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FINAL EVALUATION OF

Resources for Child Health Project

REACH

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Submitted to:

The
Office of Health
Bureau for Science and Technology
Agency for Internation Development

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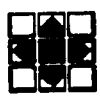

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Final Evaluation of REACH I (Resources for Child Health Project)

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A multi-disciplinary team conducted the evaluation:

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The evaluation took place in the Washington, D.C. metropolitan area during September 17, 1990, through October 13, 1990.

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Acronyms and Abbreviations

A.I.D.	Agency for International Development
CTO	cognizant technical officer
EPI	Expanded Program on Immunization
FVA/PVC	Bureau for Food for Peace and Voluntary Assistance, Office of Private, Voluntary Cooperation
FY	fiscal year
HCF	health care financing
JSI	John Snow, Incorporated
NGO	nongovernmental organization
PHC	primary health care
PRITECH	Technology for Primary Health Care Project
PVO	private voluntary organization
REACH	Resources for Child Health Project
S&T/H	Bureau of Science and Technology/Office of Health
TAG	Technical Advisory Group
UNICEF	United Nations Children's Fund
USAID	Agency for International Development (overseas missions)
WHO	World Health Organization

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EXECUTIVE SUMMARY

The Resources for Child Health Project (REACH) provided substantive technical assistance for both the Expanded Program on Immunization (EPI) and health care financing (HCF). Because of the subsequent development of REACH II before the completion of the REACH Project, this evaluation will refer to the REACH Project as REACH I.

Nine cognizant technical officers (CTOs) were responsible for REACH I during its five years and, making a virtue of necessity, the project was permitted to evolve responsively and progressively. Moreover, REACH I was not subjected to bureaucratic inaction as could have been the case with the discontinuity of CTOs.

Health care financing is an increasingly fundamental component of sustained health services worldwide. HCF evolved from a minor component of REACH I into a new, separate project, Health Financing and Sustainability, managed by the Office of Health, Bureau for Science and Technology (S&T/H). EPI was not inhibited by the growth of HCF activities during this phase of REACH I. Indeed, demand for EPI services likewise evolved into a new project, REACH II, that includes an additional component designed to reduce the impact of acute respiratory infection upon child survival.

REACH I was a successful project. Most of the people the evaluation team interviewed thought it had been flexible and responsive to the needs of regional bureaus, and especially to mission and host country requests. Consultations were generally of high quality and performed in a timely fashion. While REACH I was a centrally funded project of S&T/H, USAID missions were allowed to "buy-in" using their funds. This mechanism successfully stimulated project growth and evolution. Because of buy-ins, the budgeted ceiling of the allocated funding level was achieved much sooner than anticipated, resulting in REACH I having to ration requests for service.

The goal and objectives of REACH I coincided closely with those of other child survival endeavors managed by the World Health Organization, the United Nations Children's Fund, private voluntary organizations, and others. Close collaboration, coordination, and communication should have been important aspects of project implementation. Unfortunately, the discontinuity of CTOs, the paucity of staff resources, and the inadequacy of CTO travel funds constrained the role of S&T/H in collaborating with other agencies and managing and coordinating REACH's child survival endeavors. The effectiveness of S&T/H as a major player in international child survival activities should not be compromised; the resources needed for adequate A.I.D. managerial oversight should be committed. John Snow, Inc., the contractor, appears to have performed well despite these problems.

As only one of the many organizations involved in EPI, REACH I had to identify a role that would complement and supplement the activities of other EPI donor organizations. REACH I emphasized cost-effective delivery, strengthening information systems, and improved monitoring of immunization coverage. It also focused on working with nongovernmental organizations and PVO groups to enhance their capacity to use sound public health practices in their delivery of EPI services. REACH I significantly enhanced the training of health workers and increased the production and dissemination of information materials. Especially noteworthy was the production of the popular field guides, *EPI Essentials: Guidelines for Identifying and Implementing HCF Activities* and *Costing of Health Services Delivery Guidelines*.

In collaboration with WHO, REACH I installed and customized a computerized EPI information system in nine countries. REACH I also developed a standardized methodology for EPI costing with WHO, and tested a nonreusable syringe and needle to prevent the transmission of hepatitis B and AIDS.

REACH I stimulated the development of new ideas and helped initiate policy dialogue, including a renewed commitment to eliminate neonatal tetanus, a leading killer of infants. Urban areas with their growing population of underserved children are a special challenge to effective EPI administration. REACH I called attention to and, through REACH II, continues to address this problem.

Initially, A.I.D. had anticipated that HCF would constitute only a minor part of REACH I system support for primary health care technology. Instead, USAID missions submitted so many requests for HCF technical assistance that initially REACH I could barely meet the demand. As a result, significant quantities of resources were dedicated to health financing activities in such areas as accounting, social insurance schemes, user fees, health maintenance organizations, hospitals, primary health care, and systemwide reform.

At the inception of REACH I there was a shortage of HCF experts, particularly within PVOs. The prime contractor, John Snow, Inc., and its HCF subcontractors thus took some months to develop their HCF capacity. Currently, however, John Snow, Inc. contributes positively to the worldwide HCF effort.

REACH I represents an ongoing development program, not a distinct and isolated project. The evolution of priorities during the course of REACH I changed the project's components in a positive and desirable way.

Efficient, effective management is required to ensure the flexibility, responsiveness, and change characteristic of successful programming. Indeed, without the continuity of a CTO who possesses the requisite support, technical, and managerial skills, the risk of project failure increases dramatically. REACH I succeeded largely because of the aptitude and professionalism of the contractor, John Snow, Inc. and its subcontractors. A.I.D. must strengthen the capacity of its CTOs to exercise the kind of leadership required to ensure success.

I. Introduction

This assessment covers the entire REACH I experience, including all the organizations and institutions involved with furthering its objectives. These include the Science and Technology Bureau of A.I.D., A.I.D.'s regional bureaus, USAID missions, and the prime contractor and its subcontractors. Findings and conclusions about the REACH I project experience pertain to the whole project.

I.A. Nature and Objectives of the Evaluation

The administrative and managerial issues encountered during the implementation of the REACH I project required special attention during the course of this evaluation. The evaluation team hopes that the lessons learned from the REACH I experience will contribute to greater managerial efficiency in future A.I.D. endeavors. The team anticipates that its findings will augment the body of information concerning A.I.D.-assisted

- immunization programs,
- health financing activities,
- health development interventions, and
- worldwide centrally managed technical assistance projects.

Technical and administrative problems are considered, as well as their subsequent resolution. A.I.D.'s attention to child survival interventions expanded from an initial emphasis on oral rehydration therapy to the inclusion of EPI. An interest in health care financing followed. These changes offer a case study in bureaucratic evolution in response to changing priorities. REACH II continues the EPI effort and incorporates a program to mitigate acute respiratory infections, while the health care financing aspect has evolved into the new Health Financing and Sustainability Project.

Our evaluation was limited to the Washington, D.C. metropolitan area and did not include any site visits. We appraised secondary data concerning program implementation and interviewed a variety of individuals available locally who were involved in the managerial, administrative, technical, and collaborative enterprise that constituted REACH I. This list of individuals went well beyond the personnel of John Snow, Inc. (JSI), the prime contractor for REACH I.

The team was asked to assess several factors:

- the effectiveness of REACH I in achieving its objectives,
- the quality of JSI's management and administration,
- the quality of A.I.D.'s management of REACH I, and
- the quality of collaboration and coordination between all the relevant institutions.

We have also recommend how future activities, particularly REACH II, might be more effectively implemented.

The Agency for International Development, through a contract with The Pragma Corporation, assembled a four-person team to evaluate the REACH I effort. The team's expertise included immunization, primary health care and public health administration, economics and health care financing, and international health program management and sustainability. During the course of the evaluation, the team reviewed a large quantity of documents and held interviews with personnel from each A.I.D. regional bureau; REACH I; subcontractors; specialists from collaborating institutions such as WHO, UNICEF, the World Bank, the U.S. Centers for Disease Control; and former and newly returned health, population, and nutrition officers from USAID missions.

The evaluation was conducted from September 17, 1990, to October 13, 1990. The evaluation team arrived at a high degree of agreement on their observations and conclusions.

I.B. Project Approaches

REACH I (1985-90) was a major contributor to the development of primary health care through technology transfer, health care financing, and communication. A.I.D.'s Office of Health facilitated the collaboration of and dialogue between major donors. REACH I provided the technical expertise to design, implement, and evaluate Expanded Programs on Immunization (EPI) and health care financing (HCF) initiatives. REACH I was also a vehicle for introducing new technologies, especially with regard to EPI. The utility of short- and long-term interventions was recognized from the beginning of REACH I. Initially, HCF was a distinct secondary component of REACH I, subsumed within "systems support," and combined with assistance in management and training. As REACH I evolved, USAID mission demand for HCF became enormous, and HCF became a major component of the project.

Respondents agreed that REACH I met its objectives effectively and successfully. The reports the team reviewed revealed that REACH I met or exceeded its contract deliverables in terms of the number of long-term interventions, technical assistance activities, financial consultations, workshops, and research reports. REACH I provided technical assistance in EPI to 32 countries during the course of the project.

