

PN-ABM-847

80108

PRITECH II
Technical Advisory Group
Meeting

February 16, 1990
Washington, D.C.

PRITECH

Technologies for Primary Health Care

Management Sciences for Health
1925 North Lynn Street
Suite 400
Arlington, Virginia 22209

Agency for International Development
Bureau for Science and Technology
Office of Health
Health Services Division

PRITECH II - TECHNICAL ADVISORY GROUP MEETING
FRIDAY MORNING, FEBRUARY 16, 1990
AGENDA

Location: Administrators' Conference Room
Room 5951
U.S. State Department
Washington, DC

8:30-8:40 Welcome B. Langmaid
Chairperson of Session One A. Van Dusen

8:40-8:45 Introductions

8:45-9:00 The Global CDD Problem: Overview M. Merson

9:00-9:15 THE PRITECH PROGRAM: Introductory Remarks R. Simpson
PRITECH I: Lessons Learned J. Alden/R. Northrup

9:15-9:30 Review of PRITECH II Activities in Year 2;
summary presentation of program including
status report on field programs; presentation
of program implementation issues R. Simpson
J. Brown

9:30-9:45 Summary presentation of PRITECH II technical
program and planned activities; presentation of
critical technical issues D. Sencer

9:45-10:25 Discussion A. Van Dusen

10:25-10:30 Summary A. Van Dusen

B R E A K

Chairperson of Session Two R. Clay

10:55-11:00 Introduction to TAG discussion of issues

11:00-11:45 Issue one: Expanding access and use to ORT
Discussion: The Commercial Sector W. Smith
Discussion: The Non-Profit Sector W. Foege

11:45-12:30 Issue Two: Building on CDD
Discussion D.A. Henderson

12:30-12:45 Summary and Conclusions L. Feinberg
Closing A. Van Dusen

L U N C H E O N

PRITECH TECHNICAL ADVISORY GROUP
LIST OF PARTICIPANTS

FRIDAY, FEBRUARY 16, 1990

STATUS

Mr. Andy Agle Coordinator, CCCD Centers for Disease Control 1600 Clifton Road, N.E. Atlanta, GA 30333	Unable to attend
Professor Rajeev Batra Graduate School of Business Administration University of Michigan Room 4209 F Ann Arbor, MI 48109	Accepted
Dr. Robert Black Chairman Department of International Health School of Hygiene and Public Health The Johns Hopkins University 615 North Wolfe Street Baltimore, MD 21205	Unable to attend
Ms. Kathleen Cravero Programme Officer, CDD/ARI UNICEF 3 United Nations Plaza New York, N.Y. 10017	Accepted
Dr. William Foegen The Task Force for Child Survival Carter Presidential Center One Copenhill Atlanta, GA 30307	Accepted
Dr. D.A. Henderson Dean, School of Hygiene and Public Health The Johns Hopkins University 615 North Wolfe Street Baltimore, MD 21205	Accepted
Dr. Michael Merson Director, CDD/WHO World Health Organization Avenue Appia 1211 Geneva 27 Switzerland	Accepted

STATUS

Dr. William Smith
Executive Vice President
Academy for Educational Development
1255, 23rd Street, N.W.
Washington, D.C. 20037

Accepted

Ms. Anne Tinker
Public Health Specialist
The World Bank
1818 H Street, N.W.
Washington, D.C. 20433

Accepted

Dr. Juan Urrutia
RA/CDD
Pan American Health Organization
525 23rd Street, N.W.
Washington, D.C. 20037

Unable to attend

PRITECH TECHNICAL ADVISORY GROUP
LIST OF OBSERVERS

FRIDAY, FEBRUARY 16, 1990

Ms. Peggy Curlin
President
Centre for Development and
Population Activities
1717 Massachusetts Avenue, N.W.
Washington, D.C.

Dr. Audrey Naylor
Co-Director
WELLSTART
4062 1st Avenue
San Diego, CA 92130

Dr. Jeanne Newman
Deputy Director
PRICOR
7200 Wisconsin Avenue
Bethesda, MD 20814

Dr. Ron O'Connor
President
Management Sciences for Health
165 Allandale Road
Boston, MA 02130

Ms. Peggy Parlato
Director, Nutrition
Communication Project
Academy for Educational Development, Inc.
1255 Twenty-Third Street, N.W.
4th Floor
Washington, D.C. 20037

Mr. Mark Rasmuson
Director, HEALTHCOM
Academy for Educational Development
1255 23rd Street, N.W.
Washington, D.C. 20037

Mr. John Simon
The Applied Diarrheal Disease
Research Project (ADDK)
Harvard Institute for International
Development
1 Elliott Street
Cambridge, MA 92138

Dr. J. Ellis Turner
Project Director
WASH
1611 North Kent Street
Room 1001
Arlington, VA 22209

PRITECH TECHNICAL ADVISORY GROUP

A.I.D. REPRESENTATIVES

FRIDAY, FEBRUARY 16 1990

Bradford Langmaid
Acting Assistant Administrator
Science and Technology

Dr. Roxann Van Dusen
Acting Director
Office of Health

Robert Clay
Acting Supervisory Public Health Advisor
Health Services Division

Lloyd Feinberg
Public Health Advisor
Health Services Division

**PRITECH REPRESENTATIVES AT TECHNICAL
ADVISORY GROUP MEETING
FRIDAY MORNING, FEBRUARY 16, 1990**

STAFF

Mr. Robert Simpson
Acting Director

Dr. Dave Sencer
Acting Technical Director

Ms. Jane Brown
Chief Operations Officer

Ms. Danielle Grant
Chief Financial & Admin. Officer

Dr. Martita Marx
Chief Technical Officer

Mr. Camille Saade
Social Marketing Specialist

Ms. Karen Davis
Operations Officer

Ms. Karen White
Information Manager

CONSULTANTS

Mr. John Alden

Dr. Rob Northrup

ISSUE I

Should PRITECH Direct Some of Its Efforts to
Help Mobilize The Private Sector for ORT?

PRITECH's efforts to date have correctly concentrated on establishing ORT as an integral part of the public sector health systems. These efforts will continue. However, in many countries the public sector is the minority health provider with limited coverage and accessibility.

If the full benefit of the ORT technology is to be realized the non-governmental sector health providers must become engaged and mobilized. From our perspective, effective private sector involvement is key to both expanding access and use and enhancing prospects for sustainability.

Are we correct to direct some of our efforts to help mobilize the private sector for ORT? If so, with which of these groups should PRITECH work?

How can we correctly prioritize among them?

MANUFACTURERS
↓
PHARMACEUTICAL
HOUSES
↓
DISTRIBUTORS

Commercial Sector

- Private Physicians
- Pharmacists
- Traditional practitioners

Non-Profit Sector:

- Religious and community interest groups
- Teachers

MD'S
↑
DRUG
MEN
→
WHOLESALE
↓
PHARMACEUTICALS
&
RETAILERS

Commercial Sector

Drug manufacturers
Distributors of home
products
Retailers
Mining companies
Plantation farmers

Non-Profit Sector

Missionary hospital groups
PVO's/NGO's

What program mechanisms should we use to engage these groups?

How can the quality of services being provided be monitored?

What are the most important pitfalls we should seek to avoid?

TRAINING

ISSUE II

How can PRITECH Best Exploit the Constructive Linkages Between CDD and Other PHC Preventive and Curative Services?

1. Thus far PRITECH has devoted only modest attention to encouraging countries to emphasize prevention or to establish program linkages with preventive interventions like breastfeeding, growth monitoring, nutrition and water supply and sanitation. PRITECH should do more, but experience suggests that practical program opportunities in some of these areas are difficult to identify and exploit. For some interventions, we seem to know neither what to do nor how to do it!

What are the most promising preventive linkages? Under what circumstances have they been successfully incorporated with MOH-based CDD? How much effort should PRITECH place on this program component?

2. ARI kills 2.5 million children a year. Some studies have shown that PHC workers can effectively diagnose and treat ARI with a simple regimen of inexpensive anti-biotics. Developing countries, WHO and UNICEF are all moving ahead with ARI programs. Can the same case management approach which is used to train primary health care workers be

developed for ARI? Can PHC workers be trained to effectively manage both CDD and ARI? Is this a linkage we should encourage? What, if any, steps should PRITECH take now to incorporate ARI into CDD country program interventions? What are the principal problems and issues that PRITECH should consider in developing specific plans?

PROGRAM MANAGEMENT LESSONS LEARNED

The following is a summary of the principal program management lessons learned and not yet learned resulting from our experience implementing the PRITECH I Project.

1. AID's continuing long term policy and program commitment to CDD is essential to realizing AID's and PRITECH's CDD objectives.

For the past ten years AID has provided worldwide advocacy, leadership and funding support for CDD. AID has vigorously supported CDD programs within the agency. AID has contributed to both WHO and UNICEF CDD activities. AID has supported the CDD work of the PVO's. AID has provided the major funding support for the three ICORT conferences.

For PRITECH, the AID program commitment to CDD has made it possible to stimulate governments in 24 countries to start or strengthen their programs, and in PRITECH II, to move beyond the "sizzle" of start-up to help country programs tackle some of the more fundamental implementation and program coverage issues.

The 1986 promise of a decade long commitment by AID to CDD has enabled PRITECH to stimulate national interest in allocating some of their scarce health resources to CDD, to attract able country technical specialists to solving local CDD problems, to involve top-quality international specialists in guiding PRITECH's activities, to leverage AID's assistance to enhance support from other donors, to implement an effective CDD information system that reaches program managers and policymakers worldwide, and to address the longer term issues of sustainability and behavior change by mothers and health providers outside the public sector systems. As our country specific experience has grown and countries have gained

confidence in us we have also started to gain access to some of the more sensitive program areas such as drug procurement.

AID's long term commitment to CDD has enabled PRITECH to work credibly with countries on long term CDD issues and be accepted as a serious participant in helping countries realize national CDD program goals. AID's continued commitment is essential for PRITECH to continue as an effective resource in implementing AID's CDD strategy.

2. PRITECH's country program interventions should be developed from a comprehensive and balanced national CDD strategy that starts with the MOH.

PRITECH's country programs should concentrate on working with the public sector from inception for the following reasons:

- National governments establish the country's diarrheal disease policies, develop national plans and strategies, and allocate public sector resources for CDD.

- National governments establish case management and training standards. Governments generally take the lead in the initial national CDD training programs.

- National governments are responsible for maintaining appropriate referral capacities.

- National governments provide sanction for external donor involvement and are responsible for coordinating their work.

PRITECH has found that developing a strong technical and program base for CDD within the MOH is a key ingredient in mobilizing national leadership support and moving progressively to a technically and institutionally sustainable activity. Governments must have the capacity to provide correct diarrhea case management at the facilities they manage. Governments must have the capacity

to train and supervise staff. Governments must be able to deliver a reliable and adequate supply of ORS to the public sector.

Governments must understand how to use modern communications technology to sustain public CDD education. Governments must be able to collect relevant program information to make informed management decisions. Governments must have the capacity to solve the program's operational problems in a systematic way.

PRITECH sees support to the MOH in developing these capacities as our first priority.

3. Effective program implementation by PRITECH requires both leadership quality CDD expertise and capable program managers with an understanding of AID systems.

Since inception PRITECH has sought two kinds of professionals to lead the project: internationally recognized CDD technical experts and AID-experienced program managers. PRITECH believed that this combination of expertise would provide both the project and AID with assurance that the technical initiatives that were being undertaken were sound and represented the best technical judgement available and that the substantial program resources made available by AID would be effectively managed. During PRITECH I we were able to attract internationally recognized CDD experts to both the staff and to the advisory groups and AID-experienced managers to direct project implementation.

This program management strategy has proved effective. PRITECH's CDD experts have provided the project technical credibility with AID and the outside technical community. They have enabled the

project to stay abreast of changes in CDD technology and program strategy and fully engage in technical dialogue as these changes are considered. They have permitted the project to adapt and incorporate changes in CDD technology with confidence. The AID-experienced program managers have facilitated the CDD experts in transferring their expertise into tangible and viable program interventions that meet AID programming standards in a complex and unfamiliar administrative environment.

4. The PRITECH organizational partnership is an effective mechanism to combine the resources of a variety of institutions for a common purpose.

PRITECH is a consortium of institutions including the Academy for Educational Development, Johns Hopkins School of Hygiene and Public Health, PATH, Creative Associates and CEDPA led by Management Sciences for Health. Each group brings particular skills and experience to the program. No single institution could undertake this task alone. From the outset we decided to operate PRITECH as an integrated unit with staffs from each of the major partners working full-time at headquarters and participating in decision making at every level.

This has worked out very well and can serve as a good administrative/management example for implementation of other large and technically complex projects.

5. PRITECH's program should focus on the effective implementation of available technologies. PRITECH should not seek to develop a capacity to develop new CDD technology.

When the PRITECH project started AID believed that ORT/CDD technology was essentially in place and that the project would need

to be almost exclusively concerned with program implementation. It soon became clear that this was not the case.

Program implementation was still the major concern but important shifts in CDD technical approaches and emerging unresolved technical problems raised important questions about program implementation strategy. To meet these unanticipated needs PRITECH strengthened the project's technical staff. While the bulk of the expanded technical staff's responsibilities was directed to country based program implementation, the technical unit also undertook a few small technology development activities. All these activities were useful and a few were of high priority. Unfortunately this limited technology development program became extraordinarily time consuming and began to detract from the project's capacity to effectively support the field programs and exploit emerging opportunities.

After six years of experience we are convinced that PRITECH's unique strength is in flexible support to country programs both in the public and private sector. This is where we should concentrate all our efforts and only under the most extraordinary circumstances should the project undertake technical activities that do not directly relate to the effective implementation of the country programs we are helping. We do not now see a role for PRITECH in CDD technology development.

What is now required is more effort by others to resolve the outstanding CDD technical issues and better communication from PRITECH regarding the practical problems that the unresolved issues are creating for program implementation.

6. PRITECH's country interventions cannot be effectively implemented without resident long-term field staff.

The PRITECH project design contemplated that country based activities could be effectively supported from Washington by short-term non-resident staff. It soon became clear to us that the fragile national CDD programs could not absorb a succession of short-term external experts because they drained rather than strengthened the local institutional capacities. What countries wanted and needed was not more advice but more capacity to implement and the assistance of institutions and individuals who were prepared to make a long term commitment to help countries to carry out their national programs.

PRITECH's strategy to support national programs with long-term resident staff has proved effective in Africa, Asia and Latin America. PRITECH now has in the regions 19 professionals who are working directly with and are integrated into national CDD programs. PRITECH's resident staff are mostly mid-level professionals with a public health and program management background. The PRITECH overseas staff is international and includes a number of very well qualified resident Americans and foreign nationals hired locally. Recruiting a staff locally has enabled the project to field well-qualified professionals at half AID's normal cost. The savings have provided additional support for country CDD activities.

7. Each PRITECH intervention must address the issues of sustainability.

CDD programs need to build toward technical, institutional and financial sustainability. This means establishing a cadre of nationals that can provide effective technical and policy

leadership, developing national institutions for training and referral, and designing and implementing program activities that can be financially sustained over the long term with national resources. Programs must avoid relying too heavily on international experts in program and strategy design, employing a large and expensive cadre of CDD-specific staff funded by the public sector, building a program based on subsidized packets that will place an unreasonable strain on national budgets when the transition to local funding takes place. Because of the pressure to meet goals there is a strong temptation to short-cut sustainability. Countries often do so, sometimes with external encouragement and funding. External donors, along with PRITECH, have a particular responsibility to encourage countries to address sustainability issues realistically and resist using donor resources to fund activities that detract from that goal.

8. It is unlikely that in most "PRITECH" countries national CDD program and coverage goals will be reached through the exclusive efforts of the MOH programs and resources. PRITECH needs to help countries to effectively engage the private sector.

There is a growing recognition that in many countries the public sector is the minority provider of health services. If the full benefits of ORT are to be realized other primary care providers have to become active users and promoters of ORT. These sectors include the private practice of medicine, missionary groups, PVO's, traditional healers and dispensers of medicine. PRITECH believes that governments - even as they strengthen public sector coverage and performance - need to reach out to mobilize the untapped resources of the private sector. Private sector providers are now treating a large segment of the population. These providers

need to be trained to treat diarrhea correctly with ORT. In addition to expanding program coverage an effective private sector strategy will also clearly enhance the chances for longer-term sustainability of this technology.

PRITECH's planned support for the private sector should not diminish or replace the public sector effort which represents the core of PRITECH's activities.

9. PRITECH should continue to enhance the effectiveness of its modest resources through collaboration with other CDD donors.
AID has an important and growing coordination role between the multiple CDD projects it funds.

Throughout the project PRITECH has worked hard to develop close working relationships with a variety of bilateral donors. This has enabled PRITECH and others to plan CDD activities collaboratively with the countries and multiply the effectiveness of all our limited resources. For example, UNICEF and WHO helped PRITECH establish the program in Zambia. PRITECH's technical resources have been combined with Italian program support funds to finance the MOH's CDD communications program in Kenya. PRITECH will need to continue to maintain this close collaboration.

AID's coordination role is growing and becoming more complex. In addition to the numerous CDD projects funded centrally, regional bureaus and AID missions are supporting and providing additional technical and financial assistance to CDD through bilaterally funded projects. There is at present no structure in place to assure the coordination between these multiple activities, provide central technical support to bilaterally funded TA or to assure quality control. This function cannot be delegated to a contractor, although contractors can help AID to carry out this function.

Lessons Not Yet Learned.

1. How to convince AID's Africa region to support CDD programs in needy countries.

PRITECH continues to struggle to gain AID's regional support to establish CDD programs that will assist needy countries in Africa. AID/Africa management's priority for health programs is low, and the mission based health staffing that should serve as health's advocate is either very thin or non-existent.

We believe that our experience over the past five years in the Sahel has demonstrated that PRITECH can implement effective and country supported CDD programs at relatively low cost and at a minimal management burden to the AID missions.

We need to find a way to convince AID's Africa region to enlarge its support for CDD.

2. How to collaborate effectively with AID's CCCD project.

At PRITECH's inception we believed that our CDD expertise could effectively support CCCD's programs in Africa. Despite some promising initial joint planning activities field based collaboration has not materialized. We are not prepared to abandon the prospects of collaboration but do not see clear next steps.

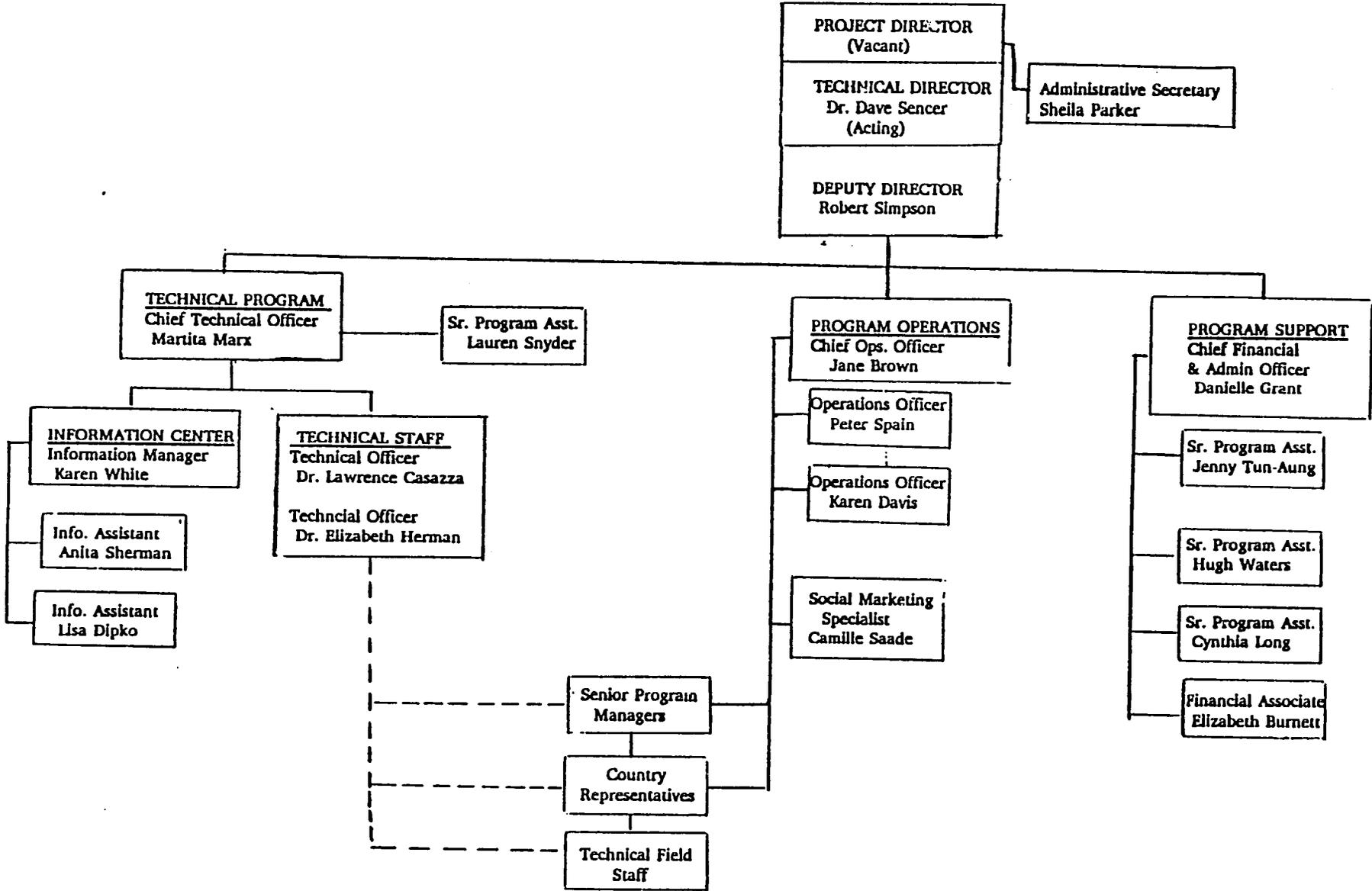
3. How to provide effective technical support to the US PVO's that are engaged in CDD activities.

We have not been able to become successfully engaged with the US Child Survival PVO's that are engaged in CDD activities. Most of our support has been supplying name-requested short-termers for evaluation of CS project proposals. We are convinced that most CS PVO's working in CDD in the field need

help and that only a few (e.g. Save the Children) have enough in-house expertise. PRITECH stands ready to help but cannot engage on this issue.

