau & 94,435 from Office of Nutrition
Modification 13-Extend Contract from 12-9-84 to 6-9-87 (Signed 12-10-84) (Signed 1-28-85)	884,455	248,000	837,554 from Africa Bureau & 282,444 from Office of Nutrition
Modification 14-Provide Authorization to Purchase 2 Portable Computers (Signed 1-28-85)	0	0	
Modification 15-Add Funds for Brighton Conference and POPW, Thailand	87,144	87,144	871,773 for Brighton Conference from Office of Nutrition and 815,371 for POPW, Thailand from Asia Bureau
Modification 16-Add Incremental Funds to Contract (Signed 10-8-85)	0	175,777	
Modification 17-Add Incremental Funds to Contract for B. Eckerson (Signed 12/16/85)	0 00	89,523 00	Free Africa Bureau
Modification 18-Add Funds for Brighton Conference Proceedings (1/16/86)	6,000 00	6,000 00	
Modification 19-Authorize Purchase of 13 th AT Conferences (2/2/86)	0 00	0 00	
Modification 20-Change Negotiated Overhead Rates (Signed 3/4/86)	0 00	0 00	
Modification 21-Add Incremental Funds to Contract (Signed 6/12/86)	0 72	150,323 00	
Modification 22-Increase Scope of work with Funds (8/1/86)	94,372 00	74,372 00	
Modification 23-Add Incremental Funds for Eckerson (9/23/86)	0 00	100,000 00	
Modification 24-Add Incremental Funds to Contract (3/2/87)	0 00	47,000 00	
Modification 25-Add Incremental Funds to Contract (4/3/87)	0 00	25,825 00	
Modification 26-Add Incremental Funds to Contract (5/13/87)	56,913 00	56,913 00	
Modification 27-Extend Contract to Mar. 31, 1987 (5/19/87)	236,177 00	236,177 00	
Modification 28-Increase total contract amount and increase obligated amount (12/31/87)	-17,000 00	30,266 00	
TOTAL	92,305,347	92,305,347	

69

Breakdown of Funds from S&T Nutrition

DESCRIPTION	COMMITMENT BY AID
Original FISA No. 1-77 for period 10/1/77 to 9/30/78 (Signed 8/77)	210,700 00
Amendment No. 1 to extend agreement with additional funds from 9/30/78 to 9/30/79 (Signed 8/78)	143,140 00
Amendment No. 2 to extend agreement from 10/1/79 to 12/31/79 with no additional funds (Signed 10/79)	0 00
Amendment No. 3 to extend agreement from 9/30/79 to 6/30/80 with additional funds (Signed 9/80)	215,000 00
Amendment No. 4 to extend agreement from 6/30/80 to 6/30/81 with additional funds (Signed 7/81)	200,000 00
New FISA No. 2049-R-E-2054 to extend agreement for cost effectiveness of interventions Asian Countries to 9/30/84 (Signed 9/82)	72,000 00 Asia Bureau Funds not Available for LTS/Nut Contract
Amendment No. 1 to extend agreement through 9/30/83 with additional funds (Signed 9/82)	200,000 00
Amendment No. 2 to provide detailed budget for Mod.1 (Signed 8/31/83)	0 00
Amendment No. 3 to provide for funds for Cairo Nutrition Conference 1/16-17/84 (Signed 8/31/83)	150,000 00
Amendment No. 4 to provide support for Sri Lanka Nutrition Survey and Nutrition Plan-8/1/83-9/30/84 (Signed 8/31/83)	10,000 00 Asia Bureau Funds not Available for LTS/Nut Contract
Amendment No. 5 to provide support for design and implementation of the Lucha Arma Program and Evaluation-Ecuador 9/15/83-12/30/83 (Signed 9/20/83)	7,500 00
Amendment No. 6 to provide support for project design and review assistance to USAID Bangladesh 10/1/83-9/30/84 (Signed 9/25/83)	13,000 00 Asia Bureau Funds not Available for LTS/Nut Contract
Amendment No. 7 to provide support of the continuation of assistance to AID's Bureau for S&T Office of Nutrition 6/1/84 - 12/31/84 (Signed 10/21/84)	200,000 00
Amendment No. 8 to provide support for Asian Conference Nutrition in Primary Health Care (Signed 3/25/85)	2,900 00
Amendment No. 9 to Provide support of the continuation of assistance to AID's Bureau for S&T Office of Nutrition & Brighton Conference 1/1/85 - 12/31/85 (Signed 3/30/85)	275,000 00
Amendment No. 10 to Provide support of the continuation of assistance to AID's Bureau for S&T Office of Nutrition January 1 through March 31, 1986 (Signed 5/1/86)	325,000 00
Amendment No. 11 to provide scope of work for dietary management of diarrheal disease during period April 1-Jan 31, 1987	0 00
Amendment No. 12 to provide support of the continuation of assistance to AID's Bureau for S&T Office of Nutrition from February 1, 1987 to December 31, 1987	325,000 00
Total Funds Obligated by AID (S&T Nutrition)	2,347,000 00
Plus: Africa Bureau Funds	319,613
Total AID Funds Available	2,666,689
Less: LTS Contract Expend.	2,305,347
Balance	361,342*