Though initially a minor component of REACH I, demand for HCF consultation resulted in studies and interventions in 37 countries. Topics included revenue generation, resource allocation and mobilization, efficiency, and equity. Since the beginning of REACH I, many countries have undertaken health financing policy reviews and innovations. The Central African Republic, El Salvador, Kenya, and Zaire have revised their health care financing policies as a direct result of REACH I's HCF activities.

I.B.1. Technology Transfer

As stated in the original contract of September 30, 1985, the goal of the Primary Health Care Technology Project (under which the REACH contract was authorized) was to lower infant, child, and maternal morbidity and mortality. This was to be accomplished by introducing, promoting, and improving the delivery of key disease control technologies by emphasizing immunizations (EPI) and strengthening systems support through HCF.

At contract completion, the following outputs were expected:

- immunization and other selected disease control measures adopted or improved within the primary health care programs of approximately 15 countries;

- increased government support for and ability to deliver selected disease control technologies;
- greater private sector involvement in health service management and delivery;
- successful use of systems support technical services in approximately 25 countries to improve the management of PHC programs, strengthen capability to develop manpower, and design and evaluate PHC programs;
- financial analysis undertaken in ten countries with significant follow through in five countries to improve the health sector's financial status; and
- convening of one inter-regional and five regional conferences.

To meet these objectives, REACH I provided technical and managerial expertise, collaborating with other organizations and individuals as needed in disease control, commodity supply, PHC management, financing, training, and project design and evaluation.

One of REACH I's outstanding contributions to EPI technology transfer was the production of the program guide *EPI Essentials*. REACH I sought to produce an analytic, concise document in a "user friendly" format. The guide explained the principal components of EPI, the operation of each component, and how to evaluate and correct problems in EPI in a well-integrated combination of text and graphics, with an emphasis on presentation. To produce such a readily usable, useful product, REACH I obtained extensive feedback concerning reader's needs. It was used in training seminars for A.I.D. health officers and by Boston University's training program for country health professionals. As an indication of the demand for this manual, printing to fill requests for *EPI Essentials* has exceeded 4,000 copies since August 1988.

REACH I also implemented a number of other technology transfer activities: the manual *The Costing of Health Services Delivery Guidelines* (including spreadsheet software); a computerized EPI information system installed in nine countries (in collaboration with WHO); a standardized methodology for costing EPI; a field-tested disposable syringe and needle to help prevent transmission of hepatitis B and AIDS (in conjunction with WHO); and new methods to track and ascertain why so many children are not immunized on time.

REACH I helped to generate a number of new ideas that led to policy dialogues within countries and among major donors, including a renewed commitment to eliminate neonatal tetanus, the second leading killer of infants among the immunizable diseases. REACH I provided major new concepts in implementing and evaluating such an effort. REACH I also helped to stimulate new thinking about immunizing the growing population of underserved children in urban areas. The project contributed substantially to defining and understanding issues of sustainability pertinent to EPI and health financing. REACH I's work with private voluntary organizations and other private sector groups helped strengthen and broaden the commitment to ministries of health. In addition, REACH I contributed to communication and marketing strategies in several countries, each requiring unique approaches (Bangladesh, Bolivia, Haiti, Indonesia, Kenya).

With regard to the transfer of appropriate technology, REACH I learned that collaboration, coordination, and communication skills are at least as important as the actual technology in improving EPI and HCF within a specific country. REACH I demonstrated the importance of market research in assessing the needs of specific target groups within particular countries or settings, for example, to determine the needs of working mothers, who constituted a third of

the participants in REACH I's anthropological study in Dhaka. Other groups similarly studied were seasonal migrants and illegal residents. The project also noted the importance of assessing and reducing the social distance between health providers and poor mothers. Thus, REACH I effectively reiterated the essential role of anthropology in the process of technology transfer, especially in regard to health interventions.

I.B.2. Effectiveness in Achieving Outputs and Goals

The absence of sufficient epidemiological data constrained the team's ability to evaluate REACH I's impact. Quantified output measurements or criteria would have facilitated assessment of the project; however, such a thorough evaluation of impact would require a much more rigorous scientific and statistically sound research design. Collection of the required data would be a much more expensive (and probably not cost effective) endeavor. The money should presumably be spent on enhanced service delivery. In addition, the fact that REACH I was only one of many agents involved in EPI further complicates any measurement of its effectiveness. An assessment of REACH I's marginal contribution to total EPI efforts worldwide would entail a sophisticated, difficult, and expensive research effort far beyond the scope of this evaluation. The relative success and impact of REACH I is reflected by a general anecdotal affirmation of its contribution; the objective evidence of increased immunization; the very high demand for buy-ins; and the requests for technical assistance, especially relating to HCF.

The effectiveness of REACH I is at least partially attributable to its flexibility and responsiveness regarding HCF. As REACH I unfolded, the demand for HCF soared. In response to mission demand, HCF became an endeavor on the same scale as EPI, and eventually this generated a new project, Health Financing and Sustainability, devoted solely to health financing issues. This phenomenon demonstrates the pragmatism of an A.I.D. policy that espouses programmatic flexibility.

I.C. Constraints

This section examines the constraints encountered by REACH I. Many of the issues discussed below were presented to the team as informed judgements. They are presented here as the team believes that all the comments were made in good faith. Even if not ultimately validated, REACH II, and A.I.D. more generally, need to address the shortcomings.

I.C.1. Assessing Impact

The numeric and objective measurement of a PHC project's impact often suffers from the many exogenous variables found in cooperative projects between multiple donors and host country governments. Direct causality for changes in public health status (in this case, immunization coverage and reducing the incidence of disease) is virtually impossible to attribute to any single intervention. REACH I is subject to the same complicating factors.

Recognizing the limitation of current measurement technology for public health interventions, more measurable goals and objectives are, in the opinion of the evaluation team, essential not only for more efficient project implementation, but also for REACH I to have been fully evaluated. The team recognizes that quantified objectives are not common in the health sector and can, if badly expressed, limit the scope of work. Still, the evaluation team believes that better defined objectives were possible for REACH I and would have facilitated more focused work. One of the ultimate goals of EPI is to reduce morbidity and mortality from the vaccine-preventable diseases (objectives include, for example, introducing new vaccines and promoting other PHC practices). Although success in attaining these objectives can be fairly well measured, the relative or marginal contribution of A.I.D. and REACH I toward achieving them cannot be separated from the other organizations working toward the same ends. Process indicators become important, but these alone cannot document progress in improving maternal and child health. Therefore, selective outputs should be addressed where possible, recognizing the difficulty of measurement inherent in public health interventions.

I.C.2. Determining REACH II's Role

A.I.D. should ask JSI to prepare a position paper to identify expected outcomes in EPI and acute respiratory infections over the life of REACH II and to articulate specific means of measuring those outcomes. This paper need not be much longer than three to five pages and would not replace the terms of the contract. Using such a *Statement of Technical Purpose* of REACH II, A.I.D. could measure its progress during the contract. A draft *Statement of Technical Purpose* should be shared with other organizations active in international health at an early stage of REACH II, for example, A.I.D. regional bureaus and USAID missions, UNICEF, WHO, the Centers for Disease Control, and Rotary International. Each organization can thus have a clear idea of how REACH II work fits in with their program.

Several respondents from other organizations expressed concern about REACH II's role. The team urges that the two recommendations above, measurable indices and a clearly defined *Statement of Technical Purpose*, be given high priority. We believe that this process will go a long way toward resolving some of the coordination difficulties encountered with other organizations during the implementation of REACH I. This process will also facilitate more effective collaboration between donors during the life of REACH II. The *Statement of Technical Purpose* should be reviewed periodically, perhaps annually, and each significant

change should be shared and discussed with other organizations as appropriate. The team believes that this is sufficiently important to be worth the investment of time.

I.C.3. A.I.D. Management

The evaluation process raises several issues regarding changes in the formal review of project implementation. First, the "continuous review process" (contract, page 26) must be strengthened and the mid-term and final reviews reduced in scope. The continuous review process could be greatly strengthened by increasing the ability of the cognizant technical officers (CTOs) to travel to project sites and to interview ministry of health staff. It is difficult to see how a CTO can be expected to manage an international development project effectively without being able to see its progress and results in the field. A basic principle of good management is that the manager should keep in contact with the customer (in this case the ministries of health). This recommendation is further reinforced by the fact that most of the problems seen in REACH I have been in the USAID recipient countries, and not in Washington where the CTO is located. Furthermore, the formal reporting from REACH I to the CTO could have been reduced in volume. Streamlining the information flow with more frequent face-to-face communication would have helped the CTO assess the status of REACH I.

Although A.I.D. relies heavily on contractors to provide the technical expertise needed in development initiatives instead of maintaining adequate technical skills "in house," the agency must still invest the necessary resources to manage such contracts adequately. The management, and more important the leadership, of the contracts is a highly demanding and complex task that should be given to an experienced manager with solid technical expertise. The CTO must also have adequate support. Ideally, the CTO's task should be to lead projects technically without specifying solutions, to support without losing technical control, and to manage without imposing constraints.

I.C.4. Too Many Clients

Many times during this evaluation the team asked REACH I staff, "Who is your primary client?" Rarely did two people give the same answer. The answers varied according to the source: JSI, the CTO, A.I.D. in general, the missions, or the regional bureaus. Rarely did anyone mention the ministries of health. At the operational level, JSI averred its strong commitment to the ideal that its ultimate clients were the children in the developing countries served.