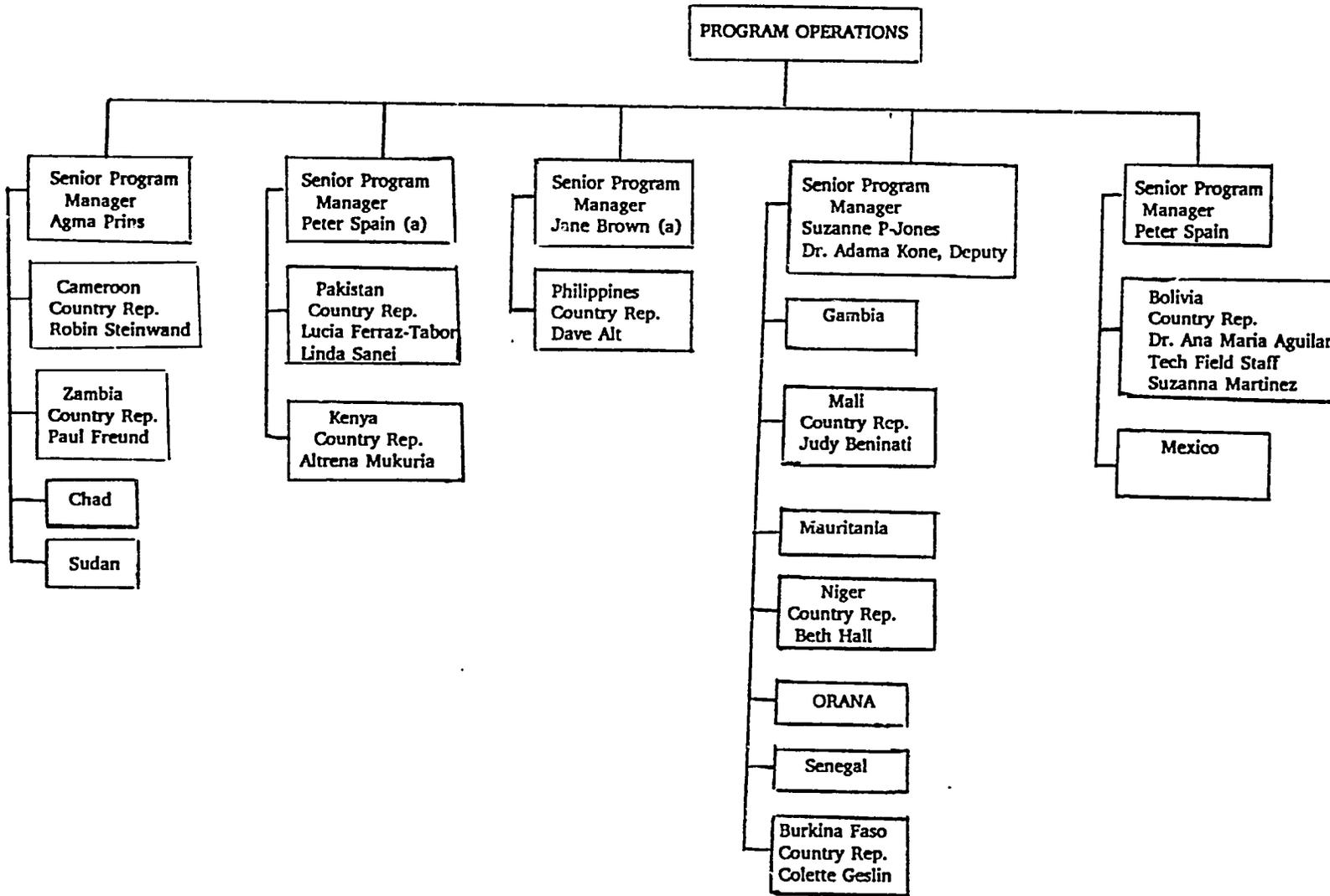
W

PRITECI ORGANIZATIONAL CHART



22

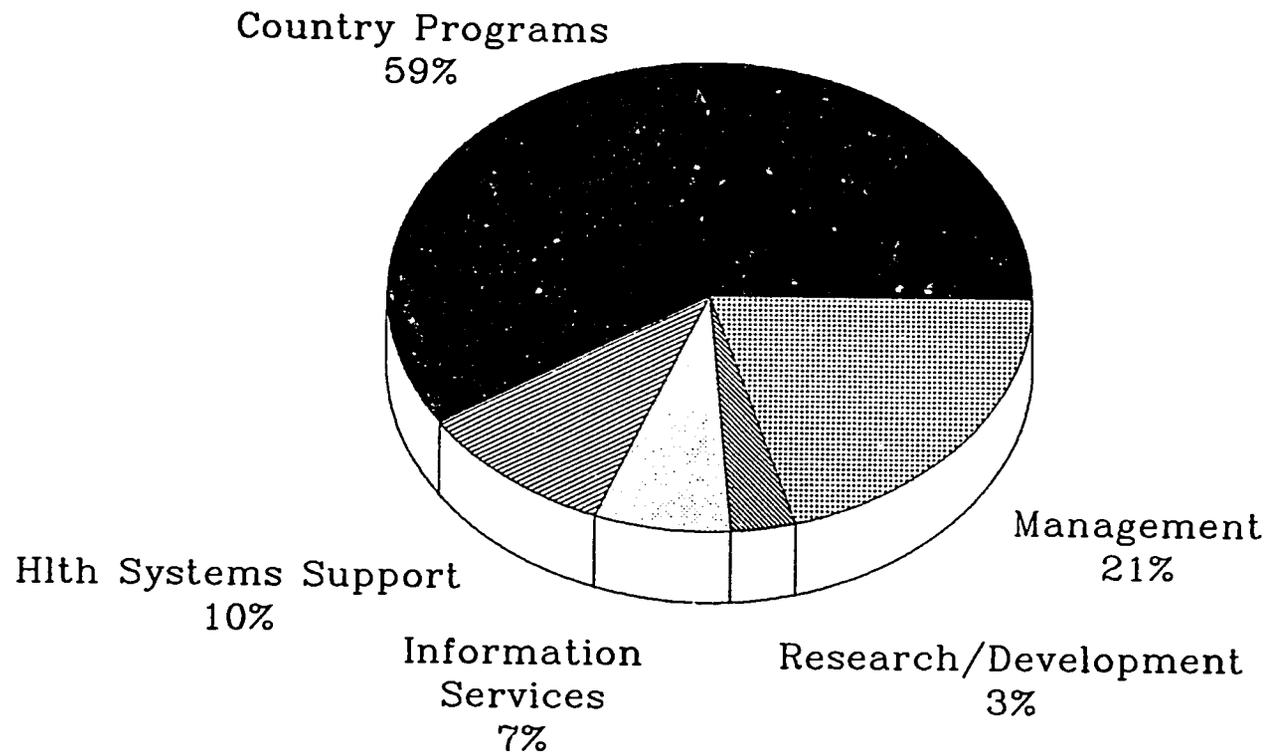
PRITECH FIELD ORGANIZATIONAL CHART



22

PRITECH II COMPONENTS

By Person Months



From PRITECH II Contract

PA

**PRITECH II
ANNUAL REPORT**

October 1, 1988 - September 30, 1989

**Contract No: DFE-5969-Z-00-7064-00
Project No: 936-5969**

**By: The PRITECH II Project
Suite 400
1925 North Lynn Street
Arlington, VA 22209**

25

**PRITECH II
ANNUAL REPORT
October 1, 1988 - September 30, 1989**

TABLE OF CONTENTS

I.	EXECUTIVE SUMMARY	1
II.	PROGRAM REPORT ON ANNUAL WORKPLAN	3
	A. Disease Control Operations Components: PRITECH II	3
	1. Summary	3
	2. Country-specific summaries	7
	3. Issues Relating to Disease Control Operations	56
	B. Health Systems Support	58
	1. Overview	58
	2. Current Status vis-a-vis Project Year Workplan	61
	C. Information Support Component	63
	1. Overview	63
	2. Activities	63
	3. Conferences	69
	D. Diarrheal Disease Control - Research & Development Component	70
	1. Overview	70
	2. Activities	70
	E. Project Management	78
	1. Overview	78
	2. Country Program Management Structures	78
	3. Strengthening Technical Staff for Country Programs	81
	F. Quality Control for Disease Control Country Programs	82

APPENDIX 1 - Assignment Reports by Country & Region

APPENDIX 2 - Project Expenditures and Level of Effort

26

I. EXECUTIVE SUMMARY

Program Year 1, from August 1987 to September 1988, was a transition year, overlapping with the last year of PRITECH I. As planned, very few program activities occurred under PRITECH II during this first year, because program funding came from PRITECH I. Only about \$900,000 was spent for PRITECH II, with about half this amount for program management. By the end of Program Year Two (PY2), the PRITECH II program was successfully underway. The total amount of "buy-ins" for country programs had reached \$7.1 million, almost half the buy-ins expected for the total contract. Twelve country programs, with 20 full-time and four part-time resident staff, were in full operation by the end of the year.

Top priority was given to assessing PRITECH I country programs and, when appropriate, designing and securing approval for new multi-year programs. At the beginning of the year, attention was focused on the eight programs in the Sahel; multi-year approvals were given to six programs. A large share of senior management time, in Washington and the field, was needed to define PRITECH's role in a few countries: Indonesia, México, Pakistan, Kenya and Nigeria.

- The Indonesia program was designed as a one-year effort to create capability within the GOI, at national and provincial levels, to manage the CDD program. PRITECH agreed that the Indonesia Mission would direct this effort, with PRITECH staff in Washington playing a support role. Once these roles were defined, activities went forward quickly.
- An extension and expansion of the México program was planned by PRITECH with the MOH and PAHO. The plan was put on hold pending resolution of who will take responsibility for implementation within México's Ministry of Health.
- The Pakistan program, centered on a rapidly growing DTU effort, began to stretch implementation capacity at the National Institute of Health. Because the arrival of a large child survival project was repeatedly deferred, the forward movement of the DTU effort was in jeopardy. The PRITECH field team filled the gap. A series of negotiations between PRITECH, the Mission and the Pakistanis was needed to define PRITECH's roles and staff requirements. A large buy-in was in process at the end of the year.
- A plan for a \$1 million PRITECH program in Kenya was developed in February and approved by the GOK; S&T/Health and USAID/Nairobi have split the costs. A large amount of time was consumed by PRITECH and USAID/Nairobi managers trying to define a training program; finally, long-term overseas training was dropped from PRITECH's workscope.

- A plan for the Nigeria program was developed in Nigeria and endorsed in principle by the MOH; subsequent negotiations with the USAID and CCCD representatives did not produce agreement about PRITECH's role, so PRITECH agreed to provide short-term assistance upon request of CCCD.
- During the year, four other programs with resident staff shifted from PRITECH I to PRITECH II: Bolivia, Cameroon, Zambia and The Philippines.

In each of these country situations, except for the Sahel programs, S&T/Health funds have been essential: to finance program planning, transition periods between programs while buy-ins are being processed, entire programs where USAID funds were not available, or to add funds to ensure that adequate expert technical assistance is available.

In addition to the country program activities, PRITECH continued to provide a wide-range of consultants for Systems Support assignments, 43 assignments to 20 countries. The Information Center expanded its services, for example, responding to 490 requests, a 30% increase over the prior year.

PRITECH has the management structure in place to handle a steadily increasing program. We anticipate that annual spending will increase to above \$8 million by PY4. We expect to request a one-year extension of the project, because the first transition year was devoted to completing PRITECH I activities. Management costs are being held at the level provided in the contract; however, PRITECH believes that the size of the core staff is small compared to other similar A.I.D. contracts in relation to total funding, to number of country programs, and to numbers of staff in the field. As country programs proceed into implementation, management will hopefully become more routine and the management burden will lessen. Over time, management and technical resources will be shifted increasingly to strengthening the technical content of programs, for example by transferring new methods of ORS supply management among countries. If resources, staff time and funds, are available, more effort will be given to private sector program opportunities and to links with other primary health care programs such as acute respiratory infections.

II. PROGRESS REPORT ON THE ANNUAL WORKPLAN

A. Disease Control Operations Component: PRITECH II

1. Summary

The workplan for PY2 anticipated a consolidation of the assessments of PY1, by establishing long-term implementation plans leading to sustainable programs. Most of the PRITECH I countries have continued into PRITECH II, and PRITECH II program strategies, developed with each country's MOH and with the other donors, are focusing on longer-term implementation and the strengthening of local institutional capabilities. Working closely with A.I.D., PRITECH has been seeking opportunities for new country interventions, especially in Sub-Saharan and East and Central Africa. A keystone in this strategy has been the establishment in PY2 of a second regional office, this one based in Kenya for East and Central Africa, staffed by a Senior Program Manager.

The PY2 workplan stipulated outputs by activity category. The planned outputs, and the actual outputs during PY2, were as follows:

<u>Activity category</u>	<u>Planned</u>	<u>Actual</u>
Promotional visits	6	6
Program assessments	6	7
Program plans	7	7
Program starts	14	12
Implementation countries	12	15
Ad Hoc Tasks	5	2
Program Reviews/Evaluations	0	0
Completed Programs	1	1

Promotional visits

Six promotional visits were undertaken -- to Uganda, Rwanda, Malawi, Jordan, India, and Morocco. The results of these promotional visits:

Uganda: Follow-up PRITECH/WASH team to visit in February 1990 to undertake limited assistance to CDD program in collaboration with UNICEF.

Rwanda: USAID unable to buy-in to PRITECH at this time. PRITECH to make follow-up visit.

Malawi: Awaiting mission decision on future assistance to national CDD program.

Jordan: USAID mission not able to buy-in to PRITECH. However, USAID did directly fund local ORS advertising and promotion among doctors and pharmacists -- activities recommended by the PRITECH team.

India: PRITECH to follow-up with mission and UNICEF.

Morocco: USAID not ready to move in CDD-related areas at this time. Future possibility of combined CDD, nutrition, and family planning social marketing interventions.

Assessments and Program Plans

The assessments in Nigeria and Kenya led to the development of program plans. In Cameroon and Zambia, the PY2 assessments supported planning to be done in PY3, while the assessments in Tunisia and Chad concluded that PRITECH could not play an immediate role in national CDD activities there. The Bolivian program was expected to be completed at the conclusion of PRITECH I, but the assessment team found new opportunities to contribute through a consortium of PVOs working in health; as a result, PRITECH was able to channel its technical assistance through this PVO group.

Other Tasks from the PY2 Workplan

a. Twelve sustained programs.

Last year, nine sustained programs were underway, and the plan was to propose three more to A.I.D. during PY2. In fact, four were proposed (Kenya, The Philippines, Sudan, and Nigeria), while Bolivia moved from the sustained to the intermittent category. Of these four, Kenya and The Philippines have been implemented and are operational, sustained programs. The Nigeria proposal was not approved by CCCD and AAO/Lagos. Sudan had to be placed on hold due to Brooke Amendment constraints. As a result, eleven sustained programs were approved during PY2.

b. Twelve intermittent programs.

Eight intermittent programs were identified for nomination to A.I.D. during PY1, with four more to be selected in PY2. Six programs, continuations from PRITECH I, were proposed; five programs were approved, including the West African Nutrition Institute, ORANA. The Chad proposal was not approved pending arrival of a new USAID Child Survival Project team. Hopes for several other intermittent-candidate countries (Ghana, Rwanda, Malawi, Zimbabwe, Uganda, and Turkey) have not yet yielded additions to this list. As a result, five intermittent programs were in place during PY2.

c. Ad-hoc programs.

Over the life of the project, PRITECH II will provide 125 person-months of short-term technical services to USAID missions and country programs which support A.I.D.'s CCD or broader health sector objectives. During PY1, 1.24 person months were provided. During PY2, this increased only to 1.86 person months with a total to date of 3.10 person months. All ad hoc activity thus far has been supported by central funds.

Regional Strategies

In consultation with S&T/H and the bureaus, PRITECH II planned the following breakdown of anticipated regional use of project resources:

Region	Sustained programs	Intermittent programs
Africa	40%	40%
Asia/Near East	40	35
Latin America/Caribbean	20	25

However, the regional use of PRITECH resources is determined by the interest and demands of the missions and their decision to buy-in to the project. While the S&T/H allocation of funds reflects the regional breakdown of the RFP, mission demand or lack thereof has resulted at the end of PY2, in the likelihood that African country programs and funding targets will be surpassed, while those of the Latin American/Caribbean region and the Asia/Near East region will probably not be met. At present, the PRITECH development efforts over the project's first two years have produced the following distribution, given in actual numbers of programs and percentages:

Region	Sustained programs		Intermittent programs	
	#	%	#	%
Africa	7	63	4	80
Asia/Near East	3	27	0	0
Latin America/Caribbean	1	10	1	20
Totals	11	100	5	100

Country Selection Process

PRITECH workplans have consistently stated that the following factors would be considered in establishing priorities for starting or continuing PRITECH country programs:

- estimated number of children at risk of death from diarrhea;
- prospects for effective CDD efforts;
- availability of resources from A.I.D. and other donors;

31

- selection as Child Survival emphasis country;
- receptivity to PRITECH involvement.

With the first factor in mind, PRITECH had sustained programs approved or active in seven countries with "very high under-five mortality rates", in six more countries with "high" rates, and two with middle rates. These last two have high annual deaths for children under five: The Philippines (142,000) and México (166,000). (See the attached table.) In PY3, PRITECH plans to visit up to seventeen candidate countries, such as Bangladesh, Turkey, India, and Ethiopia, among other potential sites. Altogether, these countries are about half of all countries in UNICEF's top priority categories with "very high" and "high" rates.

Regarding collaboration with other A.I.D.-funded projects and other donors, PRITECH worked this year with HEALTHCOM in Indonesia, Jordan, and The Philippines, and anticipates collaboration in Bolivia, Turkey, and the Sahel. Already in the Sahel, PRITECH staff have worked closely with consultants from the Nutrition Communication Project. In Bolivia, PRITECH's work is directly through PVOs that have received A.I.D. funds to work in health. Our efforts to develop the diarrheal components of CCCD program interventions have not borne fruit this year, despite our expectations that this would be possible in Nigeria.

At the country level, one of PRITECH's most important contributions is to facilitate coordination among donors -- WHO, UNICEF, A.I.D., and other bilateral donors -- that are working closely with the national program. In addition, PRITECH is often able to support program components and areas where there are gaps left by the major donors. PRITECH looks to WHO for leadership on CDD policy and case management, for example, where WHO has an in-country resident Associate Expert who is the CDD case management advisor to the national program. UNICEF often assumes responsibility for assistance with ORS supplies and training in CDD. SIDA and DANIDA are major suppliers of essential drug kits. PRITECH always seeks to collaborate closely with the major donors and often helps to coordinate the donors' assistance to the national program.

PRITECH has sustained country programs in five Child Survival emphasis countries (Mali, Niger, Kenya, Indonesia, Pakistan) and intermittent programs in another two (Senegal, Bolivia). The program for Sudan, another Child Survival emphasis country, was cancelled.

Support for the Field

The PY2 workplan called for an increase in the number of technical staff at PRITECH headquarters, an increase from two people to four. There are now four technical experts on staff in Washington, though one of these works 40% time. These staff

PRITECH II COUNTRY PROGRAMS
Under 5 mortality: rates and deaths, annual

PY2 Approved/Active		USMR	US deaths	PY3 Candidate	USMR	US deaths
Countries with "Very high USMR"						
S						
	I					
S						
S						
	I					
S						
	I					
S						
	I					

Countries with "High USMR"

S						
S						
	I					
S						
S						
S						

Countries with "Middle USMR"

S						
S						

S=sustained

I=intermittent

Source: UNICEF's "State of the World's Children - 1990"

members were able to take part in key country assessments, such as Cameroon and Zambia.

The field-reporting system planned in PY1 is now in place, providing regular, systematic information to headquarters from the field and equally regular, systematic feedback to the field from headquarters. Revisions to streamline the system are under consideration.

2. Country-specific summaries

The following country profiles detail PRITECH activities in each country. It should be noted that PRITECH's role is a facilitative, coordinating one which is difficult to separate out from the activities of the national CDD program. The country profiles often highlight the accomplishments of the national CDD programs, as part of PRITECH's reporting responsibility to A.I.D. In addition, in almost all these countries the donors, including WHO and UNICEF, provide substantial assistance in terms of funding, personnel, equipment, transportation, and supplies, which is not described in these country profiles.

PRITECH Representatives:
Ana Maria Aguilar M.D., Pediatrics
Susana Martinez, Communication

BOLIVIA: Intermittent

A. STATUS

Approved in October 1988 by S&T/H, Bolivia is a four-year PRITECH intervention budgeted at \$360,676. PRITECH's role in Bolivia, defined during PY2, is to be responsive to a set of opportunities unique to Bolivia.

B. PROJECT DESCRIPTION

With the creation of the PVO Secretariat by USAID and the conclusion of the PRITECH I agreement between PRITECH and Caritas, PRITECH was able to offer the services of its Bolivian professionals to the Secretariat. These two technical people, one a pediatrician and the other a communications expert, have been available to all member PVOs, providing technical expertise that no individual PVO had on staff.

During PY2, the PRITECH intervention in Bolivia focused primarily on diarrheal-disease control, and included such activities as:

- o research on the composition and efficacy of home fluids in collaboration with Dra. Martha Mejia, the MOH CDD Director;
- o revision of the CDD educational materials developed during PRITECH I for use by PVOs;
- o organization of CDD training seminars for physicians at the National Children's Hospital;
- o evaluating the CDD activities of the PVOs to provide feedback to health workers on diarrhea and growth monitoring;
- o publication of the first of a series of bibliographies based on the PVO Secretariat's library holdings. This was on diarrhea, covering the extensive collection the Secretariat received from PRITECH I. The librarian herself worked for and was trained by the original PRITECH team.

PRITECH's work in Bolivia is conducted in collaboration with the A.I.D.-funded Coordinated Child Survival Program for PVOs, and is contributing to the integration of CDD activities with other child-survival efforts. The combination of PRITECH's emphasis on diarrheal disease and the PVO Program's broader health activities has highlighted and strengthened the links between CDD and other high-priority child-survival measures.

At a PY2 training course for CARE field staff, for instance, PRITECH staff provided training in diarrhea control as well as in breast-feeding and growth monitoring, giving emphasis to the interrelationships among these three strategies for improving children's health. PRITECH has also collaborated with CARE on a diarrhea knowledge-attitudes-practices (KAP) study in Oruro and Potosi, where CARE has begun a water and sanitation project.

An indication of PRITECH's respected role within the Secretariat and among the PVOs is the request that Susana Martinez be one of the evaluators on the CRS team that, in late October and early November, was to evaluate the Caritas Mejoramiento Infantil project in the altiplano and valley regions of the country. This project was carried out PRITECH technical assistance. In addition, Caritas is about to embark upon the third stage of this project, in the lowland regions to the east, where they are proceeding with direct support from USAID. They are most interested in calling on PRITECH's two technicians within the Secretariat. This represents good progress with Caritas, which at times had looked on PRITECH more as a financial resource than as a technical resource.

In addition to integrating CDD activities with other child-survival programs, PRITECH/Bolivia is contributing to the integration of PVO and government health services. PRITECH sponsored this year the attendance of the head of Bolivia's MCH program, the head of the PVO Secretariat, and the PRITECH health specialist at a PAHO-sponsored Latin American NGO forum in Bogota to discuss PVO-government coordination. Since Bolivia's coordination efforts have been concrete and substantial, the Bolivia model was a centerpiece in the Bogota discussions.

In PY3, PRITECH will continue these initiatives. One activity that will increase will be collaboration with the bilateral Child Survival Project, with PRITECH participation in educational materials workshops in Santa Cruz and Cochabamba. In addition, PRITECH/Washington will be reviewing the arrangement by which PRITECH works through the PVO Secretariat. Several developments warrant such a review:

1. The Executive Secretary of the PVO Secretariat (PROCOSI) has resigned following an outside evaluation of the Secretariat, carried out by the accounting firm of Cooper and Lybrands, that was extremely critical of its management and accounting. What does the prospect of a new Executive Secretary mean for PRITECH's role within the Secretariat?

2. The Ministry of Health and the Children's Hospital in La Paz have occasionally sought assistance from the PRITECH physician. The job description, approved at the start by all parties, contains the flexibility necessary to be responsive to limited requests and, indeed, recognizes the value of linkages between the PVOs and the

public sector. Should PRITECH continue to encourage collaboration with the MOH CDD program?

3. The individual PVOs have not developed strong diarrhea-focused programs; rather, like the MOH, their emphasis has been on integrated programs, touching on several aspects of child survival. Dra. Aguilar has just completed a review of the PVOs' CDD activities. She found that all had CDD among their priorities and all were committed to the norms published by the government (conforming with WHO guidelines). But, in fact, applied programs are few, people trained in proper case management are few, little has been done on training others or in communicating with mothers. Medical records are also weak. A few PVOs have rehydration units; the best ones seem to be those run by Project Concern in Sucre, where about 30 units are in operation. The review recommends a workshop to identify and shore up weak areas of CDD programs.

C. PROGRESS AND PROBLEMS

In sum, the PVOs are committed to CDD but in practice have no robust activities or vision for CDD. They are doing some things in CDD, but their efforts are slender and constrained by lack of skilled persons. They work in an integrated fashion, uniting efforts on several child-survival interventions. The question arises: Should PRITECH insist that its resources go only to CDD efforts?

In January 1990, the PVOs are holding an assembly to discuss several policy issues of PROCOSI. At that time, the assembly could recommend legal status for the Secretariat. This, coupled with tightened procedures within the Secretariat, would contribute greatly to its effective and timely operation in service of the PVO members. As in any group, views are divided. As far as continuing PRITECH's role within the PVO Secretariat, we favor doing so. The PVO Executive Secretariat expect no major changes and very much want PRITECH to carry on.

