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MID-TERM EVALUATION -

VECTOR BIOLOGY AND CONTROL II PROJECT
(DPE-5984-C-00-9030 and 9031)

by

David F. Pyle, Ph.D. - Team Leader
Mary Church, MA - MIS Specialist
John Edman, Ph.D. - Vector Biologist
Wilbur Hoff, Dr.PH - Health Education/Community
Development Specialist

April-May 1992

JSI JOHN SNOW INC.
210 LINCOLN STREET
BOSTON, MA 02111

This report prepared for R&D/H/CD, A
A.I.D./W under IQC PDC-5929-I-00-0109-00.

JOHN SNOW, INC.

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Finally, thanks to the staff of the VBC II Project for answering the seemingly unending stream of questions posed by the evaluation team and for providing the documents and materials requested.

GLOSSARY

AAAS	American Association for the Advancement of Science
A.I.D.	Agency for International Development
API	Annual Parasite Index
BTI	Bacillus thuringiensis israeliensis
CCH	Child and Community Health Project
CDC	Centers for Disease Control
CTO	Cognizant Technical Officer
GIS	Geographical Information System
HE/CP	Health Education/Community Participation
HFS	Health Finance and Sustainability Project
HHR	Health and Human Resources
HIS/MIS	Health Information System/Management Information System
HPN	Health, Population, and Nutrition
ID	Institutional Development
IDP	Ivermectin Distribution Program
I/HRD	Institution/Human Resource Development
IPTBH	Improved Productivity through Better Health Project (Belize)
IRRI	International Rice Research Institute
LAC	Latin America and Caribbean
MCP	Malaria Control Program (Pakistan)
MCU	Malaria Control Unit (Swaziland)
MSCI	Medical Services Corporation International
OCCGE	Organisation de Cooperation pour la Lutte Contre les Grandes Endemies en Afrique de l'Ouest
OYB	Operational Yearly Budget
PACD	Project Anticipated Completion Date
PAHO	Pan American Health Organization
PASA	Participating Agency Service Agreement
PID	Project Identification Document
PVO	Private Voluntary Organization
R&D/H	Research and Development/Health
REDSO	Regional Economic Development and Support Office
SAC	Senior Advisory Committee
SAIS	School of Advanced International Studies
TAC	Technical Advisory Committee
TACS	Technical Advisor, Child Survival
ULV	Ultra Low Volume
USUHS	Uniformed Services University of the Health Sciences
VBC	Vector Biology and Control Project
VCIC	Vector Control Information Center
WASH	Water and Sanitation for Health Project
WHO	World Health Organization

EXECUTIVE SUMMARY

R&D/Health requested JSI to assemble a team to carry out the mid-term evaluation of the Vector Biology and Control II Project. The Scope of Work for this $9.8 million (core contract) project includes three principal activities: technical assistance, technical information services, institutional/human resource development.

A team of four experts conducted the review, including a vector biologist, management information specialist, a health education/community participation expert, and a project management specialist. The evaluation team reviewed a large number of project documents and reports, interviewed officials in VBC II, R&D/H and A.I.D./Washington and in the collaborating donor agencies, interviewed missions by phone (7) and fax (9), and made site visits to five countries where significant project activities were taking place. The team split into two groups, one (Edman and Hoff) went to Latin America (Belize, Bolivia, and Honduras) while the other group (Church and Pyle) visited Niger in West Africa and Pakistan.

The evaluation team found that the missions and bureaus generally had a positive impression of VBC II. They view the project as a quick and reliable source of technical assistance in a specialized area. However, there is a difference in expectation between the A.I.D. missions/bureaus and R&D/H. The former perceives the project more as a provider of technical support in a relatively narrow, vector-control aspect, while the latter has a broader vision of what the VBC II Project should be. R&D/H designed the effort as being involved with vector-borne disease assessment and control, requiring that the project have expertise in a number of aspects which were not included in the first VBC project.

The VBC II Project has been more successful in responding to requests for technical assistance for support of vector control activities than in initiating innovative approaches to address vector-borne disease control problems. Some success in the latter can be identified in places like Bolivia where the VBC II Project has played a role in a successful Chagas' Disease control effort. However, problems have been experienced in recruiting and integrating the new project personnel who were supposed to bring the broader perspective to VBC II. The evaluation team is concerned with the effectiveness to date of positions such as the Epidemiologist, the Institutional and Human Resource Development Specialist and someone to address the Health Education and Community Participation aspect. The I/HRD position was vacant for over one year and has yet to be integrated into the VBC II Project in any significant way. Later a HE/CP person was added, but has only been involved in Ivermectin Distribution Project-related activities and only recently has addressed the important health education and community participation aspects of other VBC II Project activities.

Because the VBC II Project has had little success in broadening its operations it continues to function much as its predecessor, VBC I, did. The same contractor and two out of the three top professionals in the VBC II Project were involved in the first effort. The key decision makers in the corporation (MSCI) and the project reinforce the vector-control perspective. Those familiar with the project over the last several years describe the

difficulty of reorienting the project, one example being the search for the I/HRD position. The more narrow technical vector-control orientation is reinforced by a group of consultants who are often recruited from colleagues of the senior project staff; while competent in their respective areas of expertise, they are typically old school specialists who may be less familiar or comfortable with the broader perspective that is called for in a vector-borne disease control approach.

The lack of a strategic plan for how the VBC II Project resources (core funds) are going to be invested concerned the evaluation team. To date the resources have been spread too thinly among 27 countries and nine different vector-borne diseases. Almost half of the field work has been done in Latin America, the continent whose morbidity and mortality rates are least affected by vector-borne diseases. The project's success in the region can be attributed to the personal energy and vast network of the project's deputy director who is to be commended. However, the lack of any concerted effort, especially in malaria, in Africa is a concern. While the evaluation team accepts the difficulty of programming in Africa which has so little absorptive capacity in this area, it feels that the allocation of project resources might have been different if priorities had been established within a strategic project plan. For example, questions were raised about the rationale for spending more core funds on Guinea worm than on malaria in Africa and why over $80,000 of core funds were spent on malaria in Swaziland, a small country with little malaria. At the same time, the evaluation team considers that there were a number of missed opportunities to actively "market" broader, more innovative activities. As a result, VBC II has generated a relatively limited number of buy-ins, approximately $0.25 worth of buy-ins for every dollar of core funds expended.

The evaluation team is also concerned about project management, especially the lack of participation of project staff in the decision making process. Although staff meetings are held on a regular basis, decisions are made by the high level corporate and project managers with virtually no input from responsible staff members who have appropriate expertise and experience to contribute. This has led to the turnover of critical project staff, especially those tasked with bringing the broader perspective to the project. They did not feel that their ideas were being properly taken into consideration in the hierarchical decision making process.

Recommendations: The evaluation team made a series of 32 recommendations that would improve the effectiveness of the VBC II Project. The most important recommendations dealt with broadening the scope of the activities, improving decision making, intensifying and targeting activities, increasing "marketing" efforts, and strengthening project management. In the first case, the project staff tasked with the broader development agenda (i.e., epidemiologist, I/HRD and HE/CP specialists) should play a more prominent role in the project. To do this a senior project manager, at the deputy director level, should be appointed to represent the social aspects. In addition, any follow-on project should consider appointing an economist to the professional staff.

A serious strategic planning exercise is desperately needed to define with precision project objectives and how they are to achieved. As part of this process, the project must identify priority countries and vector-borne diseases that will receive core funding. This will allow the project to

devote greater resources to a serious problem in a few countries so that greater depth, and possibly results, can be achieved. In any future, follow-on effort, the name of the effort should be changed to Vector-Borne Disease Assessment and Control Project. A.I.D. should spell out its expectation in any future vector/vector-borne disease control effort in much greater detail. In addition, a provision to allow long-term technical assistance should be included to permit sustainable institutional strengthening and development.

To increase buy-ins which have been very limited to date, the VBC II Project or any follow-on effort should carry out a series of needs assessments in a limited number of priority countries. In the process, innovative techniques and strategies should be identified, giving local mission and ministry personnel a clear sense of the options and opportunities. More emphasis should be placed on applied and operations research. Marketing efforts will be helped by the production and distribution of a brochure describing the broad range of services available through the project. Moreover, A.I.D. should clarify with the contractor what it can and cannot do in terms of developing scopes of work for buy-ins. Finally, the project should collaborate more closely with centrally-funded activities and with any bilateral effort that includes a vector-borne disease control component .

Project management should be improved to ensure that all members of the professional staff, especially those representing the broader social aspects of the effort, have a role in decision making. Such a participatory management style would improve morale and decrease staff turnover. Specialists responsible for I/HRD and HE/CP should play a more significant role in project activities. A senior staff member should be made responsible for regional programming in Africa and another in Asia, concentrating energies on developing connections and networks that will result in more support from the missions in those regions. In this way it is hoped that at least some of the missed opportunities in vector-borne disease control outside Latin America can be recovered.

I. INTRODUCTION

The Research and Development/Health (R&D/H) Bureau of Agency for International Development in Washington (A.I.D./W) requested JSI to conduct the mid-term evaluation of the Vector Biology and Control (VBC) II Project. Both the core ("C"), DPE-5948-C-00-9030-00, and the buy-in ("Q"), DPE-5948-C-00-9031-00, contracts which make up the project were evaluated. This evaluation was carried out under JSI's IQC, PDC-5929-I-00-0109-00. The evaluation team initiated the review in Washington during the last week of April and completed the exercise by the end of May 1992.

1. Scope of Work

The evaluation was conducted in accordance with the Statement of Work which was prepared by the Division of Communicable Diseases, R&D/H (Appendix I). The principal aspects of the evaluation included project and contract management, project collaboration, technical aspects of vector biology control, transfer of VBC technologies and skills, community participation and health education, institutional and human resource development, financing of VBC activities, information systems, and responsiveness.

The terms of reference for the mid-term evaluation called for a four-person team consisting of a range of experienced and qualified consultants who had the expertise between them to address all the issues raised in the Statement of Work for the exercise. The team consisted of a project management and evaluation expert, a management information systems specialist, an entomologist/vector biology specialist, and a human resource/community participation expert. The evaluation was to include an A.I.D. person, but official business prevented him from participating.

2. Methodology

The evaluation team collected information and data in four principal ways. First, it reviewed relevant project documents. This included technical reports, trip reports, administrative documents (e.g., project paper, request for proposal, contract) and the last evaluation conducted (mid-term) on the previous project (VBC I). Team members also reviewed the breakdown of VBC II Project activities, by country, region and vector-borne disease. Appendix II provides a list of documents reviewed by the team.

The second means of collecting data was interviews with people who had been familiar with and been involved in some substantive manner in the VBC II Project. Officials in A.I.D., both in Washington and abroad, VBC II Project personnel (both current and former), members of the Senior and Technical Advisory Committees (SAC and TAC), subcontractors, collaborating projects (e.g., Water and Sanitation for Health or WASH and Health Finance and Sustainability or HFS) and organizations (e.g., WHO, PAHO, International Eye Foundation, Helen Keller International, Africare). The list of persons interviewed can be found in Appendix III.

Site visits were the third way the evaluation team collected information. The team selected the countries to be visited during the first week in Washington when they had the opportunity to review country specific project activities. The countries to be visited were chosen based upon the vectors-borne diseases being addressed by the VBC II Project, the type of activity and the level of project programming. The team also ensured that one of the five countries having the Ivermectin Distribution Program (IDP) was included. The country visits themselves took place in May, depending on when the missions could accommodate the team. The evaluation team was divided into two groups, one (Edman and Hoff) visited countries in Latin America (Belize, Bolivia and Honduras), while the other (Church and Pyle) reviewed project activities in Niger and Pakistan. A set of issues to be explored in the field and with the missions (Appendix IV) was prepared to ensure that both groups focused on similar aspects of the project and collected similar data.

The fourth means of collecting data was via a questionnaire (Appendix V). Approximately thirty A.I.D. missions were asked to give their opinions of the VBC II Project. About half of the missions were contacted by phone by one of the evaluation team to discuss the issues raised in the questionnaire which had been faxed to them. The other half were asked to respond to the questionnaire by faxing their answers to the evaluation team at JSI. The questionnaires enquired as to whether the country had vector borne diseases, if the mission knew of VBC II, if they had utilized the services, and what their experience with the project had been. The response rate to the written questionnaire was 75%. A listing of missions contacted by phone and fax is provided in Appendix VI.

3. Report Content

The VBC II mid-term evaluation report consists of four sections. Following this Introduction, there is a chapter addressing the background of the VBC II Project which discusses the nature and extent of the vector-borne disease and vector control problem around the world. In addition, the VBC I Project is discussed and the findings of its mid-term evaluation (August 1988) reviewed. Chapter II concludes with a description of how the VBC II Project was developed.

Chapter III is the body of the mid-term evaluation report. It is in this section the findings of the evaluation team are reviewed, and recommendations made on how the problems identified might be rectified. The chapter is divided into seven sub-sections:

- Project Design and Strategic Planning
- Appropriateness of Leadership and Staffing
- Identification and Prioritization of Actions
- Communications and Marketing of Services
- Internal Project Management
- Collaboration and Relationships, and
- Effectiveness of Activities Undertaken
    - technical assistance
    - technology transfer
    - institutional and human resource development
    - community participation
    - information support

The mid-term evaluation concludes with Chapter IV, a summary of the findings and recommendations that might be considered in the latter half of the VBC II Project and in any subsequent effort to address vector-borne diseases and vector control.

II. BACKGROUND

A.I.D. has made a major commitment to vector-borne disease and vector control in the past decade. This includes a major malaria vaccine development effort and since 1985, a Vector Biology and Control Project. This chapter reviews the importance of vector-borne diseases as a determinant of health status of the population, especially the vulnerable under five age group, in developing countries. In addition, the history of the VBC I Project (1985-90) is summarized as are the major findings and recommendations of the VBC I Project mid-term evaluation.[1] The final sub-section of this chapter describes the development of the VBC II Project and sets the stage for the mid-term evaluation findings and recommendations that follow in Chapter III.

1. Nature and Extent of Problem

Vector-borne diseases are a major cause of morbidity and mortality in the developing world. Of the ten most common parasitic diseases[2], malaria has the most devastating impact. It is estimated that 270,000,000 people are infected every year with malaria. Approximately 110,000,000 of these develop clinical symptoms, 90,000,000 being in sub-Saharan Africa. Deaths may number 2,000,000, with approximately half being in the under-five age group in Africa. In the Gambia malaria may cause about one out of four deaths in the under-five population. It is the leading cause of mortality among this vulnerable sector of the population in several African countries (e.g., Ghana and Malawi). It is stated that approximately 80 percent of malaria cases and 90-95 percent of all malaria-related deaths in the world occur in Africa.

Adding to the urgency of the malaria situation is the increase in falciparum malaria, especially in Africa where it now reportedly accounts for 90 percent of the infections in most of tropical sections of the continent. In addition, chloroquine and multi-drug resistance is rendering the treatment of malaria even more problematic. At the same time, there is a growing resistance to pesticides, making it much more difficult to control the vector.

Mortality and morbidity rates due to malaria are increasing. In Zaire, for example, reported deaths due to malaria have increased from 2.1 percent in 1982 to 5.8 percent in 1988. In the same country, malaria deaths as a percentage of mortality has risen from 29.5 percent in 1983 to 56.4 percent of all mortality in 1986.

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[1] The mid-term evaluation of the VBC I Project was the last evaluation carried out. No final evaluation of the VBC I Project was ever conducted.

[2] Arboviruses (dengue, Japanese encephalitis, yellow fever), Chagas' disease, dracunculiasis (Guinea worm disease), filariasis, leishmaniasis, malaria, onchocerciasis, schistosomiasis, trypanosomiasis ("sleeping sickness"). Leprosy was included in the series as a tropical disease.