REACH I's own description of its activities (see *REACH I Final Report*, pages 5-12) lists more than 20 different organizations as collaborating organizations, but makes only one reference to a ministry of health (where the local REACH I acts as a liaison between the ministry and Rotary International in the Philippines). Clearly, REACH I staff must work more with local ministry of health officials; indeed, it would be hard for them to avoid working with ministries. The evaluation team observed in both REACH I and in A.I.D. an attitude fostering a diversity of goals at the country level that may not be helpful for improved public health.

The A.I.D. contract for the original REACH I (September 23, 1985) rarely refers to the host governments, and the section on Services to be Provided (page 12) lists nine different clients (one being the A.I.D.-assisted countries). The *Statement of Technical Purpose* described earlier should list the clients in rank order so that project staff, A.I.D., and the other collaborating organizations clearly understand who is being served by the project.

The role of the USAID missions in this area is also sometimes vague. During discussions, it emerged that the USAID missions were often described as a surrogate for the host government. Although the aims of host governments and USAID missions are usually similar in the area of child survival, field missions are not synonymous with host country ministries of health.

I.C.5. Sustainability of REACH I

Two ideas stand out in the EPI part of this review. First, REACH I demonstrated work of exceptional quality when carried out independently of host country agents. The *EPI Essentials* and the study of the costs of 23 national immunization programs serve as good examples. Second, respondents from REACH I believed the project was most effective at clearly defined, short-term interventions (a disease incidence survey, for example, or a cost-effectiveness analysis). Long-term contracts functioned most effectively when conducted by an in-country REACH I staff member who stayed in close contact with the client and the other agencies involved. REACH I was much less successful in attempting long-term development work with short visits. In addition, some respondents reported a concern that REACH I sometimes used insufficiently experienced consultants for short-term visits. This may have contributed to some of the problems found in countries that experienced only a series of short-term visits.

The evaluation team therefore recommends that to effect a long-term impact on a target country, REACH II must provide an in-country resident staff member to manage its activities. Special consideration should be given to employing personnel from developing countries. The evaluation team has one further suggestion.

A.I.D.'s contracting and procurement process is explicitly designed to foster open competition. This competitive environment hinders the implementing contractors' ability to collaborate freely and coordinate their activities unless there is very strong technical leadership from the agency (that is, A.I.D./S&T/H). Therefore, S&T/H must make a greater effort to encourage more collaboration between different central health projects and their prime implementing contractors. However, optimal technical coordination between prime contractors may not be attainable given the extremely competitive procurement process the agency requires.

In contrast, REACH I was not competing with the various sections of A.I.D., other international agencies, and private voluntary organizations. The evaluation team therefore recommends that efforts concentrate on cooperative arrangements with counterpart organizations. To this end, country visits should include a stop-over in relevant host organization offices when possible. In addition, projects such as REACH I must be diligent in copying documents to all relevant parties. The team recognizes the laboriousness of this bureaucratic exercise. Nevertheless, if the agency wants REACH II to be more effective and continue to have an impact in target countries, following these recommendations is essential.

I.C.6. Overextended Staff

Many respondents complained that the unanticipated volume of activities and resultant work loads of REACH I often exceeded the ability of the limited number of project staff. This is not an effective way of working, especially when the work is collaborative in nature. This problem had two causes: first, the turnover of senior personnel in REACH I; and second, the view that REACH I often employed relatively junior staff and trained them on the job. These two issues are discussed below.

I.C.7. Staffing Patterns

Dr. Hirschhorn was the designated leader of REACH I at its inception, but subsequently went overseas. He was replaced for one year by Dr. Russell. Following Dr. Russell, the position was filled by Ms. Hedgecock, who remains as project director for REACH II. This succession of senior directors may have caused some of the coordination problems encountered during implementation. REACH II should try to avoid repeating this pattern.

Concerning the employment of relatively junior staff, if REACH II is to have a good reputation, it must employ adequate mid- to senior-level professionals. Some of the consequences of the employment pattern in REACH I included late production of documents and inadequate support of field staff.

REACH II should continue recruiting to fill its vacant senior positions. It might consider looking more vigorously for people outside the United States, in particular from developing countries.

Those interviewed recognized that REACH I brought a high level of expertise to A.I.D. in the area of EPI. The evaluation team considers it unwise to allow this expertise to be left working without the guidance and experience of outside experts. Many discussions were held on the nature of the old Technical Advisory Group and its replacement, the External Advisory Group. The latter, as a technical review committee, could serve this role, maintaining the high standard that REACH I achieved.

II. Expanded Program on Immunization Activities

This presentation of REACH I's strengths provides positive feedback on the project's work; it also attempts to identify how REACH I's strengths might be applied to other organizations active in immunization.

The shortcomings of REACH I are presented in a cooperative spirit, not to criticize, but to determine how a strong contributor to the global immunization effort could be made even stronger. At the time this review was undertaken, A.I.D. had already competitively awarded the REACH II contract to JSI. Analysis of REACH I's shortcomings hopefully will contribute to the improved effectiveness of REACH II. If both A.I.D. and JSI take heed of the recommendations, the team believes that REACH II will make an even greater contribution to immunization services than REACH I.

REACH I had many strengths in EPI. The best description of the enormous amount of work achieved during the five years of the contract can be found in *Resources for Child Health Project - Final Report* (John Snow, Inc. 1990). The figures are impressive. REACH I:

- collaborated with more than 20 agencies;
- prepared more than 200 technical documents;
- managed ten long-term country interventions;
- carried out 49 country studies in primary health care (including EPI and HCF);
- conducted financial analyses in 20 countries; and
- organized three regional and four international conferences.

REACH I achieved these goals with an average core staff based in Washington, D.C. of 12 people (calculated over five years).

The evaluation team found that REACH I's strengths in EPI included technical competence, JSI's corporate philosophy, responsiveness to host country needs, innovation and adaptability, and funding.

Important lessons learned (as cited by private voluntary organizations in their implementation of REACH I-assisted EPI activities) include the following:

- Supervision and training are the keys to program success.
- Inadequate supervision of transportation vehicles is a major constraint.
- Information gathered must be analyzed to be of use, and it must be shared with the community.
- The community must want the project. Time, money, and manpower must be expended to promote community demand.
- Coordination and collaboration among private voluntary organizations, ministries of health, and USAID missions must be fostered.
- Field personnel should participate in project design.
- Home visiting is the best way to promote immunization.

- EPI projects require clear and attainable objectives and indicators to measure output and/or impact.
- The availability of vaccines at stationary and outreach health facilities is important to sustain high immunization coverage.

II.A. Technical Competence

During the interviews, almost all the respondents gave high praise for the technical competence of REACH I staff in EPI: they were characterized as highly qualified, motivated, and experienced. The team shares this view.

In EPI, four topics stand out as projects of special merit under REACH I. First, the work on urban immunization has been repeatedly mentioned as being at the cutting edge in EPI. No other agency works so effectively in the area. Second, the development of the computerized EPI information system has been a genuinely collaborative effort to produce a global standard for this type of information collection, analysis, and management. Third, the *EPI Essentials* effectively brought senior professionals up to date with EPI policies in the developing countries. Fourth, the combination of EPI with health care financing increased the effectiveness and scope of REACH I.

During the five years of REACH I, much has been learned about EPI costing and financing, and the team hopes that the innovation that characterized this learning process in REACH I will continue in REACH II. The team sees a similar opportunity in REACH II with the combination of EPI and work on combatting acute respiratory infections, and REACH II has an opportunity to lead in this regard. Furthermore, the U.S. government's recent interest in measles control introduces a third dimension to this opportunity.

II.B. REACH Project Management Philosophy

REACH I staff worked very well as a team; this was perhaps one of their greatest strengths. The guidance for this clearly comes from the top, and the evaluation team was impressed by the leadership's productivity.

II.C. Responsiveness to the Countries' Needs

The REACH I team took considerable pride in its ability to react quickly to field requests for technical assistance. This capability was especially valuable in an environment that normally requires more than one clearance at several A.I.D. administrative levels. In one case, REACH I managed to field a specialist within 16 hours of receiving the request from the USAID mission.

REACH I's ability to respond to missions' requests seems to have been almost perfect. No mission request was refused, and only on rare occasions did mission and REACH I staff disagree. However, some disagreement is entirely normal in an area where technical specialists meet generalists in unfamiliar environments. Indeed, a lack of disagreement could be seen as symptomatic of a group that is not innovating. One respondent even characterized REACH I as "a useful irritant."

II.D. Innovation and Adaptability

REACH I excelled in developing new areas of work where, to the team's knowledge, no other organization has worked as effectively. The work in urban immunization services and costing of EPI are examples. Not all the work was successful, but this is to be expected when new topics are being investigated. Moreover, it is one of the major strengths of the design of REACH I that it was allowed to lead thinking in EPI to some new directions. The professionals employed by REACH I and A.I.D. disagree somewhat as to how well these innovations have been managed, but this is less important than the fact that the innovations occurred.

The innovative spirit of REACH I demonstrates that it was an adaptable group that could turn its hand to many activities on short notice. This adaptability is impressive when seen in the context of A.I.D.'s administrative process, which could be viewed as restrictive and limiting, rather than encouraging groups to react quickly and innovative.

II.E. Funding

REACH I was relatively well funded. As a result, REACH I could use its funds more flexibly than some of the larger and slower organizations active in the field of EPI. One country respondent was especially appreciative of REACH I's ability to provide small sums of money on short notice, thus enabling REACH I to address some relatively small obstacles hampering EPI programs when other agencies could not transfer money with such alacrity.