All public-sector medical facilities in Bolivia are suffering severe deficits. Bolivia is a country where annual per-capita income is \$600 while external debt per-capita is \$700. Consequently, although the PVOs have not been outstanding in their CDD work, the PVO Secretariat represents a better institutional base for PRITECH support than does the public sector. Keeping our people with the PVOs, but giving them the flexibility to work with the public sector -- this seems to be the best posture for PRITECH in Bolivia. What is being done in CDD is far from mature at this point, but PRITECH represents a strong, positive force for developing CDD work.

PRITECH Representative:
Colette Geslin, M.D.

BURKINA FASO: Sustained

A. STATUS

Program plan approved in June 1989 authorizing \$400,000 over four years to support part-time resident advisor and short-term technical assistance

B. PROJECT DESCRIPTION

In close collaboration with the Burkina Ministry of Health and Social Affairs (MOHSA), UNICEF, WHO, and other donors, USAID/Ouagadougou targeted four of 30 provinces for PRITECH assistance. With the intention of expanding to other provinces, and contributing to the development of a national CDD program, the primary focus of PRITECH assistance has been on organizing and carrying out training activities within these four provinces. Strengthening program management, producing and distributing educational materials, and developing an effective ORS monitoring and distribution system have also been major objectives of PRITECH's assistance to the program.

PRITECH's contribution to the Burkina program is made through a resident advisor and Sahel Regional Office consultants who provide assistance in organization and management, supervision and follow-up, training, and educational materials development. UNICEF and WHO have supported program activities through the financing of training, educational materials, and ORS packet supply.

PRITECH is also assisting the Mission with the development of the CDD component of its five-year bilateral child survival project scheduled to start up in 1990. Under it, CDD activities will expand to cover at least four more provinces. CDD activities will be closely coordinated with nutrition activities at the provincial level.

C. PROGRESS AND PROBLEMS

The Burkina program has made remarkable progress since its effective start-up which was marked by a workshop in late October 1988. Approximately 325 health workers have been trained. Educational materials on diarrhea and nutrition have been tested, produced, and distributed. The PRITECH representative, who began working with the program in November 1988, is largely responsible for the successful implementation of project activities.

Despite this progress, however, the overall development of the national CDD program has been impeded by the absence of a national coordinator and the lack of an updated national CDD action plan.

This situation has meant that the PRITECH representative has had to take major responsibility for administrative and other matters that should normally be handled by MOH personnel. Furthermore, several issues requiring the action of a national coordinator, for instance, helping the Ministry to clearly define an ORS policy, remain unaddressed.

Program Management

In November 1988, a physician with considerable experience in MCH began working with the Burkina program on a part-time basis as PRITECH's resident advisor. Her responsibilities include assisting the national CDD coordinator with the organization and implementation of project activities, coordinating the efforts of the various donors, administering PRITECH funds in accordance with USAID contract requirements, and helping the MOHSA to manage projects funds.

Unfortunately, the national CDD coordinator's position has been vacant since January 1988; the former coordinator left the program to begin long-term training abroad. While the MOHSA has expressed a commitment to finding a replacement, the gap has left several issues requiring the action of a national coordinator unattended. These include the development of an updated CDD national action plan and the clarification of policy issues on ORS and other matters. The implementation of supervision trips is also difficult without the participation of a CDD coordinator. Other impediments to the timely implementation of project activities include delays in disbursement of UNICEF funds.

In the meantime, the focus of CDD activities continues to be on provincial-level activities. USAID/Ouagadougou, which has demonstrated a strong commitment of CDD, is gearing up for a five-year child-survival project which is projected to commence in 1990. Under that project, an additional four provinces at minimum will be selected for CDD activities. Emphasis will continue to be placed on education and training, and a concerted effort will be made to coordinate CDD activities with nutrition interventions.

Training

A national-level workshop, which brought together representatives from the Nutrition, Training, Planning, and Health Education Units as well as three of four Provincial Medical Directors, was held for four days in October 1988. At this workshop, the curriculum for provincial-level training was discussed, and the CDD periphery-level health-worker training manual, which represents a compilation of information from, among other sources, PRITECH's Intermediate-Level Nursing School Modules, was introduced.

Following the national session, training was carried out in each of the four provinces. With the guidance and active participation of the PRITECH representative, approximately 325 periphery-level health-workers were trained.

As for pre-service training, PRITECH Intermediate-Level Modules have been successfully integrated into both nursing schools. The Medical School has asked for copies of the PRITECH/WHO training modules, and is considering strengthening the coverage of CDD in its curriculum.

Education and Communication

Discussion guides in the form of flash cards were field-tested and printed in Dakar with PRITECH assistance. These cards focus on key themes relating to diarrhea and nutrition, and were designed for use by health staff and VHWs. PRITECH and UNICEF anticipate working closely with the Health Education Unit to help the program define a national IEC policy and communications strategy.

Case Management

Infant weighing scales were purchased in the U.S. and shipped to Burkina for utilization in 50 ORT corners. Once personnel are trained and funds are made available for the purchase of additional equipment required for the corners, these scales will be distributed so that at least one aspect of the nutrition component of diarrhea case management can be effectively addressed.

PRITECH Representative:
Robin W. Steinwand

CAMEROON: Sustained

A. STATUS

- o PRITECH visit to Cameroon in 1986 to assess potential for national program and for PRITECH assistance to the program
- o Complete four-year national-program-strategy document signed by the Minister of Health December 1988
- o Two full-time CDD staff now being brought into the program in addition to the program director
- o Training of personnel for correct case management by the largest public hospitals (provincial hospitals, large reference and teaching hospitals) has been completed; other training on-going
- o Strategy in process for a major communications (IEC) initiative to improve diarrhea case management by parents
- o Formal agreement with Government of Cameroon for PRITECH assistance through the life of the PRITECH II Project in process

B. PROJECT DESCRIPTION

With the approval by the Minister of the national-program-strategy document, the CDD team began a more systematic planning of activities, with corresponding budgets. These plans have formed the basis for progress in a number of important program areas. Nevertheless, the pace of progress was slow in FY89 due to insufficient program personnel and a nearly one-year delay in putting a new Ministry of Health organizational chart in place.

- o Early in 1989, the national strategy document was printed and widely distributed. Based on the strategy, a four-year budget was developed.
- o In December 1983, three Cameroonians attended the ICORT III meetings in Washington, D.C. The Cameroon delegation included the President of the National Assembly, the Minister of Health, and the Director of the CDD Program.
- o A three-poster series for health-facility-based evaluation and treatment of diarrhea was developed, tested, printed, and widely distributed to trained personnel. The series,

which is accompanied by supporting technical aids, is in French and English.

- o PRITECH and the MOH conducted a joint PRITECH assessment in March 1989.
- o In April, a new Director of ORT activities for the national diarrheal training unit attended a clinical course at Mama Yemo Hospital in Kinshasa.
- o Save the Children, PRITECH, and the Ministry of Health collaborated to conduct three ORT training sessions in the Save the Children impact areas. All trainers had participated in previous years in the training-of-trainers course. Provincial trainers thus gained an opportunity to enhance new training skills.
- o The USAID bilateral SESA Project placed early emphasis on ORT; by mid-FY89 personnel from all health facilities in the two provinces down to the health-center level had received training in ORT.
- o Three other provinces and the national Catholic Health Services organized their own courses in ORT.
- o Based on training experience to date, a complete set of Cameroon CDD training modules is in the preparation-and-testing phase. These should facilitate training by those who participated in the TOT.
- o PATH/Project Support visited Cameroon in April to follow up its assistance to Plantecam for local ORS production. Though the MOH maintains the freedom to purchase from the cheapest provider, agreements were reached to collaborate on packet size and design and the marketing efforts of the two parties should be mutually supportive.
- o The CDD program worked with EPI and the Nutrition Service to train personnel and launch efforts to integrate ORT-nutrition-EPI activities in eight centers in Yaounde. These will serve as models for similar integration efforts around the country.
- o Focus-group studies were completed nationwide, for six sociocultural regions, with broad participation by members of the multisectoral collaborative group.
- o A national communications workshop was held in July to develop a communications strategy, which blends the findings of the focus-group studies about mothers' beliefs and practices with the national CDD policies.

- o A program logo has been designed and tested in preparation for the communications campaign which will begin in early 1990.
- o The ADDR project is funding a further study of traditional practices surrounding diarrhea. MOH/CDD input is helping to assure that this study complements information already obtained during the focus-group study.

C. PROGRESS AND PROBLEMS.

The CDD program remains a priority program of the Ministry of Health in Cameroon, demonstrated by the continuation of a budget line item for the program in the face of the continuing national economic crisis. The Minister has placed special emphasis on ORT during several field visits and public appearances.

In spite of improved planning of activities, program progress toward its goals has been hindered by a lack of full-time personnel at the central level. This difficulty was further exacerbated by the delay in making appointments to new directorates created by the January 1989 reorganization of the Ministry. Without program personnel, follow-up in the field of people trained has been severely limited. By year-end, however, most nominations had been made and two full-time staff appointed to the CDD program.

The continued supply of oral-rehydration salts has been a major concern as the program plans a communications campaign to reach the general public. Ministry officials are clearly sensitive to the overriding importance of this program element. Efforts in the next fiscal year should reflect serious planning to resolve resupply difficulties and monitor stock use.

Activities surrounding the focus-group studies and the development of a communications strategy have allowed for continued involvement of the multisectoral group. While the broad participation by several ministries and projects has not been uncomplicated administratively, it is considered a major asset of the CDD program in Cameroon.

42

CHAD: Intermittent

A. STATUS

PRITECH plan for a full program approved by A.I.D. December 1984; \$160,000 for two years. Activities extended to February 1989 within the original budget and scope of effort. A.I.D. grant to Africare approved March 1985 and executed August 1985; extended to August 1988. Implementation began in September 1985.

B. PROGRESS AND PROBLEMS

"Project ORT", PRITECH and Africare's contribution of technical assistance to the Chadian National ORT Program, primarily in the area of educational-materials development, was initiated in 1986. Over 700 health workers, teachers, and extension agents all throughout the country participated in workshops designed to increase their awareness and knowledge about ORT. The impact of this training on sustained health worker behavior was limited, however, by the brevity of the training sessions, the lack of practical exercises during training, uneven availability of ORS packets and other supplies, and the lack of supervision and follow-up.

The mother-education component of the project started with the development and printing of over 60,000 copies of various types of printed materials which were distributed to all provincial capitals. In addition, an intensive ORT educational campaign, using radio spots and sketches, a national "ORT contest", and other community activities, was carried out. The results of an impact survey of women at social centers in and around N'djamena revealed that the educational campaign had had a positive impact.

In April 1989, "Project ORT" ended. The national ORT coordinator, who was the MOH counterpart to the Africare "Project ORT" staff, was designated to serve a National Coordinator for Diarrheal Disease Control. At the time the project ended, the MOH appeared prepared to continue national-level CDD activities. USAID/N'djamena, UNICEF, and WHO also expressed support for further development of national CDD activities. However, national-level program activities were placed on hold, pending the initiation of a five-year bilateral child survival project (CCSP).

This project is projected to start-up in FY90. It will create a Maternal and Child Health/Child Spacing Division within the Ministry of Health for the purpose of emphasizing prenatal care, ORT, and child-spacing services in two prefectures in southern Chad. To help prepare for the upcoming project, USAID/N'djamena requested that PRITECH field a project paper (PP) design team; that team spent approximately six weeks in Chad beginning in April 1989. During the final phase of their visit, the PRITECH Senior Program

Manager responsible for backstopping Chad overlapped with the team to help clarify some of the ORT sections of the PP document.

To maintain the momentum gained during "Project ORT" and to prepare for an effective dovetailing of past ORT activities into the new child survival project, USAID approved a \$100,000 buy-in to PRITECH. Originally intended as a six-month "bridge" support, it became evident during the planning of the child survival project that the interim between the end of "Project ORT" and the effective debut of the new project's ORT activities would probably last at least one year and possibly up to a year and a half.

With the prolongation of the bridge period in mind, PRITECH put together a proposal which detailed activities to be completed prior to the start-up of the child survival project. The proposal was submitted to the Mission on May 27, 1989; it focused on the establishment of ORT training capacity in two locations and the development of ORT educational materials for use by health and social workers. To oversee implementation of these activities, PRITECH proposed fielding a country representative and short-term technical assistance over a 12-month period to start in September 1989.

In response to PRITECH's proposal, the Mission requested short-term TA for only a three-month period but asked that a resident advisor be provided for an unspecified period of time, which would end three months after the arrival of the Chief of Party of the CCSP. Unclear about the Mission's rationale for hiring a PRITECH-sponsored representative to serve for an undefined period of time, reporting to someone other than PRITECH staff, PRITECH suggested that it might be more appropriate managerially and less expensive to hire a PSC to act as program advisor. PRITECH offered its assistance in the recruitment process and reaffirmed its willingness to provide short-term TA.

In September 1989, the Mission announced that it expected to have a child survival management team in Chad by early 1990. Once this team is in place and functional, the Mission stated that PRITECH might be requested to help further define the scope and timing of CDD-related activities and provide other technical assistance in response to Mission initiatives.

THE GAMBIA: Intermittent

A. STATUS

Program plan approved by USAID in February 1989; \$200,000 authorized for support of short-term technical assistance and local costs over four years

B. PROJECT DESCRIPTION

The focus of The Gambia National CDD Program has been on the improvement of case management through intensification of community education efforts and training of health workers and other personnel. Activities designed to carry out these objectives have had to remain simple due to the program's limited financial and human resources. The national CDD coordinator, who assumed the position in 1986, has been the only full-time staff member actively involved with the program. No operational support committee exists to follow up on CDD initiatives and activities. And while the Medical and Health Department (MHD) has demonstrated considerable commitment to the program, they have had little success in locating competent personnel to assist the program.

PRITECH provides technical assistance to the national program in the areas of program planning, case management, training, production and distribution of educational materials, development of strategies to increase access to ORS through the private sector, and program monitoring and evaluation. PRITECH also funds local costs associated with training, supervision, social mobilization activities, and educational materials development. These funds are channelled through UNICEF/Banjul for management purposes, an arrangement that has not been without problems.

C. PROGRESS AND PROBLEMS

Despite some delays caused by difficulties in the release of PRITECH funds through UNICEF, the program successfully carried out a number of training activities aimed not only at health care personnel but at school teachers. Progress was also made on the printing and widespread distribution of educational materials on ORT as well as the setting-up of a surveillance system.

In view of the importance of ARI as a major cause of mortality of children under five, WHO and UNICEF have decided to try out linkages between CDD and ARI activities in The Gambia. While integration of these two interventions may further limit the capacity of the already overburdened CDD unit, an ARI plan has been drawn up and is being implemented on a small scale in one region of the country.

Program Management

The national CDD coordinator, while quite conscientious, is considerably overburdened and has not always had time to carry out program responsibilities. This year, an administrative assistant was assigned to the program; unfortunately, this individual has had little program or field experience and has demonstrated little interest in taking on program responsibilities. Thus, the management capacity of the program remains limited.

Yet another challenge faced by the program was the slow disbursement of PRITECH funds through UNICEF. This difficulty, due partly to understaffing at the UNICEF/Banjul office, resulted in the delay of some program activities. A new program officer responsible for health activities has recently been assigned to that office, and it is expected that disbursement problems will soon be resolved.

Training

In May, PRITECH facilitated a three-day workshop for teachers from four training schools in The Gambia as well as representatives from some central services, for a total 19 people. A major objective of this TOT was to introduce PRITECH modules, translated from French into English, into the curricula of these training schools. The State Enrolled Nursing School used PRITECH modules during the last part of the 1988-90 academic year with apparently few difficulties. At another TOT course facilitated by, among others, a representative from PRITECH's regional office, 14 participants, mostly from regional health teams and hospitals, were trained in case management.

Education and Communications

Two thousand copies of a flip-book for use by health care workers were printed in Dakar with PRITECH funding, and then returned and distributed throughout the health system down to level of VHWs. PRITECH also funded the printing of 5000 copies of a new SSS mixing flyer which puts emphasis on the use of a liter plastic cup. The printing of those materials was also done in Dakar. PRITECH is currently overseeing the development of a flyer on ORS and a poster on a special diet for diarrhea. Both are modifications of existing materials, and are being tested by the Health Education Unit. Some progress was made on translating CDD radio spots into additional languages but getting Radio Gambia to broadcast the spots in a systematic manner has been difficult.

Information and Evaluation

Analysis of the first community surveillance system survey was completed by PRITECH; the latest draft report on the findings is with the CDD Coordinator and has not yet been finalized. There appears to be some question about how the surveillance system should be used -- either as a means to get valid data on infant and child mortality, for instance, or as a management tool to keep track of what mothers are doing when their children have diarrhea. In the meantime, PRITECH has agreed to assist with modifications of the survey instrument, once decisions are made on how it will be used, and will help to implement the second survey.

Private Sector

In March 1989, two PRITECH consultants met with the MHD and private-sector distributors, including representatives from commercial outlets and various non-governmental and private voluntary organizations, to develop initiatives for their involvement in the distribution of ORS. Recommendations were made for supply and distribution of ORS to the private sector, establishing prices, and generating demand through the use of marketing strategies.

PRITECH Representatives:
Bill Emmet: Public-health Management
Jim Bates: Drug-supply Management

INDONESIA: Sustained Program

A. STATUS

A one-year PRITECH II program, building on a three-year PRITECH I program, was jointly funded by the USAID Mission in Jakarta (\$667,000) and S&T/Health (\$100,000). The program began in October 1988 and was completed by September 1989.

B. PROGRAM DESCRIPTION

Under the conditions of the USAID buy-in, PRITECH II -- through a combination of long-term and short-term technical assistance -- was to help the Indonesian Ministry of Health (MOH) establish by September 1989 the institutional capacity to manage development of a national CDD program. PRITECH's long-term experts were a full-time public-health-management specialist and a part-time drug-supply-management specialist. Decentralization of program management to the provinces was an important objective; PRITECH worked with managers at the national level and in three provinces: West Java, South Sumatra, and South Sulawesi. PRITECH concentrated on the following: introducing a new WHO-sponsored curriculum for training physicians at eight medical colleges, setting up program-management systems for CDD program managers and training them to use these systems at the national and provincial levels, improving management of ORS supplies, monitoring prescribing practices to identify problems such as use of anti-diarrheals, and developing activities to expand private-sector sales of ORS.

C. PROGRESS/PROBLEMS

1. CDD Program Planning and Management

An important legacy of the PRITECH II effort is a planning process which the MOH has adopted and now uses to design and monitor its annual CDD workplan. In October 1987, PRITECH participated with WHO and other donors in a CDD joint planning workshop which marked an important turning point in the history of the CDD Program. Although Indonesia had had a CDD program since 1981, no real planning or collaboration with provincial health departments had taken place. The workshop changed the approach to developing a new CDD workplan. PRITECH's public-health-management specialist helped organize and design the new planning process. Instead of continuing to make decisions at the central level only, personnel at all levels of the CDD program were involved in the planning process. This decision gave health personnel from the

district and provincial levels a vested interest in the definition and successful implementation of the workplan. Responsibilities were redefined so that CDD managers at the national level would set policy and distribute funds, while personnel at the provincial level would develop workplans and implement them. As a result of the new planning process, the provincial and national CDD program managers prepared a workplan analysis for the 1987-89 period, much of which was successfully implemented. Some of the results as of September 1989 are shown in the accompanying table.

Beginning with the development of provincial workplans and with a financial management structure to support the implementation of the workplans, the CDD Program's support of provincial responsibility for the management of local initiatives represents the strongest possible evidence of the program's commitment to the development of appropriate institutionalized management capacity at each organizational level. In other words, the CDD Program has made every effort to vest authority for planning and implementation of the CDD's range of activities in those persons who are most directly responsible for seeing that the activities are in fact implemented. At the same time, at the central level, the CDD Program has maintained oversight responsibility as a means of ensuring that the program meets its overall objectives. This planning and program-management approach is a remarkable departure from a traditional centrally oriented organizational/management orientation; it enhances the prospects for the CDD Program's long-term sustainability.

2. Training of Medical Students

In early 1986, staff from WHO and PRITECH began the development of ORT-related training material (MEDIAC). The objective was to provide medical schools with technically current curricula on the control of diarrheal diseases and on the appropriate response to dehydration. PRITECH's Dr. Robert Northrup provided technical assistance from the beginning of this effort, continuing through PRITECH II. In early September 1988, senior GOI medical school staff -- all of whom had earlier been trained by the ICDDR/B in Dhaka, Bangladesh -- began the process of adapting the international MEDIAC training material for use in Indonesia. Adaptation and translation of this material for use in Indonesia's teaching-hospital curricula has now progressed through its first phase of being introduced into eight teaching institutions. Following an August 1989 evaluation of PHASE I activities, it is expected that between September 1989 and the termination of the USAID project in September 1990, an additional eight institutions will be included in the program's second phase of development. In preparation for this second phase of MEDIAC-material introduction, ten physicians and ten nurses were sent for training at ICDDR/B during the month of December 1988. Upon their return to Indonesia, those persons who received training have been expected to establish DTUs in their respective institutions. With the assistance of an

expert committee, the CDD Program continues to evaluate this DTU-development process.

3. Management/Information

In the assessment of development needs prior to the design of the workplan, the CDD Program determined that the program's staff would benefit from training in basic computer skills as a means of establishing a foundation for continued strengthening of the program's management-information systems. With the assistance of a local computer-training firm provided through PRITECH, the CDD program assessed the training needs of its central-level staff and of staff associated with the program in the three selected provinces. Following this assessment, a basic skills-training course was developed and implemented for staff from the three targeted provinces and a slightly higher-level training course for the central level's more experienced staff. Twenty-seven staff from the provinces and nine staff from central level have successfully completed this training.

4. Drug-Supply Management

As indicated in the following paragraphs, CDD Program efforts to strengthen its drug-supply-management capacity have followed a deliberate and steady pattern:

a. Drug-Supply-Management Assessment Package

Over the past year, CDD Program staff have developed a computer-assisted drug-supply-management assessment package through a step-by-step process of data collection, computer development, field trials, and staff training in the use of the package. As currently designed, the computer package enables the CDD program to assess prescribing practices, level of supply, and quality of drug-supply management through inputting relevant data from any level of the developed CDD Program's delivery system. In addition to providing the program with summary data in a tabular layout, the program has been designed so a novice user can design and use graphic presentations. Although the program has been developed for use by central-level staff, its applicability to provincial-management needs has already been demonstrated on a trial basis.

b. Drug-Supply-Management Information Systems

On the basis of a November 1988 assessment of its drug-supply-management information system, the CDD Program concluded that there was a need for more reliable and comprehensive information on national supplies of ORALIT. The CDD Program has designed, tested, and trained its staff on the use of a program which pulls together data on levels of supply from the many separate sources within Indonesia which presently maintain stocks of ORALIT. As with the drug-supply-management assessment package,

the CDD Program's drug-supply-management information system has been designed so the relatively novice user can design and use both tabular and graphic presentations.

c. Training in Drug-Supply Management

In September 1988, CDD central-level staff with PRITECH technical assistance carried out a survey to assess training needs for provincial staff who manage ORS supplies. This assessment led to two training efforts:

- o To set the stage for drug-supply-management training for CDD Program staff and to provide for a common understanding of supply-management needs among all health-care staff at provincial level, the CDD Program selected key individuals in each provincial health structure for a one to two-day training course in basic drug-supply-management course issues. A total of 158 health-care staff from the three selected provinces completed the training.
- o Following the completion of the decision-maker training, central-level staff collaborated with provincial staff in the development and implementation of a one to two-day drug-supply-management training curriculum for CDD program staff at provincial, district, and health-center levels. A total of 488 health-care staff from the three selected provinces completed the training.