*OIH Overhead plus Travel and Other Costs Processed Directly by OIH (Mostly Prior to 1981 before LTS Contract).

70

ATTACHMENT VII

Attachment VII

Estimated
Non - S&T/N Funds Generated
(1982-88)

<u>Source</u>	<u>\$('000)</u>
REDSO/WCA (+ UNDP - Mali, Burkina Faso, Togo)	1,370
Food for Peace (FFP) - Ecuador, Pempaami	7.5
OIH International Travel - Sri Lanka	10
Bangladesh	22
 <u>Missions</u>	
Bolivia (+ PVOs)	15
Ecuador (+ PVOs)	9
Dominican Republic (Workshop and Evaluation)	42.5
Liberia (Workshop)	30
Thailand (+ MOH)	94
<hr/>	
TOTAL	\$1,600,000*

* This does not include almost \$320,000 which came from the Africa Bureau and is shown in Attachment VI in Breakdown of Funds from S&T/N.

Source: LTS, 24 June 1988.

ATTACHMENT VIII

ATTACHMENT VIII

**Suggested Revised Monthly/Quarterly
Growth Surveillance Indicators Worksheet**

1-5 Same routine headings

6 Type(s) of personnel who weighed and plotted:

MOH _____
NGO _____
Community _____

7	Total no. of children 0-35 months in village catchment area (VCA) registered in program [at time of previous weighing session (PWS)].	+	_____
8	Number of new permanent residents 0-35 mo. in VCA area since PWS	+	_____
9	Number of live born children in VCA since PWS	+	_____
10	SUBTOTAL (#7+8+9)=		_____

11	No. registered children 0-35 mo. who: died	+	_____
12	No. registered children 0-35 mo. who: Emigrated (transferred)	+	_____
13	No. registered children 0-35 mo. who: Graduated (completed 36 mo.)	+	_____
14	SUBTOTAL (#11+12+13)=		_____

15	Number of registered children in VCA eligible to be weighed at this time (subtract #14 from 10)	#10 _____	
		-#14 _____	
	TOTAL (#10-14)	=	_____

16	Number of children 0-35 mo. in VCA weighed at this time		_____
17	Efficiency of coverage of registered population (#16 ÷ #15) x 100		_____ x

18	Number of child weighed outside VCA and above 35 mo.		_____
----	--	--	-------

14

Growth and Nutrition Status - Quarterly

19	of those in #22: No. gained weight adequately*	+	_____
20	: No. gained inadequately	+	_____
21	: No. did not gain any weight or lost	+	_____
22	Number of children 0-35 in VCA weighed both last time and this time (#19+20+_1)	=	_____
23	Effectiveness: % gained weight adequately		_____ %
<hr/>			
24	Number of children 0-35 in VCA who fell below 80% of median since his previous weighing		_____
25	Number of children 0-35 in VCA who didn't fall below 80%		_____
26	Prevention: % who didn't fall [$\#25 \div (24+25)$]		_____ %
<hr/>			
27	Current nutritional status of children 0-35 mo. in VCA:		
	90% and above of median	+	_____
	80-89%	+	_____
	70-79%	+	_____
	Below 70%	+	_____
28	Total 0-35 mo. weighed this time	=	_____

* Adequacy determined by weight gained per month by age according to bottom curve of road-to-health card. Eg: between 4 and 5 months, .8 kg gain; between 29 and 30 months, .1 kg. gain.