II.F. EPI and Private Voluntary Organizations

A major activity involved working with private voluntary organizations (PVOs). REACH I's strategy for strengthening PVOs emphasized a coordinated effort to provide technical assistance in planning, implementing, and evaluating EPI interventions. Private voluntary organizations have been active in international humanitarian assistance for more than 100 years. In recent years, PVOs and other nongovernmental organizations have emerged as laudable partners in child survival. Since fiscal year (FY) 1985, $87 million in child survival funds have been directed toward PVOs. In FY89, some 73 child survival projects managed by PVOs in 25 countries have received child survival central funds, of which 30 percent were used to support EPI activities. Immunization is often one of the first child survival activities that PVOs implement. The problem areas that PVO field projects faced during implementation were:

- PVOs' lack of basic training and staff development in EPI,
- lack of systems to monitor and supervise program activities,
- absence of epidemiological expertise needed for EPI coverage surveys and program evaluation, and
- professional and technical isolation from recent developments in immunization.

PVOs often act as autonomous institutions that have minimal contacts with the local and national public health system. For example, respondents observed that PVOs often scheduled immunizations differently from the host country ministry of health. Collaboration has been the key to overcoming this adverse autonomy. It takes time for each group to learn to trust and respect each other and share ideas. In addition, any such relationship must transcend the basic differences in philosophies and constraints of the private and public sectors.

To overcome these obstacles to national EPI efforts in recent years, the Bureau for Food for

Peace and Voluntary Assistance, Office of Private Voluntary Cooperation, has hosted coordination meetings to foster collaboration and information exchange in Bolivia, Haiti, Indonesia, and Mali. At these meetings, PVOs and A.I.D. contractors, including REACH I, discussed their activities, sharing problems and accomplishments.

There is a growing realization among health financing experts that while recovering costs for preventive and promotive health services is extremely difficult, communities are more likely to be willing to pay for curative services. Therefore, the PVOs' capacity to raise funds through the provision of simple curative services and drugs can be used to subsidize promotive and preventive activities such as EPI.

II.G. Sustaining EPI Programs

Another important achievement of REACH I has been the work done on sustainability as related to immunization. These efforts produced a number of important financial, economic, and methodological findings.

- Sustainability is beyond the scope of many countries for a variety of financial and economic reasons.
- For many countries, the resources needed to immunize 80 percent of the projected 1990 target population would take decades to accrue, even using high economic growth estimates.
- The average cost to fully immunize one child is $13.00 to $15.00 (based on 11 cost estimates from a number of countries).

These studies have been instrumental in alerting the donor community to the fact that to be cost effective, financing strategies for a single health service such as immunization cannot be developed in isolation from the financing and service delivery structure of the total health system. Furthermore, the studies show that some countries simply will not be able to take any health financing initiative to make immunization services sustainable through local resources, except in the very long run.

III. Health Care Financing Activities

REACH I became A.I.D.'s vehicle to provide technical assistance in health care financing to all A.I.D.-assisted countries. When REACH I began, health care financing was regarded as one of the systems support activities in the contract, along with management, personnel training and development, and design and evaluation. As REACH I evolved, however, HCF dwarfed all the other systems support activities. HCF even began to rival EPI activities as one of the priority interventions under REACH I. As of August 31, 1990, REACH I had committed $5.1 million and 635 person-months of effort toward direct support of HCF, while EPI activities accounted for about $6.5 million in obligations, and its level of effort totalled a comparable 637 person-months.

The REACH I contract was very vague as to the specific HCF requirements that the contractor would be asked to fulfill. Besides stating that "financing shall be an area of particular emphasis for this contract and therefore shall be approached somewhat differently," the contract called for REACH I to move beyond simple analysis and "recommend action-oriented interventions, designed to help government and private organizations in developing countries improve their policies, management, and skills related to health care financing." Measured against this statement, REACH I was clearly successful.

III.A. Definition of a HCF Strategy

The initial project design defined HCF activities only in general terms. Meanwhile, missions placed a wide variety of requests ranging from help with accounting, social insurance schemes, user fees, health maintenance organizations, hospitals, and primary care expenditures to systemwide reform. The evaluation team feels that REACH I was generally successful in supporting A.I.D.'s broad objectives, while making significant specific changes in the field of health financing in developing countries. These successes were achieved despite wide ranging philosophical, managerial, and technical difficulties encountered throughout the life of REACH I.

The HCF activities REACH I pursued were at times criticized for their wide diversity: REACH I lacked an overall strategy for technical assistance in HCF. The *Mid-Term Evaluation* (November 1988) called for a more clearly defined HCF strategy in order to have an impact beyond the specific pieces of technical assistance provided. It further concluded that REACH I should have been providing greater leadership by clearly stating its HCF strategy, in simple terms, to its clients.

The final evaluation team feels that, for a variety of reasons, REACH I never had much of a chance to develop a HCF strategy for its technical activities. Moreover, such a strategy may have proven unnecessarily confining and rigid, as explained below.

III.A.1. Policy

Only since 1986 has the agency specifically recognized health financing as an activity supported by A.I.D. that may affect child survival, as set down in the *A.I.D. Policy Paper* of December 1986. That paper listed policy dialogue, design and implementation of health projects, and special health financing initiatives as mechanisms for supporting the development of sustainable health care systems. Such a broad policy obviously leaves open the possibility of a variety of types of technical assistance.

III.A.2. Health Financing Guidelines

Also published in 1986, A.I.D.'s *Health Financing Guidelines* called for the same three mechanisms to support the development of sustainable health programs. In particular, *Guidelines* called on A.I.D. to "take the lead, where possible and appropriate, in stimulating a policy dialogue with host-country decision makers on issues of health care financing."

The evaluation team made several observations on REACH I's efforts to establish general health financing guidelines.

- **Contractor Expertise**. The evaluation team is not convinced that REACH I staff possessed sufficient HCF technical experience in developing country environments during the early years of REACH I to prepare a proper "strategy." At that time very few HCF specialists were available to A.I.D. Because the initial REACH I contract gave so little weight to HCF, the JSI-led group proposed few HCF technicians.
- **Tendency Toward Regional Strategies**. As REACH I evolved and began to develop a strong cadre of HCF specialists capable of working in various countries, A.I.D.'s regional bureaus began to develop their own regional HCF strategies. In particular, the Bureau for Latin America and the Caribbean designed its own HCF project, the Bureau for Asia/Near East began to address the issue separately, and the Africa Bureau dealt with HCF activities largely under the auspice of its African Child Survival Initiative/Combatting Communicable Childhood Diseases Project. These regional efforts, to some extent, obviated the need for a more global approach.
- **Flexibility**. The evaluation team believes that one of the true strengths of REACH I was its inherent flexibility in dealing with an enormous variety of HCF activities. This flexibility was vital, as the area of HCF was ill-defined when REACH I commenced. The broad strategic framework offered in the *Health Assistance Policy Paper* and the *Health Financing Guidelines* was generally sufficient. The lack of a specific strategy in HCF highlights a dichotomy that continued throughout REACH I. The fact that the global EPI had a well-defined strategy defined by WHO, while HCF lacked such an explicit strategy, indicates the relative maturity of each field more than anything else.
- **Contract Structure**. REACH I, and particularly its HCF component, was very demand-driven through the buy-in mechanism. The extent to which a project such as REACH I can have a true strategy is very debatable, given its mandate to be responsive to mission exigencies.

III.B. Results and Impact of REACH I's HCF Activities

The *Mid-Term Evaluation* concluded that there was a "great need for a more refined Health Care Financing Strategy on the part of both A.I.D. and REACH I giving greater priority to developing promising interventions for revenue generation." The evaluation team believes that updating and further refinement of A.I.D.'s HCF strategy would be useful, as A.I.D.'s *Health Financing Guidelines* (1986) represent no more than a broad framework under which the agency could address any type of HCF issue. Given such circumstances, the team recommends

that S&T/H, by means of its Health Financing and Sustainabililty Project, remain as flexible as possible in its approach to HCF.

During its five years, REACH I undertook 98 country-specific health financing activities in 37 countries in the Asia/Near East, Africa, and Latin America and the Caribbean regions, and an additional 36 non-country-specific developmental activities. While this diversity may have drawn criticism, the team feels that by concentrating excessively on any one theme--cost recovery, for example--a project and the donor agency run the risk of being perceived as mono-focused, a perception likely to hinder future interventions of different types.

The evaluation team concludes, as REACH I did in its own *Final Report*, that: "Almost every strategy works somewhere under some set of circumstances. Alternatively, specific financing schemes that are successful in one country are not necessarily successful in another. What is important now is to understand better what the conditions are for success of alternative strategies in different country circumstances."

As a significant achievement, REACH I successfully articulated four principal issues in health care financing. All other aspects of HCF fall under one or more of these categories:

- resource mobilization,
- resource allocation,
- efficiency of production, and
- equity.

The final evaluation was not intended to measure REACH I's country-level impact in either EPI or HCF. However, impact is important for conceptual understanding of a rapidly evolving subject area. The evaluation team arrived at the following conclusions and observations based on a review of voluminous amounts of documentation and analysis.