5. Private Sector and Social Marketing

The CDD Program is considering the private sector's marketing advantages for sustaining the public's use of ORALIT. With the assistance of USAID funding and an initial PRITECH subcontract with the Program for Appropriate Technology in Health (PATH), the CDD Program has begun to set in place the elements of an aggressive social-marketing program for the city of Jakarta. Supported by extensive consumer research and by pro bono assistance from local industry and the media, this CDD initiative will become the first test case for public-service announcements to be promoted and developed by the newly developed USAID-supported "Indonesian Advertising Council".

TABLE 1. REPUBLIC OF INDONESIA - MINISTRY OF HEALTH
PROGRAM FOR THE CONTROL OF DIARRHEAL DISEASES
WORKPLAN OUTPUT SUMMARY
MARCH 1988 - SEPTEMBER 1989

<u>ACTIVITY TYPE</u>	<u>OUTPUT PER ACTIVITY LOCATION</u>			
	<u>CENTRAL LEVEL</u>	<u>SOUTH SULAWESI</u>	<u>SOUTH SUMATRA</u>	<u>WEST JAVA</u>
1. TRAINING				
1.1 CASE MANAGEMENT (PHYSICIANS)		46	70	364
1.2 CASE MANAGEMENT (NURSES)		56	70	488
1.3 VILLAGE HEALTH WORKERS - CRT (IN PROCESS)		1200	1800	19465
1.4 VILLAGE HEALTH WORKERS - LOGISTICS (IN PROCESS)		1200	1800	12427
1.5 DECISION MAKERS - LOGISTICS		56	55	52
1.6 HEALTH CARE STAFF - LOGISTICS		70	75	343
1.7 SUPERVISORY SKILLS	10	96	90	4
1.8 COMPUTER SKILLS	12	9	9	9
1.9 MANAGEMENT SKILLS	10	3	3	3
1.10 ICDDR/B	20			
2. COMMUNICATIONS				
2.1 COMMUNICATION STRATEGY	COMPLETED			
2.2 COMMUNICATIONS PROGRAMS		IN PROGRESS	IN PROGRESS	IN PROGRESS
2.3 NCDOP ORIENTATION (EGYPT)	9	5	5	6
3. ORGANIZATIONAL DEVELOPMENT				
3.1 DECENTRALIZED WORKPLANS	DONE	DONE	DONE	DONE
3.2 DECENTRALIZED FINANCIAL MANAGEMENT	DONE	DONE	DONE	DONE
3.3 INFORMATION DISSEMINATION				
3.3.1 WARTA DIARE	3 ISSUES			
3.3.2 INFORMATION CENTER DEVELOPMENT	ESTAB. 3/89			
3.4 M.I.S. DEVELOPMENT	GENERAL GUIDELINES DEVELOPED	INDICATORS DEVELOPED	INDICATORS DEVELOPED	INDICATORS DEVELOPED
3.5 SUPERVISORY SYSTEM DEVELOPMENT	GENERAL GUIDELINES DEVELOPED	FORMS DEVELOPED	FORMS DEVELOPED	FORMS DEVELOPED
3.6 DRUG SUPPLY MANAGEMENT				
3.6.1 MANAGEMENT ASSESSMENT PACKAGE	DONE	TESTED	TESTED	TESTED
3.6.2 MIS PACKAGE	DONE	TESTED		
3.6.3 OUTBREAK ASSESSMENT PACKAGE	DONE AND TESTED IN CENTRAL JAVA			

53

TABLE 1. REPUBLIC OF INDONESIA - MINISTRY OF HEALTH
 PROGRAM FOR THE CONTROL OF DIARRHEAL DISEASES
 WIGRAPLAN OUTPUT SUMMARY (continued)
 MARCH 1988 - SEPTEMBER 1989

<u>ACTIVITY TYPE</u>	<u>OUTPUT PER ACTIVITY LOCATION</u>			
	<u>CENTRAL LEVEL</u>	<u>SOUTH SULAWESI</u>	<u>SOUTH SUMATRA</u>	<u>WEST JAVA</u>
4. RESEARCH				
4.1 OPERATIONAL ASSESSMENT				
4.1.1 PROGRAM ASSESSMENT - 1988 & 1989	DONE	DONE	DONE	DONE
4.1.2 DRUG SUPPLY MANAGEMENT ASSESSMENT	DONE	DONE	DONE	DONE
4.1.3 M.I.S. DRUG SUPPLY ASSESSMENT	DONE	DONE		
4.1.4 COMPUTER TRAINING ASSESSMENT	DONE	DONE	DONE	DONE
4.2 FORMATIVE RESEARCH - COMMUNICATIONS		DONE	DONE	DONE
4.3 DESIGN RESEARCH				
4.3.1 LOGISTICS ASSESSMENT	DONE	DONE	DONE	DONE
4.3.2 M.I.S. ASSESSMENT	DONE	DONE		
4.3.3 COMPUTER TRAINING ASSESSMENT	DONE	DONE	DONE	DONE
4.4 SURVEY RESEARCH				
4.4.1 MORBIDITY/MORTALITY STUDY	COMPLETED IN 10 PROVINCES			
4.4.2 COMMUNICATIONS BASELINE		DONE	DONE	DONE
4.5 QUALITATIVE RESEARCH				
4.5.1 BREASTFEEDING AND DIARRHEA	COMPLETED UNDER THE DIRECTION OF CENTRAL LEVEL STAFF			
4.5.2 VILLAGE HYGIENE	COMPLETED UNDER THE DIRECTION OF CENTRAL LEVEL STAFF			
4.5.3 BEHAVIORAL DETERMINANTS OF DIARRHEA	COMPLETED UNDER THE DIRECTION OF CENTRAL LEVEL STAFF			
5. PRIVATE SECTOR DEVELOPMENT				
5.1 MEDIA MESSAGE DEVELOPMENT		DONE	DONE	
5.2 SOCIAL MARKETING	IN PROCESS UNDER THE DIRECTION OF CENTRAL LEVEL STAFF			

PRITECH Representatives:
Altrena Mukuria: Management
John Alwar: Operations Research
Nicholas Dondi: Communications

KENYA: Sustained

A. STATUS

The Kenya intervention is being co-funded by S&T/H (up to \$488,000, approved April 1989) and USAID/Nairobi (\$567,000, PIO/T 615-0232-3-80075).

B. PROJECT DESCRIPTION

During PRITECH I, emphasis in Kenya was on communications and operations research. The government has asked PRITECH II to continue its communication work, but the portfolio of PRITECH II activities is more comprehensive. Operations research will still be supported, but according to guidelines that ensure its direct and immediate relevance to the CDD program. The PRITECH II agreement has been fashioned to have PRITECH serve as a timely provider of support to the CDD program -- according to the MOH's definition of its technical-assistance needs, in any component of the program.

Principal accomplishments during PY2 have been:

- the design and negotiation of the PRITECH II Program plan with the MOH and USAID;
- the establishment of PRITECH offices within the Ministry of Health;
- hiring the new PRITECH representative;
- a planning workshop, which produced a workplan for the period 1989-1991;
- a curriculum-development workshop, which produced diarrhea-related materials for the schools that train mid-level health workers;
- the production of (a) print materials (three posters, two flyers, and one booklet); (b) a series of 13 fifteen-minute radio programs in seven different language versions; and (c) the production of a radio jingle/spot to be broadcast after the completion of the 13-week series of longer programs;
- the sponsoring of travel by two Kenyan CDD officers to Egypt to observe the functioning of that successful

ORT program, with emphasis on Egypt's changeover from one liter packets to 200 ml. packets;

--visits by PRITECH consultants to participate in development of the PRITECH program plan, in the planning workshop, in the curriculum-development workshop, in discussions on the changeover in packet size, and in planning for the operations research.

As PY3 begins, a key CDD activity is the changeover to half-liter packets. As noted, PRITECH has already supported consultants and a study tour by Kenyan staff to address this issue, and will be responsive to further requests by the MOH. Other areas that may benefit from technical assistance in PY3 are financial management, health-information systems, and operations-research design. ORS sales by the private sector has received little attention so far, but the private companies have agreed to produce half-liter sachets, giving the government (through PRITECH) an opportunity for widespread generic promotion of the new packets.

The government has the task of collecting all one-liter packets from its health facilities before the end of 1989. At first, it was thought that the ORS in these packets would be re-packed in 500 ml. packets, but this plan was abandoned as cumbersome and as problematic in quality-control terms. These collected packets are now slated for donation to a neighboring country.

C. PROGRESS AND PROBLEMS

At the end of PY2, Dr. Dominic Mutie retired from his post as Director of the Division of Family Health, which houses the national CDD program, and was replaced by Dr. A. Oyoo, the Provincial Medical Officer from Western Province. In a short time, Dr. Oyoo has demonstrated his serious support for the CDD effort, and promises to continue the initiatives negotiated by Dr. Mutie earlier in the year.

The Kenyan CDD team is energetic, but lacks experience. PRITECH is discussing observation tours to other countries whose national CDD programs contain components that deserve consideration by the Kenyans. Through JHU, PRITECH will also make available case-management experts to guide the Kenyan program as needed in its technical judgments; JHU will be particularly focussing on the development and implementation of operations research. What we are looking for most in Kenya is to strengthen the MOH CDD Unit, so that they can carry out the government's commitment to reduce child morbidity and mortality due to diarrhea. The Kenyans are taking the lead; PRITECH will continue its broad support.

We also expect to be sponsoring two members of the Kenyan CDD team for short-term training courses in 1990, in communications for one and in training-of-trainers for the other.

Also in PY3, PRITECH will be recruiting a new communications person, after Mr. Dondi leaves the project in December to devote full-time to his own company.

PRITECH Representative:
Judy Beninati

MALI: Sustained

A. STATUS

Program plan approved by A.I.D. February 1989 authorizing \$940,000 for full-time resident advisor, local costs, and short-term technical assistance

B. PROJECT DESCRIPTION

The Mali National CDD Program is a broad-based operation which has focused on four components: (1) training of health workers; (2) promotion of ORT in the community; (3) local production and distribution of ORS, initially through health facilities and later through sales by commercial outlets; and (4) education of mother to use ORT effectively, with ORS packets and SSS prepared in the home.

The program is managed by a team who have been assigned to work full-time for the CDD program. Team members have individual responsibilities for program management, case management and information systems, training, IEC activities, and distribution systems.

PRITECH funds provide a full-time resident advisor who works as part of the team to help administer the program under the direction of PRITECH's Regional Office based in Dakar. In addition to program management, PRITECH provides short-term technical assistance aimed at improving case management, promoting community awareness and use of ORT, and increasing access to ORT through a variety of channels. PRITECH also funds local costs associated with educational materials development, meetings for CDD coordinators, follow-up activities, and the implementation of special studies. UNICEF and WHO finance training and promotional costs as well as equipment and supplies to produce ORS packets. Overall, USAID/Mali, UNICEF and WHO, who collaborate regularly, have shown strong support for the CDD program.

C. PROGRESS AND PROBLEMS

This past year, the Mali National CDD Program has moved forward on a number of fronts. Oral-rehydration units have been set up in three regions, and the local parastatal pharmaceutical manufacturing facility has been readied for start-up of ORS production. To prepare for local production, the program has been actively involved in the design of packet instructions, and the development of strategies aimed at increasing ORS packet demand and access throughout the country. The team's management capacity has

been strengthened through exposure to new technical and managerial information.

A good deal of work remains to be done, however, to ensure routine utilization of ORT in both clinical and domestic settings. Results of a KAP carried out in three regions and Bamako revealed that, while the vast majority of mothers know about ORT, they continue to treat diarrhea using traditional remedies or medications that may be inappropriate and ineffective.

Program Management

The program is now firmly integrated into the Family Health Division (DSF), an arrangement that, while logical, has had some unfavorable side-effects. For one thing, the program cannot carry out its own supervision visits when required. Its members must participate in integrated MCH supervision trips, which do not allow much time to be spent on CDD issues.

Furthermore, the six-monthly meetings for regional CDD coordinators that the program initiated have now been converted into meetings for the DSF Regional Coordinators. CDD responsibilities are often assigned to individuals who have a wide range of other functions; they may not be able to give CDD issues adequate attention.

Nor are there CDD plans at the regional level. CDD activities are to be integrated into DSF regional plans, but in most cases, these plans have not yet been completed. A similar problem exists with training. An integrated MCH training course is being designed but the process is proving to be difficult.

Yet another constraint to the smooth implementation of program activities is the national CDD coordinator. In principle, she has been assigned to work full-time on CDD activities, however, she is often unavailable to the CDD team because of her involvement in other activities which may be only peripherally related to the CDD program.

Case Management

Oral-rehydration units have been set up in three regions (Sikasso, Kayes, and Koulikoro) and Bamako. The establishment of these units, accomplished with assistance from representatives from PRITECH's Sahel Regional Office, included training staff in charge of case management, providing equipment and material, and the setting up of an information system for data collection.

A case-management strategy document, stimulated by results of the health-facility survey of 1988, is being prepared with help from PRITECH consultants. Once finalized, this document will be distributed to all health facilities.

Communication and Education

The national CDD team member responsible for IEC activities was selected to participate in a month-long stateside training workshop on IEC strategy and materials development in September. PRITECH supported her participation in this training.

In preparation for the start-up of local ORS production, PRITECH consultants provided assistance with the development and field-testing of ORS packet design, product name, and program logo.

The broadcasting of radio and television spots that were developed and aired extensively in 1988 has been blocked due to problems between the program and the radio and TV networks. Efforts made to renegotiate with the networks have thus far proved unsuccessful.

ORS Production and Distribution

The start-up of local production of ORS at UMPP, the parastatal pharmaceutical manufacturing plant, is scheduled for early 1990. A PRITECH-sponsored production specialist spent two months training UMPP staff and helping them carry out quality control tests and production trial runs.

To further prepare for the establishment of local ORS production, a PRITECH consultant worked with the program to develop marketing and promotional strategies for the new product. Emphasis was also placed on the development of an effective ORS stock and distribution system aimed at making ORS easily accessible from both public and commercial sources.

Evaluations and Studies

A PRITECH-sponsored KAP study, which gathered information from 600 mothers in Bamako and three regions, was completed in July. Major findings were that most mothers (71%) treat diarrhea at home using traditional remedies, while 35% use ORS, and only 18% use SSS. Of those mothers who went to health facilities, 71% had received advice on ORT and were given at least one packet. At the same time, 62% were given additional medications. Educational materials, face-to-face communication, and mass-media spots were all found to have had an impact on increasing mothers' awareness and education about ORT.

In an effort to prepare strategies for the potential commercialization of ORS, a price-sensitivity survey was carried out. Findings revealed that most mothers are willing to pay a reasonable price for an ORS packet.

MAURITANIA: Intermittent

A. STATUS

Program plan approved in February 1989 authorizing \$100,000 during FY89 for evaluation of national CDD program, studies, and other short-term technical assistance

B. PROJECT DESCRIPTION

The objectives of the Mauritania CDD Program are to (a) train all health services personnel in appropriate CDD case management; (b) organize and carry out public education about ORT; and (c) provide ORS packets throughout the country. The national CDD coordinator, who has been with the program since 1985, has moved the program forward despite severe financial and human constraints, as well as disruptions caused by frequent cholera epidemics which absorb almost all of the attention of the MOH when they occur.

PRITECH provides program management support from its Sahel Regional Office, assisting the national CDD coordinator with such activities as defining operational plans, identifying sources of funding, and developing unified plans and budgets with donors. PRITECH also provides short-term technical assistance in program planning, case management, educational materials development, and evaluation. Local costs associated with training, supervision, and office management are also supported by PRITECH. Additional assistance to the CDD program is provided by UNICEF and WHO, who finance educational and training materials development, training courses for health workers, supervision, and the supply of ORS packets.

C. PROGRESS AND PROBLEMS

Various aspects of the CDD program and the impact of its activities were formally assessed on three different occasions this past year. The findings of the health facility survey and KAP study indicate that the CDD program has made considerable progress in educating health workers and mothers about the importance of utilizing ORT to treat diarrheal disease. A program evaluation made specific recommendations about actions required to consolidate and build upon progress.

Project activities were disrupted in April and May as a result of violent border conflicts between Mauritania and Senegal as well as internal civil strife which led to numerous deaths and forced relocations. Despite these problems, however, the national CDD coordinator insisted upon continuing work as usual, and ensured the completion of the five-region KAP study, the convening of a national training workshop for regional CDD coordinators and PHC supervisors, and the implementation of other activities.

Program Management

A first step towards decentralization of CDD activities was taken when participants at the national training workshop outlined and discussed one-year workplans for their respective regions. They also explored possibilities for finding sources of funding from within their regions. While funding for some local costs is provided by UNICEF and WHO, not all training and supervision activities at the regional level can be supported.

The program was encouraged by UNICEF's re-affirmation of its commitment to CDD activities. Despite funding difficulties they have experienced, they have still managed to fund the KAP study, ORS packets, equipment for oral-rehydration units, revision of radio spots, and some gasoline and supplies for the CDD program office. PRITECH financed a program evaluation, a health-facility survey, and the analysis of KAP study results.

Training

A total of 25 people, including regional CDD coordinators, PHC supervisors, and supervisors from other national divisions, participated in a 10-day workshop held in Nouakchott in July. The workshop, which had been delayed due to a cholera outbreak and then the political upheaval, covered the physiopathology of diarrhea, case management, organization of ORT corners, management of cholera epidemics, and development of IEC strategies.

In the area of pre-service training, PRITECH Intermediate-Level Modules, in both French and Arabic, have been successfully integrated into the nursing school curriculum. PRITECH CDD modules were also provided to the national public health school.

Education and Communications

Results of the health facility survey revealed that 56% of health staff give appropriate advice to mothers on treatment of children with diarrhea and moderate dehydration. KAP survey findings indicated that 80% of mothers interviewed had heard of ORT; of those, over 75% had received information from personnel at health facilities. Other sources of information were radio (29%), family and friends (12%), TV (10%), and community health workers (3%).

Given these findings, indications are that health workers are utilizing the myriad of printed materials that have been developed to educate mothers. The program has expressed interest in taking a closer look at the attitudes of health staff towards educational materials in order to understand determinants of use so that future materials may be tailored to their likes and dislikes.

As for mass-media education, long-standing difficulties between the MOH and the radio and TV stations continue to block the routine broadcasting of CDD spots. Efforts were made to renegotiate but thus far, the media has been very uncooperative, possibly because the program is not in a position to pay for the broadcasts.

Program Evaluation and Studies

At the request of the MOH and USAID, PRITECH sponsored an evaluation of the national program in December 1988. The team found that while health workers may treat children according to WHO protocols, they often give or prescribe inappropriate drugs. They also found widespread, chronic shortages of basic materials for appropriate case management and education, especially ORT packets. Among other things, the team recommended the development and dissemination of a clear national CDD policy, the development of an effective nationwide ORS monitoring and distribution system, the strengthening of program management at all levels, and improved communication activities.

A health-facility survey, carried out by two consultants from PRITECH's Sahel Regional Office in February, revealed that approximately 50% of the health workers observed had received formal training in CDD, 75% of those observed chose the correct treatment plan for diarrhea cases, 68% gave appropriate advice (findings which conflict with those of the evaluation team) but less than 10% gave practical demonstrations on the mixing of ORS and SSS. Another observation was that 60% of health facilities had stock-outs.

Yet a third look at the impact of the CDD program was allowed by the KAP study which was carried in May-June in four regions and Nouakchott. Data showed a 54% ORT use rate among mothers, compared to data from other Sahel countries (Mali 40.6%, Niger 38%, The Gambia 34%). Also, over 70% of mothers who had used ORT during the two-week period immediately preceding the survey gave correct information on the preparation and administration of both SSS and ORS. It should be noted that these findings should be viewed with a bit of caution as the survey was carried out only in those areas where health facilities were available and accessible.

PRITECH/PAHO Representative:
Dra. Martha Lopez de Montero

MÉXICO: Sustained

A. STATUS

In July 1988, following concurrence by A.I.D./México (México 17367), S&T/H approved a proposal for up to \$500,000 over the period of PRITECH II. Since that time, implementation has been awaiting political developments (the December 1988 change of government) and resolution of restructuring within the Health Secretariat's Diarrheal Disease Program.

B. PROJECT DESCRIPTION

PRITECH I concentrated on the training of public-sector health personnel in México, complementing efforts of other donors who are supporting communications and ORS distribution. With a full-time representative serving both as catalyst and trainer, PRITECH has been able to contribute to extensive training coverage in the six states with the highest IMRs due to diarrhea. PRITECH has also teamed with HEALTHCOM to fund training for teams from all thirty-one of the Mexican states. Many of these teams have found resources to develop state-level training for their colleagues, out to the peripheral primary-care facilities. Observations by the PRITECH representative and her MOH colleagues in the priority states reveal that proper case-management is much more common at the periphery, while hospitals continue to use intravenous therapy far more than needed. But even where IVs persist, the use of needless drugs has dropped.

For PY3, PRITECH is seeking to put into place a new agreement with the Secretariat of Health, for training programs in an additional six states, again chosen according to IMR due to diarrhea. In addition, the PRITECH II agreement supports on-going supervision in the six original states to consolidate those gains. To address the basic problem of doctors' non-compliance with good diarrhea case-management practice, PRITECH is supporting seminars for pediatrics professors; the first of these was held from August 21-25, 1989. This seminar was attended by 45 professors, of medicine, nursing, and public health, from eight medical schools and eight nursing schools. It became clear during the seminar that many of these professors, in key positions for the formation of future doctors and nurses, knew very little about the national norms of diarrhea treatment. Influencing pre-service medical training is not easy in México, because the universities are autonomous -- the government does not have a direct role in defining the curriculum. Each pediatrics professor teaches his or her own course, according to a syllabus he or she has designed, subject to no review. Into a system like this, innovation comes slowly. The purpose of the seminars is to influence these courses,

eventually to make available the MEDIAC materials when WHO makes them available in Spanish.

C. PROGRESS AND PROBLEMS

Delays have occurred during PY2 which have deferred PRITECH II implementation. Several negotiating visits were made to México in PY2, but because the Mexican health structure in general and the diarrhea program structure in particular were unsettled following the December 1988 change of government, PRITECH has been unable to move definitively. The Secretary of Health has now restructured the administration of the national CDD program, having formed an executive council made up of the directors of Preventive Medicine, Epidemiology, Health Promotion, and Maternal and Child Health. The Secretariat has asked PRITECH to place a national in the job of representative; however, selection of a representative must await clarification about this new administrative structure, with counterparts specified and working mechanisms made precise.

PRITECH Representative:
Elizabeth Hall

NIGER: Sustained

A. STATUS

Program plan approved in February 1989 authorizes \$640,000 over a four-year period to support full-time resident advisor and short-term technical assistance

B. PROJECT DESCRIPTION

The Niger National CDD Program is built upon a foundation of widespread training and supervision of health staff, production of educational materials for use by health workers and other extension agents, development of ORT messages for broadcast by the mass media, and local production, distribution, and sale of ORS packets. These activities have served as part of the government's expansion and strengthening of the primary health care system at the village level, with the assistance of USAID's Rural Health Improvement Project (RHIP). USAID/Niamey also pledged to support local costs for the program through its Health Sector Grant. Other donor assistance has come from UNICEF, WHO, World Bank, Belgium, and The Netherlands.

The national CDD coordinator, who has been with the program since its inception, provides strong and competent leadership, and a national CDD committee, made up of representatives from various departments within the Ministry of Public Health and Social Affairs (MOPHSA) as well as from donor organizations provide strong operational support. Regional CDD coordinators, in collaboration with the national program, plan and oversee CDD initiatives within their respective regions.

PRITECH provides technical and managerial support for program implementation through its full-time resident advisor, regular visits from Sahel Regional Officers, and consultants who offer technical guidance in a number of areas. The objectives of PRITECH's assistance are to increase the effectiveness of management and planning strategies, improve case management procedures, promote awareness and practice of ORT at the community level, and ensure widespread accessibility to ORS packets.

C. PROGRESS AND PROBLEMS

The program has been able to take important steps to consolidate its accomplishments. Key activities carried out include the development of a five-year plan incorporating many of the recommendations from the evaluation of early 1988, the addition of three new national CDD committee members, the implementation of supervision trips to four regions and Niamey MCH centers, the study

of prospects for commercialization of ORS, and the production and field-testing of packet instructions for a new ORS packet.