While malaria is the most serious vector-borne disease from the standpoint of numbers of people affected and in terms of morbidity and mortality, there are other debilitating vector-borne diseases. For example, Guinea worm is said to affect approximately 15,000,000 in 19 African countries. Another 17,000,000 people are suffer from onchocerciasis, over 300,000 of them being blind as a result. Large areas of productive land has been abandoned in 36 countries because of the threat of trypanosomiasis ("sleeping sickness").

Asia suffers from malaria, dengue, Japanese encephalitis and filariasis, but their impact on the mortality and morbidity rates and on productivity is less than in Africa. In Latin America, vector-borne diseases are present but at a considerably reduced rate. For instance, in 1987, it was estimated that there were 1,000,000 cases of malaria in the region, less than 1 percent of the cases estimated in Africa.

In addition to the human toll in terms of illness and death, vector-borne diseases have significant developmental and economic impacts. In Africa, for instance, large tracts of rich agricultural land have been abandoned due to vector infestation. One estimate is that 10,000,000 square kilometers, or 45 percent of all the land in sub-Saharan Africa, have abandoned livestock grazing because of high infection rates in cattle and horses by a form of trypanosomiasis. Moreover, vector-borne diseases dramatically decrease the productivity of the labor force. The loss from Guinea worm infection globally has been estimated as high as $1 billion a year. Successful vector and vector disease control programs can have a significant economic impact by facilitating the rehabilitation of farming and livestock-raising areas and by permitting the work force to reduce their absenteeism due to vector-borne illnesses.

2. Vector Biology and Control I Project

The first Vector Biology and Control Project was designed and awarded to Medical Services Corporation International (MSCI) in September of 1985. This 5-year centrally-funded project was funded and monitored by the Office of Health in A.I.D./Washington and had a budget of slightly over $8.6 million.

The primary objective of the VBC I Project was to provide technical assistance to control vector-borne diseases and introduce and strengthen vector control technologies, methods and tools. While the project was also supposed to provide support in institution and human resource development and the development of information management, most of the expert assistance requested and provided was in the form of technical vector control advice.

Mission interest in vector control was indicated by the fact that in the first half of VBC I approximately 40 percent of VBC resources expended were from mission buy-ins.

Recommendations in the mid-term review of VBC I included a call for more emphasis and strengthening of project capabilities in design, planning and human resource development. The mid-term evaluation report called for the

enhancement of project capabilities in the areas of training, operations research, information services and social/ behavioral aspects of vector control. It was noted that a high portion of the VBC I Project activities consisted of responding to requests for assistance (reactive). The project was also encouraged to be more proactive, that is, take the initiative and promote vector and vector-borne disease control efforts.

Because of the high level of buy-ins, the project ceiling was reached before the originally scheduled end of the contract (i.e, prior to the Project Anticipated Completion date or PACD). For this reason, A.I.D. rebid the project a year early and for one year VBC I and VBC II were operating simultaneously. However, because the same contractor was awarded the VBC II Project, this caused no difficulty.

3. Development of Vector and Biology Control II Project

With the contractor fast reaching the budget ceiling in VBC I, the Office of Health of A.I.D./Washington decided to rebid the VBC Project. While the Work Statement in the Request for Proposal (RFP) initially mentions the improvement of vector-borne disease control in A.I.D.-assisted countries, most of the rest of the document refers to strengthening vector control programs in the developing world. The distinction is very important in that it determines the nature of the technical assistance to be provided and, correspondingly, the composition of the VBC II Project team responsible for providing that assistance.

The three major areas of support to be available through the VBC II Project were:

- technical assistance
- technical information services
- institutional and human resources development

To carry out the work, the contractor was expected to staff a multi-disciplinary team that would include expertise in:

- vector ecology
- medical entomology
- epidemiology
- environmental engineering
- operations research
- information services
- institutional and human resource development
- public health
- technology transfer

The RFP list 36 examples of the kind of technical assistance that might be called for in the course of the VBC II Project. While several of the illustrative examples referred to the control of vector-borne diseases, the majority of them mentioned vector control. The difference is significant in that vector control requires vector specialists. In contrast, vector-borne

disease control effort also calls for the inclusion of social scientists (e.g., experts in public health, epidemiology, community participation, training, health education, materials development, management, information systems, economists, finance).

Five key personnel are identified in the RFP; they are the project director, deputy director, institutional/human resource development specialist, vector biologist, and epidemiologist. The project has a total staff of 15; Appendix VII is a listing of staff members.

The RFP also required the contractor to identify experts in a significant number of functional categories. A total of 39 specialists were specified and grouped in four major categories: vector-borne diseases specialists, biomedical researchers, public health consultants, and general technical specialists. Appendix VIII is a list of the experts asked for in the RFP.

An innovative aspect of VBC II Project is the issuing of two contracts, one concerned with the core activities and supported out of central A.I.D./Washington funds (this is referred to a the "C" Contract; DPE-5948-C-00-9030-00), the other for buy-ins from the missions and regional bureaus (referred to a the "Q" Contract; DPE-5948-C-00-9031-00). The VBC II Project was one of the first centrally-funded projects to be designed in this manner.

III. FINDINGS AND RECOMMENDATIONS

This chapter addresses the evaluation team's assessment of the first two and a half years of VBC II activity. After a brief overview and summary of findings, the team's observations and recommendations to address identified problems are presented under seven headings: project design and strategic planning, appropriateness of leadership and staffing, identification and prioritization of activities, communications and marketing of services, internal project management, collaboration and relationships, effectiveness of activities undertaken.

1. Overview

The evaluation team's overall assessment of the VBC II Project during the first half of the projected 5-year effort is that it has responded to mission and bureau requests in a timely and satisfactory manner. The missions and bureaus appreciate the technical assistance that they have received. VBC II is viewed by the missions as a good source of specialized support when they have a vector control or related problem, or a programming issue that must be resolved.

After reviewing project documents, interviewing project and A.I.D. officials, and visiting project activities in the field, the evaluation team had concerns about the project's record of accomplishment and ability to make a significant impact on vector-borne diseases in the developing world. The overall impression was that the project has spread its resources too thinly geographically and among the various vector-borne diseases. After project administrative expenses are deducted, slightly less than $2.3 million has been expended. This has been divided between 27 countries and 9 different vector-borne diseases. The resources invested in any one disease in any one country are very limited, and the ability of the VBC II Project to have any impact with small amounts of resources is questionable. Moreover, the project's investment of core funds has generated little response in terms of buy-ins or OYBs. The evaluation team thought that a strategic planning effort to define more precisely what the project wants and is able to achieve, and to establish priorities (both in terms of countries and vector-borne diseases) would be most helpful.

The evaluation team also was concerned by the apparent vector control orientation as opposed to a vector-borne disease control orientation in VBC II. The social science component associated with the disease control features institutional and human resource development as well as health education and community participation. These aspects have yet to be fully developed. Consequently, a number of opportunities to test and introduce innovative approaches to disease control have been missed. A similar problem was identified in the VBC I mid-term evaluation. The effort to rectify the problem by adding specialized staff was not fully successful for several reasons that are discussed in greater detail below.

2. Project Design and Strategic Planning

a. Design

The current 5-year VBC contract was broadened from a vector control focus under VBC I (1985-89) to more of a vector-borne disease control focus under VBC II (1989-94). This change was called for in the mid-term review of VBC I and was reinforced by the contracting office, R&D/H. This called for a philosophical and physical restructuring of the project by MSCI, which won the contract for both VBC I and II. A single ten year Project Identification Document (PID) covered both contracts. Neither the PID nor the name of the project was changed when the contract was rewritten and rebid by A.I.D. in 1989, although both options were considered. In retrospect, this may have been a mistake because much of the terminology used in the new contract, the project's image, and the expectations of those who use VBC services seem to have remained largely unaltered. While the initial paragraph in the new contract refers to the control of vector borne diseases, the remainder of the document refers repeatedly to vector control and does not reflect the broader approach that should have been guiding the project to reorient many of its activities.

Although the team understands the need to keep the language in the contract broad, priority diseases and geographic regions should have been clearly delineated in this document to give some long-term focus to decision making during the life of the project. In addition, the contract should have explicitly stated the contractor's responsibility to emphasize the social and behavioral sciences, as well as the biological, in its approach to disease control.

Under VBC II, the contractor has added three new professional positions: epidemiologist, institutional/human resource development (I/HRD) specialist; and deputy director for administration; more recently, a health education/community participation (HE/CP) specialist was added. This brought expertise in non-vector control areas and clearly reflects MSCI's acknowledgement that the new five-year mission is significantly broader than its predecessor. Unfortunately, the academic background, level of field experience, and job stability of the new individuals recruited to the project have seldom matched that of the senior core staff who were already on board and activity engaged in project activities. This lack of seniority, coupled with turnover and delays in hiring, led to staffing insufficiencies that continued to tilt VBC's programmatic activities more in the direction of VBC I than in the broader direction mandated for VBC II. This disparity may improve with time, provided the current staff can be maintained, and their expertise recognized and efficiently utilized in a wide variety of projects. The need to broaden has not been expedited by the fact that the Liaison Officers, who are also TAC members, for all three subcontracting universities are also biological rather than social scientists.

RECOMMENDATION 1. In any follow-on project, the name should more accurately reflect the project's scope of work, eg., Vector-Borne Disease Assessment and Control Project.

RECOMMENDATION 2. The Statement of Work in the VBC II contract should be clarified, focused and priorities spelled out.

The second phase of the VBC contract also restructured the funding mechanism. Buy-ins from missions were separated from core funding in order to stimulate VBC to be more innovative in investment of core funds to develop new activities, and hence encourage mission financial support in the form of buy-ins. (VBC was the first centrally funded contract to be structured in this fashion; this mechanism has been used in subsequent central projects.) The Office of Procurement felt that this would allow VBC to greatly expand its activities and impact. VBC II staff have not found this change desirable because it limits flexibility in the way in which specific projects can be funded. It also means that VBC must better advertise and market the services they have to offer to missions. This role of salesperson is one in which many VBC staff may feel unfamiliar and even uncomfortable. Thus far, the new arrangement has not resulted in more buy-ins and greater financial contributions from missions as was hoped. During the first half of VBC II, only seven missions have made buy-ins using less than $1.5 million of the more than $7 million ceiling on buy-ins. Although never explicitly stated in either the VBC II RFP or contract, it is not unusual for centrally-funded projects such as this to solicit several times more mission/bureau buy-ins for every dollar of core money invested by R&D/H. However, VBC II has generated only about $0.25 of buy-ins for each $1.00 of core funds invested in programming[3]. Appendix IX provides the details.

In the evaluation team's communications with mission staff, it was clear that many were unaware of any programmatic difference between VBC I and VBC II. This suggests that VBC staff have not effectively communicated their new capabilities and broader focus to their clientele. In general, mission staff seem to agree with the more community-based approach to disease control, but they are unaware that VBC has the expertise and mandate to address all the issues involved in such an approach. Both missions and regional bureaus seem satisfied with the "old" VBC, the technical biological approach. They conveyed no sense of disappointment or frustration over VBC's failure to broaden, and appeared largely unaware of R&D/H's identification of human and resource development aspects as a priority. Thus, VBC continues to receive strong support from some segments within A.I.D. to maintain the status quo.

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[3] As the final table in Appendix IX shows, the OYB and buy-ins together come to $1.7 million; 28% of this amount is from OYBs which were programmed centrally with minimal "marketing" effort from the VBC II Project staff. If the total OYB plus buy-in figure is divided by the total amount expended to date, $6.7 million (both administrative costs and core-funded program activities), the percentage of buy-ins is approximately 25 percent. If calculated as percentage of fund utilized for support of field programming, it amounts to 68 percent ($1.7 million divided by $2.5 million).

At the same time, the evaluation team received some mixed views concerning the expectations of VBC II in discussions with various A.I.D. offices. This might be explained by the fact that most of the staff in the missions and regional bureaus are generalists who do not have the background to know what they should expect in the way of parasitic disease assistance. They need to be educated by VBC in this regard rather than used as justification for maintaining the narrow, vector-control focus.

RECOMMENDATION 3. The perception of the VBC II project's goals and performance is different in the missions and bureaus and the contracting office, R&D/H. There should be a rationalization of project activities so that a significant portion of core funds are used to orient and educate missions/bureaus/health ministries and to invest in broadly based activities, including more socially-oriented ones, that are most likely to result in future buy-ins. These activities should be limited to the most important diseases and focus on high priority countries.

b. Planning

Like every other organization with a broad mandate and the capacity to engage in a wide variety of activities, VBC II would have greatly benefited from more effective long-range planning at the beginning of the new contract. Every organization should have a realistic and well thought out strategic plan to help guide its decision making. The team found no evidence that VBC had developed such a document even though they apparently had undertaken a strategic planning exercise. It was difficult to uncover the rationale for many of the decisions made by VBC II management: for example, spending $83,000 of core funds in depauperate Swaziland; spending more on Guinea worm than on malaria in Africa; and using nearly half the regional activities budget in Latin America. Appendix IX spells out this disparity in detail. There may be good reasons for such apparent regional, country and disease disparities in resource allocation but the justifications need to be articulated in a planned, programmatic setting.

Having a strategic plan would also have made it easier to restructure the organization so that new professional staff could have quickly and smoothly found their niches in the operation. It also makes the preparation of annual work plans much easier and more uniform from year to year. Moreover, the lack of a strategic plan frequently results in missed opportunities.

RECOMMENDATION 4. The professional staff of VBC II and any future project, should commit to a serious strategic planning exercise, facilitated by an outside consultant in order to thoughtfully identify clientele, needs, priorities, resources, and objectives for the remainder of the VBC II contract; the project should be modified to reflect the directions identified in the strategic planning effort. In any future VBC project, a strategic planning exercise should be conducted at project's outset.

Since its inception in 1985, VBC has been involved in a large number of activities in numerous countries throughout the tropics. It has accomplished a great deal and in the process learned a great deal about how and how not to provide vector control and related assistance to overseas missions. This review panel was impressed with the "Lessons Learned" document prepared by the WASH project and believes that the present and any future VBC project would greatly benefit from a similar summary of VBC activities to date. This review panel had difficulty getting an accurate grasp and assessment of the impact of all the various VBC activities. A "Lessons Learned" monograph would have been a great help in this regard. More thoughtful planning and presentation of information to the Review Team by VBC also would have facilitated its understanding of this very complex project. Almost every document given to us presented data in a different way or contained figures that were inconsistent from other iterations of the same data (see Appendix IX).

A lessons learned summary also would pull together fragmented information from different activities that deal with common issues and communicate those findings cohesively. There is undoubtedly much more information than the team was able to see, but it needs to be consolidated for the benefit of those who can profit from the lessons it contains.

RECOMMENDATION 5. VBC institutional memory would be improved and the missions/bureaus would benefit from the publication of a "Lessons Learned" monograph (a la WASH). his should be drafted prior to the strategic planning effort and used as basis for discussion.

c. Long-Term Technical Assistance

Under the terms of the VBC II Project contract, the contractor is limited in the length of time a technical advisor can spend in a country. A consultant can remain no longer than one year in a particular country. While most of the technical assistance consultancies are short term, usually no more than a month in duration, a few have been longer. In Bolivia, for example, the VBC-supplied computer analyst was required for more than a year and was contracted through an alternative mechanism.

USAID/Pakistan contracted with VBC to prepare an information system for the Malaria Control Program (MCP). A database management system, called PAKMAL, was produced and installed in each province. The system does not provide the reports required for MCP management, and, although follow-up assistance has been discussed, it is not clear that the inadequacies in the current system have been identified or addressed. Section 8.c, "Technology Transfer," includes a description of PAKMAL activities.