- **Cost Effectiveness**. REACH I promoted a widespread knowledge of the issues and policy options pertinent to health care financing. Two examples are the three-year longitudinal study of the cost effectiveness of alternative ways to control polio in India and the publication of the *Cost of EPI* studies.
- **Policy Reform**. The shift from addressing single financing or project issues to consideration of sectorwide health policy reform marks one of REACH I's major contributions to the practice of health financing in developing countries.
- **Cost Recovery and User Fees**. The REACH I approach to cost recovery was generally appropriate, given the widespread and increased interest in cost recovery during the past five years. REACH I conducted numerous studies and analyses of cost recovery proposals and user fee schemes; a more pro-active approach would likely have proven detrimental.
- **Equity**. REACH I did not neglect equity considerations in its analyses, although it was never a specific focus of its work. For example, in Kenya REACH I assisted in the design of a fee waiver policy to ensure that newly instituted user fees would not adversely affect the ability of the poor to receive needed health benefits.

- **Efficiency and Cost Containment.** REACH I conducted various hospital cost studies that addressed efficiency. While these studies did not specifically address primary health care issues such as EPI, such studies can prove very useful in addressing the frequent imbalance between curative and preventive care.
- **Public and Private Sector Roles.** Under REACH I, few efforts specifically addressed the private sector provision of health services. Rather, REACH I succeeded in addressing the issue by means of privatization studies. Also, REACH I did not neglect to identify other possible private sector interventions besides health service delivery.

III.C. Sustainability

REACH I was designed in response to increasing demand for EPI activities within the agency's growing child survival portfolio, while the Health Financing and Sustainability Project evolved from REACH I as a direct result of the booming demand for technical assistance in HCF. Each project was an appropriate response to a specific need.

The Health Financing and Sustainability Project explicitly recognizes the importance of sustainability at a time of growing agency concern for sustainable development. The initial contract for REACH I, however, never raised the issue of sustainability. It was not until late 1986 that A.I.D. demonstrated concern about the sustainability of health programs and projects. At that time, the Center for Development Information and Evaluation began a series of ground breaking studies of the sustainability of health benefits. The sustainability concept quickly became integrated into the rubric of health care financing, probably out of the simplistic tendency to associate project sustainability with the capability of the host government or implementing body to meet the recurrent costs of a project after the donor funding ceases.

Notwithstanding this narrow view of sustainability, REACH I did a good job of broadening the definition. As REACH I points out: "One type of sustainability refers to the continued production of services (or activities) originally supported as part of the project [REACH I]" (*How Important is Sustainability*, February 1988). This definition represents a narrow approach to assess the ability to meet recurrent costs. The paper goes on to state that "an alternative interpretation of sustainability focuses on the outcomes of the project [REACH I] rather than on its activities." As such, one would look to see, for example, if higher rates of immunization coverage continue after a project terminates, regardless of financial inputs.

The Center for Development Information and Evaluation, in an unrelated study, found the following six project characteristics to be most closely related to sustainability in general (*A.I.D. Evaluation News*, July-August 1990):

- a project's perceived effectiveness,
- the extent to which activities were integrated into existing institutional hierarchies,
- community participation,
- financing through government budget sources and cost recovery mechanisms,
- inclusion of training components as project activities, and
- a mutually respectful project negotiation process between A.I.D. and host countries.

A clear majority of those interviewed during the evaluation thought that REACH I inputs in HCF were effective in many ways, particularly in raising awareness of the complexity of financing issues. The team believes REACH I became increasingly adept at integrating local technicians into HCF activities, with Kenya being the prime example. Generally perceived as above average, the quality varied among REACH's HCF efforts, which included technical assistance activities in revenue generation, resource allocation, efficiency, privatization, and sustainability.

Perhaps the most important lesson learned from REACH I in the area of HCF was that to achieve success in any country, project interventions have to address issues in which the host country has a strong interest. The successful REACH I interventions were those that analyzed and addressed issues that were presented by host governments and missions. Once given this opportunity, REACH I was generally adept at broadening the focus to address other financial constraints to improved health care, as well as working in a collaborative manner in the host country.

As part of sustainability, REACH I addressed issues of institutional strengthening. REACH I helped to raise awareness and foster a national commitment to improved HCF in many countries: much of the technical assistance included informal training of counterparts. REACH I efforts generally succeeded in addressing the need to develop a strong infrastructure (both skills and capital that will facilitate the long-term sustainability of a project's activities and benefits). REACH I, however, did very little to improve institutional strength through formal technical training. Such efforts, which can be useful to reinforce sustainabilty, were not a part of REACH I.

III.D. Response to Field Demand for Services

The demand for technical assistance in HCF through REACH I was enormous. As already mentioned, the initial contract viewed HCF simply as a systems support activity for EPI. However, during the life of REACH I, levels of effort for EPI and HCF activities became virtually identical. The evaluation team consistently heard variations of the comment that the Health Services Division was surprised at the unanticipated demand for assistance in HCF. (This strong demand for HCF activities is being seen, once again, in the Health Financing and Sustainability Project.)

REACH I had mixed results in satisfying mission demands for technical assistance in health care financing. Early in REACH I a variety of difficulties arose that, in many ways, reflected the state of the field in international health financing in general, and A.I.D.'s lack of expertise in particular.

- The supply of available personnel was far short of the strong demand for HCF assistance.
- JSI had virtually no experience in providing international technical assistance in health care financing.
- A.I.D. provided very little technical direction to REACH I, particularly in HCF.
- The cognizant technical officers for REACH I changed frequently.
- The personnel REACH I provided were sometimes viewed as junior or too inexperienced.

As REACH I progressed, a core of HCF personnel began to emerge. JSI consolidated its

subcontractor relationships and began to increase its own technical staff. Thus, by mid-term in 1988, the external evaluation team concluded that "REACH I with S&T/Health encouragement has been extremely responsive to mission requests." The final two years of REACH I demonstrated further success in HCF.

III.E. Coordination with Other Organizations Active in HCF

In contrast to EPI, REACH I had little need to coordinate its early HCF activities with other donors. Because HCF was in its nascent stage, A.I.D. had a more open field. As REACH I evolved, its staff developed a solid relationship with the Economic Development Institute, the training section of the World Bank, which used a number of the microeconomic tools of analysis employed by REACH I, such as cross-price elasticities.

III.F. Role and Contribution of the Technical Advisory Group

The Technical Advisory Group (TAG) met only twice during REACH I: first in early 1986 after REACH I had just begun, and again in November 1987. The consensus among A.I.D. staff and REACH I personnel was that the TAG was of minimal use in both EPI and HCF. The evaluation team concurs with the *Mid-Term Evaluation* that the "concept of the TAG for a health finance project would make more sense if it were more of a paid 'Technical Board of Directors' that met once or twice a year for working meetings in which REACH I's main strategic decisions would not be discussed." This could be complemented by regular communication during the remainder of the year.

The other major purpose of the TAG was to communicate to all interested parties the general goals, objectives, and strategies to be pursued by the project. This could be better accomplished by convening annual half-day meetings for larger audiences. Participants would include A.I.D. staff from the technical offices of the regional bureaus, personnel from the Bureau for Program and Policy Coordination and the Bureau for Food and Voluntary Assistance, contractor staff, and personnel from other interested parties and agencies.

III.G. Dissemination of REACH I HCF Activities

The *Mid-Term Evaluation* concluded that information dissemination was a "gap in the REACH I approach." S&T/H and REACH I were both considered responsible for this gap. The team went on to conclude that dissemination of lessons learned in an easily understood form for mission and country policymakers, health administrators, and the academic community could be an important device for extending the understanding of health financing issues.

A.I.D.'s Health Services Division in the Office of Health, Bureau for Science and Technology (S&T/H/HSD) apparently succeeded in prompting REACH I to produce a number of useful final synthesis reports that should prove usable by USAID health, population, and nutrition officers, as well as a broad cross-section of technicians interested in health financing. The more generic document is *Health Financing Activities That Support Policy Reform: The A.I.D. Mission Experience* (Leighton 1990). This publication should prove especially useful, particularly to new health, population, and nutrition officers with little expertise in HCF. The report

- provides a field perspective on current issues and the state-of-the-art in health financing;
- identifies lessons learned through USAID mission experience with health financing policy reform during the 1980s;

- provides the USAID missions' view of factors that have affected their role in health financing and of policy reform by ministries of health; and
- identifies global and regional patterns, as well as country examples, of changes that have taken place in HCF during the past five years.

A second document produced, *How to Estimate Incremental Resource Requirements and Costs of Alternative Immunization Strategies, A Manual for Health and Program Managers* (Brenzel and Foulon 1989), is a more technical document that could prove very useful in ascertaining the additional costs of tetanus toxoid immunization programs above and beyond the costs for routine immunization of infants and children.

Other recently published REACH I documents that should prove useful on a continuing basis include the following:

- **Health Care Financing Annotated Reports.** A compendium of papers, reports, technical notes, and special publications that provides a valuable summary of most of A.I.D.'s HCF work from 1985 to 1990.
- **Toward Ensuring the Financial Sustainability of EPI.** Prepared for the WHO Global Advisory Group on EPI, this discussion paper should prove particularly useful in explaining the concept of financial sustainability to a broad international audience.
- **Technical Assessment Report: Lessons Learned on Cost and Financing of EPI.** This technical paper describes the extent of knowledge of EPI costs prior to the inception of REACH I, summarizes the lessons learned from REACH I studies, and discusses the financial sustainability of immunization programs. It is generally "user friendly" and descriptive.
- **The Costs of EPI.** REACH I conducted a three-part series of studies for the Bureau for Program and Policy Coordination: *The Costs of EPI: A Review of Cost and Cost Effectiveness Studies (1979-1987), The Economic Burden of Sustainable EPI: Implications for Donor Policy,* and *Immunization Sustainabilty Study.* Designed particularly for HCF policymakers, these three publications developed a policy framework within which relationships, targets, program strategies, costs, financing, and coverage levels can be examined.