One obstacle the program faced was difficulty in accessing funds for support of program activities through the A.I.D. Health Sector Grant. And despite the addition of a staff member to the CDD program, its management capacity still remains strained. Finally, results of a health-facility survey carried out in May-June, revealed some weaknesses in the area of case management and health education.

Program Management

To assist with management of the CDD program, the MOPHSA appointed a program assistant who assumed his position in April 1989. While his participation has been helpful, he has not yet demonstrated the ability to effectively handle complex issues. A concerted effort will therefore have to be made to identify a replacement for the current CDD coordinator who is expected to leave for long-term training in the very near future.

Three new members were added to the national CDD committee which continues to be responsible for overseeing the implementation of CDD activities. Four of seven regional CDD coordinators were replaced due to post re-assignments. Both groups met following a training workshop to discuss regional plans and activities. At that meeting, they expressed a clear understanding of their roles and responsibilities but, at the same time, noted their universal frustration with the inability to locate reliable sources of funding to carry out supervision visits on a routine basis. Central-level supervision visits, however, were made to four regions and the Niamey MCH centers this year.

The Health Sector Grant to which the national program applies for funding to cover costs for some program activities, such as supervision and training, has proven extremely difficult to access. As a result, some program activities had to be delayed. In some cases, funding was successfully secured from other sources, such as UNICEF.

Case Management

PRITECH carried out a health-facilities survey in three regions and Niamey center in May/June. In brief, the results indicated that less than 44% of health workers give an appropriate assessment of diarrhea, a figure which is comparable to findings in other Sahel countries (Mali, 41.4%, Mauritania 41.8%, and Senegal 50%). About 60% of health workers were able to correctly evaluate dehydration. Of those who correctly assessed diarrhea, correct treatment, which included provision or prescription of ORS packets, was made 80% of that time. At the same time, however, in

more than half the cases observed, other medications were prescribed.

These findings indicate that gains have been made since the beginning of the program. Nonetheless, there is a critical need for extensive training, as less than half the health workers observed have received formal training in CDD. The last rounds of widespread training of peripheral-level health workers occurred in 1986-87; since then, there has been considerable turnover in personnel.

A simplified case-management reporting form, adapted from the WHO protocol was tested, printed, and distributed. Its use in health facilities is being closely monitored.

Finally, some demonstration equipment has been provided to some health facilities for use in oral-rehydration units. Plans have been made to start setting up these units and oral-rehydration corners in Niamey as well as in regions within the next year, with oversight from the national CDD committee and regional CDD coordinators.

Training

A 10-day course was held in June for regional CDD coordinators and new members of the national CDD committee. The first three PRITECH Continuing Education Modules (Case Management, OR Unit Organization, and Supervision) were used. PRITECH training modules have also been successfully integrated into the nursing school. The medical school is working to strengthen coverage of CDD in its curriculum. Plans are being made to carry out continuing education sessions nationwide with technical assistance from PRITECH.

Education and Communications

The Program has been successful in mobilizing the Health Education Unit to work on CDD issues. A weekly meeting schedule was established and has been fairly well-respected.

Progress has been made on revised radio and television spots. Broadcasting of these spots, however, has been blocked because of strained relations between the State Radio and TV, which is asking exorbitant sums to carry the broadcasts; UNICEF has refused to pay the high fees requested. The MOHSA has not yet intervened to try to unblock the situation.

In preparation for the changeover in ORS formula, PRITECH assisted the Health Education Unit with the design of a new ORS packet with mixing instructions, and program logo. Extensive focus group testing was conducted and several revisions were made. Preliminary drafts were sent to Dakar to be touched up by a graphic artist; these will re-tested and finalized once the date for

production start-up for the new citrate formula ORS packets has been established.

ORS Supply and Distribution

An official decision was made to reduce the price of ORS in order to increase its accessibility to the public. The decision, which was largely influenced by the PRITECH study on distribution and pricing in late 1987, did not, however, take into consideration storage and distribution costs for the pharmacies where packets are sold. Nor did it resolve the issue of how VHWS are to be resupplied, as they receive no discount from the depot holders at the moment. These factors may wind up being a disincentive to pharmacies to encourage the sale of packets.

This potential problem may be offset, however, by the implementation of recommendations made by a PRITECH marketing consultant who visited Niger in April to study prospects for commercialization of ORS. Recommendations, designed to increase demand, included the definition of a promotional strategy using messages to be disseminated using printed materials, mass media, traditional theater, and other mechanisms. Another decision was made to use sodium citrate in the formula instead of sodium bicarbonate.

ORANA (Organisation de Recherche pour l'Alimentation et la Nutrition Africaine): Intermittent

A. STATUS

Program plan for PRITECH II approved by S&T/H June 5, 1989 with budget of \$650,000 for four years.

B. PROJECT DESCRIPTION

The strategy for ORT programs in the Sahel Region provides for collection and dissemination of information about ORT and related issues. ORANA, a Dakar-based regional institution with a mandate to conduct research and provide information on nutrition, works with PRITECH to perform this function. The effort is managed by PRITECH's Sahel Regional Office.

ORANA maintains an ORT Information Center which, among other activities, gathers technical documents and educational materials on CDD, publishes regular acquisitions lists, distributing them to over 600 decision-makers, and puts together an African supplement insert for Diarrheal Dialogue, a publication distributed to over 12,000 readers in 20 Francophone countries. The Information Center also sends out the French version of PRITECH Technical Literature Update (TLU), compilations of articles, on diarrhea and nutrition, and photocopies of selected key articles as well as articles requested from the acquisitions lists.

Other activities carried out by ORANA include the preparation for publication of resumes of theses and studies on diarrhea and diarrhea-related nutrition issues, an analysis of diarrheal-related data in the Sahel region, and a compilation of African community educational materials on ORT.

C. PROGRESS AND PROBLEMS

To continue its current activities and expand its involvement in educational and research activities, particularly in area of diarrhea-related nutrition issues, PRITECH negotiated a three and one-half year cost reimbursement contract with ORANA. Under the contract, ORANA agreed to continue the services at the ORT Information Center it has provided up until now. ORANA also agreed to continue to collaborate with PRITECH on the development of technical education materials, such continuing education mini-modules, technical fiches for health staff, and counter-detailing materials on ORS for physicians and pharmacists. Follow-up of the integration of CDD modules into medical and nursing schools was yet another activity supported by ORANA.

A major undertaking carried out under ORANA in collaboration with PRITECH was the finalization and publication of a reference document which compiled CDD-related statistics for all the Sahel

countries in which PRITECH works. ORANA also published and distributed a technical chart on etiologies and treatment of diarrhea in the Sahel.

To cover the steadily expanding activities, PRITECH funded up to 60% of the salary of Dr. Makane Kane, whose is charged with the implementation of PPSS and operations research studies in the Sahel country programs. PRITECH also agreed, along with UNICEF and Helen Keller International, to contribute to the funding of an assistant documentalist who will work on PRITECH-related nutrition activities at the Information Center on a half-time basis. PRITECH will continue to support the full-time services of a documentation specialist.

PRITECH Representative:
Lucia Ferraz-Tabor

PAKISTAN: Sustained

A. STATUS

The PRITECH II program follows a three-year PRITECH I effort and provides a transition to the new USAID Child Survival Project, with its five-person technical-assistance team. Funding is being provided by the USAID for PRITECH's activities through November 1989: \$280,000 committed in PY2, \$782,000 in process. Additional funding is needed to extend PRITECH, perhaps through June 1991.

B. PROGRAM DESCRIPTION

PRITECH is providing a resident team including a country representative, part-time experts, and technical and program-management support to the National CDD Program. The primary objectives are:

- 1) to provide assistance in activities related to the Control of Diarrheal Diseases (CDD) to the Ministry of Health, particularly Basic Health Services Cell and the National Institute of Health (NIH);
- 2) to develop a standard curriculum for Diarrheal Training Units (DTUs) and to test this curriculum in at least one leading medical college;
- 3) to organize a program to establish DTUs in at least three additional provincial-level institutions;
- 4) to follow through on recommendations to strengthen logistics-management and management-information systems;
- 5) to maintain the public-education program, and to improve the message and educational materials, as appropriate;
- 6) to provide general management and administration support and assistance to the National CDD Program.

C. Progress/Problems

The centerpiece of the program is case-management training for physicians, provided at a nationwide network of Diarrhea Training Units (DTUs); new curriculum materials are being tested, staff have been hired for ten DTUs and training is well underway. PRITECH's role with the DTUs has been both administrative -- helping the GOP's National Institute of Health and USAID organize and supervise the program -- and technical -- introducing the curriculum, training trainers, and working with WHO to assess the

program. Other activities include development of communications materials, design of management-information systems, helping plan ORS marketing, and conduct of operations research.

In the four provinces, ten DTUs have been established. Financial and logistics assistance is provided by USAID through a contract with Rawal Associates; PRITECH provides technical and administrative oversight for Rawal's activities, although PRITECH has no contractual responsibility for supervision of the Rawal contract. The DTU training effort began in late March 1989. By the end of September, 34 DTU workshops had been conducted in the four provinces, 251 physicians were trained, and 161 health facilities were assisted with ORT equipment and follow-up supervision visits. According to the project plan, each of the DTUs was to be staffed by a physician, a Lady Health Visitor and a driver, all to be paid through the Rawal contract. Out of the ten functional DTUs, half have physicians deputed from the Provincial Government; this development is promising for sustainability. To help manage the program at the national level, NIH has agreed to hire a physician to assist and coordinate the DTU effort under the National CDD Manager. The DTU curriculum, developed with assistance from PRITECH, has been assessed jointly by the WHO resident CDD expert and a PRITECH consultant; the conclusions will be reviewed in October 1989.

PRITECH also assisted with communications, MIS, ORS supply, and operations research. For example, PRITECH assisted NIH with the development of six radio spots for CDD; these radio spots were tested by a professor from the Department of Anthropology of the Quaid-i-Azam University and his students. The pre-testing was funded by CIDA/NIH Communications and Motivations Unit. These radio spots are currently being broadcast. As a short-term approach, NIH has requested that PRITECH work on and fund the development and testing of other mass media for CDD. As another example, NIH and PRITECH staff coordinated with Wilson's, the ORS producer which has the contract to produce ORS for the national program, to have educational materials enclosed in the shipments of ORS. This approach for distribution of information materials to health facilities should partially solve the problem of distribution, i.e., every facility which receives ORS also receives education materials about ORT.

The PRITECH representative and staff play an active role assisting the national CDD manager and the USAID/HPN office. There is close coordination with WHO and UNICEF, so that NIH and the donors work as a team with the Provinces. The PRITECH staff has shouldered a larger than expected administrative responsibility, going far beyond the normal technical-support role. The need for PRITECH assistance is in part caused by delay of the technical-assistance team planned as part of the Child Survival Project. NIH and the Mission have requested PRITECH to provide an additional resident staff person, to help administer the DTU program.

PRITECH Representative:
David R. Alt

THE PHILIPPINES: Sustained

A. STATUS

In 1988, USAID/Manila bought-in to PRITECH II in the amount of \$251,982.69, most of which is to cover the costs of the PRITECH Resident Operations Advisor, plus some short-term technical assistance. The mission anticipates a balance of \$20,000 for short-term technical assistance, which will be used to cover consultancies on breast-feeding, medical-school curriculum, and the follow-on technical assistance for the DOH drug and logistics study. S&T/H is providing up to \$100,000 for short-term technical assistance.

B. PROGRAM DESCRIPTION

PRITECH's efforts are being channeled into the following activities:

1. CDD Medical Education

The DOH and the Association of Philippine Medical Colleges Foundation (APMCF) have signed an agreement on a project for Enhancing the Teaching of Diarrheal Diseases in Six Medical Schools. This project is the follow-on to an August 1988 medical-education workshop in Manila which was facilitated by Dr. Robert Northrup and Dr. Mary Carnell of PRITECH.

The six medical schools taking part in this activity are incorporating into their curricula the MEDIAC materials prepared jointly by PRITECH and WHO. The APMCF is collaborating closely with the DOH on this activity, and both PRITECH and WHO have sent technical advisors to launch and monitor this innovation.

2. Private-Sector Promotion (pharmacists)

The DOH has launched a major initiative in CDD with both practicing pharmacists and pharmacy colleges. To a certain extent, this activity parallels the medical-education activities. After a lull early in the project year, this activity was revitalized by the visit of a PRITECH pharmacist. The result: the Philippine Pharmaceutical Association (PPhA) has now held two sessions on CDD as a part of its continuing-education program for PPhA members. The PRITECH advisor has served as a reviewer at these programs.

In PY3, the PPhA expects to revise the curricula for its sixteen pharmacy colleges. The DOH and PRITECH are both ready to assist this process, most likely through the supply of educational

materials.

3. Prevention Activities

The CDD program's main focus on diarrhea prevention is breast-feeding. Very little has been done to date to inform government obstetricians of the most up-to-date ideas about breast-feeding and of the need to reverse the move away from breast-feeding in The Philippines. Focusing on this group of doctors will facilitate the DOH's policy on rooming-in and breast-feeding.

The dates for this workshop have been set for April 12-14, 1990. PRITECH has offered to identify and fund a consultant from WELLSTART to assist in planning and preparation of the workshop, serve as a facilitator during the workshop, monitor local lactation-management programs, and provide follow-up.

4. Child-Survival Information Center

The idea for an Information Center grew out of the need to provide the DOH staff with up-to-date information materials and to support the training activities of the DOH in CDD. The Center would give doctors and nurses, at the time of their re-training, access to literature to support and reinforce the information from their courses. In addition, the Center could supply material to outlying provinces on request.

PRITECH consultants Judy Brace and Bill Amt gave assistance to the Center this year. Judy Brace assisted the DOH to prepare the final design, operating policies, procedures, and forms for the Center, and prepared a two-year plan, with budget, to make the Center operational. Bill Amt worked with the Center staff to introduce the PROCITE bibliographic software for the Center's information database. While the final equipment is being installed in the Center, they have already produced an informational brochure detailing their services.

5. ORS Commercialization

While HEALTHCOM is taking the lead in this activity, PRITECH has provided technical assistance through its social-marketing technical officer. The DOH identified several dozen companies that might possibly be interested in marketing ORS commercially, then the PRITECH consultant drafted a letter to be sent out to all of them. When the replies came in, numbering about twelve, the PRITECH consultant returned to the Philippines and, with the local HEALTHCOM advisor, visited these interested companies. He then prepared a series of options for the DOH, a workplan for next steps, and a scope of work for a local consultant who would work with the DOH on ORS commercialization.

A number of questions remained unresolved, particularly relating to staffing for this activity. No decision has been made on a local consultant, but this complex task cannot be covered by the local HEALTHCOM advisor because of his many duties.

6. Drug-Supply Study

This study was geared to the entire drug-distribution system of the DOH, because problems encountered in ORS distribution are common to the whole drug-supply system. These include lack of warehousing or improper warehousing, lack of vehicles or transport budget, lack of a re-ordering system, and inadequate record-keeping. The DOH, with World Bank money, contracted with the Foundation for People's Concern, a local group, to study the existing system and make recommendations for improvement.

At first, the FPC considered the possibility of doing the job on their own, but later they requested technical assistance from PRITECH. PRITECH responded with a management specialist and a pharmacist (whose presence catalyzed the PPhA continuing-education activity mentioned above). The FPC has requested further assistance in PY3.

7. ORS Supply

While this was not a specific activity called for in the PRITECH workplan, circumstances have put ORS supply and distribution on to the agenda of everyone working in the public CDD program. A major shipment of ORS, procured by USAID from UNICEF, was to account for most of the DOH supply this year. This shipment, some 3.9 million liter packets, did arrive early in 1989, but each packet was wrongly stamped with a 12/88 expiration date. A series of obstacles ensued, preventing the use of most of this shipment during the peak May-August diarrhea season -- interminable delays in customs, bureaucratic delays in authorizing the re-labeling of these packets, delays in starting some local manufacture, delays in the process that is working toward ORS commercialization.

Some emergency air shipments were brought in by UNICEF, but in sum there was not enough ORS in The Philippines during PY2. This meant that the re-supply system could not be tested, that the communications messages were in many places talking about packets that did not exist in the clinics.

Decisions are pending about how to supply ORS to the DOH: whether the private sector or the public sector will be responsible, or if both, in what proportions and through what mechanism. PRITECH stands ready to provide assistance in this basic area, which is the underpinning of all other program elements.

C. PROGRESS AND PROBLEMS

A number of important initiatives are underway in The Philippines -- medical training and continuing education, pharmacists' training and continuing education, drug-supply-system reform, ORS commercialization, information dissemination. Cooperation among the donors and among A.I.D. projects, strong DOH commitment and leadership, widespread training of health staff, viable supervision systems -- all these positive factors contribute to the potential of the CDD program in The Philippines. The basic problem so far has been the ORS supply.

PRITECH Representatives:
Suzanne Prysor-Jones, Ph.D.: Regional Director
Adama Kone, M.D.: Technical Officer and Deputy

SENEGAL: Intermittent

A. STATUS

Program plan approved by S&T/H in December 1988; \$820,000 authorized for support of short-term technical assistance and assistance from the PRITECH Regional Office over four years

B. PROJECT DESCRIPTION

At the request of USAID/Dakar, in 1985, PRITECH proposed a short-term technical assistance plan to SANAS, the Nutrition Division responsible for overseeing CDD activities. SANAS never reacted to that plan nor did they ever develop a comprehensive workplan for the national CDD program. Furthermore, the program has been without a national CDD coordinator since May 1988 when the part-time coordinator left for long-term training. Thus, with no firm basis upon which to proceed, PRITECH has been obligated to provide ad hoc assistance in response to specific problems identified by the MOH, the A.I.D. Mission, donors or Sahel Regional Officers.

C. PROGRESS/PROBLEMS

The program has developed in a piecemeal fashion; some educational materials have been produced, intermediate-level health staff have been trained, and an ORS-production feasibility study has been carried out. Some health regions, supported by local authorities, have been effective in implementing ORT activities. However, due to institutional rigidities and logistical constraints, PRITECH has been unable to provide assistance directly to regions.

Some accomplishments have been made at the regional level. The Fatick region has organized 40 oral-rehydration units where children are given ORS and kept under surveillance for some time. A supervision trip to Kaolack, which included PRITECH's participation, was less encouraging; ORS stock-outs were observed at the hospital and all centers visited, despite a stock of 19,000 packets in the regional pharmacy. There was also evidence of lack of supervision, suggesting poor organization of diarrhea case surveillance, poor distribution of educational materials, and confusion among health staff on issues of case management and reporting.

A KAP study was authorized and finally completed in July. The data has been entered into the computer but because analysis

and write-up of the Mali and Mauritania KAP studies by PRITECH Sahel Regional office consultants took precedence, given the interest of the CDD programs concerned, the processing and analysis of the Senegal KAP had to be delayed. The findings are expected to be completed and released soon, and efforts will be made to discuss the findings with the MOH.

USAID/Dakar is expecting to start up a five-year project that will focus on strengthening the systems required for decentralization of health services. It is expected that PRITECH will work on CDD and nutrition activities in four regions targeted for special support by that project.

PRITECH Representative:
Dr. Paul Freund

ZAMBIA: Sustained

A. STATUS

The PRITECH II Program Plan has been approved by A.I.D./W and is being reviewed by the MOH of the Government of Zambia. The proposal calls for \$883,000 over a four-year period through 1992.

B. PROGRAM DESCRIPTION

The CDD program in 1986 began with only a newly appointed program manager, an assistant PM, and one public-health nurse; ORS was being stocked primarily for use in cholera outbreaks. Within the course of three years, the range of activities has expanded rapidly. A national CDD coordinating committee was formed with subcommittees to deal with ORS production and health-education-materials production. The program has carried out research on various aspects of Zambia's health system, with a focus on diarrhea incidence and treatment. Health-education efforts have been accelerated, with the research giving solid basis to message development. Health-staff training has gone forward steadily, supported in the main by UNICEF and WHO. In Zambia, the donors have worked together and with the MOH to take responsibility for the various components of the national CDD program.

C. PROGRESS/PROBLEMS

Research. An impressive array of research activities was conducted to fill in information gaps, establish baselines, and answer key program questions. The research included a nationwide CDD/UCI Baseline survey; an ORS distribution study in health centers, private surgeries, and chemists; an effective-use study; a study of diarrhea case management by health workers; a survey of traditional healers; and an assessment of local nursing-school curricula. All of this research was carried out in close collaboration with the MOH, from its planning and design, through the data collection and analysis. Moreover, the surveys required little in terms of resources but paid big dividends in raising program awareness among health workers and the community.

Health Education. A wide variety of health-education activities were implemented through the CDD health-education committee in collaboration with UNICEF, WHO, media personnel, and the School of Medicine. The major activities included production of posters, leaflets, radio programs, television spots, newspaper ads, and popular-theater presentations. The use of popular theater in particular proved to be an effective, culturally appropriate and cost-effective method for promoting ORT in the community. The idea of using popular theater has spread, and now other donors and PVOs

like WHO, UNICEF, NORAD, SIDA, Red Cross, and YWCA have used theater to promote ORT; other health messages have also been taught to drama teachers throughout the country, thus moving toward sustainability.

The popular theater is indeed popular, and well established throughout Zambia, drawing large crowds of mothers and children. The two popular-theater groups hired by PRITECH in Zambia to develop and perform ORT plays have gone a step further by publicizing performances on a house-to-house basis. Popular theater is a very low-cost investment with a very large return.

Competitions and contests have also resulted in songs and posters by local artists, providing access to Zambian talent and also ensuring materials which have culturally recognizable and accepted messages.

Training. The MOH had been carrying out training courses for health-center staff and mid-level supervisory-skills courses since 1984, but found that those trained soon encountered problems in implementing what they learned because their provincial or district medical officers were resistant or unfamiliar with ORT or ORT corners, etc. The MOH has now realized that top-down training is also necessary and has now developed plans for training all provincial medical officers, district medical officers, and medical superintendents at the DTU facility at the University Teaching Hospital in Lusaka. The importance of the hands-on training, which is emphasized at the DTU, has also been accepted as essential to CDD training at all levels. At the other end of the spectrum, the value of very simple ORT corners with a minimum of equipment in every health center has been recognized and it is now planned to provide the basic requirements for ORT corners/units throughout the MOH health system.

Donor Collaboration. PRITECH has worked in close association with WHO staff, particularly with the APO, in many of the key areas of the CDD program, including research; construction of the subregional DTU facility at Lusaka's University Teaching Hospital is an example of a project that required the efforts of a committed APO to become a reality in the face of constant bureaucratic delays and frustrations brought about by the Zambian economic situation.

Increasing Coverage of the Population. During PRITECH I, PRITECH worked primarily with the MOH health services; however, there was little contact with other health services that are part of the national system: the mission health system of the Church Medical Association of Zambia (CMAZ) and the other two major players in the delivery of health care in Zambia, the mines and the military. We recognize the need to make greater efforts to access all the non-MOH systems in PRITECH II. The first step in this process is the recent agreement of the MOH to have representatives of the CMAZ, the mines, and the military on the National CDD

Coordinating Committee. In addition, PRITECH is considering proposing to A.I.D. the funding of a Zambian pediatrician to work with the central staff of the CMAZ. The tasks will be to improve case management of diarrhea in the mission system and to coordinate the efforts of the CMAZ and the MOH. The network of CMAZ hospitals and clinics serves about 25% of the total population and perhaps half the rural population. CMAZ staff and facilities are incorporated into the MOH system with 40% funding from the Ministry's budget; however, private funds and well-trained staff may make the CMAZ services more effective and more easily sustained for the rural population.

PRITECH played a major facilitating, coordinating role in Zambia during PRITECH I, but principally with the MOH and the major donors. With such scarce resources and an ever-dwindling economy, it is increasingly evident that the efforts of all the players, large and small, need to be accessed, encouraged, and coordinated in PRITECH II -- to include the 16,000 traditional healers, the PVOs, the schools, the women's organizations, and the foreign non-English-speaking physicians who dominate the public-health system of Zambia.