VBC's biomedical computer specialist has observed that "development of a sustainable national VBD HIS/MIS requires a commitment of 2-3 years." (draft of "Vector Biology and Control Health and Management Information Systems: A Strategy", p. 6) In the Pakistan example, a several-year assignment could be envisioned that would provide time to learn about the Malaria Control Program in detail, establish a close working relationship with the MCP administration,

involve the MCP senior staff in the development of the MIS, test several different versions of the system, make any modifications that might be required, training trainers in the use of the information for management decisions, and oversee its institutionalization. The Pakistan Child Survival Project, which includes a substantial health and management information system (H/MIS) effort, extends over several years; this sustained effort has allowed the project to work closely with the government. The design of the VBC II Project, limiting technical assistance to no more than one year, does not permit the project to provide such much needed support.

The evaluation team identified the constraint raised by precluding longer-term technical assistance in the VBC II Project which is supposed to support the developmental aspects of vector-borne disease control such as institutional and human resource development and community participation. In fact, the new orientation of VBC II makes the need for long-term assistance compelling. These activities require considerable time in order to orient the staff, establish good relations, and carry out significant behavioral and structural change. This is considerably different that having a vector control specialist visit a country and provide technical advise on how to resolve a problem. Thus, if R&D/H really expects the VBC II Project to achieve the broader set of objectives that have been established, the possibility of having long-term consultants when and where appropriate should be available. Most other centrally-funded health and family planning projects (e.g., REACH, PRITECH, PRICOR and QA, FPLM, SEATS) have this option.

RECOMMENDATION 6. Any follow-on VBC Project should permit and encourage long-term technical assistance to facilitate the institutionalization of new and innovative approaches and techniques.

3. Appropriateness of Leadership and Staffing

The VBC II project is managed by two senior biologists, both of whom were in the same positions during the VBC I project. The Project Director is a parasitologist, while the Deputy Director is a vector biologist. These two positions provide a solid expertise in vector control methodology and undoubtedly account for the high reputation which VBC I and VBC II have obtained for supplying technical assistance in vector control strategies, methods and technologies to A.I.D. missions. In addition, the third most important senior project official is a vector biologist and is often involved in project-related decision making.

The negative side of the staffing pattern is that with the shift in emphasis of programs from vector control to the control of vector-borne diseases a similar shift has not occurred in the staffing and the leadership of the project. The epidemiology position has only recently been filled for the second time. The I/HRD (Institution/Human Resource Development) specialist was a new position; it has been occupied by two different people, for only 18 of VBC's life of 30 months, with a long gap when the position was not occupied. No position was included in the VBC II project for a HE/CP

specialist despite the new emphasis placed upon community participation and health education. This was a serious omission.

There is ample evidence from water and sanitation, vector control and other health programs that unless people accept, use, and maintain health services, even the most carefully planned technical services and programs are doomed to failure. Sustainability and self-sufficiency in disease control programs are impossible without community awareness, participation, and control of health services.

Examples from three projects visited indicate that local staff recognize the need for assistance in HE/CP. However, local project staff did not identify VBC as an organization with these skills, and VBC has not been active in marketing its skills in these areas. In the Chagas' Control Project in Cochabamba, Bolivia, the coordinator was asking for help to develop more effective health education materials, and design and conduct a training workshop for his health educator and health promotors. In the town of El Progreso, Honduras, the director of the Dengue Control Project was asking for assistance in community development in the barrios. In Belize, the Ministries of Health and Natural Resources will soon be looking for a specialist in community development to help them train district staff and community leaders to promote an integrated program for water, sanitation and vector control.

These will be missed opportunities for VBC unless the project takes the initiative to provide the services that are required. However, it is difficult to conceive how VBC can expect to provide these kinds of services without staff having expertise and experience in health education and community development. Beginning in September, 1991, a Health Educator was added to the staff with funds from the Ivermectin Delivery Program (IDP). She has been working full time on that activity until very recently when she was allowed to do some health education and community development work for VBC II core activities.

Because of her commitments to the IDP, the person hired for health education/community participation has not been able to provide health education services to other VBC projects. If her schedule allowed more time to be spent on other VBC activities, some of most critically needed health education services could be provided. Because there is some overlap in the nature of duties between the I/HRD and HE/CP jobs, (e.g., development of training programs and materials), the two persons should collaborate closely so as to more efficiently use their time and resources.

The team believes that in order for vector-borne disease control programs to be effective, assistance in institutional and human resource development and health education and community development methods must be provided to USAID Missions and country ministries.

RECOMMENDATION 7. In accordance with the broader developmental objectives, any future vector-borne disease control project should have a senior social scientist with experience in community development and health education

included as one of the key project staff (i.e., senior decision-making team). This person should be placed either as a director or as a deputy director on a par with the deputy director for technical biological aspects, to ensure this new orientation is given adequate attention.

RECOMMENDATION 8. The person hired to address and provide support to health education and community participation efforts should be allowed to focus on these issues as soon as possible, giving support to any/all VBC activities.

During the course of VBC I and VBC II there have been six changes in the Cognizant Technical Officer (CTO) who manage the project for A.I.D. This has not presented VBC staff with a consistent and stable management style and has contributed to uncertainties and difficulties within the management of VBC. This seems to be an unusually large number of management changes in contrast to the WASH project which operated for 12 years with only three CTOs.

RECOMMENDATION 9. A.I.D. should make every effort to ensure continuity and stability in the project management post (CTO) to reduce shifts in project emphasis and management styles.

The mid-term review of VBC I recommended strengthening the subcontractor role of the three Universities. In discussions with the Liaison Officers for the subcontractors, there was general agreement that their role has been significantly expanded under VBC II. It is difficult to ascertain just what activities originated with subcontractors as apposed to being assigned to them on paper by VBC as a result of project consultants having some affiliation with the university. In the 1991 Plan of Work, the three core contracts for coordination with the Universities are budgeted at $401,999, a significant amount of money. An additional $188,850 is budgeted to support the development of concept papers, which seemed to be one of the main core activities of the university partnership. These budgeted amounts were both far less in the 1992 Plan of Work ($172,000 and $107,000 respectively). Although the evaluation team understands that the salary of Dr. Andre is included in the Jackson Foundation budget and accounts for it being much larger than the Harvard and Tulane budgets, it is not clear how the remainder of this money is being spent or how much of the budgeted amounts actually were spend. Some innovative new activities appear to have been generated through VBC's university partnership arrangement, but it is impossible to assess the full impact because of the reporting system used. The universities expressed some frustration with not having more of their ideas funded by VBC, but their return might be better if VBC had clear funding priorities to guide university staff in the development of projects for consideration.

It appears that the three VBC subcontractors are being used primarily to supply technical consultants with biological expertise. Since these subcontractors represent universities that may have specialists in other areas such as social and behavioral sciences, community development and health education; and since these are areas in accord with the broader developmental objectives of the VBC II project, the evaluation team recommends that VBC draw upon these additional specialties to a grater extent.

- Internship Program

The internship program with the three universities was initiated under VBC I and both VBC and the universities spoke positively about this program. It clearly provided good training and experience for the graduate students involved but the benefits to VBC seem more abstract. The three current interns appear to have been assigned projects that consist mainly of literature reviews. The evaluation team questions whether their efforts might be more supportive of VBC's mission if they were assigned to develop informational documents outlining new opportunities in vector-borne disease assessment and control for distribution to targeted A.I.D. missions. The Review Team supports the internship concept and feels it could be expanded to include students from other institutions as well.

The PASA arrangement that R&D/H has with CDC, and collaboration with WHO and PAHO has provided valuable collaborations and consultants on some VBC projects. Examples are CDC involvement in the project to help the Kenyan government develop a malaria control strategy, the evaluation of the ULV (ultra low volume) mosquito control technology in Jamaica and Venezuela, and the interagency collaboration that resulted in the drafting of a new dengue control strategy for the Western Hemisphere. The PASA mechanism has been a good one for bringing a strong disease focus into certain VBC activities. It should be encouraged, especially with the CDC which has a broad range of excellent staff with contemporary expertise from which VBC can draw. CDC's expertise in malariology has been particularly valuable to VBC.

Given malaria's growing importance and A.I.D.'s reemphasis on malaria in Africa, future VBC contracts would be greatly strengthened if a malaria specialist with considerable public health experience were on staff. This might encourage the development of more projects in Africa as well as strengthen the malaria portion of VBC's portfolio of activities. In the future, it may even be desirable for VBC to have the ability to station a staff member in the African region, perhaps at a REDSO office. The addition of Dr. Sonnemann (project epidemiologist) has finally brought someone with considerable experience in the African region (including French skills) to VBC's own staff. The evaluation team sees this as a very positive move in the right direction since it is desirable to have a designated coordinator for all activities in each of the three regions. Up to now the regional coordinators for Africa and Asia have been less than effective, both at the mission level and with the bureaus (as reflected in the underutilization of the budget allocations for liaison with the different regions and bureaus).

RECOMMENDATION 10. VBC II should consider the possibility of locating the regional coordinator/technical advisor in the region itself.

RECOMMENDATION 11. The senior staff of VBC II should include a malariologist/ public health expert who can develop activities and increase funding in this priority area.

The Africa and Latin American Bureaus made it clear that decisions for funding health programs are increasingly based upon economic arguments, and the lack of assessments of the economic impact of vector-borne diseases puts VBC's programs at a disadvantage when competing for funds. The bureaus strongly advised that more economic studies be conducted to show how a reduction of malaria, dengue, Guinea worm, river blindness and other diseases can have a positive economic effect. Economic studies could also be conducted to identify the costs of institutional development, human resource development, community participation and to measure their effect upon the delivery of health services and human productivity.

Economic studies are particularly needed to justify funding and development of an overall strategy for malaria control in Africa. The recent paper by D.S. Shepard, et. al. on "The economic cost of malaria in Africa", funded by VBC, surveys and synthesizes the literature on the subject. R&D/H has commissioned further studies, and VBC is collaborating with the Health Finance and Sustainability Project (HFS) to conduct the studies.

RECOMMENDATION 12. Future vector borne disease assessment and control efforts should include an economist capable of carrying out economic analyses to determine cost implications of vector-borne diseases.

4. Identification and Prioritization of Activities

MSCI created a Senior Advisory Committee (SAC) to "advise VBC II on maintaining a balanced portfolio of activities" and to "help identify new opportunities and monitor the quality of VBC products." (1990 work plan, p. 43) The SAC is an international group of six senior persons experienced in entomology, vector and vector disease control, economics, management, anthropology, and environmental engineering.

The SAC met twice early in VBC II, in April 1990 and again in July 1990. The second meeting extended over several days with an agenda that included presentations by SAC members, by USUHS, and high-lighted by the presentation of VBC's 1991 work plan. Discussions became polarized between the technical/ vector control specialists and those representing the broader/social perspective. Finally, R&D/H proposed that the meeting be adjourned; no further SAC meetings have been convened.

The corporate culture of the VBC II contractor is not supportive of collaboration with other USAID subcontractors. The evaluation team was told of several occasions in which the project managers were reluctant to cooperate or take action because it might suggest that the contractor was not capable or would be viewed as a sign of weakness.

The advice which a SAC would provide assumes greater importance in light of the suspicion with which MSCI views other USAID subcontractors. The members of the SAC need to be chosen with care. Besides representing a broad range of professional expertise, they should have no personal agendas. The Technical Advisory Committee (TAC), composed of representatives from VBC's

major subcontractors, may not provide entirely disinterested advice, since the members may be advocates for specific activities undertaken by their university staff. In addition, SAC members can encourage networking, to enable the broader vision called for in VBC I. Entrée to the community of social and behavioral scientists, which could be provided by the SAC, would open a body of expertise that appears to be currently unavailable to VBC.

RECOMMENDATION 13. A Senior Advisory Committee (SAC, often called a Technical Advisory Group, or TAG, in other projects) should be reactivated as soon as possible to provide the senior project staff and R&D/H with innovative approaches, to keep them abreast of the most recent advances in the field and to identify windows of opportunity.

As detailed in Appendix IX, VBC II has undertaken a number of activities to address different vector-borne disease problems in different geographic settings. These activities do not appear to be informed by an overall strategic plan or set of objectives. After priority diseases and geographic areas have been defined in the strategic planning exercise proposed above, needs assessments could identify both gaps in the current activity portfolio and opportunities for new activities. Conscious focussing of resources and effort leads to greater leveraging of those resources.

Subcontractors appear to have had difficulty identifying activities that yield VBC support. They have not been impressed with the way decisions are made at VBC. Some have avoided VBC and successfully approached missions directly for support of activities. Clear programming guidelines could encourage subcontractors to prepare concept papers and revitalize VBC's ability to take advantage of its subcontractors' expertise.

RECOMMENDATION 14. Needs assessments should be carried out on a limited number of vector borne diseases in a limited number of countries (identified in the strategic planning exercise) to identify gaps and possible programming opportunities.

5. Communications and Marketing of Services

a. Publicity

One of the first things that a new, centrally funded project does is develop a brochure to familiarize missions and bureaus with the services that it will be providing. These brochures are short and easy to digest by the generalist who might not be familiar with the particular subject being addressed. This is the first step in "marketing" a centrally-funded project.

Although money was budgeted for a publicity brochure in the first year of VBC II, no brochure was ever printed. Instead, VBC II sent each mission and bureau a copy of its 1990 Work Plan. There is no doubt that the document contained a good description of what VBC II was and what services it could provide. However, it was lengthy (44 pages) and looked rather imposing. It is doubtful if many of the extremely busy health officers in the missions ever opened the document.

Discussions with mission personnel indicated that the health officers were not aware of the range of services that VBC II offered. For example, several health officers did not know about the VBC II information service. Nor were they familiar with the broad range of technical assistance offered by the project.

Part of the rationale for not producing a brochure was that VBC had already existed and that the same contractor was implementing it. While it is true that the name recognition was excellent, the image was that of a provider of biological technical assistance for vector control. There was no sense that VBC had a broader interest or capability. For this reason, it was even more important that the VBC II Project publish a brochure to orient all those who might utilize the project's services to the new direction and strengthened capacity in the social sciences.

VBC has made a video showing the relationship between vector-borne diseases and development. VBC is also preparing materials for discussion and further exploration of the issues raised in the video. These could stimulate health officials and others to learn more about VBC. While the review team saw the video, VBC did not draw attention to the supporting materials, and another opportunity to "sell" the project, this time to the review team, was lost.

RECOMMENDATION 15. The current and any future project should produce a brochure that briefly and simply presents the main features and services provided by the VBC II Project.

b. Education/Orientation Materials

As stated above the health officers in USAID missions are typically generalists. They have little detailed knowledge regarding vector-borne diseases and less knowledge of how to control either the diseases or the vectors that are responsible for transmitting the diseases. Even if the officers are familiar and interested in vector-borne disease(s) and read promotional materials distributed by the VBC II Project, they should be kept informed of advances in the field of vector-borne disease control and what options and opportunities (e.g., methods, techniques) exist that might assist them in dealing with one or more of their vector-borne disease problems. Because turnover in USAID missions is high, the health and development officers must be reminded of VBC II's existence regularly. The idea that technical assistance is available in a number of different areas must be reinforced on a regular basis.

Because the health officers are generally unfamiliar with issues relating to VBC, there is a need for the project to develop materials to educate them on the nature of vector-borne diseases and what can be done to control them. The health officers would be much more likely to consider utilizing VBC resources and doing something about vector-borne diseases in their countries if the options and opportunities were explained to them in understandable and

programmable ways. There is a general feeling of despair when it comes to attacking malaria - vector control is difficult and expensive and treatment is problematic due to logistics and resistance. However, some approaches in preventing malaria have been found effective. One example is the use of bednets impregnated with insecticide; it is reasonably inexpensive and may last through a transmission season (depending on methods of use).