IV. Management and Administration

Management and administration are two aspects of REACH I experience that affected how REACH I's work was accomplished and the degree to which REACH I attained its objectives. To examine these two features of REACH I, the evaluation team focused on

- the management structures that were necessitated by the financial foundations of REACH I (that is, a combination of buy-ins and core funding);
- the influence of A.I.D.'s own administrative environment; and
- the management approach adopted by JSI, the prime contractor.

IV.A. Financial Premises

REACH I was designed so that approximately 40 percent of the total budget would be financed through mission or regional bureau buy-ins. Such a financial premise required REACH I to be responsive to mission- or regional bureau-defined priorities in both EPI and HCF. Without sufficient responsiveness or sensitivity to missions and regional bureaus, the buy-ins simply would not have materialized. In addition, to accomplish all the objectives envisioned during the design, REACH I had to attract and execute successfully a full complement of buy-ins.

The buy-in funding mechanism had a marked effect on the entire course of REACH I management. It produced a situation of too many clients and task masters, a characteristic that complicates the administration of any activity. Similarly, project management had to be sufficiently flexible to accommodate the different interests of all the field mission or regional bureau clients. Managerial pressure to accommodate this broad spectrum of clients was compounded by the need to make progress in attaining specific objectives.

IV.B. The Administrative Environment Within A.I.D.

The administrative and managerial issues encountered during the implementation of the REACH I project required special attention during the course of the evaluation. The evaluation team hopes that the lessons learned from the REACH I experience will contribute to greater managerial efficiency in future A.I.D. endeavors.

IV.B.1. Missions and Regional Bureaus

Because REACH I depended significantly upon buy-ins, the administrative importance of field missions and regional bureaus within A.I.D. was a critical factor in project implementation. Regional bureaus and their constituent missions had considerable influence on the buy-in process. Those activities funded by buy-ins would address EPI or HCF tasks as defined by themselves or the missions. In effect, the missions and regional bureaus assumed leadership in identifying and defining the technical issues and approaches they wanted pursued in these buy-in activities.

From those interviewed who represented missions and regional bureaus, it is clear that one administrative imperative was to make REACH I a mechanism that would help missions further their own EPI and HCF initiatives. Toward this end, they perceived REACH I as a tool to obtain the technical ingredients deemed necessary for EPI or HCF programs. The resulting managerial priority in each region was to try to ensure that REACH I activities were specifically tailored to the needs of each country. This tendency exerted pressures on REACH

I to be very country-relevant in its implementation.

Those interviewed generally credited REACH I with successful implementation of activities that were relevant to each countries' needs. Universally, regional bureaus and mission staff noted that REACH I served a useful function in delivering technical support to missions, which most admitted was intimately related to the buy-in process. In a few instances, however, specific missions or regional bureaus would have liked REACH I to accept bigger or more buy-ins, or move more quickly in an existing buy-in than actually occurred. Most of these instances seem to have arisen later in REACH I's life when the amount of buy-ins was already high and the contract was approaching its maximum budgetary limits.

Another characteristic of the regional bureaus and missions was their lack of agreement on technical emphases and priorities, particularly in the HCF area. For example, the Latin America and Caribbean Bureau already had its own health financing project, and the Asia/Near East Bureau possessed a very distinct philosophical orientation that emphasized a particular HCF approach for the private sector. Responsiveness, therefore, also meant accommodating a variety of technical approaches and differing technical opinions. Through the buy-in process, different mission or bureau clients could determine the technical parameters for discrete REACH I activities.

IV.B.2. The Science and Technology (S&T) Bureau

Aside from administering the core S&T funding for REACH I, the S&T Office of Health was also the source of overall technical management for REACH I. In a project with many regional bureaus and missions determining the nature of buy-ins, overall technical management and leadership became a critical issue. This managerial role was greatly complicated by the structure of REACH I itself, the limited financial resources for project management, and frequent management turnover.

Since REACH I combined both EPI and HCF as substantive areas of project activity, the technical management of REACH I required accommodating widely disparate and often unrelated technical disciplines. The placement of these two very different subjects within a single project seems to have been the result of a project design that anticipated minor attention to HCF within the rubric of systems support. Such a decision eventually complicated the ability of any one CTO to provide credible technical leadership for such a diverse array of technical specialties. Furthermore, S&T/H possessed few in-house staff with HCF expertise during the course of most of REACH I's implementation.

The lack of definitive priorities for HCF interventions by S&T/H was seen by some to be a serious management problem of REACH I. On the other hand, this situation was viewed by others as one of the project's inherent strengths. The fact that the REACH project had no definitive priorities in HCF meant that there was flexibility to respond to a very wide variety of requests in the field. Consequently, REACH was able to pursue a varied menu of efforts in HCF. Furthermore, the resulting uncertainty of direction in HCF meant that the management of that portion of REACH I had to evolve to meet mission interests and demands. This required a flexible administrative style, something that initially proved difficult for REACH management.

Those interviewed by the evaluation team also consistently pointed out that the reporting and documentation expected under the REACH I contract was excessive. Monthly progress reports, for example, coupled with other required documentation, significantly increased the management burden of S&T/H personnel. The evaluation team found that this heavy volume

of reporting and documentation did not significantly improve S&T/H's ability to monitor and understand the course of implementation. Biannual or even annual progress reporting would have been sufficient.

As noted above, the wide range of disparate technical activities of REACH I, coupled with the variety of field buy-ins, increased the complexity and variety of project activities. Difficulties in coordination with other donors active in EPI also demanded direct attention by the CTOs. However, limited operational expense budgets required S&T/H to severely restrict CTOs travel to REACH I field sites. Without being able to travel, the CTOs' management of project activities was restricted largely to the secondary level, relying on the "go-betweens" of mission staff, or even the primary contractor's staff, to assess implementation direction and conditions. The inability to travel, the evaluation team believes, represents a continuing serious constraint to effective technical management of any centrally funded project.

During REACH I's five-year life, S&T/H reassigned CTO responsibility on nine different occasions, using a total of eight different individuals. This changing parade of CTOs represented a major management problem for REACH I. First, the rapid changeover of CTO personnel resulted in a loss of leadership continuity. Each new CTO required time to become familiar with the nature and purpose of REACH I before being able to provide technical or administrative leadership. Most CTOs moved on before they gained that familiarity. As a result, there was no consistent technical leadership for REACH I coming from S&T/H. The prime contractor was thereby forced to step in and provide part of that function. Such a substitution, however, can never be completely satisfactory, and it created problems for REACH I. Certainly the complications encountered with donor coordination in particular may have been resolved had there been more continuity in CTO leadership.

IV.C. REACH's Managerial Approach

Efficient, effective management is required to ensure the flexibility, responsiveness, and change characteristic of successful programming. Without the continuity of a CTO, the risk of project failure increases dramatically. REACH I succeeded largely because of the aptitude of the technical specialists and dedicated work of the CTOs.

IV.C.1. Setting Direction and Technical Standards

Given many of the factors affecting project implementation described above, REACH concluded that it must assume the initiative to set technical standards in project implementation. Respondents consistently characterized these technical standards as being high. The contractor's managerial approach stressed technical quality. At the same time, REACH understood that it needed to be responsive to mission and regional bureau buy-ins and, as a result, that administrative flexibility was necessary to accommodate requests for a variety of technical assistance (particularly in the area of HCF). The management structure the contractor instituted was very successful in accomplishing both high quality technical work and administrative flexibility.

The lack of consistent technical leadership caused by the rapid changeover of CTOs also forced the contractor to assume a much greater role in recommending and adopting technical priorities and direction for REACH I. This self-direction was more consistent in EPI than HCF, which was driven by the priorities of missions and regional bureaus via the buy-in process. Such a management posture also contributed to the difficulty in implementing the mid-term evaluation's recommendation to develop a more "coherent health care financing strategy."

IV.C.2. Significant Reliance on Less Experienced Staff

Several individuals interviewed commented that REACH I relied significantly on younger staff who were still acquiring experience in their respective fields of expertise. Such a staffing pattern normally requires increased technical oversight by senior staff. Even with this need increased oversight, REACH I used few senior, full-time, technical staff. It is laudable that REACH I nevertheless managed to maintain generally high technical standards; however, in a few instances the presence of additional, more experienced technicians on staff would have improved implementation, or at least expedited implementation.

IV.C.3. Coordination Weaknesses

Many of those interviewed remarked that REACH I experienced difficulties coordinating its activities with other organizations and projects operating in the field of international public health generally, and immunization specifically. Although, as noted above, several structural factors contributed to the coordination difficulty, one seems to have been the administrative style or organizational "personality" of the REACH I office. The initiative the contractor displayed in trying to respond quickly to HCF or EPI needs and to set its own high technical standards was perceived by some in other organizations as being too "aggressive." Interviewees characterized this aggressiveness as a tendency to identify and pursue technical issues in EPI and HCF independent of other actors in the international public health arena.