Since August 1986, the presence of a PRITECH representative, whose advocacy, coordination, and assistance in program implementation in close collaboration with the resident WHO CDD expert, has succeeded in raising the CDD program from a low-priority status with only a few activities to a high-priority, active and highly visible program. Evidence for this comes from the fact that donors, including WHO, UNICEF, and the PVOs, have increased their level of support in view of the numerous accomplishments and projected plans of the CDD program. Moreover, in 1990 the Government of Zambia has for the first time included CDD in the MOH budget. A recent PRITECH-funded MOH/CDD planning workshop, which was attended by the Permanent Secretary and Assistant Director of Medical Services, the Director of Pharmaceutical Services, and representatives from all MOH departments, NGOs, private physicians, the School of Medicine, and PVOs, bears witness to the increasing interest in the CDD program and points to encouraging prospects of further program coordination and integration.

The most serious constraint to program progress during PRITECH I has been a severe shortage of health personnel, particularly doctors. This manpower crisis threatens the effective operation of every health program at all levels -- central, provincial, and district -- but is particularly felt in a new program like CDD. Therefore, it is important that the CDD program justifies the allocation of staff and time by the MOH through its activities and demonstrated progress. Fortunately, this has been done, and the MOH has realized the importance of CDD and has increased financial support and allocated additional staff. A third public-health nurse has been appointed to the CDD program.

While financial self-reliance for the CDD program is unlikely, at least for the foreseeable future, there are a number of encouraging signs by the government and the Ministry of Health which do point to program sustainability. For example, the government has, for the first time allocated funds specifically for the CDD program and the CDD staff has been increased, with additional personnel promised for the near future. Moreover, general interest in CDD program activities has increased within the ministry, NGOs, and PVOs. Active lobbying for a larger CDD budget during recent WHO and UNICEF planning meetings has resulted in more funds, with allocation and responsibilities divided among the major CDD-program donors. Since the first national clinical-management training course at the UTH DTU, there is already evidence of interest in CDD/ORT spreading among district and provincial medical staff. When more district/provincial staff are trained, our confidence in a more sustainable program will be increased even further. Sustainability will also be enhanced by reaching beyond the MOH to the CMAZ network and to other PVOs (e.g., the Red Cross, Jaycees, etc.), to other ministries (e.g., Agriculture/Water Development and Labour/Social Services), and to the political-party organization at all levels. Finally, the new emphasis by the government on private-sector initiatives should encourage private manufacturers to enter to ORS market and help relieve the public-sector burden and reliance on donor support for ORS supply.

22

3. Issues Relating to Disease Control Operations

From the experiences in the field described above, four principal issues have arisen that PRITECH has addressed in its PY3 workplan. These are

- improving the technical quality of country programs;
- new initiatives in the private sector: going beyond the Ministry of Health;
- making connections with other primary health services, i.e., moving beyond CDD;
- establishing additional program activity in East and Central Africa.

A. Improvement of the Technical Quality of Country Programs

Within the public-health sector, a key responsibility of PRITECH is to assist national CDD programs in two principal areas: to assure the highest attainable quality of technical performance and to assure the greatest possible reach of services within the public sector. While these should be applicable to any CDD program, PRITECH takes the lead in assisting programs for which it has direct responsibility. PRITECH has identified certain factors or approaches which improve effectiveness of CDD programs.

For example, gaining the commitment of a critical mass of key decision-makers and enlisting their support, while time-consuming, yields positive results in program progress. Likewise, a critical mass of key practicing physicians who have received hands-on clinical training improves case management not only because of what they learn through practical learning, but because of the encouragement and support they then give to their colleagues. This critical-mass approach also appears to yield favorable results when trying to institute changes in such areas as hospital breast-feeding practices. Good teaching of training methods and follow-up to assure use of good methods lead to improved case-management performance of health practitioners. Poor management of drug supplies has been improved by a computer-based program which helps a country manager determine the practices and costs of current activities in the management of ORS supply. And, changes can begin in the inappropriate, costly and often harmful, prescription of drugs by close work with policy-makers in changing national drug policies.

B. Making Connections with Other Primary Health Services:
Moving Beyond CDD

Children brought to clinics with diarrhea frequently have other health problems: malnutrition, acute respiratory disease, malaria, lack of immunization. Limiting case management to only ORT can prevent death from dehydration, but the child may still die of pneumonia, or by being malnourished die of measles. The case-management approach has been shown to be successful in preventing death from diarrhea in the health-facility setting. PRITECH sees an opportunity to deal with other health symptoms by augmenting the practitioner's armamentarium. This would be done only where there is an established CDD case-management program, and would entail adding new modules to training, particularly in refresher training. Key topics to cover include ARI, nutrition, and malaria.

C. New Initiatives in the Private Sector: Going Beyond the
Ministry of Health

In most of the countries where PRITECH is working, for example, Mali and Pakistan, government health services reach less than 25% of the population. In hardly any country will these services reach more than half the population. In Zambia, half the rural population may have access to health services, but most of these services come from church-sponsored hospitals. Thus far, PRITECH has concentrated on national CDD programs managed by Ministries of Health. Establishing ORT in these public-health systems is an essential first step: providing the policies and political support which are the bases for nationwide programs, and getting the influential public-health professionals to adopt ORT practices. Even fully successful programs which mobilize all the resources of the MOH are nevertheless limited by the reach of these public systems. Most families, and perhaps those families whose remote location or low income place children at higher risk, will not be reached by these programs. It is time to organize new approaches which can go beyond the reach of government services - - to increase access -- and which do not depend on government funding -- to increase sustainability.

The list of groups outside the MOH who can participate in the CDD effort is long: private physicians and their professional associations, private pharmacists and their professional associations, pharmaceutical companies and their detailmen, retail distributors and sellers who handle over-the-counter medical products, private clinical facilities often supported by religious groups or by companies, urban health services, community-based health services such as mothers clubs, traditional healers and their supporting organizations, primary schools and other educational systems. PRITECH has carried out programs which involve some of these groups, especially in the commercial private sector: physicians' professional associations in India,

pharmaceutical firms in Pakistan, PVOs in Bolivia. This experience will be used in designing new activities as part of country programs. PRITECH will explore the likelihood of success of a conference of organized traditional healers. It is likewise important to increase the involvement of the private physicians in the appropriate management of diarrheal disease. Experience in India has shown that organized medicine will participate in educational efforts around ORT; the India Medical Association has adopted a favorable position on ORT.

D. Establishing Program Activity in Eastern and Central Africa

Demographic projections make clear that the numbers of African children who fail to survive are growing rapidly each year, and begin to rival Asia's child mortality toll. A.I.D.'s African programs, with a primary focus on food production, have given lower priority to child-survival programs: despite a 16% increase from FY 1987 in overall funds, the FY 1990 budget for child-survival activities proposed by the Bureau is below the FY 1987 level. We believe that PRITECH's programs in the Sahel demonstrate that a relatively low-cost investment can significantly improve national health programs with modest demands on Mission staff. Moreover, PRITECH's Sahel programs demonstrate how to mobilize and to make more effective the contributions of other donors. We offer the same effective program model for other African countries. We have comprehensive programs underway in Kenya and the Cameroon, mainly funded by the Missions, and in Zambia, funded by S&T/Health.

B. HEALTH SYSTEMS SUPPORT

1. Overview

In PY2, 43 assignments were conducted under the Health Systems Support component of the PRITECH II Project. This included fielding 102 consultants and providing 64.54 person months of short-term technical assistance in the areas of child survival, ORT/DDC and primary health care. Assignments were conducted in approximately 20 countries.

The number of assignments conducted regionally and by countries are as follows:

	<u>Number of Assignments</u>	<u>Number of Countries</u>
Africa	14	10
Africa/Near East	9	5
Latin America	12	5
Inter-Regional	<u>8</u>	<u>-</u>
Total	43	20

To date, a total of 80.86 person months of short-term technical assistance has been provided to AID. This includes the 16.32 provided in PY1. Expenditures total \$845,983; \$115,354 in PY1 and \$730,629 in PY2. Regionally, the break-out of expenditures for each project year is as follows:

	<u>PY1 Expenditures</u>	<u>PY2 Expenditures</u>	<u>Total</u>
Africa	---	238,827.06	238,827.06
Asia/Near East	---	83,726.09	83,726.09
Latin America	99,415.15	263,855.02	363,270.17
Inter-Regional	<u>15,938.48</u>	<u>144,221.38</u>	<u>160,159.86</u>
Totals	115,353.63	730,620.55	845,983.18

As in PY1, buy-ins continued to fund a major portion of the assignments conducted. Of the 43 assignments completed, 27 were funded by buy-ins, or approximately 62%. Buy-ins were received from USAID/Guatemala, Malawi, Mali and Chad. Additionally, the FVA Office, ANE Bureau and S&T/Health provided funds to cover specific assignments. In total, buy-in funding for PY2 was \$644,032. Regional representation included:

51

	<u>Amount</u>
Africa	\$134,514
Asia/Near East	100,000
Latin America	50,000
FVA	274,518
S&T/Health	<u>85,000</u>
Total	\$644,032

Unlike PY1 when assignments were conducted exclusively in the Latin America and Inter-Regional areas, during PY2 technical assistance was provided in all regions. The largest number being in Africa where assignments included: (1) in Mali, developing a maternal child health training strategy, (2) in Malawi, conducting a health manpower needs study and participating in an evaluation of the CDD project, (3) in Rwanda, evaluating the nutritional ORS plan, and (4) in Guinea, conducting an ORS marketing study.

As with PRITECH I, through Health Systems Support, the project continues to provide short-term technical assistance to the FVA Office in support of their child survival activities. During PY2, 14 of the 43 assignments conducted were for FVA. These included nine evaluations of PVO child survival projects; such as evaluations of the SAWSO projects in Kenya and Haiti, Freedom from Hunger in Bolivia and Nepal and ADRA in Rwanda and Nigeria. Other FVA activities included PVO child survival proposals review, and supporting child survival workshops in the U.S. and Guatemala.

The 14 assignments conducted for the FVA Office can be regionally broken down as follows:

<u>Number of FVA Assignments</u>	
Africa	3
Asia/Near East	3
Latin America	4
Inter-Regional	<u>4</u>
Total	14

Over the past year, PRITECH has developed a good working relationship with the FVA Office. We have designated one staff member to coordinate and follow-up on all FVA assignments. This has assisted us in responding to requests on behalf of the FVA in a timely and efficient manner.

During this past year, FVA spent a large portion of its \$274,518 buy-ins. In order to continue at the existing level of activity in PY3, FVA will need to consider adding additional funds to the project.

During PY2, Health Systems Support became fully operational. The MIS system for tracking assignment costs, person months and PIO/TS has assisted in tracking financial information to date, but further revisions are needed to better track person months, particularly for subcontractors. Additionally, over this past year, it became apparent that the system needs to differentiate funding source, buy-in vs. central, for both expenditures and person months. These revisions are being proposed for PY3.

During PY2, the tracking system for consultant reports was further updated to generate a delinquent report list for both internal staff reviewers and A.I.D. This has proven to be a useful management tool in tracking the status of reports.

A monthly task assignment reporting system was developed and implemented this past project year. This report includes information on type of activity, category, consultants, funding, dates, country and region.

One objective for PY2, generating reports on PIO/T expenditures for the Missions, was postponed to PY3. This was due, in part, to the need to further revise the MIS system but also to the delay in updating the system with monthly financial data.

2. Current Status Vis-A-Vis Project Year Workplan

<u>Planned Activity</u>	<u>Current Status</u>
<u>First Quarter</u>	
1) Provide 14.5 person months of short-term technical assistance.	Completed
2) Design monthly task assignment reporting system.	Completed
3) Update MIS with monthly financial data.	Completed
4) Monitor PIO/TS.	Completed
5) Maintain consultant registry.	Completed
<u>Second Quarter</u>	
1) Provide 14.5 person months of short-term technical assistance.	Completed
2) Revise consultant reports tracking system.	Completed

29

- | | | |
|----|---|-----------|
| 3) | Implement the monthly task assignment reporting system. | Completed |
| 4) | Update MIS with financial data. | Completed |
| 5) | Monitor PIO/TS. | Completed |
| 6) | Maintain consultant registry. | Completed |

Third Quarter

- | | | |
|----|--|-----------|
| 1) | Provide 14.5 person months of short-term technical assistance. | Completed |
| 2) | Test the consultant reports tracking system. | Completed |
| 3) | Implement the monthly task assignment reporting system. | Completed |
| 4) | Review MIS system. | Completed |
| 5) | Monitor PIO/TS. | Completed |
| 6) | Update MIS with financial data. | Completed |
| 7) | Maintain consultant registry. | Completed |

Fourth Quarter

- | | | |
|----|--|------------------------------|
| 1) | Provide 14.5 person months of short-term technical assistance. | 21.04 person months provided |
| 2) | Implement the consultant reports tracking system. | Completed |
| 3) | Generate and send financial PIO/TS expenditures reports to Missions. | Postponed |
| 4) | Review MIS system. | Completed |
| 5) | Update MIS with monthly financial data. | Completed |
| 6) | Implement the monthly task assignment reporting system. | Completed |
| 7) | Monitor PIO/TS. | Postponed |
| 8) | Maintain consultant registry. | Completed |

90

C. Information Support Component

1. Overview

During the second year of the PRITECH II project, the Information Center increased acquisitions, expanded its dissemination activities, started producing French and Spanish translations of the Technical Literature Update, and provided technical assistance to two new child-survival information centers in Asia. In addition, the Center produced the third annotated bibliography of holdings.

As a result of an outside evaluation, the Center assumed several new responsibilities, including the establishment of PRITECH central files; producing the weekly activity reports to A.I.D.; arranging for the translation, production, and distribution of key PRITECH reports; and contributing to the monthly PRITECH News Bulletin. These responsibilities have helped to fully involve the Information Center in the daily activities of the project as a whole.

2. Activities

The current status of the Information Center activities in relation to the PY2 workplan is as follows:

OBJECTIVE 1: INCREASE THE NUMBER AND SCOPE OF ACQUISITIONS

Planned Activities

- 1.1 The Information Center will subscribe to and search the MEDLINE data base.
- 1.2 Strengthen or improve exchange relationships with other information centers and PVOs both here and abroad.
- 1.3 Improve computer efficiency and cataloging procedures.

Current Status

During the project year, the Information Center collected approximately 650 documents pertaining to technical CDD issues, as well as to program implementation, evaluation, and health education. These documents continue to be supplied through the Institute for Scientific Information, A.I.D./R&RS, and POPLINE. In keeping with the project's priorities, the Information Center expanded its collection in the areas of home-available fluids, persistent diarrhea, breast-feeding as a preventive activity, and self-financing of health systems. The Center also began subscribing to MEDLINE and performing searches for PRITECH staff and field representatives.

In Fall 1988, the Information Center contacted PVOs registered with the A.I.D. PVC Office to inform them about PRITECH's services and to request information that the PVOs had produced in the CDD area. As a result of the letters, the Center added several PVOs to the mailing list and established exchange relationships with organizations such as the Aga Khan Foundation, World Neighbors, and World Vision. In addition, the Center strengthened existing exchange relationships with the Diarrhoea Information Services Centre of the ICDDR,B in Dhaka, Bangladesh.

The Information Center also met with other child-survival information centers in the Washington, D.C. area for the purpose of exchanging information and discussing bibliographic software issues. The Center collaborates particularly closely with the APHA Clearinghouse on Infant Feeding and Maternal Nutrition, WASH, REACH, and A.I.D./R&RS for purposes of exchange and referral.

During the past year, the Information Center made great strides in improving the efficiency of technical operations. First, the Center produced a new hierarchical thesaurus that facilitates cataloging and computer retrieval of documents. Second, the Monthly Acquisitions List, which was previously produced as a separate document and re-keyed into the computer, now feeds directly into the computerized data base each month. This new procedure is much more time-effective than the previous one. Third, the Center purchased a 40-megabyte hard disk, replacing the aging 10-megabyte disk. The new disk will comfortably hold the Center's collection for the life of the project. Finally, the Center hired a temporary cataloger to catalog the backlog of documents. For the first time since the project began, the Center is cataloging current documents only.

OBJECTIVE 2: IMPROVE EFFECTIVENESS OF DISSEMINATION

Planned Activities

- 2.1 Respond to information requests.
- 2.2 Disseminate the second annotated bibliography.
- 2.3 Produce the addendum to the bibliography.
- 2.4 Improve use of country background files.
- 2.5 Exhibit at conferences.

Current Status

During the past year, the Information Center responded to 490 requests (up 30 percent from 1988) from A.I.D. missions and bureaus, TLU readers, A.I.D. contractors, PRITECH field representatives, and health workers in developing countries. The number of such requests continues to grow.

The breakdown of requests was as follows:

- o 51% asked for specific documents from the bibliography, such as WHO policy papers and journal articles
- o 20% requested documents from the Acquisitions List
- o 14% asked for information on particular topics, such as physicians' prescribing patterns, antidiarrheals, or cereal-based ORS
- o 9% asked for back issues of or articles reviewed in the TLU
- o 6% asked for a/v materials or PRITECH reports

In June 1989, the Center began to computerize the information requests with a database manager program. This log enables the Center to generate statistics on number and type of request, user group, subject of request, and which documents are requested most often.

The Center continued to distribute the Monthly Acquisitions List, which lists all new acquisitions by topic. The list is sent to approximately 250 people. The volume of requests in response to the acquisitions list has reached a very high level, most people asking for 5 to 10 different documents per request. The Information Center received requests for 195 documents from the April 1989 Acquisitions List, for instance. Analysis of the requests revealed that 42 percent came from A.I.D. HPN officers, 18 percent from A.I.D. contractors, 19 percent from A.I.D.-funded information centers, nine percent from PRITECH staff, and nine percent other.

The Information Center disseminated about 500 copies of the second annotated bibliography during FY89. The bibliography consists of a topically arranged annotated list of holdings plus an author index. The Center sent copies to TLU readers who returned the TLU readership survey, A.I.D. HPN officers, A.I.D. contractors, information centers, and others who requested information in the CDD field. The bibliography has been particularly useful to those in developing countries who have little or no access to libraries; it has generated many requests for documents.

The Information Center also distributed copies of two PRITECH manuals "Improving Young Child Feeding during Diarrhea," and "Improved Nutritional Therapy of Diarrhea" -- to the A.I.D. HPN

officers and to readers of the TLU who requested it. An additional 300 copies of the two manuals were distributed at ICORT III.

During the summer, the Center also worked on producing an addendum to the bibliography. The addendum covers acquisitions from February 1988 through May 1989. It is currently awaiting printing and will be distributed in 1990.

Based on the low level of use of the country background files, the Information Center decided to retain only those documents that are specific to child survival and to transfer these to the project's central files. The Center will acquire documents on potential PRITECH countries as the need arises.

During FY89, the Information Center staffed PRITECH exhibits at two conferences: The American Public Health Association (APHA) conference in October 1988 and the National Council for International Health (NCIH) conference in June 1989. While both conferences generated requests for documents and raised public awareness of PRITECH and the CDD field, NCIH attracted more interest. In the future, PRITECH will share an exhibit at the APHA conference with A.I.D., rather than staffing its own exhibit.

OBJECTIVE 3: IMPROVE QUALITY AND QUANTITY OF THE TECHNICAL LITERATURE UPDATE

Planned Activities:

- 3.1 Conduct a readership survey to evaluate the TLU.
- 3.2 Expand the mailing list.
- 3.3 Arrange for the translation and distribution of the French and Spanish versions.
- 3.4 Produce a subject index for the first three volumes.
- 3.5 Disseminate back issues of the TLU in French and Spanish.

Current Status

In Fall 1988, the Information Center conducted a survey to determine the relevance of the TLU's content to readers' work and to solicit suggestions for improvement. Sixteen percent of those contacted by mail completed and returned the survey, an unusually high percentage reflecting the TLU's reputation. Thirty-five percent of the respondents reported that the TLU is their main source of information on CDD issues. Three-quarters found the TLU very relevant to their professional responsibilities. Eighty-seven percent indicated that they share the TLU with colleagues. Readers suggested that the TLU present more information on CDD

programs, the dietary management of diarrhea, and social and environmental aspects of control and prevention. Several readers requested French and Spanish versions.

As a result of the survey, the Information Center implemented a number of changes. First, 95 libraries and 180 individuals noted by respondents were added to the mailing list. Second, more articles on the social and preventive aspects of CDD will be featured in future issues. Third, PRITECH decided to produce French and Spanish versions. Finally, along with a more appealing layout, the TLU became the Technical Literature Update on Diarrhea, a name that clarifies its content.

The English version of the TLU has grown to 4,700 readers, including multiples, a 30 percent increase over last year. This growth can be attributed to: (1) word-of-mouth in developing countries; (2) publicity at conferences; and (3) multiple copies distributed by PRITECH field representatives, PVOs, and various donor agencies.

In March 1989, the Information Center began producing French and Spanish versions of the TLU. The Center arranges for the translation and production on a desktop publisher program. Distribution of the French version is handled jointly by ORANA, which sends copies to 600 decision-makers in Francophone Africa, and PRITECH, which distributes about 200 copies to those in other parts of the world. The Information Center is currently distributing about 575 copies of the Spanish TLU. Both new versions have been advertised in child-survival newsletters and demand should grow in FY90.

In the spring, the Information Center sent all TLU readers a copy of a subject index for the first three volumes of the TLU. The index, which includes country and subject lists, has generated numerous requests for back issues as well as articles previously reviewed.

The Center advertised back issues of the TLU in French and Spanish and has sent out about 30 copies of each in response to requests.

OBJECTIVE 4: DEVELOP THE AUDIOVISUAL COLLECTION

Planned Activities:

- 4.1 Collect a/v materials from PVOs, PRITECH field representatives and donor agencies and purchase equipment for them.
- 4.2 Hire an intern to organize and catalog the collection.
- 4.3 Produce a directory of sources of a/v materials.

Current Status

During FY89, the Information Center acquired numerous CDD posters, flip-charts, and other educational materials, mostly from staff visits to PRITECH countries and from field representatives. The Center acquired the ORT video produced by Jon Rohde of UNICEF and distributed it to field representatives in the appropriate format.

An intern organized the a/v collection by country and stored it in hanging folders and poster boxes. Following the Information Center evaluation, PRITECH decided against producing a directory of a/v materials, as WHO had recently produced such a guide. The Center also decided not to publicize the a/v collection because of the expense and time involved; instead, the staff will refer requests directly to the groups that produce such materials.

OBJECTIVE 5: PREPARE FOR AND CONDUCT AN EVALUATION OF THE INFORMATION CENTER

Planned Activities:

- 5.1 Prepare a scope of work for the evaluation and hire a consultant.
- 5.2 Make changes based on the evaluation results.

Current Status

In May 1989, an Information Specialist conducted an evaluation of Information Center activities, including acquisitions, technical processing, and dissemination; manageability of the annual workplan; technical assistance to overseas information centers; use of the a/v collection; and integration of the Center into other PRITECH activities.

The evaluation recommended that the Center drop certain activities, such as the country background files and the guide to a/v materials, and assume new activities, such as production of the Weekly Activity Report to A.I.D. and maintenance of the PRITECH central files. The Center also agreed to arrange for the translation, production, and dissemination of key PRITECH reports, while MSH will cover the costs.

The most important result of the evaluation was the integration of Information Center staff into other project activities. This integration has benefited both the staff and the project.

D. Diarrheal Disease Control - Research & Development Component

1. Overview

During the second project year, PRITECH II focused in its Research and Development component on the three areas noted in the workplan:

- completing products (documents, papers) in support of PRITECH country programs and other CDD efforts
- providing more effective technical support to PRITECH country programs
- providing technical support, liaison, or assistance to S&T/Health and CDD-related organizations, projects, and meetings.

PRITECH completed most of the objectives outlined in the second-year workplan. The section which follows describes the status of each of the planned PY2 activities.