RECOMMENDATION 16: VBC and any follow-on project should develop educational/ orientational materials for the health officers at A.I.D. missions and periodically publish and distribute circulars outlining new opportunities and options in the control of vector-borne diseases.

c. "Q Contract"

Since the "Q (buy-in) Contract" has been become a common part of centrally-funded projects, there has been some confusion as to the development of buy-ins and what the contractor can and cannot do in this regard. In most cases, the contractor has taken a relatively free hand in generating the concept papers and even draft scopes of works for the buy-ins. Officially, the contractor is not supposed to be too intimately involved in the process. However, because the health officers in the missions are both extremely busy and in many cases do not have a solid knowledge of the subject, the contractors for the central projects assist them in the development of the buy-in.

The Office of Procurement views this involvement unevenly. In the case of the VBC II Project, the contract officer has taken a more conservative view, and the project has shied away from getting involved in the development of buy-ins. This is one explanation of why the project has relatively few buy-ins from the missions. Given the fact that A.I.D. mission personnel are becoming ever more stretched and unable to deal with the paper work required for buy-ins (especially as "Q contracts" become ever more common), a case can be made for relaxing the conflict of interest regulations and recognize what is being done in most cases at present. This is particularly true in VBC II's case since it has virtually no competition in the field.

RECOMMENDATION 17: The Office of Procurement in A.I.D. should clarify what contractors can and cannot do in terms of developing scopes of work and terms of references for buy-ins under the "Q contract" portion of centrally-funded projects.

d. Activity Development

The evaluation team noted that some of the senior VBC II Project staff are devoting their time to inappropriate activities. In some cases they are providing technical assistance that could more appropriately be provided by a consultant. In one case, a senior VBC staffer spent several weeks of his time designing, developing and giving a malaria training course. In another case, the VBC officer carried out insecticide susceptibility test training (in Bolivia). In both instances, the VBC person did a commendable job; the point raised by the evaluation team, however, is whether this is the best use of expertise and time.

In the eyes of the evaluation team the most important function of the senior staff of the VBC II Project is to "market" the project's services. The most effective means of attracting the attention of the missions and gaining their support in the form of a buy-in is to establish a relationship with the A.I.D. health officers in priority countries and to conduct needs assessments that demonstrate the nature and the extent of the priority vector-borne disease problem in their respective countries. By identifying the problems and outlining possible strategies and approaches to address the problem, the VBC senior officer can demonstrate options and windows of opportunities that exist. At the same time, the health officer must be educated and oriented about vector-borne disease control and the need to do something about the problem. If the senior VBC II Project staff is devoting their energies to the orientation and education of the health officers, conducting the needs assessments and designing projects to control the vector-borne disease(s), they will be quite busy and will need to hire consultants to carry out most of the technical assistance assignments. Of course, the senior staff has the responsibility to identify quality consultants and monitor and supervise their work.

RECOMMENDATION 18: Senior VBC II staff should do more to develop project activities.

6. Internal Project Management

VBC II has described its activities in three annual work plans: for 1990, 1991, and 1992. Using these documents, even with additional resource allocation information supplied by VBC, it has proven difficult for the review team to establish which activities VBC II has undertaken, and how these activities fit into a broader agenda. Appendix IX discusses this problem in some detail.

Radical and unexplained changes in the methodology for organizing and presenting an annual work plan suggest that the project itself has difficulty defining its overall plan of action and determining the activities to be undertaken in pursuit of its own goals. Lack of clear managerial direction is often accompanied by unfocussed or inefficient allocation of resources; this appears to be the situation in VBC and is documented elsewhere in this report.

The absence of clearly defined organizational strategies can make the integration of new staff difficult and time consuming. This is particularly true when the new staff bring new skills to be integrated into activities. VBC II appears to be experiencing some difficulties in integrating the skills of new staff members in community participation/health education and institutional/human resource development into its professional perspective.

Unless one is intimately familiar with the evolution of these activities, and the procedures used to allocate and account for resources, it is exceedingly difficult to understand what is being done where and how much it all costs. Besides making review of the project difficult, these inconsistencies suggest a lack of institutional clarity in activity definition and in the procedures used to allocate resources. These findings reinforce the observations made above and elsewhere in this review regarding weaknesses in managerial direction and difficulties in integrating new staff.

a. Decision Making

The evaluation team was concerned about the way in which decisions are made in the VBC II Project. At present, many decisions appear to be made on an ad hoc basis. Of course, when a portion of your project depends on buy-ins, the project is not a completely free agent; it must respond to mission and bureau requests. As described in Section 2 of this chapter (on project design and strategic planning), there is a need for strategic planning and the establishment of priorities. This will help focus attention and concentrate resources so that there is a greater chance of achieving impact and a reduction in morbidity and mortality rates attributable to vector-borne diseases. By programming more core funds to deal with the vector-borne disease with the highest mortality rates (i.e., malaria) in the region (i.e., Africa) and countries having the most serious problem, VBC II can expect to achieve better results. There is always a trade-off between programming project funds in a country (e.g., in Latin America) which has a well established infrastructure and can absorb and utilize project funds more effectively versus putting funds into a country with a poor health system and little capacity to address the control of vector-borne diseases (e.g., in Africa). However, as A.I.D./ Washington plans to increase funding for the most serious vector-borne disease (i.e., malaria) and add it to the priority list of Child Survival interventions. It makes good sense that VBC II concentrate more of its resources in the continent which currently suffers most from this disease. While the absorptive capacity in Africa is only a fraction of what it is in either Latin America or Asia, there is more than enough for VBC II to do in Africa to begin effective malaria control programming. The challenge is there.

RECOMMENDATION 19: Project decisions should be made in accordance with a strategic plan.

b. Management Style

According to comments from several past and present VBC II staff, decision making in the project is highly centralized. While staff meetings are held regularly, decisions are seldom made there; they are made at the top by the most senior corporate and project administrators. There is a lack of participatory management.

The top-down management approach is a concern in VBC II when there is supposed to be a reorientation of project activities from mainly vector control to vector-borne disease control. This requires a significant broadening of perspective and new ideas and approaches. The senior officers at MSCI and in the project had more of a technical orientation and neither fully appreciated nor supported the new direction. When the new staff members brought on to develop the new approach tried to introduce innovative and creative approaches, their ideas were often not accepted favorably or not adopted.

MSCI and the VBC II Project are run in a highly structured, hierarchical manner. The staff members who do not belong to the top echelon of two or three feel that they are not listened to and that their ideas have no chance of being incorporated into project activities. Problems have been faced especially by

those staffers who were hired as part of the effort to add a social science perspective to the project. Several project staff have left the project for this reason. They saw little chance of the new direction ever prevailing given the strong technical biological bias and orientation of the senior staff.

If the broader aspects of the VBC II Project (e.g., institutional/human resource development, health education and community participation) are ever to be developed to any extent, the management style of the project will have to change. Innovative ideas and approaches from individual staff members will have to be listened to and appreciated and, where found reasonable, tested in the field. While impossible to verify, there seems to have been a number of missed opportunities because of the management style practiced by the VBC II Project.

RECOMMENDATION 20: The VBC II Project should adopt a participatory style of management to increase the effectiveness of the contractor's project management.

c. Activity Monitoring

The review team has seen no evidence that activities' objectives or accomplishments are defined or monitored in any systematic fashion. Lack of defined objectives can lead to omissions in the design or performance of activities.

For example, the project does not make a case or provide a rationale for either of the trials being conducted in Honduras (on malaria diagnosis and BTI). While the short-term objective is clear (i.e., testing the efficacy of new methods under local field conditions), it is not apparent how these tools fit into the overall strategy. There are other, equally new, alternatives for diagnosis and vector control, but these were not evaluated.

A strategic problem was also identified in Bolivia where a significant difference existed between the objectives of the government and the other participants in the Chagas' project. Because the project was initiated quickly for political reasons, it never underwent the planning process that normally identifies and defines objectives.

In Pakistan, the information system supplied to the Malaria Control Project does not provide the information required in project management. In fact, the MIS-generated data is less useful than reports currently prepared manually. While the evaluation team recognizes the difficulty of working in Pakistan, these problems make it all the more important to define precisely the sub-project activities' objectives. It is also extremely important when the technical assistance is provided in the form of short-term TA, where all those involved must be kept informed of what the others have done to move the project ahead in relation to those objectives. No evidence could be found that this had been done.

The emphasis on a multidisciplinary approach in VBC II means that the concerns of several areas of expertise will be addressed in a single activity. An activity manager cannot be expected to have expertise in all aspects of a

broadly based activity. Written guidelines for activity review, as well as regular peer review within VBC, could help the project maintain and improve the quality of the multidisciplinary approach.

RECOMMENDATION 21: Project effectiveness would be improved by defining objectives and the regular monitoring of each activity.

d. Job Descriptions and Recruitment

When the evaluation team requested to see job descriptions for the professional staff positions, it was informed that none existed. This is curious since the evaluation team was told by A.I.D. that job descriptions, at least for senior project staff, do exist. The lack of detailed, well thought out job descriptions makes it difficult to recruit candidates to fill these positions. There is little evidence of a broad-based recruitment to fill some of the VBC II Project positions. They recruited some of their senior project staff through their network. This can sometimes result in high caliber candidates being hired. In other cases, it can be serendipitous and the project can end up with a less than optimally qualified staff member.

The project would especially benefit from broader searches for some of the social science positions. In addition, the top project directors would benefit from asking for and accepting advice from institutions and individuals having expertise and experience in areas in which the project and its directors have little knowledge. The project's reluctance to seek or accept advice from outsiders for fear of exposing weakness or lack of knowledge must be overcome. No group can reasonably be expected to have intimate knowledge of all programming aspects and to have a roster of professionals that can respond to a broad range of needs.

RECOMMENDATION 22: Detailed job descriptions should be written for each position, and in the future there should be nation-wide searches when key staff positions have to be filled.

e. Consultant Selection

While the majority of consultants hired by the VBC II Project were found to be satisfactory, the evaluation team identified some concerns. As mentioned, a number of the consultants used were from a network of retired vector control specialists who have worked together for many years. They are certainly experienced, but as pointed out, they may not be fully familiar with or supportive of the newer and more innovative strategies, approaches and techniques.

A particular problem with a consultant team that visited Belize in 1990 was noted. Although the particular assignment may have been funded under the VBC I Project, it was carried out during the transition year when both contracts were in operation, and the USAID officer in Belize considered it as

part of the VBC effort. Four of the five consultants on the mission were identified by the USAID mission in Belize as being unqualified. The mission maintained that it never received a consolidated report. None of the four consultants was ever used again by VBC II.

One consultant who has been used in three countries (i.e., Jamaica, Belize and scheduled to be used in Pakistan) does not appear to have appropriate expertise or cultural experience for all his assignments. Two of the assignments required major expertise in malaria epidemiology and control of Anopheles vectors, subjects on which the consultant has no publications or work experience. He is part of a group of consultants which come from one southern state; it may be unhealthy to rely so heavily on one group of consultants and it reduces the chance of getting new ideas and approaches into projects. The trade-off between continuity of technical assistance and need for new blood occasionally must be considered and a balance achieved.

RECOMMENDATION 23: VBC II should do a better matching of consultants with assignments so that the person's expertise and background fit well with the technical needs.

7. Collaboration and Relationships

a. Country-Based Projects

The Chagas' Disease Control Project in Bolivia is a good example of how collaboration between projects and local agencies could facilitate a greater use of scarce resources, provide a more smoothly coordinated operation of multiple demonstration projects, and multiply the transfer of appropriate technology for housing improvements.

The Child and Community Health (CCH) Project, supported by A.I.D., has a Chagas' Disease component which is conducting demonstration projects in four different regions of the country (Topisa, Tarija, Cochabamba, and Sucre). Each project is focusing on a somewhat different approach to control. For example, community participation is emphasized in one, spraying for vectors in another, and improving houses in another. Although there is overlap in activities each project is using a different strategy to achieve effectiveness. The different regions represent different ethnic and environmental differences and local politics play an important role in how decisions are made in the communities. The lack of central leadership and coordination of the projects from the CCH office in La Paz, together with local political some factions among the projects have created frictions between project participants. Communication and collaboration between the projects and between the project leaders and PVOs could be improved.

For example, Habitat, the UN Agency in La Paz, has excellent resources to develop health education materials and provide community organization assistance, which it is doing successfully in Tarija. But the Cochabamba project, which desperately needs this type of assistance, is not getting it because project leaders are not communicating well. The other projects also

need assistance with health education and community participation. The Technical Advisor for Child Survival (TACS) for the CCH project in La Paz is aware of the needs and problems and efforts are underway to negotiate a contract with Habitat to provide these services. This may take some time to finalize.

The evaluation team members who visited Cochabamba discovered through discussions with the director of Habitat that health education and community organization services could have been provided much earlier had better collaboration occurred between the projects. The VBC II had secured a consultant with Chagas' and community organization experience in Venezuela to work with the project. He made two trips and his services were highly valued by the coordinator of the Cochabamba project, but future trips by the consultant were terminated by the TACS officer due to personal differences between them.

The evaluation team believes this example demonstrates that if the VBC II project had staff persons experienced in HE/CP and I/HRD involved early on with other staff members in the planning and implementation of this project, these difficulties could have been avoided. Increased collaboration between all organizations and agencies concerned can improve communication, avoid duplication of services, and maximize the use of scarce resources.

RECOMMENDATION 24: Greater collaboration within selected country-based projects will increase the chances of impact.

b. A.I.D.-Funded Projects

In some of the projects visited, i.e., Honduras and Belize, the staff mentioned that vector borne diseases such as dengue and malaria were not considered to be of high priority among many families and that they had begun to look for ways to integrate vector control activities with other priorities of people. Other priorities that assumed a higher place in some of these communities were safe water and sanitation. In the El Progreso project in Honduras the staff were organizing families in the barrios so the people could identify their own priorities for improvements and develop leadership skills to accomplish their goals with their own resources. In some cases dengue was not a high priority, but when the community developed enough confidence that they could accomplish some other things, they wanted to began work on dengue control.

This demonstrates the importance that when organizing skills are developed among community members and they begin to realize they have the ability to achieve things for themselves, they can begin to focus on priorities at different levels and be more successful in accomplishing them. Even though vector control may not assume a high priority, if it is integrated in a program with other related activities, such as water, sanitation, drainage, etc., it may eventually be regarded by people as more important.

This principle demonstrates the importance of integrating vector control whenever possible with other related programs such as water and sanitation, agriculture, forestry, irrigation and housing. In order to do this it is necessary to collaborate with other agencies who have responsibilities in these areas.

The project in Belize, where VBC II is collaborating with WASH to carry out an integrated project, is a good example where joint efforts are being made with the A.I.D. mission, the Government Ministries of Health and Natural Resources, and several non-governmental groups to combine resources and activities to promote water, sanitation and the control of vector borne diseases at the community level. Even though this integration is proceeding at the local government level, the inputs from VBC have not been entirely positive. The technical assistance provided by the VBC I/HRD person was viewed by the USAID staff in a very negative way; of greatest concern was his inability to work as part of a team. In addition, the WASH contractor has described the collaboration with VBC as being difficult, especially in getting them to participate in the broader development activities associated with vector-borne disease control.

The Health Finance and Sustainability (HFS) Project is another example of problematic collaboration with a complementary A.I.D. contractor. While this effort to study the economic implications of malaria is only in its most formative stage, VBC II's reaction to having to collaborate with another A.I.D. contractor has been negative. The project views all other contractors as competitors and is reluctant to join forces with them to achieve what should be a shared goal.