Another common complaint from those interviewed in other organizations was that they had little, if any, idea about what REACH I was doing during most of its life. This complaint is illustrative of REACH I's difficulty in establishing and maintaining contacts with complementary agencies in the health field. More purposeful face-to-face meetings on a regular basis might have helped to alleviate this problem, particularly with UNICEF and WHO. However, even the dissemination of copious amounts of written reports did not effectively inform these international agencies. Some REACH I staff interviewed did not see coordination with WHO or UNICEF as a major role of the prime contractor. These individuals claimed that A.I.D. had consistently noted that donor coordination was to be the agency's responsibility.

IV.C.4. A.I.D. as Client

A factor contributing to REACH implementation style that made external coordination difficult was that JSI wanted to please its client, A.I.D. Project staff commonly considered each buy-in as having a distinct and separate client. Some bureaus in A.I.D./Washington (such as the FVA/PVC Bureau) also became different clients. Of course, S&T/H was always a major client.

Pleasing the client is an expected motivation in project implementation. However, with so many clients, REACH I staff had some difficulty in satisfying all to the same degree. Meanwhile, the different A.I.D. clients had different ideas about prioritizing technical issues and REACH I activities. REACH I staff felt they had to choose among these at times, without consistent direction from A.I.D. as to which client took priority. Part of the problem of multiple clients stems from the nature of the buy-in process within REACH I and from the problem of multiple CTOs. However, greater clarity about client ranking would have been possible if project technical directors had had a greater understanding of A.I.D. as an organization.

IV.D. Functions of the Technical Advisory Group

Drawing from the design of REACH I and interviews with S&T/H staff, the TAG was apparently envisioned originally as playing both a coordination role (by involving representatives from other donor organizations) and a technical guidance role (by including leading experts in pertinent fields.) In practice, the TAG did neither very well. The TAG only met twice during the course of project implementation. Both meetings consumed considerable amounts of project staff time and solved none of the technical leadership or coordination problems that troubled REACH I. For REACH I at least, the TAG was a management burden that failed to produce any of its expected benefits.

CONCLUSIONS AND RECOMMENDATIONS

The conclusions and recommendations of the evaluation team reinforce most observations made earlier by the *Mid-Term Evaluation* (November 1988) of REACH I. A.I.D. made the transition from REACH I to REACH II by including acute respiratory infections and health care financing(HCF) initiatives in the project design, while increasing the emphasis upon sustainability and private sector involvement.

There is no need to doubt the importance of HCF, originally a smaller component in the design of REACH I. The S&T/H approach established a centrally funded HCF activity with a liberal buy-in authority by the USAID missions and unexpectedly found a bull market. The resulting Health Financing and Sustainability Project continues to experience this high level of demand.

The evaluation team concludes that while the flexibility evident in REACH I might have caused anxiety on the part of some program managers and contractors, nonetheless, it was the secret of REACH I's success. Development is a dynamic and evolutionary process; should A.I.D.'s programming not reflect this? Our primary recommendation to A.I.D. is:

Continue the flexible programming approach evident in REACH I. If flexibility and evolutionary change are to be characteristic of successful programming, then strong, effective, and efficient management is required. Indeed, strong leadership is desirable. During REACH I's tenure, nine CTOs administered REACH I; hardly evidence of continuity and efficient management. Though certainly most of the individual CTOs were capable persons (as is the case with the last CTO), such a rapid turnover serves to undermine contractor performance. REACH I was very successful. Nevertheless, the evaluation team believes the lack of CTO leadership and stability inhibited what could have been an even higher degree of success.

We also recommend that:

1. A.I.D. should require strong leadership by the CTO, who should possess the requisite technical and managerial skills.

2. Enhance and continue collaboration among the agents involved in REACH II and the Health Financing and Sustainability Project. This calls upon the CTOs to demonstrate involved leadership.

3. Provide CTOs with adequate support staff so they can execute their leadership role. Adequate support staff would help alleviate CTO "burn out" because of demands on them to perform administrative, nonmanagerial tasks.

4. Provide CTOs with a travel budget adequate to ensure effective execution of their leadership role, especially with regard to enhancing collaboration with USAID missions, WHO, UNICEF, and other organizations, and program efficiency. The agency should evaluate how this responsibility can be fullfilled.

5. Mitigate the heavy paper flow presently characteristic of the operation. S&T/H should ascertain if there is redundancy in the documentation and other management procedures required for effective and responsible management.

6. The Office of Health should continue organizing regular seminars on a variety of topics related to health care financing to strengthen the capacity of non-economist CTOs and other

A.I.D. professionals working in the health sector. (This activity recently commenced under the auspices of the Health Financing and Sustainability Project.)

7. Introduce a mechanism to bring expert advice to A.I.D. in a responsive, specific, and timely manner. The present TAG mechanism is too costly and time consuming, and of questionable effectiveness. The TAG should be replaced by a smaller, truly technical advisory group. A coordinating meeting should be instituted periodically to advise, share information, and review progress. Regional bureaus, international agencies, and contractors (among others) should attend.

8. Provide adequate funding for applied research and core functions that are essential to progress and improved programming. The evaluation team perceived the inherent conflict resulting from centrally funded projects driven by USAID mission buy-ins. Necessarily, the USAID missions usually have different priorities than S&T/H, thus such projects must have adequate central funds to accomplish the range of outcomes desired.

9. Encourage contractors to pursue some high risk activities (for example, health care financing, acute respiratory infections) to ensure innovation. This means there must be some tolerance for "failure." Many problems exist for which no "solution" is currently available.

The evaluation team was cognizant of the increasing importance of sustainability as an essential doctrine of A.I.D. philosophy. REACH I's experience provided some valuable lessons in this regard, prompting the following recommendations:

a. A.I.D. must recognize that HCF is only one component of the sustainability of health programs.

b. As such, each project should have a more clearly defined list of objectives that are realistic in terms of sustainability.

c. Sustainability requires an adequate infrastructure, a receptive framework, and trained staff. There must be more emphasis upon training, including HCF and primary health care skills.

d. The Office of Health should consistently demand that HCF activities be integrated into the existing administrative structure of a host country institution to ensure incorporation of HCF activities into host government management. The host country should continue to use local technicians as a key component of HCF.

List of People Interviewed

A.I.D/Washington and Former A.I.D Staff

Susan Abramson	Former REACH I CTO Health Services Division Office of Health Bureau for Science and Technology
Kenneth Bart	Former Director Office of Health Bureau for Science and Technology Currently: Director of National Vaccine Program Office & Deputy Director of National Vaccine Program Office of International Health Health and Human Services
Robert Clay	Chief Health Services Division Office of Health Bureau for Science and Technology
Stephen A. Dean	Contracting Officer Health, Population Office of Procurement Bureau for Management Services
Robert Emery	CTO Health Financing and Sustainability Project Health Services Division Office of Health Bureau for Science and Technology
Allen Fairbank	Former Deputy Project Director REACH Project, Health Care Financing Currently: Health Economist Congressional Budget Office
Holly Ann Fluty	CTO REACH Health Services Division Office of Health Bureau for Science and Technology

Lois Godiksen	Social Science Analyst Bureau for Program and Policy Coordination Center for Development Information and Evaluation
James Heiby	CTO PRICOR, ARCS Project Applied Research Division Office of Health Bureau for Science and Technology
Charles Johnson	Retired Chief Health, Population and Nutrition Division Office of Technical Resources Bureau for Asia/Near East Currently: Senior Associate, International Science and Technology Institute
Pamela Johnson	Chief Applied Research Division Office of Health Bureau for Science and Technology
Michael Jordan	Chief Health, Population and Nutrition Division Office of Technical Resources Bureau for Asia/Private Enterprise
Linda Lankeneau	Former Health, Population, Nutrition Officer USAID/Kenya Currently: Health, Population, Nutrition Officer Health, Population and Nutrition Division Office of Technical Resources Bureau for Africa USAID/Senegal
John McEnany	Chief Child Survival and Health Division Office of Private Voluntary Cooperation Bureau For Food For Peace and Voluntary Assistance
Gary Merritt	Chief Health, Population and Nutrition Division Office of Technical Resources Bureau for Africa
Jeremiah Norris	Acting Chief Health, Population and Nutrition Division Office of Technical Resources Bureau for Europe and Near East

Nancy Pielemeier	Former Senior Health Policy Advisor Bureau for Program and Policy Coordination Currently: Acting Deputy Director Office of Health Bureau for Science and Technology
Allen Randlov	Former REACH I CTO Office of Health Bureau for Science and Technology
James Shepperd	Deputy Chief Health, Population and Nutrition Division Office of Technical Resources Bureau for Africa
Nicholas Studzinski	Former Health and Population Development Officer Health, Population and Nutrition Division Office of Technical Resources Bureau for Asia/Near East Currently: Health and Population Development Officer Health, Population and Nutrition Division Office of Development Resources Bureau for Latin America and the Caribbean
John Thomas	Former Health, Population, and Nutrition Officer Health, Population and Nutrition Division Office of Development Resources Bureau for Latin America and the Caribbean Currently: Health Development Officer USAID/Dominican Republic
Anne Tinker	Former Chief Health Services Division Office of Health, Bureau for Science and Technology Currently: Health Specialist, The World Bank
Ann Van Dusen	Acting Director Office of Health Bureau for Science and Technology
John Wiles	Former Health, Population, and Nutrition Officer USAID/Sanaa, Yemen Currently: Health, Population and Nutrition Division Office of Technical Resources Bureau for Africa