RECOMMENDATION 25: The project should improve its collaboration with complementary A.I.D. centrally-funded projects, such as WASH and HFS.

VBC II has collaborated and joined forces with several health organizations and multi-lateral donor agencies. One example is their collaboration with CDC, PAHO, and A.I.D. to develop a new strategy for managing dengue outbreaks. Another collaboration still in progress is their joint work with WHO/PEEM in the rice project in the Philippines.

Areas where they might integrate efforts are with other sectors of A.I.D. that have responsibility for housing, agriculture, transportation, forestry and irrigation/rural development. R&D/H could take more responsibility to facilitate interaction and collaboration with these sectors.

The team has observed that VBC staff have been reluctant to look at and talk about their own weaknesses and shortcomings. They have apparently not felt confident to acknowledge their weaknesses and to seek out individuals and other sources of expertise that might be able to complement what they have not been able to provide. The review team feels that it is a sign of strength, not weakness, when a person or organization can look at their weaknesses, learn from mistakes, and go forward to do a better job.

RECOMMENDATION 26. When the VBC II project does not have a particular expertise required, they should consider subcontracting or seeking collaborations with a group that does.

8. Effectiveness of Activities Undertaken

a. Technical Assistance

Technical assistance is generally most successful when it is provided in a manner that helps people learn to do things for themselves. It is a process that creates a relationship between the giver and the receiver so that the receiver develops new insights and learns new skills. The effectiveness of this interactive process largely depends on the quality of the interpersonal relationship. It is built upon mutual trust and respect and fostered by sensitivity and effective communication. The evaluation team attempted to include these issues in evaluating the effectiveness of technical assistance activities on the part of VBC consultants. In addition, it is often difficult to separate technical assistance from technology transfer. Moreover, assistance without transfer is of more limited value.

Technical assistance within VBC has involve a wide diversity of activities. These have been grouped by VBC into one of nine different categories. Most projects, whether Core or Buy-in Contracts, generally involve multiple categories, i.e. from 1 to 5. The activities of the 24 buy-in projects and 79 core projects listed by VBC II as of Spring 1992 are distributed among these 9 categories as follows:

Activity Category	Core	Buy-In	Total
Design, Evaluation & Implementation	22	14	36
Emergency Response & Disaster Control	3	0	3
Evaluating New & Existing Control Tools	17	9	26
Operations Research & Monitoring	19	11	30
Vector Bionomics & Transmission	10	4	14
Surveillance & Monitoring Systems	12	6	18
Social & Economic Analysis	3	6	9
Strengthening Host Country Capacity	36	12	48
Community-Based Approach to Vector-Borne Disease Control	20	8	28
Total Activities	142	70	212*

* The VBC II Project has not had 212 separate activities; some of the sub-projects are double counted, primarily because of the two contract ("C" and "Q") system.

The continued reduction of A.I.D. bilateral agreements has significantly reduced VBC activity in the evaluation of bilateral malaria control programs. Only two remain and their life expectancy in limited. This also has served to reduce the proportion of overall VBC technical assistance activity that is associated with malaria, a trend that is inconsistent with the importance malaria is afforded by A.I.D. missions and bureaus. All the missions without

exception which responded to the evaluation questionnaire cited malaria as a serious problem in their country. It was clear to the Review Team that all the regional bureaus, and the African Bureau in particular, consider malaria the highest priority (among parasitic diseases) and one which they increasingly want to address. Nonetheless, it is a health problem whose solution, at least in Africa, must be justified by A.I.D. in terms of economic development.

Recently, VBC has initiated activity in the area of economic impact analysis of malaria in Africa. More assistance of this type is clearly needed. R&D/H is funding a more detailed follow-up analysis which suggests that VBC's venture into this new area was wise and well received by A.I.D. The collaboration with WHO/PEEM/IRRI in the Philippines to investigate irrigated agriculture practices in relation to malaria and other vector-borne diseases is another recent activity. It, along with the analysis of BTI in Honduras, emphasizes new environmentally-friendly approaches to malaria control and is consistent with the VBC II mandate to examine new control options. It seemed unfortunate to us that VBC has not been more involved in the development and testing of impregnated bed nets for malaria control. VBC is ideally positioned to do the sort of standardized field evaluations and behavioral analyses in a variety of malaria settings that are so needed.

VBC continues to be involved in the field evaluation of new malaria diagnostic methods (i.e., polypeptide diagnosis project) in Honduras. The Review Team was able to observe a training workshop on ELISA and Dotblot techniques conducted by a VBC consultant and Honduran graduate student in the Chulotecha hospital. This is a highly appropriate activity provided it is a technology that is within one to two years of being field ready. The field testing of diagnostic tools should be expanded at the proper time to include unbiased comparisons of other new diagnostic methods as well. The field testing of this diagnostic method revealed that well over half of all malaria cases are being missed by microscopists examining thick blood smears in Honduras. This points up the great need for better diagnostic tools.[4]

One of the largest single activities involving malaria is the development and testing of the six malaria training modules. This effort seems to have been well done. Perhaps there is still a need for additional malaria control training materials aimed at less sophisticated audiences. The field-testing of the modules that is currently planned should help clarify future technical needs in this important area of training and institution building. This investment by VBC should lead to several buy-ins once the availability of these modules is advertised.

The geographic distribution of VBC technical assistance does not correspond particularly well with the regional impact of vector borne diseases in terms of morbidity and mortality as shown below:

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[4] In fact, this expansion of testing is already being readied. Co-testing of the DNA probe, blood slides and QBC will begin in July.

Impact Rank	VBC Proj.(#)	Budgeted	Spent
1. Africa	29	$1,095,414	$496,021
2. Asia/So.Pacific	18	697,193	377,216
3. Latin America	36	1,275,732	694,460

There are undoubtedly valid reasons for some of this disparity but VBC should be encouraged to bring their level of effort more in line with the geographic importance of vector-borne diseases in various regions of the world.

There is a critical need to provide technical assistance in health education and community participation in vector-borne disease control programs. The Review Team visited two field sites where community participation is being practiced at some level. In the Chagas' Control Project among the Aramasi people near Cochabamba, Bolivia, the evaluation team thought that VBC could have been more assertive and aggressive in developing community participation and health education activities associated with house improvement. The A.I.D. mission has contracted Habitat to provide this service, largely is seems because they did not view VBC as an organization that was equipped to provide this technical assistance. VBC is much involved in providing technical assistance in other aspects of this excellent project.

In El Progreso, Honduras, a community-based dengue control program based on non-chemical vector control methods has been initiated. The Rockefeller Foundation is the primary donor but VBC is providing important technical assistance in biological control methodology. The long-term VBC consultant is also contributing substantially to the community participation component of this project. More long-term assistance of this type is clearly needed. One only hopes that the untested biological control methods being encouraged among the people in El Progreso will in fact reduce mosquito populations sufficiently to interrupt transmission.

Given the wide variety of technical activities that VBC has carried out, it seems probable that greater synergism and impact would be achieved if innovative activities were concentrated in a smaller number of priority countries and dealt with broad issues involving only the most important diseases. VBC can not solve all the problems that they could reasonably address so they should be encouraged to pick big targets where they have the best chance for maximizing their impact and thereby encourage mission investment. For example, VBC is uniquely equipped to field evaluate new diagnostic and vector control technologies (e.g., bednets) if they were to choose to concentrate some resources in this area.

RECOMMENDATION 27: VBC technical activities should be innovative and have broad application, concentrating more on operations research and the field testing of new techniques and approaches. These efforts should be focused in particular regions and on diseases having the greatest impact on morbidity and mortality.

b. Quality and Effectiveness of Consultants

The team members visited five missions and had telephone conversations with and FAX responses from another 20 missions and individuals who have interacted with VBC II consultants[5]. The responses included a wide array of reaction to inquiries relative to the quality and effectiveness of consultants. In general, host country health officials were the most positive about consultants and their usefulness. Mission staff were usually positive about their experiences with VBC consultants, although out of one team of five consultants in Belize in 1990 when both VBC I and II were functioning simultaneously, four were considered to have done an inferior job. With but one exception, the consultant activities of VBC's own staff were viewed as high quality and effective. Dr. Arata's activities in the LAC region were often singled out for unsolicited praise.

Contracted consultants varied from very effective to situations where they were unwelcome to come back to the country. The most negative reactions generally involved personality conflicts or ignoring work plans rather than lack of technical expertise. However, there were situations where consultants clearly had lacked the competence to do assigned tasks and several others where the consultants sent, though having competence, did not appear to be the best match for the requirements of the particular task. For example, one consultant with technical expertise in insecticide applications for adult Aedes was sent to three different countries; two of the consultancies called for familiarity with malaria and expertise in non-chemical control of Anopheles mosquitoes, which were not strengths of this particular individual.

As mentioned, VBC has shown a tendency to select a large number of its consultants (at least nine) from the New Orleans area and it is not clear why such a geographic disparity should exist. There is also a tendency to reuse a small group of experienced biologists, but who are less familiar with or willing to utilize innovative, "state-of-the-art approaches) from WHO/PAHO/ CDC/A.I.D., etc. who are often former associates of senior VBC staff members. This is discussed in Section III.6.e of this report.

It appears to the evaluation team that some less experienced consultants were not well prepared and directed by VBC for their assignment. Or, if they were, the plan of work given by VBC did not correspond with the expectations of the missions. In at least one case the plan of work prepare by the mission and faxed to R&D/H was not forwarded to VBC prior to the briefing and departure of the consultants.

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[5] Summary of Responses: Of the 13 missions responding by fax, 100% said malaria was a problem. Six more mentioned onchocerciasis, five schistosomiasis, four Guinea worm, three dengue and trypanosomiasis, and one each encephalitis, leishmaniasis and yellow fever. One mission stated that they did not know the VBC II Project. Three other missions were unfamiliar with services provided by VBC II. Those who did know the VBC II project referred to its support with such adjectives as "competent", "responsive", "useful",, "very positive" and "excellent". Five missions (38%) had had no contact with VBC II. Two missions mentioned receiving quick responses to requests for information; two more said reference materials sent by VBC II were helpful. One mission requested increased dissemination of relevant literature.

RECOMMENDATION 28: More rigor and thought in the selection of consultants and more VBC core staff involvement in development and supervision of technical assistance will improve effectiveness and continuity while helping to develop new programming opportunities in the country.

c. Technology Transfer

VBC II activities that have involved technology transfer include health/management information systems, upgrade of laboratory facilities, and development of diagnostic tools and vector control technologies. The transfers have been successful when the settings for which the new technologies were well understood, when technologies were chosen according to the needs of the setting, and when the new technologies could function quickly and usefully in their new settings.

- In Cochabamba, Bolivia, a government medical entomology laboratory was inactive. With technical assistance from VBC, equipment was obtained from the Bolivian Chagas' Control Project. Current methods for evaluating the efficacy and susceptibility of kissing bugs to candidate pesticides was being demonstrated and technology being transferred to laboratory personnel by VBC staff. In addition, an improved brick-making techniques was introduced by a VBC consultant architect. Apparently, this rather old adobe technique was still being practiced in southern Bolivia but had become a lost art in Cochabamba until reintroduced by the VBC consultant.

- In Swaziland, VBC reviewed the information system of the Malaria Control Unit (MCU). A year later VBC provided additional technical assistance to train MCU staff in basic computer skills. In collaboration with MCU staff, VBC defined and implemented a simple database system to manage the epidemiological and spray data collected by the unit. Eight months later, with no further technical assistance, the MCU had assumed ownership of the system and was using it to provide its routine management information.

- In Pakistan, VBC reviewed the information system used at the Malaria Control Program (MCP) twice. After each visit VBC proposed six months of technical assistance to develop and test a pilot information system in one province, with the possibility of extending the system to other provinces should it prove useful. Apparently the proposals were favorably received by the local USAID mission, but the MCP, which is sometimes reluctant to accept technical assistance, rejected the proposal on the grounds that since program management is centralized, activities at the periphery served little purpose.

  To encourage the use of computer technology in the MCP, the mission purchased computer systems and basic software for installation at each of the country's four provinces and at the center, and arranged for a local firm to provide basic computer literacy training for two MCP staff for each computer. VBC was asked to provide a database system to manage the case data collected, to install the system, and train staff in its operation upon conclusion of the computer training course, within a few weeks.

The database program was designed and implemented without collaboration with the MCP and apparently without reference to reporting forms and procedures currently used by the MCP. Since the database program does not provide the reports currently used to manage malaria control, there is no incentive to use the system. Consequently, there is no leverage for MCP or USAID to encourage, monitor, and expand the use of data in management decision making. While some of the problems with the database system have been recognized by MCP, the mission, and VBC, and it appears that a few fairly simple adjustments to the database program would make it useful in the MCP context, it is not clear that the situation is being addressed in a way that will result in a data management system that will be useful to, and used by, the MCP.

Several lessons can be learned from this experience. The local technical assistance provided (purchase of computers and computer literacy training for MCP staff) represent basic steps that must be taken to introduce computers into a manual data management system, and it appears that this assistance was well organized. The external assistance provided through VBC was apparently not designed with close attention to the MCP context, and there were apparently no clearly defined objectives to assess and adjust the technical assistance.

- In Bolivia, VBC funds a local computer specialist to provide regular support to the Chagas' Program. Given the nature of a pilot project with evolving data management and analysis requirements, local/on-going/on-demand support is clearly the most appropriate form of technical assistance.

- In Honduras, VBC has experimented with a Geographical Information System (GIS) to identify and pinpoint areas that are priorities for vector control operations. While GIS is an interesting technology, and demonstrations of its application are usually well received, it does not appear to be well-suited for use in developing countries. GIS applications require accurate, detailed data, which is not commonly available in the developing world. (Except perhaps in research sites, the setting used by VBC to demonstrate the GIS.)

VBC has incorporated mapping facilities into several of its data management applications. These mapping facilities display geographic areas with colors or patterns that indicate the values of variables in the area. For example, blue might indicate an annual parasite index (API) of 2.01-4.00, while red indicates an API of 4.01-6.00. This type of facility is sometimes called desktop mapping, and should be distinguished from a GIS, which allows analysis and exploration of multiple variables, including geographic characteristics.

The desktop mapping facilities can be useful in presenting information about vector-borne disease, since these disease patterns are often strongly correlated with geographic patterns. When these facilities can be incorporated into data management systems with minimal incremental cost, they provide a useful presentation facility and may add enormously to the appeal and acceptability of the system.

- In Honduras, a new diagnostic tool for malaria was field tested and then this technology was transferred to regional hospital staffs through a series of three-day workshops. Also in Honduras, a local team was trained by VBC consultants in the rearing, distribution and evaluation of cocopods and other biological control agents that were being employed in a community-based dengue control project. In a less successful effort, a group of mosquito control spraymen were taught how to formulate and apply the biological agent BTI for the control of larvae of the local malaria vector. When the consultant returned a year later, the workers had forgotten most of the techniques they were taught because they had never been directed to use them during the interim.

- In Nepal, a VBC consultant developed a mosquito identification manual and trained a group of local vector specialists in mosquito identification using this new resource.

- Each year VBC has supported the travel for several Latin American vector control specialist to attend the annual meeting of the American Mosquito Control Association. At this meeting VBC supports a Spanish session of scientific papers (including publication of bilingual abstracts) to encourage participation by non-English speaking persons. This has become a successful event and encourages technology transfer.

Two elements are crucial in technology transfer: needs assessment and the integration of the technology into a new institutional environment. While technical expertise clearly plays a role in this process, the match between the technology and the absorptive capacity of the new environment determines whether the technology takes root. The skills with which institutional and human resources are identified and developed during technology transfer may well be more important than simply understanding the technology.

Technology transfer requires a clear definition of the objectives to be accomplished, and assessment and adjustment of the transfer process in light of those objectives. Definition of goals, in terms of enhanced or new activities expected in the new context, and an assessment of how those goals have been (or have not been) achieved should be built into every technology transfer activity.

d. Institutional and Human Resource Development

The role of the I/HRD staff person in the VBC II Project is critical in providing assistance for institutional and manpower development to country projects. To carry out this function effectively this staff person must work closely with other staff members and be involved at the very beginning when decisions are made to provide assistance to A.I.D. missions. In addition to providing various types of technical assistance to missions (i.e., vector control methods and technologies) it is equally important to consider how effectively that assistance can be used, incorporated, and maintained by the institution. Important questions should be asked, such as: Does the organization have the resources to maintain the technology? What training is required to utilize it? How much responsibility can (or should) the community take? Is there duplication of resources or efforts with other agencies or organizations? Would better collaboration or cooperation between agencies, projects, departments lead to more efficient use of resources?

Getting answers to these and other types of questions at the beginning stages of project development would provide valuable information from which decisions could be made to involve representatives from government, private and community organizations and develop a cooperative linkage of efforts and resources. This in turn could strengthen the human commitment to the project and build a more sustainable effort.

In Belize, this process has successfully begun. During the last three years, the A.I.D.-sponsored IPTBH Project, WASH, and VBC II have been collaborating with the Ministries of Health and Natural Resources, local PVOs and communities to combine resources to carry out an integrated program in water, sanitation, and vector control. This project is now in the stage where, after several meetings and a workshop, the two ministries have agreed to submit a joint proposal to A.I.D. for training staff at the National, District and community level to make the program community based and more sustainable.

An example where this process of integration, collaboration and institution-building could be effective but is not yet taking place is in Bolivia in the Chagas' Disease Control Project of the A.I.D.-sponsored CCH program. This example has been described earlier under Part VI as an example where little collaboration has occurred and resources are not being fully utilized. VBC II has had considerable input to this project through various technical consultants but they have missed a significant opportunity to provide effective assistance to facilitate better collaboration among the four field projects and to help strengthen local institutions through management training and other means.

RECOMMENDATION 29: I/HRD issues should be considered and planned for at the beginning of all projects.

RECOMMENDATION 30: Assessment of the need for training activities should be an integral part of HRD planning. Such training should be designed according to the needs of the participants and be practical and experiential in nature.

The person currently holding the I/HRD position in the VBC II Project has been involved in developing a number of worthwhile activities connected with training and institutional development. Most of these activities have been based within the U.S. The development of a protocol for assessing the training needs within host countries will be valuable after it has been field tested and used with A.I.D. missions. The malaria control training units that he has assisted in developing have the potential for increasing the level of skills of technical vector control workers in host countries. He has been involved in a number of other activities such as the development of a training strategy workshop and the provision of assistance to PVOs who are carrying out community-based malaria control programs.

The evaluation team was not able to determine the number of in-country persons trained by the VBC II since they do not maintain such statistics. However, during the field visits, the team found that in Pakistan, 10 persons were trained in computer literacy; in Honduras, 22 microscopists and microbiologists were trained; and in Nepal, 31 government workers were trained

in mosquito identification. This indicates that some training was taking place under VBC II and that capacities are being developed and knowledge/skills were being transferred.

In Belize concerns were raised about VBC's capability in I/HRD. Problems arose between the VBC employee and local mission and ministry staff. In a different aspect, the evaluation team is concerned that the I/HRD person is not functioning adequately within the full range of his job responsibilities. During his 14 months in the job, he has worked only in Belize and has not visited any other country programs, although he has had other involvements in I/HRD activities.

When the evaluation team requested a job description of the I/HRD position, it was given a paragraph job qualification that contained no task statements[6]. In fact, it was the description and qualifications for the job taken from the RFP. The team was told that this is all that was available, although A.I.D. told the team that detailed job descriptions were developed. It was never provided to the team by the contractors during the course of the evaluation despite the fact that considerable time had been devoted to the development of the scope of work and description of the I/HRD position.

The evaluation team's site visits indicate that local institutional development can be facilitated most effectively by on-site consultation from someone who is skilled in relating to people in key positions, who can identify common needs and priorities, who can facilitate constructive interaction between people in different agencies, and who can make practical suggestions as to how agencies can coordinate their activities to work more effectively together. This kind of interpersonal negotiation can lead to agreements to accept further assistance in the form of workshops, seminars, training in management and other skills, and other activities that promote the development of institutions and human resources. At the present time VBC does not appear to be providing this kind of service to local A.I.D. missions.

As recommended above (number 21), a detailed job description for the position of I/HRD should be written and priorities set for his/her duties. In addition, the performance of the present staff person should be reviewed to evaluate the quality of work performed and to determine areas where improvement is needed. Based upon the new job description, the Project Director might consider who can fill the position most appropriately.

e. Health Education and Community Participation

Peoples' awareness, understanding, commitment and action towards effective vector borne disease control requires a high degree of community involvement in the planning, implementation and evaluation of activities and programs towards this end.

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[6] The description of the ID/HDR Specialist from the RFP is as follows: Mid-level professional. Overseas experience in institutional and human resource development is required. Should have strong experience and expertise in development assistance and program management. Will assist the Project Director and Deputy Director and will provide technical information throughout the contract. Fluency in foreign language required.

Successful vector borne disease control programs require the participation of families and communities in a variety of activities and these are as important as the technical aspects of vector control. For example, effective control of malaria and dengue requires that people use bed nets, eliminate mosquito breeding places in and around their homes, properly drain waste water from houses, roads and fields, and cooperate in the spraying of homes. The prevention and control of Chagas' disease requires a high degree of cooperation from families in improving their houses, eliminate sites where the "kissing bugs" live and to keep domestic and farm animals away from their homesites. Effective treatment of all vector borne diseases requires that adult family members recognize various danger symptoms and know where to go and what to do to obtain proper treatment. Getting people to understand and carry out these types of preventive and treatment measures requires appropriate health education and community organization that is integrated into the entire planning process for vector borne disease control programs.

Unfortunately, this type of planning has not taken place in most of the VBC sponsored activities. A major reason has been that until only within the past few months there has been no HE/CP person on staff. This has been discussed in section VII 3.

It appears also, with a few exceptions, that VBC II has not sought out consultants with this expertise. In Bolivia, an American VBC consultant with experience in a PAHO-funded Ghagas' disease control effort in Venezuela was used a few times, but he was asked not to return due to personal differences with the A.I.D. TACS representative. During the early phase of VBC II and as VBC I was coming to a close, VBC sent a team of five consultants to Belize - one was to consult on health education and one on community organization. But their work and reports were rejected by the A.I.D. General Development Officer and the local hire Health Officer as being "poor quality" and "useless". The VBC consultant hired to work on biological control methods in El Progreso in Honduras is providing some useful assistance in community organization, but that work is secondary to her primary purpose in the project.

The team's findings from field visits lead them to conclude that the VBC II Project does not have a good track record in providing services that promote health education and community participation to local projects.

RECOMMENDATION 31: The person responsible for health education and community participation should work closely with the I/HRD person and other project staff to ensure that HE/CP is a part of all vector borne disease control efforts. And the VBC II project should make maximum use of HE/CP consultants and local NGOs to provide these services locally.

f. Information Support

The Vector Control Information Center (VCIC) has approximately 15,000 technical documents (published and unpublished), monographs and journals/ newsletters on vector-borne diseases. It distributes VBC II project reports, some of the most popular being the Tropical Disease Series (on the 10 vector-borne diseases) and the Economic Impact of Malaria in Africa report.

According to the RFP, the VBC II Project is expected to distribute 180 documents each month. According to information provided by the VCIC, the requests for information during the first two and a half years of the project were less than expected. A total of 911 requests were received (slightly more than 30 requests per month) during that 30-month period. The requests by user category were as follows:

VBC	135
A.I.D./W	116
USAID Missions	78
Ministries of Health	80
LDC Personnel	151
Donors	13
Eastern Europe	27
Subcontractors	79
Developing Countries	80
U.S.	152

The less-than-anticipated demand for documents from the VCIC may possibly be explained by the lack of knowledge about the service that the evaluation team found in the field. Several of the USAID health officers in the countries visited by the evaluation team were not aware of the existence of the information service. This could be rectified by the publication of a brochure describing the services provided through VBC II.

The VCIC should promote the information service in a more active manner. The Information Center has done a number of proactive mailings as well, sending approximately a dozen items to list that includes multilateral donor agencies (e.g., WHO and UNICEF), USAID officers and libraries, and developing country institutions. A list of the proactive mailings can be found in Appendix X.

The VCIC also prepares what it refers to as Vector-Borne disease "TIPS" (tailored information packages) which it sends to information centers in research institutions and universities around the world. An equally productive activity would be a quarterly publication of a collection of the most recent articles on a few priority issues (e.g., malaria, social science advances/ techniques used effectively in the control of vector-borne diseases). Each issue would be circulated to interested missions/bureaus and governments (ministries of health) to increase their knowledge and enthusiasm for VBC interventions. It would help develop relationships with the leaders in vector-borne disease control efforts in priority programming countries. In addition, the publication would introduce the local program people to practical and affordable options and opportunities to reduce the mortality and morbidity rates from vector-borne diseases. The materials should be targeted as much as possible to individual mission/bureau/country needs and interests as possible.

RECOMMENDATION 32: VBC II and any follow-on project should develop and distribute, possibly on a quarterly basis, a collection of articles on a few priority vector-borne diseases and highlighting the importance of the broader perspective, utilizing innovative approaches and strategies.

IV. CONCLUSION AND SUMMARY OF RECOMMENDATIONS

Chapter III discussed the findings of the evaluation team and made a series of recommendations for action to resolve the specific problems identified. Some of the recommendations are more appropriate for immediate action; the others apply more to the longer term and should be considered in conjunction with any follow-on project which addresses vector/vector-borne disease control. The party responsible for the taking action in each recommendation is identified.

1. Issues for Immediate Attention

R&D/H/CD and the contractor should discuss and consider the issues addressed immediately. Only a little over two years remain on the current VBC II Project, not enough time to make some of the basic changes required to increase the effectiveness of the effort and make up for lost time and opportunities. However, it is important that some of the suggested activities be initiated so as to establish a solid foundation for any future vector/vector-borne disease control activities. If, on the other hand, the VBC II Project is terminated early and its activities assumed under the proposed Environmental Health Project[7], the issues discussed here can and should be considered for whoever is responsible for the vector/vector-borne disease control aspect of the new effort.

The major issues identified by the evaluation team that require immediate attention can be grouped into four categories: planning, leadership and management, personnel and marketing. The group which should take action on each specific recommendation is mentioned and indicated by bold lettering.

a. Planning

The **VBC** II Project is in need of a serious strategic planning exercise to define exactly what the project is to achieve and how (see Recommendation #3). The evaluation team strongly recommends that the project focus its efforts (especially the use of core funds which it controls) in the region requiring maximum assistance (Africa) and on diseases responsible for maximum morbidity and mortality (malaria) (Recommendation #4). R&D/H should meet with VBC II and arrange a strategic planning exercise as soon as possible. To facilitate such a strategic planning process, it would be most helpful if the **VBC II** Project were to produce a "lessons learned" monograph which summarizes the most important techniques and innovative approaches that have been utilized during the last seven years of the VBC I and II Projects (Recommendation #5).

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[7] According to R&D/H/CD, a centrally-funded Environmental Health Project under development. This project is expected to include the activities currently included in the WASH and VBC II Projects, plus new elements in environmental health and pollution control.

Closely connected to the strategic planning exercise is the recommendation that **VBC II** should define clearly specific objectives for each project activity; this will allow the project to monitor the progress of their efforts (Recommendation #21). This will help resolve some of the problems of tracking country and disease specific activities as currently found in VBC II and discussed in Appendix IX.

To assist in the planning process, **VBC II** should reconstitute and reactivate the SAC (Recommendation #13). This committee should have strong representation from the broader social sciences to assist the project operate more effectively in this area.

b. Leadership and Management

The lack of a broad perspective, including social science, among the key project/corporate decision makers has retarded VBC II's capacity to deal effectively with the broad programming issues that were emphasized in the current iteration of the project (Recommendation #7). **A.I.D.** should ensure that VBC II appoints a deputy director representing the interest of the social dimension as soon as possible from one of the existing VBC II staff currently involved in broader project programming activities (e.g., epidemiologist, I/HRD. HE/CP).

Several other staffing modifications are recommended to improve the broader social orientation of the VBC II Project. First, **VBC II** should involve the person responsible for the HE/CP aspect more in project activities, allowing her to devote a greater portion of her time to the vitally important health education/community participation components (Recommendation #8) In addition, **VBC II** should also involve the I/HRD person in more country programming activities.

The **contractor** should introduce a more broad-based and participatory management style, thereby helping to change the hierarchical, top-down structure that currently exists in the project (Recommendation #20). Increased VBC II Project staff participation will foster a greater sense of ownership in the project, which, in turn, will go a long way to reducing staff turnover and raising morale.

Secondly, the **VBC II** Project should activate and support as required the senior VBC II staff members who have the responsibility for regional liaison, making them responsible for all project activities in that particular region. They should be appointed regional directors for Africa and Asia, respectively (Recommendation #10). This will permit more intensive marketing and networking in these two regions and enable them to do what VBC II has done so successfully in the LAC region.

On **A.I.D.**'s part, project officer or CTO continuity should be improved (Recommendation #9). Although programmatic priorities have remained consistent, the frequent changes in CTOs over the course of VBC I and II has caused discontinuity, especially in terms of management style.

c. Personnel

The evaluation team suggests that **VBC II** prepare detailed job descriptions for each professional position in VBC II (Recommendation #22). This is particularly important in such positions as the I/HRD specialist and will help determine the type of person most suitable and capable to carry out this critical job.

Some concern was raised over the selection of consultants (Recommendation #23). It is recommended that the **VBC II** Project rely less on the network of retired colleagues and recruit more consultants with new and innovative approaches and representing a broader approach to the problems associated with vector/vector-borne disease control.

The **VBC contractor** should restrict senior VBC II staff involvement to the planning and development of country-level project activities (Recommendation #18). They should carry out needs assessments, develop strategies, supervise and monitor VBC activities. They should not be involved in providing direct technical assistance; this should be left to short-term consultants.

d. Marketing

VBC II has demonstrated a particular weakness in marketing its services as demonstrated by the relatively limited number of buy-ins that have been developed. Although the time remaining in VBC II may be too limited to make up for lost time and build mission interest and support in vector/vector-borne disease control, at least a strong foundation for any follow-on project can and should be developed. A series of activities to do this are recommended.

First, **VBC II** should conduct a series of needs assessments in priority countries, focusing on priority diseases (all relating to the strategic plan) (Recommendation #14). These exercises should also identify innovative approaches and strategies that might be implemented. Clearly related to the needs assessments is the need for **VBC** to do more applied and operations research (Recommendation #27). It is such activities that exciting and potentially effective options and opportunities (e.g., bednets, diagnostic tools) are identified, planned, tested and, if successful, implemented on a larger scale.

There is a urgent need for the **VBC II** Project to publish an informational brochure to publicize project services (Recommendation #15). This will familiarize the missions and bureaus with the broader perspective that was supposed to be emphasized in this iteration of VBC, including epidemiology, I/HRD, HE/CP and economics. In a similar vein, **VBC II** should develop educational materials to orient the generalists in the missions on what approaches and techniques are available to address vector/vector-borne disease control problems (Recommendation #16). Similarly, the **VCIC** should collect relevant articles on innovative strategies in priority vector/vector-borne disease control and distribute them periodically to interested missions and ministries of health in priority countries (Recommendation #32).