Others

Barton Burkhalter	Former Director Center for International Health Information Currently: Director Food and Nutrition Monitoring Project International Institute for Science and Technology
David Dunlop	Health Economist World Bank
Joel Lamstein	President John Snow, Incorporated
Maureen Lewis	Former Health Economist Urban Institute Currently: Health Financing Consultant World Bank
Marty Makinen	Director Health Financing and Sustainability Project Abt Associates
David Nicholas	Director PRICOR Project University Research Corporation
Mark Rasmusson	Director HealthCom Project Academy for Educational Development
Robert Simpson	Acting Director PRITECH Project Management Sciences for Health
Ciro de Quadros	Regional Advisor Expanded Programme on Immunization Pan-American Health Organization

People Contacted by Telephone

Dr. L. Arevshatian	WHO African Regional Office
Dr. I. Mochni	WHO Office for South East Asia
Dr. H. Mehta	WHO Regional Office for the Western Pacific
Mr. A. Schnur	WHO Regional Office for the Western Pacific
Mr. A. Creese	WHO Geneva
Dr. T. Hill	UNICEF New York
Ms. C. Chan	WHO Geneva
Dr. S. Foster	U.S. Centers for Disease Control, Atlanta
Mr. P. Evans	UNICEF and WHO Geneva
Mr. K. Olivola	Urban immunization consultant
Dr. F. Gasse	WHO Geneva

Evaluation Scope of Work

Objectives of the Evaluation

When designing a project, there are anticipated outcomes that the activities will produce. One identifies the factors that need to be understood for the expected accomplishments/outcomes to occur, thus mandating the results for which the project is responsible/ accountable.

Despite an emphasis on a specific contract, a final evaluation should have applications beyond that of lessons learned from a defined set of activities. It is anticipated that findings from the REACH I final evaluation will provide an accumulating, increasingly accurate body of evidence on A.I.D.-assisted:

1. immunization programs,
2. health financing activities,
3. health development interventions, and
4. centrally-managed, worldwide technical assistance projects.

The evaluation team will use the scope of work as given in the original contract with John Snow, Inc., as well as subsequent amendments, to identify contract deliverables, determine the actual products (required or not), and assess the project's ability to meet the evolving needs, not only of A.I.D., but also of the technical areas in which it works.

Effectiveness in achieving outputs and goals

Are there additional evaluation criteria that can be developed to assess the ability/effectiveness of the project in meeting its objectives?

Do other indicators exist that measure only the impact of REACH activities in light of the multitude of organizations working in the field of international health? (One would assume acceptance, e.g. buy-ins, or dissatisfaction - either way indicating KAP. See mid-term evaluation)

What is the relation of achievements at the end of the project as compared to the achievements anticipated at time of contract award; how did these respond/not respond to evolving A.I.D. policies and programs?

Private Sector

Are both public and private activities identified as to possible linkage and impact on project interventions?

Have any innovative partnerships with the private sector taken place? What were the outcomes, lessons learned?

Technology Transfer

How was technology transfer defined
A. in the original design, and
B. as the project evolved?

Has enough importance been placed during the life of the project on technology transfer?

What conditions, i.e. country specifics, were considered to determine the most appropriate technology to emphasize?

Sustainability

Different definitions/models of sustainability abound continuing activities five years or more after assistance ceases and/or financial support remaining following withdrawal of donor funds and/or ability of host organizations to continue newly introduced interventions - what is reasonable for a project such as REACH to be held accountable?

Is sustainability a viable part of the REACH project given its design? Why or why not?

How did REACH:

1. identify the key components of sustainability within each country's setting, e.g. leadership, technical capability, communication, logistical infrastructure, MIS and feedback, etc. and present evidence of host country commitment to REACH related activities;

2. rank the necessary inputs requiring strengthening that will influence a the country program;

3. plan the interventions according to the prioritized needs of the country; and,

4. work in a collaborative manner while still carrying out the A.I.D. mandate of the project ?

What has been learned about the variables necessary for institutionalization - are there elements common such as national commitment, perceived effectiveness, training, upgrading supervision and mamagement - or is every country setting unique? (see Bossert article)

Are there any conclusions to be drawn about working with local, indigenous organizations?

What lessons have been learned to ensure integration of project activities into the MOH portfolio?

How has REACH strengthened the management structure of those it assists?

Has any attempt been made to monitor the amount to which the MOH absorbs the costs and responsibility for all/some relevant project activities? - and what are the results?

Were there any discoveries of methods, standards of performance, rules of thumb, or risky dangers of use to others?

To what degree can REACH integrate a single intervention into the overall context of a country's health strategy?

What are the lessons to be learned from REACH for technical assistance projects to ensure sustainability?

A.I.D. Management

What has been the quality and quantity of A.I.D. oversight of REACH?

How active has the participation of the CTO been in the administrative and technical management of the project?

Are the management monitoring tools as included in the contract, e.g. annual workplans, monthly progress reports, annual reports, sufficient to measure project progress, need for change, and expected outcomes as envisioned in the project design?

Project Funding

Was the availability of funds adequate to cover expenditures necessary to achieve the project's purpose?

Have the outputs been commensurate with the resources allocated to the project?

Has the project achieved the most effective and efficient use of resources?

Did buy-ins deter/enhance REACH in achieving its original purpose? What have been the outcomes, e.g. benefits, lessons learned, of REACH with the buy-in process?

Is it possible to determine the cost per beneficiary, i.e. the cost of an activity divided by anticipated beneficiary as well as the cost of an activity divided by actual beneficiary?

Administration and Management

What has been effective/not been effective in achieving contract outputs and goals as measured through the contractor's level of effort (both personnel and financial)? How were the allocations decided, e.g. in conjunction with A.I.D., planned, changed over time, not realized.

Has the organizational structure been well suited to meet the demands of the project? How has it changed over the life of the project?

Recommendations for improving the Technical Advisory Group (TAG) were included in the mid-term evaluation - what were the follow-up actions and the results of these actions? What was the overall experience of the project with the TAG?

Did the recommendations proposed in mid-term evaluation improve the performance/make significant differences in the project following the evaluation?

To what degree has the use of consultants and resident advisors included:

- timely availability
- a far-reaching selection process
- clearly defined SOWs
- adequate administrative and managerial support
- mechanisms in place for accountability and communication issues
- emphasis on technical qualifications and cultural sensitivity?

Have the subcontractors been given:

-clearly defined SOWs
-adequate administrative and managerial support
-mechanisms in place for accountability and communication issues?

Has enough attention been placed on identifying and utilizing in-country expertise?

Dissemination

How successful and far-reaching has dissemination of findings from the project been with:

A. A.I.D.
B. A.I.D. projects
C. U.S. private sector, universities, and PVOs
D. donor organizations
E. host country government ministries/assistance groups/ private sector?

Coordination with A.I.D. and Others

Have partnerships been active, facilitative, and informed with AID/W, USAIDS, and other groups/donors active in the fields of EPI and health care financing

Did the project establish relationships with those outside of the Office of Health and has:

- systematic planning with AID/W, USAIDs, MOHs, donors;
- regular interaction and coordination at country level; and,
- monitoring of project activities taken place with the above to identify and correct problems?

How frequent - and to what degree of success - has been information exchange and coordination between REACH and other S&T projects? Bilateral projects?

Did REACH constantly define and redefine its areas of comparative advantage? How? Do others agree with the REACH estimate of its comparative advantage?

Did the project inform A.I.D. of important, new program and policy directions?

Project Design

What has been learned from the REACH contract about project design and flexibility - appropriateness of the original project design to evolving needs of the field/Agency?

How can a project respond to:
- A.I.D. internal, e.g. decentralization, increased/ decreased bilaterals,
- financial,
- political,
- technical, and,
- epidemiological changes?

Can a centrally-funded project respond not only to S&T concerns but Regional Bureau and mission needs? - and whose agenda receives priority?

How did the demand for services create changes from the original SOW, can demand measure sustainability/project successfulness?

How does a central project meet the needs of the mission who is paying for the services and still be accountable to S&T?

Application for REACH II

Does the evaluation of REACH I indicate that REACH II is worthy of maintaining funding and A.I.D. interest?

Has enough thought been placed on the special needs, problem areas, technical and managerial requirements that are not already being met or could be met through other efforts?

Since the bilateral mode is planning and managing many child survival activities - as compared to 1985 when REACH I was started - what role is there for a project such as REACH?

To what degree can REACH II deal with the issue of integrating a single intervention into the overall context of a country's health strategy?

Compare and contrast major design components for REACH I and REACH II. In light of the changed environments in A.I.D. (different mixes of bilaterals/core vs buy-in funding, donor community, EPI (financial, political, technical advancements, epidemiological transitions) what potential does REACH II have for assisting countries to attain higher/sustained coverage levels, ability to leverage resources and funds, heighten sustainable elements of their work, integrate interventions into existing infrastructures, provide technical leadership

Since REACH did/does not directly supervise programs, should its role be more focused on providing a forum for the exchange of ideas?

REACH will be introducing a new intervention,.i.e. acute respiratory infections (ARI). Given the experience of REACH I with EPI and health care financing, are there lessons that can be applied to ARI?

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