Along with the increased publicity and marketing, the **Office of Procurement of A.I.D./Washington** should clarify what the contractor can and cannot do in terms of identifying, developing and designing scopes of work for buy-ins (Recommendation #17). A more active involvement by VBC II in this regard will help increase the "Q contract" portion of the VBC II Project.

The **VBC II** Project should not feel threatened by collaborating with other A.I.D. contractors and is encouraged to collaborate more openly with those groups doing complementary work (Recommendations 24, 25, 26). A greater sense of confidence will help the project seek assistance in areas in which they are less familiar and have less experience (e.g., social sector programming).

2. Long-Term Follow-On Project

The evaluation team identified five issues that should be addressed by A.I.D. when developing the follow-on activity to VBC II. These points can be grouped into two general categories: design and personnel.

a. Design

To begin with, **A.I.D.** should give the next iteration of VBC a name that more clearly reflects the nature of the work. It is suggested that the next effort in vector/vector-borne disease control be called Vector-Borne Disease Assessment and Control Project (Recommendation #1). Such a title will go a long way in guiding the effort and keeping it focused on the broader aspects of disease prevention and control.

A.I.D. should also be provide a more specific and detailed statement of work, describing exactly what the agency expects the contractor to do (Recommendation #2). Indicators should be identified which can be tracked and monitored during the course of the contract to determine progress and effectiveness.

In order to address the broader, time-consuming development needs involving such things as institutional/human resource developments and community participation, **A.I.D.** should permit long-term technical assistance in the next iteration of the VBC Project (Recommendation #6). This will allow the vector/vector-borne disease control efforts to establish relationships and effectively work with counterparts to bring about sustainable institutional change and strengthening.

b. Personnel

The evaluation team recommended that **A.I.D.** consider adding two professional staff in any follow-on VBC effort. One is a malaria specialist (Recommendation #11) with extensive experience in public health, able to address the broader aspects of malaria programming. As A.I.D. and international donor agencies increase their efforts against malaria, a vector/vector-borne disease control effort will concentrate a significant portion of its activities in combatting this disease. To do this most effectively and with greatest credibility, the project should have an expert who has spent considerable time in the field designing and implementing malaria programs.

There is also an identifiable need to add an economist to any follow-on project in vector/vector-borne disease control (Recommendation #12). This is especially important as A.I.D. missions and bureaus must justify their programming decisions on economic/productivity grounds. The costs involved in vector-diseases, such as malaria, are significant and provide a convincing argument for investing in their prevention, control and treatment.

APPENDIX I

III. Statement of Work

The task requirement of this statement of work are extensive since a thorough assessment of the VBC project in totality is anticipated. Specifically, the contractor shall perform each of the following tasks:

Task 1: Contact, coordinate and support the services of a team of non A.I.D. persons and one A.I.D. person to participate in the evaluation.

Task 2: Arrange for the evaluation team planning meetings to organize their evaluation process, make assignments and clarify the SOW, review background, set up an action plan for conduct of evaluation process (e.g., whom to meet with, when to meet, questions to ask, team meeting times, etc.) and draft an outline of the evaluation report's content

Task 3: Select a person qualified to conduct the team planning in collaboration with the CTO.

Task 4: Arrange for domestic and international travel to interview A.I.D. direct hires, Peace Corps personnel, contract personnel, PVO personnel, international agency personnel, and host country nationals on their use of and interaction with VBC.

Task 5. Arrange for typing and reproduction of the evaluation report and an executive summary form which the project evaluation summary can be derived.

Task 6: Review Bureau of Science and Technology January 17, 1991 "Yellow top guidance on Administrative Procedures of Conducting Evaluations" Annex 1 to ensure consistency of from and substance and adherence to Agency and Bureau policy.

Task 7: Review and comment on the Bureau's cross-cutting themes which appear as attachment 3 of the January 17, 1991 guidance. The contractor is encouraged to review and comment on other cross-cutting themes which are identified in the process of the evaluation.

In addition to the task requirements stated above, evaluators must meet the following capabilities in order to perform the requirements called for in the statement of work. Each member of the team must possess experience in or have a workable knowledge of the following major areas of coverage and be able to assess each of the issues outlined.

A. Major Areas of Coverage include:

1. A.I.D. project and contract management: Experience is required with all aspects of managing centrally-funded projects and/or managing projects in the field. Requires familiarity with use of sub-contractors and consultants, office management, report preparation, buy-ins, evaluations of vector biology control projects, etc.

2. Project collaboration: Experience with collaboration of A.I.D. projects within A.I.D. (i.e., with Bureaus, other offices, etc.) or external collaboration with international agencies, Peace Corps, PVOs, etc.

3. Technical aspects of vector biology control: Experience with technical issues of vector biology control projects (i.e., planning and design, appropriate technology, operation and maintenance, etc.).

4. Technology transfer of vector biology control: Experience with the transfer of vector biology control technologies to institutions and users.

5. Community participation and health education in vector biology control: Experience with issues of public health, health education and community participation and women's involvement in vector biology control.

6. Institutional and human resource development: Experience with concepts, issues and application of institutional development and human resources development. Includes experience in training and familiarity with training methodologies (e.g., adult learning, participatory techniques, performance objectives).

7. Financing of vector biology control projects: Experience with financing issues in vector biology projects with particular emphasis on cost recovery and willingness to pay. Experience with computer applications.

8. Information systems: Experience with information systems. Includes familiarity with use of computers in information management, criteria for responsiveness to information requests and dissemination of information.

9. Service potential: A.I.D.'s ability to respond to mission and bureau requests for technical assistance; project development, implementation and evaluation; in structional and human resource types of services with and without a VBC type service.

B. Major issues to be addressed:

1. General: To evaluate the appropriateness of the VBC project; assumptions; if original objectives are being satisfied; if the efforts of

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VBC are in concert with the A.I.D.; where general changes in VBC mandate might improve VBC effectiveness; and, adequacy of VBC staffing and budget vis-a-vis A.I.D. needs and demands.

2. Scope of VBC activities: To evaluate the appropriateness and balance of the key areas of VBC (i.e., general technical assistance, technology transfer, institutional and human resource development and information support). To address the issue of long-term institutional memory and cumulative lessons learned in the vector biology control sector. Also, to review VBC's involvement with other sectors (i.e. Office of Housing, Peace Corps, PVOs, Women in Development Office, et al.).

3. VBC management: To evaluate responsiveness and cost control and effectiveness of VBC contract activities; quality and timeliness of reports; response to requests; tracking of buy-ins; adequacy of VBC staff; quality of liaison with A.I.D./W, UN, PVO and similar organizations; and procedures used to select personnel, consultants, and subcontractors to assist VBC implementation.

4. S&T/H and VBC relationships: To evaluate management, communications, collaboration, coordination, and working relations between the two groups. Is field management adequate? Is overseas management by A.I.D., especially S&T/H, adequate? In relationship to VBC and other S&T/H and USAID health projects.

5. Technical assistance: To evaluate the effectiveness and success of these activities and to determine if any changes in emphasis should be considered. Are they delivered at a level commensurate with the ability of the recipients to implement the technical assistance?

6. Technology transfer: To evaluate the effectiveness and success of these activities and to determine if any change(s) in emphasis and level of sophistication should be considered.

7. Community participation and health education: To evaluate the effectiveness and success of these activities and to determine if any change(s) in emphasis should be considered. What multiplier effect is being attained? Are others making use of VBC approach, and is there collaboration with other health projects.

8. Institutional and human resource development (ID&HRD): To evaluate the effectiveness and success of these activities and to determine if any change(s) in emphasis should be considered. Are ID and HRD strategies being incorporated into the design and implementation of A.I.D.-funded

vector biology control projects? What has been the impact of VBC products produced in ID and HRD (e.g., training guides, institutional assessment guidelines)?

9. Project identification and development: To evaluate role of VBC in development of Project Identification Documents (PIDs) and Project Papers (PPs) by Bureaus and Missions. What has been reception of this activity by Missions and Bureaus?

10. Distribution of VBC resources: To evaluate distribution and balance of VBC resources between Bureaus and Missions and between program areas. what is relationship and reception by international reference centers VBC works with? What has VBC initiated to serve the vector biology control sanitation professional community?

11. External relationships: To evaluate VBC relationships with multilateral and other bilateral organizations, NGOs, PVOs, Peace Corps, professional groups, universities, conferences, and expositions, the public, et al. Are these activities in appropriate balance with the goals and resources of the project? What experience of a collaborative nature has VBC established with these groups? What improvements could be made from the standpoint of these groups?

12. Intra-A.I.D. funding participation: To evaluate appropriateness and feasibility of VBC funding by other bureaus, and by USAID Missions. What do the Bureaus and Missions think of the buy-in mechanism? How much has the buy-in mechanism been used? What changes would help them in using it? Are there alternatives to the buy-in to accomplish similar objectives?

IV. Methodology

The team will use appropriate methods for collecting and analyzing data and information. Project documents will be reviewed and synthesized as appropriate. These documents will include the following:

a. Scope of Work (Section C.2, pages 9-14).

b. Work Force and Key Personnel (Section C.3, page 15).

c. Categories of Specialists (Section C.4, pages 15-17).

d. Evaluation (Section B.4, pages 19-21).

e. Reports/Deliverable (Section F.3.2-l, pages 23-26).

f. Technical Directions (Section F.4, page 26).

g. Requirements (Section 4.5, pages 33-35).

h. Senior Advisory Committee (Section 4.10, 11, page 37).

i. Intern Program (Section H.14, page 38).

Based on pertinent usefull questions derived from these documents and from input provided by project staff, the team will then proceed to interview key personnel in A.I.D. Washington and U.S.A.I.D.'s.

V. Team Composition

A. The team should be composed of persons with experience in:

1. Technical aspects of vector biology control (appropriate technology, control equipment).

2. Technology transfer for vector biology control.

3. Institutional and human resource development.

4. Information systems and dissemination (including library operation and computer systems).

5. Financial management of vector biology control projects (e.g., cost recovery, willingness to pay), with experience in computer applications.

6. Public health, health education, community participation.

7. Development philosophy (approach to planning, implementing and evaluation activities).

8. A.I.D. projects and contract management (headquarters, field, buy-ins, office management, report preparation, etc.).

9. Collaboration within A.I.D. (Bureaus, and Missions, OFDA, etc.) and outside A.I.D. (international agencies, Peace Corps, PVO, non-profit

humanitarian, relief, etc.) Individual should be cognizant of decade goals and objectives, and related projects.

B. The persons will be selected in collaboration with the VBC CTO, and with his concurrence.

VI. Final Report

1. The Contractor will review draft outline prepared in team planning meeting with CTO before team members leave for overseas and obtain approval from CTO.

2. The Contractor should review draft material, as prepared, with CTO to determine if any changes in action plan are needed.

3. The Contractor should be sure that action plan is realistic in time and that team member allocation of talent in preparation of final report is adequate. The Contractor will be responsible for meeting time deadlines and meeting quality requirements laid out in Team Planning Meeting and comments received from the Contractor.

4. The Contractor should be sure that the standard A.I.D. Evaluation Summary Form is completed and included in the report. The Contractor will make arrangements with VBC Project Director to review project records, arrange interviews with project staff, obtain assistance with overseas travel, and scheduling (if needed), etc.

5. As time of completion of report approaches, the Contractor will schedule a briefing for the CTO, and other staff. A second briefing may be required for contractor (principal and subs) at a later time.

6. One hundred copies of the final report will be submitted to S&T/H/CD.

APPENDIX II

List of Documents Reviewed

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Tonn, R. et al, Report of the MPSSP/CCH Chagas' Disease Control Project Planning Meeting (Rosslyn, VA.: VBC II Project/MSCI, November 1990).

VBC II Project, Workplans 1990, 1991, 1992 (Rosslyn, VA.: VBC II Project/MSCI, 1990, 1991, 1992).

Yacoob, M. et al, Improved Productivity through Better Health (IPTBH) Project - Phase One of the Amendment, Technical Assistance & Assessment (Rosslyn, VA.: WASH and VBC II Projects, January 1992).

Yoon, S. and B. Silverman, Swaziland: Malaria Control Information System (Rosslyn, VA.: VBC II Project/MSCI, October 1991).

APPENDIX III

List of Persons Interviewed

UNITED STATES

WASHINGTON, DC

A.I.D.

Ann van Dusen	Director, R&D/H
Robert Wrin	Chief, Communicable Diseases Division
John H. Austin	Environmental Engineer
Dennis Carroll	Health Technical Advisor, CTO, VBC II
Dennis Long	Health Science Specialist (former VBC CTO)
Adrienne Ertl	AAAS Fellow, R&D/H
Melan Tanamaly	Acting Head, HPN, LAC Bureau
Nicholas Studzinski	LAC Bureau
William H. Lyerly, Jr.	Africa Bureau
James D. Shepperd	R&D/H (formerly Africa Bureau)
Tom Park	R&D/H (formerly LAC Bureau)
Ray Martinformer	HPN Officer, USAID/Kinshasa

State Department

Marion Warren	Pakistan Desk Officer
John Gunning	Nepal Desk Officer

VBC II Project

Robert Lennox	Project Director
Andrew Arata	Deputy Project Director
Stephen W. Mason	Deputy Director, Administration
Richard Andre	Vector Biologist
Flemming Heegaard	ID/HRD Specialist
James Sonnemann	Epidemiologist
Barry A. Silverman	Biomedical Computer Specialist
Ellen Nayeri	Information Specialist
Linda Cobey	Community Development Specialist
Anneliese Schmid	Network Coordinator
Pat O'Connor	former VBC II HRD Specialist
Peggy Sullivan	former VBC II Epidemiologist
Jack Swartward	former VBC II Administrator

VBC II SAC Members

Grace Goodell	Anthropologist, SAIS, Johns Hopkins University
J. Ellis Turner	Project Director, WASH

VBC II TAC Members

Donald R. Roberts	Department of Preventive Medicine/Biometrics, USUHS
Andrew Spielman	Harvard University*
Barney Cline	Tulane University*

PAHO

Gabriel Schmunis	Communicable Diseases
Renato Gusmao	Communicable Diseases
Horst Otterstetter	Environmental Health

WASH Project

May Yacoob	Belize Project Coordinator

ATLANTA

CDC

Robert Kaiser	Deputy, Division of Parasitic Diseases
Kent Campbell	Head, Malaria Branch
Gary Clark	Director, San Juan Laboratory (Dengue)*
Paul Reiter	Vector Biologist, San Juan Laboratory*

BELIZE

USAID/Belize City

Patrick McDuffie	General Development Officer
Amelia Cadle	Health Project Manager

Ministry of Health/Belize City

Fred Smith	Permanent Secretary
Jorge Polauco	Director, Vector Control Department
Francis Westby	Administrator

PAHO/Belize City

Hernando Cardenes	
Rollins	Entomologist

Ministry of Natural Resources/Belize City

Anthony Nicasio	Health Educator, Water and Sanitation

BOLIVIA

USAID/La Paz

Charles Llevellen	Director, Child and Community Health Project
Sigrid Anderson	Deputy Chief, Health and Human Resources
Joel Kuritsky	Technical Advisor, Child Survival (TACS)

Ministry of Health

Jack Antelo	Health Director

CCH/La Paz

Alvaro Munoz Reyes	Executive Director
Jaime Bergoa	Administrative Coordinator
Jorge Velasco	Health Education Consultant
Antonio Gomez	Data Entry and Analysis
Juan Carlos Lea Plaza	Software Development

HABITAT/La Paz

Irene Vance	Director

Chagas Project/Cochabamba

Fanor Balderrama	Coordinator
Herman Bermudaz	Medical Entomologist
Faustino Torrico	Immunologist
Victor Chavez	Health Educator, Aramasi Community
2 local health promotors, Aramasi Community	
2 community leaders, Aramasi Community	

HONDURAS

USAID/Tegucigalpa

Robert Haladay	Health Officer
Stan Terrell	TACS

Ministry of Health/Tegucigalpa

Ramon Soto	Subdirector Vector Control

VBC Consultants

Sonya Montenegro-James	Immunologist, Tegucigalpa
Mary Cush	Biologist, El Progreso

Ministry of Health/Region 4, Choluteka

Lucy Ordonez	Chief of Malaria Control Vector Control Coordinator
Medical Director, Choluteka Hospital	

Dengue Control Project, El Progreso

Eduardo Fernandez	Director
Hector Portillo	Biologist
Israel Logos	Social Scientist

NIGER

USAID/Niamey

Carl S. Abdou Rahmaan	Health Development Officer
Oumarou Kane	Niger Health Sector Support Grant Coordinator
Susan Wright	Family Planning and Demography Coordinator
Nancy Loventhal	Child Survival Coordinator

Ministry of Health/Government of Niger

Hamissou Maoude	Director, Division of Health Services
Sani Zaqui	Coordinator National Program on Malaria Control
Fouta Aboubacar	Entomologist, PLP/DES
Mounkaila Abdou	Medical Epidemiologist, Division of Research and Planning
Dr. Soga	Director, Division of Statistics and Epidemiology
Assane Baraze	Coordinator, National Onchocerciasis Program
Salisou Kane	Director, Division of Hygiene and Sanitation

Representatives of Other Institutions in Niger

Dr. Yankalbe	Resident Representative, WHO/Niger
B. Sellin	Organisation de Cooperation pour la Lutte Contre les Grandes Endemies en Afrique de l'Ouest (OCCGE)
Jean Julvez	French Cooperation, Ministry of Health
Mary White Kaba	Sociologist, VBC Consultant

PAKISTAN

USAID/Islamabad

Anne Aarnes	Chief, Office of Health, Population and Nutrition
Rifaq A. Ismail	Project Officer, O/HPN
Jan Rozendaal	Malaria Control Advisor

Pakistan Child Survival Project, Islamabad

Theo Lippeveld	Epidemiologist/HIS Advisor

Ministry of Health

S. Mohsin Ali	Director General of Health

Ministry of Health, Directorate of Malaria Control

Chaudhary A.A. Mujahid	Director
G. Hashim	Epidemiologist
Aslam Khan	Health Education Officer

Directorate of Health Services, Peshawar

M. Iqbal Khan	Assistant Director (Malaria)
A. Aziz Khan	Senior Malaria Superintendent
Shaukat Pervez	Assistant Entomologist
Awta Muhammed	Entomological Technician
Waris Khan	Health Education Officer

Medicins sans Frontieres - Belgium/Holland, Peshawar

Mark Rowland	Malaria Project Manager

* interviewed by telephone

APPENDIX IV

ISSUES TO BE EXPLORED IN THE FIELD AND WITH MISSIONS

I. Publicity

1. How did VBC II present itself to mission (e.g., cable, packet of information, annual work plan, telephone, visit, HPN Officers conference)? How effective was it? Did VBC II educate/orient HPN staff at mission as to nature of vector borne disease problem and possible solutions?

2. Would one-page descriptions of options on the control of vector-borne diseases and synopses of success stories (like PRICOR) be helpful?

II. Services

3. What has experience with VBC II been in relation to:

   - technical assistance
   - technology transfer
   - institution and human resource development
   - information service

4. Was VBC II activity or activities developed reactively or proactively? How creative and innovative was VBC II in developing programs? Give examples.

5. Did VBC II carry out a needs assessment and identify vector borne disease-related problems? Did VBC II discuss/lay out options to solve problem(s)?

6. Was there any discussions or collaboration between VBC II and other sectors (e.g., agriculture, irrigation, housing, environment, forestry)?

7. Describe nature and effectiveness of VBC II collaboration with other donors and contractors in subject country.

8. Did VBC II work well with and respond to mission requests? Was it flexible and willing to consider other options in its response?

9. What new approaches and strategies did VBC II develop or introduce?

10. Were VBC II activities appropriate and practicable?

11. Describe the quality of work done under VBC II.

12. Did VBC II concentrate most of its energies on technical or institutional/human resource development aspects? What is the percentage split? Was community participation involved in or an important part of any of the VBC II activity/activities?

13. What are the chances that the VBC II activities will be sustained when VBC II involvement comes to an end? Describe what has been done in this regard.

14. What is the extent and quality of VBC II collaboration with A.I.D., multilateral donor agencies, NGOs, Peace Corps and other contractors?

15. What has the role of subcontractors been? Have they done good work?

16. Were any operations research efforts conducted? If so, describe them.

III. Management

17. Was support of regional bureau and R&D/H satisfactory?

18. Did mission buy-in? If not, why not?

19. Did the prohibition of long-term TA (more than 3 months) discourage interest in VBC II?

20. Would greater emphasis on economic studies be helpful to increase support for VBC II-related activities?

21. Is VBC II easy to access?

22. How fast/timely is VBC II in responding to mission requests?

23. Is there a conflict of interest between VBC II assisting in the development of Scopes of Work for "Q Contract" buy-ins"? If so, how can this be resolved?

IV. Future

24. How can next vector borne disease project be improved?

25. If more funds are made available for malaria in Child Survival programming, would you utilize VBC II and, if so, how?

26. Would it be helpful if the VBC Project were to develop for AID/Government/MOH decision makers a presentation of the cost/impact for vector borne diseases (especially malaria)?

APPENDIX V

Questionnaire

JOHN SNOW, INC.
210 Lincoln Street, 6th Floor
Boston, Massachusetts 02111
USA

Telephone: (617) 482-9485 · Telex: 200178 JSI UR · Fax Phone: (617) 482-0617

FAX MACHINE TRANSMISSION RECORD

DATE: April 28, 1992
URGENT MESSAGE: yes
NUMBER OF PAGES, INCLUDING THIS PAGE. 1

FROM: David F. Pyle, Team Leader
PROJECT: VBC II Mid-Term Evaluation
PROJECT NO.: 1718-016

TO:
FAX PHONE NO.:
NAME/ADDRESS :

Explanation: We are contacting a representative sample of A.I.D. missions to determine the value and effectiveness of the Vector Biology and Control (VBC) II Project during its first two and a half years of operations. Your answers to a few questions will assist in improving the quality of services provided by this project in the future. We request that you give some thought to these questions and send your response to me by no later than 15 May. Fax responses should be sent to me c/o of JSI's Washington office (fax number: 703-528-7480). We hope that this will take no more than a few minutes out of your demanding schedule.

1. What vector borne diseases are a major problem in your country?

2. What options does A.I.D. have to respond to these problems?

3. Do you know of the VBC II Project? What services does it provide?

4. Have you contacted VBC II or has VBC II contacted you?

5. What is your experience with the VBC II Project?

APPENDIX VI

LIST OF MISSIONS CONTACTED
(responding to questionnaire by phone or fax)

	Site Visits	Fax yes	Fax no	Phone
Latin America and Caribbean (LAC)				
Belize	X			
Bolivia	X			
Dominican Republic		X		
Guatemala				X
Honduras	X			
Nicaragua			X	
Africa				
Cameroon				X
Chad		X		
Cote d'Ivoire			X	
Egypt			X	
Ghana		X		
Kenya				X
Madigascar		X		
Malawi				X
Mali		X		
Niger	X			
Nigeria				X
REDSO/West		X		
Senegal		X		
Swaziland				X
Tanzania		X		
Togo		X		
Uganda			X	
Asia/Pacific				
Bangladesh		X		
Cambodia		X		
Fiji/PNG				X
India		X		
Indonesia				X
Pakistan	X			

APPENDIX VII

VBC PROJECT STAFFING

Robert Lennox, Sc.D.
Project Director

Andrew Arata, Ph.D.
Deputy Project Director

Stephen W. Mason, M.S.I.S.
Deputy Director, Admin

Richard Andre, Ph.D.
Vector Biologist

Ralph Schmidt
Operations Manager

Flemming Heegaard, M.P.I.A.
ID/HRD Specialist

Kathleen Henry, M.A.
Technical Writer/Editor

James Sonnemann, M.D., M.P.H.
Epidemiologist

Anneliese Schmid
Network Coordinator

Barry Silverman, Sc.D.
Biomedical Computer Spec.

Judy McIlwee
Project Secretary

Ellen Nayeri, M.L.S.
Information Specialist

Sandra Goss
Project Assistant

Linda Cobey, M.P.H.
Community Development Spec.

Sheila Ervin
Receptionist

APPENDIX VIII

List of Specialists Requested in RFP

Vector-Borne Diseases

Vector Ecologists
Medical Entomologists
Taxonomists
Arbovirologists
Malariologists
Insecticide Experts
Diseases Ecologists
Environmental Toxicologists
Malacologists
Geneticists
Field Operations Specialists
Transport and Supply Specialists

Biomedical Researcher

Epidemiologists
Mathematical Modeller
Parasitologists
Virologists
Microbiologists
Pharmacologists
Immuniologists
Public Health Advisors
Medical Logisticians

Public Health

Health Educators
Medical Anthropologists
Environmental Engineers
Institutional & Human Resources Development Experts
Sociologist
Women-In-Development Experts

General Technical

Managerial
Financial
Economists
Community Development
Program Development Specialists
Computer Analysts
Mass Media Experts
Editors
Translators
Program Planners
Needs Analysts
Information Specialists

APPENDIX IX

VBC II'S ACTIVITIES AS DESCRIBED IN PUBLIC DOCUMENTS AND DOCUMENTS SUPPLIED TO REVIEW TEAM

The review team wished to assess VBC II's activities from several perspectives: to see how activities undertaken contributed to VBC's broad mandate of vector-borne disease control, and how project goals were reflected in the allocation of financial resources. The annual work plans, as well as several internal summary financial documents supplied to the team, were used for this assessment.

Information from all of these sources was consistently inconsistent. Several examples of inconsistancies are included in this annex. This finding is so striking that it is difficult to see how the information could be used by VBC for planning or for assessment.

The documents used in preparation of this annex are: annual work plans; "VBC II Activities (by AIP No.)," an undated list of projects, with the amounts budgeted and spent, that appears to reflect project status in the early months of 1992; "VBC Project Costs by Country" and "...by Disease, Region, Type of Assistance", also undated, but apparently from early 1992; "Cumulative Status of Funds" and "Project Financial Status", both dated January 31, 1992; and "Subcontractor Status", dated March 31, 1992.

Of these documents, only the second, the list of "VBC II Activities ...", provides the information required to assess the amounts budgeted and spent from core funds in support of field projects. And the information supplied in this document required a fair amount of processing before assessment could begin.

A. Annual Work Plans

In 1990, the work plan document outlined ten objectives "for building sustainable vector-borne disease control programs". (p. 13) A matrix correlating activities undertaken in pursuit of these objectives with geographical regions was included with the work plan. Budgets and work plans for each activity were not included. While the 1990 work plan gave a general idea of VBC II's agenda, there is certainly not enough detail to assess the level of effort or resources allocated to each activity and region. Since this document was distributed to bureaus and missions to introduce VBC II, detailed information may have been intentionally limited. The result, however, is that the 1990 work plan does not provide the information required to assess the distribution of effort.

Subsequent annual work plans, while including more detail, provide little information on the outcome and followup to the previous year's plan, unless the activity continues into the next year. (And there are serious inconsistancies in descriptions and budgets for continuing activities; see example below.)

The 1991 work plan uses the same 10 objectives as the previous year to frame the activities, examples of specific activities illustrate each objective, and activity sheets, which contain details and a budget for each activity, are included. However, the activity sheets are organized by categories indicating the internal mechanism that generated the activity: on-going central support activities (called life-of-project), mission and bureau requests supported by central funds, activities originating from sources other than missions and bureaus (called proactive), continuing activities, and activities requested and funded by missions (called requirements contract). In the 1991 plan, there is no means to relate a specific activity to a programatic or strategic objective.

By 1992 the 10 objectives of the earlier two years have disappeared, apparently replaced by "work plan highlights" that describe the most significant activities and a section that describes activities by geographic area. Activity sheets are organized by generating mechanism, as in 1991.

The project appears to have some difficulty tracking individual activities. In attempting to follow the life of several activities, the review team discovered inconsistencies among the documentation related to single projects.

- Activity 157 is described in the 1991 work plan as "Phase II(a) of Chagas' Control Program Project", with a budget of $75,000, covering work by a variety of consultants in epidemiology, entomology, and information systems, among others. In 1992, activity 157 had become "Computer Analyst for Bolivia Chagas' Control Program", covering the work of one consultant, with a total budget of $67,000, $27,000 for 1991, and the remainder for 1992. In the list of resources associated with activities titled "VBC II Activities (by AIP No.)", an internal document supplied to the review team by VBC, the same activity, with AIP No. 82234, has a budget of $73,465.

- Activity 097 (AIP No. 81226) is budgeted for $96,414 in the 1991 work plan, and for $120,568 in AIP resource list. The undated AIP resource list indicates that $100,870 has been spent, while the Subcontractor Status sheet dated March 31, 1992 reports that $69,091 has been expended. The followup to this activity is 338 (AIP No. 81329), a fact that can be ascertained only by looking at each activity sheet in hopes that a followup will be found. The budgets for these two activities are very nearly the same in the 1992 work plan and the AIP resource list ($82,000 and $82,803).

B. Resource Allocation Documents

In two companion documents, "VBC Project Costs by Country" and "...by Disease, Region, Type of Assistance", VBC broke down the amount spent to date into the categories indicated by the document titles. Two breakdowns by region were supplied; while the bottom lines were the same in both documents, the amounts reported for each region were different:

from VBC II Project Costs by Country

	Amount Spent ($)	% by Region	% by Total
WORLD	525,349		23%
AFR	591,357	33%	26%
ASIA	366,088	21%	16%
LAC	805,458	46%	35%
REGIONS	1,762,903	100%	
TOTAL	2,288,252		100%

from VBC II Project Costs by Disease, Region, Type of Assistance

	Amount Spent ($)	% by Region	% by Total
WORLD	403,236		18%
AFR	736,645	39%	32%
ASIA	424,910	23%	19%
LAC	723,461	38%	32%
REGIONS	1,885,016	100%	
TOTAL	2,288,252		100%

The fact that these breakdowns are substantially different, even though the bottom line is the same, suggests that VBC has used these breakdowns only for presentations, not for making decisions.

The review team also aggregated the amounts reported in the document "VBC II Activities". The bottom line is some 3% lower than the previous breakdowns; the relative proportions correspond most closely to the first breakdown above.

from VBC II Activities

	Amount Spent ($)	% by Region	% by Total
WORLD	667,544		30%
AFR	496,021	32%	22%
ASIA	377,216	24%	17%
LAC	694,460	44%	31%
REGIONS	1,567,697	100%	
TOTAL	2,235,241		100%

To compare the amount of core funds invested in activities to the amount invested through buy-ins and OYB's, the review team combined the information in "VBC Activities" (the only source of information that allowed disaggregation by amounts budgeted and spent and by life of project, LOP, and activity investment) and in the "Cumulative Status of Funds", as of 31 January, 1992.

	Amount Budgetted ($)	Amount Spent ($)
LOP	4,189,707	2,836,091
PROJECT	2,489,237	1,466,713
TOTAL CORE	6,678,944	4,302,804
TOTAL OYB	499,624	243,274
Q CONTRACT	1,258,610	574,902
OYB+Q	1,758,234	818,176
(OYB+Q)/CORE PROJ	0.71	0.56
TOTAL	8,437,178	5,120,980