2. Activities

OBJECTIVE 1: THE COMPLETION OF PRODUCTS IN SUPPORT OF PRITECH COUNTRY PROGRAMS AND OTHER CDD EFFORTS

Planned Activities:

Status: end of PY2:

1.1 PRITECH will complete the final editing and production of the following documents:

- PRITECH field implementation aids (formerly called "Strategy Papers") on:
 - case management completed
 - dysentery completed
 - nutrition completed
 - CDD prevention-related activities not complete
 - acute respiratory infections completed
 - CDD program management completed
 - CDD financing and sustainability completed
 - training completed
 - communications completed
 - ORS production, sales, distribution, and marketing completed
 - program-problem solving studies completed

OBJECTIVE 6: RESPOND TO AD HOC REQUESTS FROM A.I.D. AND OTHERS

During the summer of 1989, the Information Center helped establish child-survival information centers in The Philippines and Pakistan. These new information centers will keep health personnel in both countries informed of the most recent literature in the child-survival area and will promote a two-way flow of information between PRITECH/Washington and the field.

3. Conferences

During PY2, the PRITECH II project provided technical support to three conferences. These included two pediatric conferences held in Costa Rica and Mexico and the ICORT III Conference held in Washington, D.C., December 1988. At the Costa Rica Pediatric Conference, Dr. Myron Levine made presentations on diarrheal disease vaccines and shigellosis. In Mexico, Dr. Salazar-Lindo made presentations on the "Treatment of Severely Dehydrated Children" and "Nutrition for Children with Diarrhea."

For the ICORT III Conference, PRITECH assisted in the preparation, editing and production of the background papers.

Expenditures in support of conferences for PY2 totalled \$79,596.17. To date, \$205,657.73 has been spent for conferences.

	<u>Conference Expenditures</u>		
	<u>Central</u>	<u>Buy-in</u>	<u>Total</u>
Project Year 1	\$126,061.56	--	\$126,061.56
Project Year 2	<u>79,596.17</u>	--	<u>79,596.17</u>
TOTAL:	\$205,657.73		\$205,657.73

98

Comments:

PRITECH completed the final editing of all but one of the field-implementation aids targeted for completion in PY2. Field staff, WHO, and other reviewer comments have been incorporated into all papers and the papers have now been updated and put into the same format. PRITECH combined the financing paper with the sustainability document. Comments from CDD professionals who received draft versions of these documents has been very favorable. Completion of the prevention paper as well as final proofing and production of these documents will take place during the first quarter of FY3. They will be produced simply as a set, but allowing the individual papers to stand on their own separately. The documents will continue to be used for PRITECH field staff, short-term consultants, and as requested by other professionals providing technical assistance in CDD.

Planned Activities:

Status: end of PY2:

1.2 PRITECH will complete the final editing and production of the following documents (continued):

- | | |
|--|-----------|
| - CDD computer model | completed |
| - Criteria for the PRITECH contract evaluation | completed |

Comments:

As noted in PY1 annual report, the CDD computer model was completed and reviewed by several individuals. The review led to the conclusion that the model did not appear to be a useful tool either for teaching or for CDD programs. The project officer at A.I.D. was informed of this and the completed model submitted "as is" to A.I.D.

The criteria for the PRITECH contract evaluation were completed and submitted to A.I.D. This document raised contract-related issues which PRITECH needed to clarify with A.I.D. PRITECH has subsequently sent a memorandum to its CTO to request clarification on these issues.

Planned Activities:

Status: end of PY2:

1.3 PRITECH will have the following manuals professionally formatted and published:

- | | |
|---|-----------|
| - "A Manual for the Investigation of Feeding Practices" | completed |
| - "A Guide for the Improved Nutritional Management of Diarrhea" | completed |

Comments:

The manuals for Improving Young Child Feeding During Diarrhea and for the Improved Nutritional Management of Diarrhea were attractively formatted and produced. Numerous copies were distributed at the ICORT III conference. There has been much demand for the manuals, particularly the manual on infant-feeding practices. Over 600 copies of the nutrition manual and the feeding-practices manual have been distributed to CDD programs and professionals. PRITECH plans to have the feeding-practices manual translated into French during the next project year.

Planned Activities

Status: end of PY2:

1.4 The documents which PRITECH will work on but not complete until year three include:

- | | |
|--|---|
| - a field guide for conducting studies of the accuracy of mixing/administration of Sugar Salt Solution (SSS) | review of final draft completed and sent out for review |
| - ORT is Best | final typing in progress |
| - field implementation aids on: | |
| - persistent diarrhea | first draft sent out for review |
| - monitoring and evaluation | not completed |
| - participation of the non-governmental sector in CDD efforts | completed |

100

Comments:

As planned, PRITECH worked on the documents noted in section I.3. PRITECH combined the community participation and private-sector papers into a paper entitled "Non-governmental Participation in CDD efforts". This paper was completed in PY2. The remaining documents only require final editing and proofing. PRITECH will complete them during the first half of PY3. These documents will be distributed to all PRITECH field staff, regular consultants, and subcontractors for use in developing and implementing country-program workplans.

OBJECTIVE 2: THE PROVISION OF MORE EFFECTIVE TECHNICAL SUPPORT TO COUNTRY PROGRAMS

Planned Activities:

- 2.1 Recruit and orient new technical-unit staff members.
- 2.2 Develop approaches to strengthen PRITECH national-counterpart-staff skills.
- 2.3 Strengthen approaches to provide technical input into PRITECH country programs.
- 2.4 Modify PRITECH's approach to support program-problem solving studies (PPSS) in PRITECH country programs.

Status end of PY2:

2.1 Recruit/orient new staff: PRITECH recruited two physicians -- one full time and one 40% time -- with strong CDD technical and program skills to strengthen its technical input into country programs. Two other physicians whom PRITECH had recruited early in PY2 remained with PRITECH only a few months. PRITECH is reassessing the need for the third physician mentioned in the PY2 workplan. New staff members participated in specific orientation activities as relevant. The social-marketing expert recruited during PY1 has transferred from the technical to the operations staff because of the close linkages necessary between his efforts and program and operations staff.

2.2 Strengthen counterpart skills: A number of PRITECH field offices have hired locally available technical experts including physicians, health educators, and sociologists, to assist in the support of country activities. The input of these national staff members is making an important permanent contribution to CDD. PRITECH therefore planned and has supported specific training opportunities for its field-based technical staff members during PY2. This has included participation in WHO program-managers

STUDIES

- | | |
|-------------------------------------|--------------------|
| ORS-distribution study | - Burkina Faso |
| Focus-group report | - Cameroon |
| KAP protocol | - Mali, Mauritania |
| KAP draft reports | - Mali, Mauritania |
| Health-facility-survey draft report | - Niger, Mali |
| Home-fluids policy statement | - Pakistan |
- development and/or dissemination of relevant documents to field staff;
 - provision of technical assistance by Dr. Robert Northrup in medical education in The Philippines and Indonesia.

2.4 Modified PPSS support: As noted in the first annual report of PRITECH II, PRITECH modified its approach to Program Problem Solving Studies as a result of input by the Task Force and the first year's program experience. During PY2, therefore, PRITECH PPSS funds have been used to supplement country-program resources to finance entire studies or components of studies not funded locally. As in year one, a number of studies have been carried out in CDD programs in the countries where PRITECH has a presence. Most of these studies have been supported locally either through PRITECH national program funds or through other sources. A substantial number of studies not supported financially by PRITECH have been given significant technical assistance by PRITECH staff in the field. A few have been supported through central funds. The distribution is as follows:

- number of studies funded through the PRITECH country programs:	11
- number of studies funded, in whole or in part, from PRITECH's PPSS budget:	7
- number of studies not funded by PRITECH but which received PRITECH TA:	<u>9</u>
TOTAL:	27

PRITECH has supported studies only in countries where it has a long-term presence. PRITECH has also reviewed a number of research protocols or reports even where the study itself was not financed by PRITECH. Finally, PRITECH/Washington has provided field staff with research-related documents to assist them as they plan and carry out their research locally.

A type of research effort exclusively managed by PRITECH staff in Washington, as originally envisioned in the contract is not needed, because most studies are initiated in the field. What is

needed from Washington is support for a broad array of problem-solving activities in the field. PRITECH is requesting approval for broader use of research and development funds for a variety of problem-solving activities, including PFSS. This redefined research and development program is described in detail in the PY3 workplan.

OBJECTIVE 3: PROVISION OF TECHNICAL SUPPORT, LIAISON, AND UPDATE

Planned Activities:

- 3.1 Provide technical support services to the S&T/Health Office in CDD areas.
- 3.2 Participate in coordination activities with WHO, UNICEF, and other projects and organizations involved in CDD efforts.
- 3.3 Provide technical support to and participate in the ICORT III conference.
- 3.4 Prepare the Technical Literature Update.

Status end of PY2:

3.1 S&T/H Support: During PY2, PRITECH supported the S&T/H office in the following set of activities:

- review of LAC bureau's CDD strategy;
- preparation of a briefing paper on persistent diarrhea and dysentery;
- participation in ARI meetings;
- preparation of briefing document for Pakistan CBORT speech;
- preparation and dissemination of ORT materials for USAID health officers;
- preparation of article for FRONTLINES
- preparation and presentation of a paper on the status of CDD requested by A.I.D. at the APHA meetings;
- preparation of materials for and participation in meetings related to A.I.D.'s evaluation of the diarrheal-disease research portfolio.

3.2 Donor/Project coordination: PRITECH participated in numerous activities related to coordination with WHO, UNICEF, and other CDD-related organizations. In August, PRITECH held its annual meeting with the director of the WHO CDD Program and with the UNICEF delegate responsible for ORT. PRITECH had numerous other contacts with both organizations. Additionally, PRITECH participated in the TAG meetings of HEALTHCOM, ADDR, and CCCD Projects. Finally, PRITECH also completed the following:

- preparation of an issues paper for the "Meeting of Interested Parties" in Geneva;
- preparation of briefing document on PRITECH involvement in medical-education project for Geneva meeting;
- manuscript review for CDC;
- preparation and presentation of two papers at the NCIH meetings: 1) The relationship between operations research and program action - the PRITECH approach to PPSS, and 2) sustaining diarrheal-disease control programs.

3.3 Support to ICORT III: A very important activity during the second project year was the technical support provided to A.I.D. and participation in the ICORT III conference. PRITECH coordinated the production, translation, and the technical review of issues papers related to each of the conference sessions. PRITECH assisted in contacting all of the conference speakers and in organizing the pre-conference planning sessions for the speakers. PRITECH also participated in planning meetings and in the conference itself. This effort consumed a substantial amount of PRITECH staff time. It is described in more detail in the section on "Conferences" in this annual report.

3.4 Preparation of Technical Literature Update: Finally, a very important contribution continues to be the preparation, translation, and dissemination of the Technical Literature Update (TLU). Dr. Robert Northrup continues his important review and comment on important published literature related to CDD. The TLU mailing list has grown to over 4,000 in English and substantial dissemination in French and Spanish (see Information section of this report).

As noted in the second-year workplan, no Task Force meeting was held during PY2. Since PRITECH's Task Force Meeting was held late in the first project year, PRITECH proposed to hold its second Task Force meeting in the third project year.

E. Project Management

1. Overview

During PY2, from October 1988 to September 1989, the PRITECH organization in Washington dealt with a series of changes and disruptions which challenged the management and the staff. The original Director, John Alden, departed, when he could not be persuaded to extend his tenure once again. A Senior Program Manager, Jane Schlendorf, was fatally stricken with malaria upon her return from a brief assignment to Nigeria. Preparations for ICORT III involved an unexpected burden; the Office of Health requested extraordinary help in organizing preparation of the technical papers for the Conference. The intense effort demanded by this assignment pre-empted the efforts of the Technical Unit for several weeks. A new Director, John Tomaro, took charge in February. During the Summer, the Technical Director, Rob Northrup, resigned to return to an academic position. At the end of the year, the office moved to another location in Rosslyn.

As is evident from the description of activities in the prior sections, the organization has been resilient in maintaining a steady course and in moving programs forward despite these changes. This resiliency is attributable to the following:

- a strong and stable field staff. Authority for directing country programs has been delegated to group of experienced Regional Program Managers and remarkably self-reliant Country Representatives. The management structure for country programs is discussed below;
- long-term continuity among PRITECH's seasoned management staff;
- sound advice and reliable support from consulting experts on technical and management issues, especially from Alden, Northrup and senior staff at MSH, AED, JHU, PATH and CEDPA;
- confidence and support from S&T/Health and some key officers in the Regional Bureaus.

2. Country Program Management Structure

The PRITECH management structure for country programs is organized around Senior Program Managers who direct PRITECH's country-based efforts. Senior Program Managers combine both technical and management skills which give them the capability to prescribe actions needed to achieve program objectives; they have the primary responsibility within PRITECH for successful planning and implementation of country programs. The Senior Program Managers and Country Representatives have working relationships

with the key decision-makers and program managers in government ministries, private organizations, and in USAID and other donor agencies in the country.

Senior Program Managers and Country Representatives, the field staff, work with the National CDD Program Coordinator to get agreement with government ministries and donors about an overall implementation plan, which defines each agency's responsibilities and resource commitments. The field staff assist the National CDD Coordinator in monitoring program progress, spotting implementation problems and recommending solutions. This role requires a clear sense of program objectives, experience with the structure of CDD programs and the functions of primary health care system, and leadership and management skills in order to organize program action. The trust and reliance underlying these working relationships are built slowly; once established, however, these relationships have become the foundation of PRITECH's country programs.

The Country Representatives are guided by the implementation plan and frequent supervisory visits by the Senior Program Managers. Particular technical problems are handled by the Senior Program Managers, in their areas of expertise, or by visiting technical experts. PRITECH assigns experts to particular countries, periodic consultants who are involved over time, enabling them to deepen their knowledge and to build relationships.

All the field staff (including the Senior Program Managers, the Country Representatives and the consultants) are given operational, technical and administrative support from the Washington office. A direct line exists between the field staff and the PRITECH Program Operations Unit in Washington. The Operations Officers in Washington are responsible for organizing review and approval of country program plans, and for monitoring the pace of implementation. The Technical Director and the Technical Unit are responsible for assuring that overall programs and individual program components are technically sound and in conformance with AID and WHO technical guidelines. The Finance and Administration Unit helps set up financial management systems, handles the hiring of field staff and arrangements for field assignments, reviews financial documents, and monitors budgets.

Senior Program Managers and Country Representatives submit regular reports to the PRITECH Director; these reports describe progress and problems with specific reference to the implementation plans.

Periodic visits to the country by Operations Officers and Technical Staff members also supply direct data on program progress. These mechanisms provide control over the direction, content, quality, and pace of each PRITECH country effort and operational and technical management while allowing appropriate

responsiveness to local conditions.

Once a PRITECH program plan is approved, a Senior Program Manager is given responsibility to direct the PRITECH activities. It is this person's judgments that determine PRITECH's activities in a country - within the guidelines of the nation's CDD plan and the PRITECH program. PRITECH management delegates considerable discretion to Senior Program Managers and Senior Country Representatives; working with national CDD program managers, they can plan and administer specific activities which they determine are needed to carry out the program plan. Specific activities are subject to financial and administrative reviews by PRITECH headquarters, and the technical direction and content of the program are approved by the Technical Director. Implementation of the program, however, is the responsibility of the field staff.

The table below lists managers for country programs during PY2. Fourteen of these managers reside in the field.

Senior Program Manager Country/Program Country Representatives

AFRICA

Suzanne Prysor-Jones Dr. Adama Kone, Deputy	Burkina Faso Gambia Mali Mauritania Niger Senegal ORANA	Dr. Colette Geslin Judy Beninati Elizabeth Hall
Agma Prins	Cameroon Chad Sudan Tunisia	Robin Steinwand
Peter Spain (acting)	Kenya	Altrena Mukuria
Jane Brown (acting)	Zambia	Paul Freund

ASIA

Dr. Robert Northrup	Indonesia Pakistan Philippines	William Emmet Lucia Ferraz-Tabor David Alt
---------------------	--------------------------------------	--

LATIN AMERICA

Peter Spain	Bolivia México	Dr. Ana Maria Aguilar Dr. Marta de Montero
-------------	-------------------	---

3. Strengthening Technical Staff for Country Programs

As field staffs have become more deeply engaged with the implementation problems encountered by national CDD programs, PRITECH been pushed to have more technical expertise available in the field. The first response is to provide more experts on short term assignments; for highly technical problems, a brief visit by a specialist can often produce a solution. Some tasks, however, require steady effort: improving supervision methods, organizing logistics management, establishing physician training, developing communications campaigns. Furthermore, countries increasingly prefer resident experts who they feel will already understand the local situation, demand less guidance from over-worked CDD program managers, and will be less expensive. PRITECH continues to rely on its extensive roster of experts for short-term assignments, but this capability is being augmented by resident experts in the field. The table below lists the resident experts employed on full or part time basis during PY2:

<u>COUNTRY</u>	<u>EXPERT</u>	<u>AREA OF EXPERTISE</u>
Sahel Region	Dr. Adama Kone	management, supervision, training, info. systems
	Mamadou Sene	communications
	Makane Kane	surveys, operation research
	Alioune Fall	training
Cameroon	Ndonko Flavien	operations research
Kenya	Dr. John Alwar	operations research
	Nicholas Dondi	communications
Indonesia	James Bates	logistics management
Pakistan	Dr. Susan Welsby	physician training
	Abida Aziz	communications research
Bolivia	Susanna Martinez	communications

In Washington, PRITECH has added technical staff positions for a marketing expert (Camille Saade, AED), and a second case management physician (Dr. Elizabeth Herman, JHU) who is giving special attention to the role of home fluids and food in ORT. Dr. Lawrence Casazza has replaced Dr. Deborah Blum.

F. Quality Control for Disease Control Country Programs

Quality control is PRITECH's means of determining whether PRITECH is doing its job. Ultimately, the national programs will tell whether PRITECH's contributions were effective; there should be close watch on the indicators of national program progress. On a day-to-day basis, however, there are other useful indicators and cross-checks, e.g., other donor views of implementation progress, and growth in managerial capability of national CDD units.

PRITECH has basically three roles in bringing about program achievements: to give the program sound technical design and content; to facilitate the flow of resources from donors; and to help institutionalize the organization and management systems necessary to sustain the program. The first line of accountability is the field staff who are assigned operational responsibility for particular country programs. The second line of accountability is PRITECH management, mainly the technical and operations staffs who have oversight responsibility.

The first means of quality control is routine internal PRITECH reporting and supervision. Management of country programs is based on PRITECH program plans, usually derivatives of national program plans developed with PRITECH assistance. The PRITECH country program plans are reviewed and approved by A.I.D. Detailed PRITECH implementation plans, usually for 12 to 18 month periods, are prepared. The field staff have active working relationships with all the key actors in the country; they are involved and know what is happening. To give effective support and oversight to this strong front line management, the PRITECH Director has established a policy of full and open monthly or bi-monthly reporting by field staff, permitting regular review of technical and managerial problems. PRITECH technical and operations staffs make periodic visits to review program progress; the frequency is determined by the nature of the program and the particular management arrangements.

Second, PRITECH consults regularly with A.I.D staff, WHO, UNICEF and other donors to check on whether PRITECH is making national programs work better. The interlocking program plans of the donors make clear if support or technical assistance is lacking from any source. When PRITECH depends on placement of a WHO associate expert, or WHO is participating in a national training program and PRITECH has helped prepare the training materials, there is plenty of opportunity to cross-check emerging problems and to deal with them before they become serious. The interdependency of the components in a national program quickly reveals time lags or deficiencies in any of the segments.

Third, beyond management of inputs and the pace of implementation, the quality of PRITECH's contributions is revealed in the achievements of the national program. When confusion is

caused by educational messages, KAP surveys will reveal the problems. PRITECH schedules surveys after the initial rounds of training and public education. If there were problems with messages or with training materials, they are revealed. If there are faulty assumptions about community health workers being able to educate mothers, they will be revealed. Re-design and re-testing is required; PRITECH's ability to carry out operations research will accelerate the process of problem identification, problem solving and program re-design.

Achievements of the national programs will be measured on multiple levels: promulgation of sound CDD policies, organization of the health services to give attention to CDD activities, preparation of health staff to carry out CDD programs (in terms of training coverage and quality), adequacy of ORS supplies to families and clinics, preparation of families to manage diarrhea and prevent dehydration (KAP measures), clinical admissions and case fatality rates, morbidity and mortality surveys.

Finally, PRITECH's performance is revealed in the capability of the national managers to organize and direct their programs. PRITECH has little influence over national commitment, quality of managers and flow of resources, but given these factors, PRITECH can enhance management of the program by putting into place workable management systems. If national CDD managers have reporting systems and supervision routines which allow them to spot problems, they will have some control over the program. If CDD managers know how to pre-test messages and how to organize effective training, they can solve some common implementation problems. Over time, the capability of CDD managers will reveal whether PRITECH is helping to institutionalize the effective management of the CDD program, and whether the program is likely to be sustained. These achievements will be observed by WHO, A.I.D and other donors. In the meantime, these indicators will be closely monitored by PRITECH management.

PRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSH DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
** -----REGION: AFRICA								
* -----COUNTRY: CHAD								
HSS	037	CHAD	CHILD SURVIVAL PROJECT PAPER	MAXRASH, VIAN, BROWN, WRIGHT	03/20/89	03/28/89	05/10/89	AFR/REGION
* -----COUNTRY: GUINEA								
HSS	040	GUINEA	ORS MARKETING	HYGINO, J.	06/05/89	06/26/89	07/01/89	AFR/S&T
* -----COUNTRY: KENYA								
HSS	020	KENYA	EVALUATE CHILD SURVIVAL PROJECT (SANSO)	BROWNEE, A.	11/24/88	11/05/88	12/06/88	FVA/REGION
HSS	046	KENYA	STUDY ORS DISTRIBUTION CHANGE	MAKHULO, J. MAINA, G.	05/10/88	05/14/89	06/24/88	AFR/S&T
* -----COUNTRY: MALAWI								
HSS	048	MALAWI	HEALTH MANPOWER NEEDS STUDY	REINKE, W.	06/07/89	06/10/89	06/24/89	AFR/REGION
HSS	050	MALAWI	EVALUATE CDD PROJECTS	PRINS, A.	05/30/89	06/02/89	06/16/89	AFR/S&T
* -----COUNTRY: MALI								
HSS	013	MALI	INTEG. OF HEALTH TRAINING FOR FAMILY HEALTH MANUAL	AUBEL, J.	09/21/88	09/25/88	10/30/88	AFR/S&T
HSS	030	MALI	COMPLETE MCH TRAINING STRATEGY	AUBEL, J.	12/28/88	01/03/89	01/17/89	AFR/REGION

PRITECH II
APPENDIX 1

12

PRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
HSS	059	MALI	EVALUATION OF WORLD VISION CHILD SURVIVAL PROJECT	CARNELL, H.	08/21/89	09/20/89	10/10/89	FVA/REGION
* -----COUNTRY: MOZAMBIQUE								
HSS	052	MOZAMBIQUE	DESIGN PROSTHETICS PROJECT	ALDEN, B. FLICHER CLEMENT, CHAPNICK	08/03/89	08/09/89	09/26/89	AFR/REGION
* -----COUNTRY: NIGERIA								
HSS	041	NIGERIA	MIDTERM EVAL. OF ADRA/NIGERIA CHILD SURVIVAL PROJ.	NEWBERRY, D.	05/17/89	05/25/89	06/20/89	FVA/REGION
* -----COUNTRY: RWANDA								
HSS	022	RWANDA	EVALUATE NATIONAL ORS PLAN	ROBERTS, R.	02/03/89	02/07/89	02/16/89	AFR/S&T
HSS	032	RWANDA	FINAL EVALUATION OF ADRA CHILD SURVIVAL PROJECT	DANFORTH, N.	02/13/89	02/20/89	03/12/89	FVA/REGION
* -----COUNTRY: SUDAN								
HSS	023	SUDAN	PRIVATE SECTOR APPLICATION OF ORS	SAADE, C.	10/28/88	10/30/88	11/05/88	AFR/S&T
HSS	057	SUDAN	EVALUATE CARE CHILD SURVIVAL PROJECT	PEREZ, L.	08/14/89	08/25/89	12/31/89	FVA/REGION

12

PRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSM DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
*-----COUNTRY: UGANDA								
HSS	053	UGANDA	DESIGN PROSTHETICS PROJECT	BELCHER, R.	07/19/89	08/31/89	09/10/89	AFR/REGION

PRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
** -----REGION: ASIA/NEAR EAST								
* -----COUNTRY: INDONESIA								
HSS	015	INDONESIA	CONDUCT PVO ASSESSMENT	QUINLEY, J.	10/12/88	10/20/88	11/05/88	FVA/REGION
HSS	016	INDONESIA	ASSIST HKI W/ EVALUATION OF CHILD SURVIVAL PROJECT	COPP, D.	11/06/88	11/06/88	11/06/88	FVA/REGION
* -----COUNTRY: JORDAN								
HSS	055	JORDAN	WORKSHOPS AT C.E.D.	TAYBACK, M.	08/28/89	09/08/89	10/05/89	ANE/S&T
* -----COUNTRY: NEPAL								
HSS	028	NEPAL	PARTICIPATE IN SCF CHILD SURVIVAL WORKSHOP	BENJAMIN, R. SOLTER, S. QUINLEY, J.	01/13/89	04/08/89	04/28/89	FVA/REGION
HSS	043	NEPAL	NEPAL RETAIL SECTOR STUDY	QUICK, J. TAWFIK, Y. FOREMAN, P.	04/20/89	04/12/89	05/12/89	ANE/REGION
HSS	056	NEPAL	FREEDOM FROM HUNGER MID-TERM EVALUATION	BROWN, L.	08/14/89	08/31/89	12/15/89	FVA/REGION
* -----COUNTRY: PAKISTAN								
HSS	018	PAKISTAN	BREASTFEEDING SEMINARS	GRIFFITHS, M. (SUBCONTRACT W/ MANOFF INT'L.)	10/21/88	11/23/88	12/18/88	ANE/S&T

115

PRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
-----COUNTRY: PHILIPPINES								
HSS	036	PHILIPPINES	ASSIST WITH NEW CHILD SURVIVAL INSTITUTE	BLACK, R.	03/16/89	03/18/89	03/27/89	ANE/S&T
HSS	051	PHILIPPINES	DRUG MANAGEMENT AND LOGISTICS STUDY	WERTHEIMER, A. ROBERTS, R.	05/26/89	06/06/89	07/17/89	ANE/S&T

FRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
** -----REGION: INTERREGIONAL								
* -----COUNTRY: USA								
HSS	044	USA	INDONESIA/NEPAL EFFECTIVE USE COMPARISON	QUICK, J. TAWFIK, Y. SOMERAI, S.	04/20/89	04/12/89	09/30/89	AWE/REGION
HSS	008	USA	ICORT III PREPARATION (CAI SUBCONTRACT)	DAVIS, A. LOCKETT, D.	07/15/88	07/06/88	07/30/88	S&T/S&T
HSS	011	USA	PREPARATION OF ICORT III DOCUMENT	FABRICANT, FIELDS, TOMARO, THOMAS	08/23/88	09/01/88	10/15/89	S&T/REGION
HSS	012	USA	REVIEW BANGLADESH REPORT	KEUSCH, G.	09/08/88	09/04/88	09/09/88	S&T/S&T
HSS	024	USA	HELP HKI WITH EVAL. OF REG. TECHNICAL ASSISTANCE	PEREZ, L.	12/19/88	12/20/88	12/26/88	FVA/REGION
HSS	029	USA	PARTICIPATE IN PVO CHILD SURVIVAL WORKSHOP	SHORR, I. MERCER, M.	01/03/89	01/04/89	01/19/89	FVA/REGION
HSS	031	USA	FVA PROPOSAL REVIEW	16 CONSULTANTS	01/25/89	02/01/89	02/17/89	FVA/REGION
HSS	035	USA	PREPARE BAMAKO INITIATIVE PAPER	BLAKNEY, B. QUICK, J. LITVACK, J.	03/01/89	03/01/89	03/15/89	S&T/S&T
HSS	038	USA	DIP REVIEWS	15 CONSULTANTS	04/03/89	04/04/89	04/06/89	FVA/REGION
HSS	039	USA	1 DAY PRESENTATION TO AID	QUICK, J. BLAKNEY, R.	07/24/89	07/25/89	07/25/89	S&T/S&T

117

PRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
HSS	042	USA	LAC TASK FORCE	KENDALL, C.	04/24/89	05/01/89	06/12/89	LAC/S&T
HSS	05B	USA	PRESENTATION TO AID/W ON ORS MGMT. PACKAGE	BATES, J. FOREMAN, P.	08/19/89	08/14/89	09/21/89	AME/REGION

1/89

PRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
** -----REGION: LAC								
* -----COUNTRY: BELIZE								
HSS	026	BELIZE	HEALTH SECTOR ASSESSMENT	NORRIS, J. COLON, D. FAIRBANK, A.	11/08/88	11/09/88	12/09/88	LAC/S&T
* -----COUNTRY: BOLIVIA								
HSS	034	BOLIVIA	FREEDOM FROM HUNGER EVALUATION	TAM, L.	03/31/89	04/03/89	04/27/89	FVA/REGION
HSS	047	BOLIVIA	MID-TERM EVALUATION OF ARHC/C.S. PROJECT	TAM, L.	05/31/89	06/18/89	07/11/89	FVA/REGION
* -----COUNTRY: DOMINICAN REP								
HSS	002	DOMINICAN REP	INSTITUTIONAL ANALYSIS/SESPAS	SMITH, B. BRIDWELL, D.	04/06/88	05/02/88	06/02/88	LAC/REGION
* -----COUNTRY: ECUADOR								
HSS	001	ECUADOR	DESIGN CHILD SURVIVAL STRATEGY	SMITH, B. SMITH, W.	10/20/87	11/10/87	12/12/87	LAC/REGION
HSS	003	ECUADOR	PUBLIC HEALTH FINANCING REVIEW	MOORE, PROANO, CANDAS, LEON	04/29/88	05/09/88	06/15/88	LAC/REGION
HSS	004	ECUADOR	MORTALITY RISK OF DELIVERY & PRE-NATAL SERVICES	CRESPO, A.	05/24/88	05/05/88	06/10/88	LAC/REGION

115

PRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSM DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
HSS	005	ECUADOR	PRIVATE SECTOR STUDY	THOMAS, M. SACOTO, E. BUCHELI, C.	06/07/88	06/12/88	07/10/88	LAC/REGION
HSS	006	ECUADOR	REVIEW LESSONS LEARNED	AGUILAR, CALDERON, CRESPO, ECKROAD, ENCALADA, VANONI	06/27/88	07/13/88	08/25/88	LAC/REGION
HSS	007	ECUADOR	SOCIAL SOUNDNESS ANALYSIS	PEDERSEN, D.	07/01/88	07/06/88	07/22/88	LAC/REGION
HSS	010	ECUADOR	FIELD WORK FOR SOCIAL SOUNDNESS ANALYSIS	ESCOBAR, M.	08/22/88	08/01/88	10/15/88	LAC/REGION
HSS	017	ECUADOR	PROVIDE INPUT FOR CHILD SURVIVAL STRATEGY	MOORE, R.	04/29/88	05/09/88	06/15/88	LAC/REGION
HSS	021	ECUADOR	CHILD SURVIVAL PROJECT PAPER	HAIGHT, PEDERSEN, MOORE, SMITH	10/27/88	11/01/88	12/20/88	LAC/REGION
HSS	027	ECUADOR	CONTINUE CHILD SURVIVAL PROJECT OF DEC. 1988	HAIGHT, H. MOORE, R.	01/15/89	01/17/89	02/28/89	LAC/REGION
HSS	033	ECUADOR	PREPARE MOH ECONOMIC ANALYSIS	FIEDLER, J. (MACROSYSTEMS SUBCONTRACT)	01/25/89	01/29/89	02/14/89	LAC/REGION
HSS	045	ECUADOR	REVIEW CHILD SURVIVAL PROJECT	CALDERON, R.	08/15/88	08/01/88	08/30/88	LAC/REGION

PRITECH II HEALTH SYSTEMS SUPPORT
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	NO.	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSM DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
* -----COUNTRY: GUATEMALA								
HSS	009	GUATEMALA	IMMUNIZATION AND ORT SERVICES FOR CHILD SURVIVAL	ENGE, K HEWES-CALDERON, S.	07/11/88	07/14/88	09/25/88	LAC/REGION
HSS	025	GUATEMALA	COMMUNITY-BASED HEALTH WORKERS ASSESSMENT	SMITH, B., PUTNEY, P.	12/02/88	01/15/89	02/15/89	LAC/REGION
HSS	049	GUATEMALA	PVO WORKSHOP SPONSORED BY HOPE	SMITH, G.	06/08/89	08/01/89	08/21/89	FVA/REGION
HSS	061	GUATEMALA	PROVIDE MANAGEMENT ASSISTANCE TO AID/GUAT.	SMITH, B.	09/11/89	09/18/89	10/03/89	LAC/REGION
* -----COUNTRY: HAITI								
HSS	019	HAITI	EVALUATE CHILD SURVIVAL PROJECT (SAWSO)	SIMMS, A.	12/29/88	01/08/89	02/15/89	FVA/REGION
HSS	054	HAITI	EVALUATE AGAPCO	HUFF-ROUSSELLE, M.	09/08/89	09/11/89	09/25/89	LAC/S&T

121

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
** -----REGION: AFRICA							
* -----COUNTRY: BURKINA FASO							
ICP	002 BURKINA FASO	CONDUCT TRAINING WORKSHOP	PRYSOR-JONES, S.	10/19/88	10/24/88	11/05/88	USAID BURKINA
ICP	005 BURKINA FASO	PROVIDE ASSISTANCE TO CDD HEALTH EDUCATION UNIT	GESLIN, C. KANE, M.	11/16/88	11/23/88	09/30/89	USAID BURKINA
ICP	010 BURKINA FASO	PLANNING/BUDGET DISCUSSIONS	PRYSOR-JONES, S.	01/10/89	02/01/89	09/30/89	USAID BURKINA
ICP	031 BURKINA FASO	COUNTRY REPRESENTATIVE	GESLIN, C.	08/31/89	10/01/89	09/30/90	USAID BURKINA
LPC	003 BURKINA FASO	FIELDTRIP TRAINING COURSES		01/20/89	12/15/88	02/15/89	USAID BURKINA
LPC	004 BURKINA FASO	LOCAL COSTS/ TRAINING ACTIVITIES		03/22/89	03/01/89	03/01/90	USAID BURKINA
LPC	008 BURKINA FASO	PURCHASE OF BABY SCALES		07/21/89	07/21/89	/ /	USAID BURKINA
RAD	017 BURKINA FASO	LOCAL COSTS FOR ORS DISTRIB. STUDY		05/17/89	05/29/89	06/29/89	CENTRAL FUNDS
* -----COUNTRY: CAMEROON							
FOS	005 CAMEROON	FIELD OFFICE SUPPORT		12/01/88	11/01/88	04/30/90	USAID CAMEROON
STP	012 CAMEROON	STRATEGY ASSESSMENT	PRINS, A. ROBERTS, R. PIGOT, D. BROWN, R.	02/13/89	03/01/89	03/16/89	CENTRAL FUNDS

122

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSM DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
SUP	008 CAMEROON	ASSIST COD W/ DEMOGRAPHIC STUDY	NDONKO, F.	11/07/88	11/12/88	02/28/89	USAID CAMEROON
SUP	013 CAMEROON	PRITECH COUNTRY REP.	STEINWAND, R.	12/01/88	11/01/88	04/30/90	USAID CAMEROON
SUP	019 CAMEROON	DEMOGRAPHIC RESEARCH/ANALYSIS	AUBEL, J.	01/17/89	02/01/89	02/28/89	USAID CAMEROON
SUP	047 CAMEROON	FACILITATE NATIONAL IEC WORKSHOP	PRINS, A. DE MALVINSKY, J.	06/05/89	06/19/89	07/08/89	USAID CAMEROON
SUP	054 CAMEROON	ASSIST W/IEC W-SHOP AND RECOMMENDATIONS	NDONKO, F.	07/05/89	07/05/89	07/25/89	USAID CAMEROON
* -----COUNTRY: CHAD							
ICP	024 CHAD	MOH STAFF TO ATTEND CAMEROON IEC WORKSHOP		06/08/89	06/19/89	06/25/89	CENTRAL FUNDS
STP	004 CHAD	STRATEGY VISIT CONDUCT SEMINAR	PRINS, A.	09/19/88	10/02/88	10/17/88	CENTRAL FUNDS
STP	016 CHAD	DISCUSS SCOPE FOR MISSION BUY-IN	PRINS, A.	05/02/89	05/07/89	05/14/89	CENTRAL FUNDS
* -----COUNTRY: EAST AFRICA							
SUP	016 EAST AFRICA	REGIONAL REP.	PRINS, A.	01/23/89	01/01/89	12/31/90	CENTRAL FUNDS
SUP	065 EAST AFRICA	ASSIST W/SETUP OF REGIONAL OFFICE	WATERS, H.	09/06/89	09/18/89	10/06/89	CENTRAL FUNDS

12/1

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
* -----COUNTRY: GAMBIA							
ICP	006 GAMBIA	DATA ANALYSIS FOR ORT COMMUNITY SURVEY	PRYSOR-JONES, S. KONE, A.	12/28/88	12/05/88	08/31/89	USAID GAMBIA
ICP	007 GAMBIA	PLANNING/BUDGET DISCUSSIONS	PRYSOR-JONES, S.	12/28/88	01/04/89	01/15/90	USAID GAMBIA
ICP	013 GAMBIA	DISCUSSIONS W/MOH FACILITATE TOT WORK.	PRYSOR-JONES, S. DIENE, S.	02/06/89	02/16/89	06/06/89	USAID GAMBIA
ICP	017 GAMBIA	PRIVATE SECTOR PROMOTION	SAADE, C. KANE, H.	03/06/89	03/20/89	03/22/89	USAID GAMBIA
ICP	028 GAMBIA	TRAINING OF TRAINERS WORKSHOP	KONE, A.	08/14/89	07/02/89	07/12/89	USAID GAMBIA
LPC	007 GAMBIA	PRINTING TRAINING MODULES, SSS FLYERS		04/25/89	05/01/89	06/01/89	USAID GAMBIA
* -----COUNTRY: INTERREGIONAL							
ADG	002 INTERREGIONAL	ATTEND WHO CDD MANAGERS MEETING	PRINS, A. STEINWAND, R.	01/12/89	02/21/89	02/25/89	CENTRAL FUNDS
* -----COUNTRY: KENYA							
FOS	010 KENYA	FIELD OFFICE SUPPORT		08/05/89	07/01/89	06/30/92	USAID KENYA
ICP	003 KENYA	CONTINUATION OF PRITECH PROGRAM	DONDI, M. ALWAR, J. ROBERTS, R.	11/10/88	10/01/88	05/31/89	CENTRAL FUNDS

124

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
ICP	012 KENYA	PRITECH II MANAGEMENT/ IMPLEMENTATION	ALDEN, J. TOMARO, J.	02/03/89	02/11/89	05/23/89	CENTRAL FUNDS
ICP	015 KENYA	PRITECH II MANAGEMENT	BROWN, J. SPAIN, P.	02/21/89	02/25/89	06/16/89	CENTRAL FUNDS
ICP	021 KENYA	ASSIST W/PLAN FOR ONE-HALF LITER PACKETS	CLAYTON, C. MAHROUS, H.	06/02/89	06/11/89	06/30/89	CENTRAL FUNDS
STP	003 KENYA	STRATEGY ASSESSMENT	PRINS, A. BROWN, J. GRANT, D. SANTOSHAM, M. RASMUSON, M. ALDEN, J.	09/06/88	09/01/88	09/30/88	CENTRAL FUNDS
SUP	055 KENYA	PARTICIPATE IN CDD PLANNING WORKSHOP	SIMPSON, R. SPAIN, P.	07/11/89	07/22/89	08/05/89	CENTRAL FUNDS
SUP	058 KENYA	PRITECH COUNTRY REP.	MUKURIA, A.	07/27/89	07/17/89	12/31/90	CENTRAL FUNDS
SUP	059 KENYA	OPERATIONS RESEARCH	ALWAR, J.	07/26/89	07/01/89	09/30/89	USAID KENYA
SUP	060 KENYA	COMMUNICATIONS	DONDI, N.	07/27/89	07/01/89	12/31/89	USAID KENYA
SUP	070 KENYA	FAC. CURR. DEV. WORKSHOP	LAMB, M.	09/21/89	09/27/89	10/25/89	CENTRAL FUNDS
* -----COUNTRY: MALI							
FOS	003 MALI	FIELD OFFICE SUPPORT		10/15/88	10/01/88	09/30/89	USAID MALI

125

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSM DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
FOS	012 MALI	FIELD OFFICE SUPPORT		09/13/89	10/01/89	06/30/89	USAID MALI
LPC	001 MALI	LOCAL PROGRAM COSTS		10/15/88	10/01/88	09/30/89	USAID MALI
RAD	018 MALI	KAP STUDY	KONE, A. KANE, M.	05/22/89	06/06/89	07/15/89	CENTRAL FUNDS
RAD	019 MALI	SET UP ORT UNITS	COULIBALY, M.	06/07/89	07/03/89	07/17/89	CENTRAL FUNDS
SPM	003 MALI	ORIENTATION DISCUSSIONS W/USAID, MOH	DAVIS, K.	12/28/88	01/13/89	01/18/89	CENTRAL FUNDS
SUP	001 MALI	ORS DISTRIBUTION STUDY	ROBERTS, R.	09/21/88	10/08/88	11/20/88	USAID MALI
SUP	006 MALI	COUNTRY REPRESENTATIVE	BENINATI, J.	10/15/88	10/01/88	09/30/88	USAID MALI
SUP	011 MALI	DEVISING DIARRHEA TREATMENT STRATEGIES	KONE, A.	12/22/88	01/07/89	01/21/89	USAID MALI
SUP	023 MALI	ESTABLISH LOCAL ORS PRODUCTION UNIT	HYGINO, J.	04/13/89	05/01/89	06/20/89	USAID MALI
SUP	024 MALI	PRIVATE SECTOR PROMOTION	SAADE, C.	03/06/89	03/13/89	03/20/89	USAID MALI
SUP	025 MALI	KAP STUDIES	KONE, A.	03/06/89	03/08/89	01/05/90	USAID MALI
SUP	032 MALI	SUPERVISION	PRYSOR-JONES, S.	03/06/89	03/19/89	03/26/89	USAID MALI
SUP	035 MALI	INTERIM PRITECH COUNTRY REP.	KENTA, MONA	04/13/89	06/01/89	09/30/89	USAID MALI

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
SUP	038 MALI	IMPLEMENT NURSES TRAINING MODULES	FALL, A.	04/24/89	04/26/89	05/01/89	USAID MALI
SUP	064 MALI	DEV. ORS MARKETING STRATEGY	PRYSOR-JONES, S. SAADE, C. MORALES, L.	09/11/89	10/08/89	11/15/89	USAID MALI
SUP	067 MALI	FOR MS. FATIMATA TONY - ATTEND TRAINING COURSE		09/14/89	10/23/89	11/15/89	USAID MALI
SUP	069 MALI	COUNTRY REPRESENTATIVE	BENINATI, J.	09/13/89	10/01/89	06/30/91	USAID MALI
* -----COUNTRY: MAURITANIA							
ICP	008 MAURITANIA	HEALTH FACILITIES SURVEY	COULIBALY, M.	01/10/89	02/01/89	03/31/89	CENTRAL FUNDS
ICP	014 MAURITANIA	CDD REGIONAL COORDINATORS WORKSHOP	PRYSOR-JONES, S.	02/06/89	02/11/89	02/15/89	CENTRAL FUNDS
ICP	018 MAURITANIA	ATTEND DONORS MTG DISCUSS MANAGEMENT	PRYSOR-JONES, S.	03/06/89	03/11/89	01/23/89	CENTRAL FUNDS
ICP	019 MAURITANIA	PREPARE NUTRITION TRAINING GUIDE	COULIBALY, M.	03/22/89	04/02/89	04/30/89	CENTRAL FUNDS
ICP	025 MAURITANIA	ATTEND REGIONAL CDD COORDINATORS W-SHOP	KONE, A.	07/13/89	07/19/89	08/05/89	CENTRAL FUNDS
ICP	029 MAURITANIA	SET UP ORT UNITS	COULIBALY, M.	08/24/89	10/04/89	10/25/89	CENTRAL FUNDS

127

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSM DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
RAD	016 MAURITANIA	KAP STUDY	KONE, A. KANE, M.	06/07/89	07/17/89	07/31/89	CENTRAL FUNDS
STP	002 MAURITANIA	STRATEGY ASSESSMENT	CORREL, F. GUYON, A. SHAFRITZ, L.	10/12/88	11/25/88	12/18/88	CENTRAL FUNDS
* -----COUNTRY: NIGER							
FOS	002 NIGER	FIELD OFFICE SUPPORT		10/15/88	10/01/88	09/30/90	USAID NIGER
SPM	002 NIGER	ORIENTATION DISCUSSIONS W/USAID, MOH	DAVIS, K.	12/28/88	01/09/89	01/13/89	CENTRAL FUNDS
SPM	008 NIGER	ROUTINE SUPERVISORY VISIT	GRANT, D. DAVIS, K.	07/24/89	07/30/89	08/04/89	CENTRAL FUNDS
SUP	004 NIGER	COUNTRY REPRESENTATIVE	HALL, E.	10/15/88	10/01/88	09/30/90	USAID NIGER
SUP	012 NIGER	MTG. OF REGIONAL CDD COORDINATORS	KONE, A. PRYSOR-JONES, S.	11/07/88	11/21/88	12/04/88	USAID NIGER
SUP	017 NIGER	DEVISING CASE MANAGEMENT STRAT.	KONE, A.	01/10/89	02/06/89	02/05/90	USAID NIGER
SUP	033 NIGER	CASE MANAGEMENT/ HEALTH FAC. SURVEY	COULIBALY, M.	03/22/89	03/24/89	06/23/89	USAID NIGER
SUP	039 NIGER	DISCUSSIONS/GEN. SUPER.	PRYSOR-JONES, S.	04/25/89	05/21/89	01/31/90	USAID NIGER
SUP	056 NIGER	ASSIST W/DEVELOP. OF CDD LOGO	MORALES, L.	07/18/89	07/21/89	08/31/89	USAID NIGER

128

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
SUP	061 NIGER	ADAPT NURSES TRAINING MATER.	FALL, A.	07/28/89	08/10/89	09/10/89	USAID NIGER
SLP	063 NIGER	FACILITATE T OF T WORKSHOPS	PRYSOR-JONES, S. SENE, M.	09/07/89	09/25/89	11/30/89	USAID NIGER
* -----COUNTRY: NIGERIA							
STP	001 NIGERIA	DEVELOP PRITECH II STRATEGY PLAN	NORTHROP, R. SCHLENDORF, J.	07/06/88	07/18/88	07/31/88	CENTRAL FUNDS
STP	006 NIGERIA	STRATEGY IMPLEMENTATION TRAINING COURSE	SCHLENDORF, J. PELOQUIN, L.	10/26/88	11/04/88	11/30/88	CENTRAL FUNDS
* -----COUNTRY: ORANA							
ICP	001 ORANA	INTERIM FUNDING FOR ORANA		07/27/88	05/01/88	12/31/88	CENTRAL FUNDS
ICP	016 ORANA	ORANA SUBCONTRACT		03/06/89	01/01/89	03/31/89	AFRICA REGIONAL
ICP	020 ORANA	EDITING/REVISING TECHNICAL DOCUMENTS	FALL, A. KANE, M. SENE, M.	04/24/89	03/01/89	06/30/90	AFRICA REGIONAL
ICP	023 ORANA	SUBCONTRACT	AISSATOU-WADE ASS'T DOC. SPEC.	08/01/89	04/01/89	08/31/92	AFRICA REGIONAL
ICP	026 ORANA	SUBCONTRACT	KANE, M.	08/01/89	04/01/89	08/31/92	AFRICA REGIONAL
ICP	032 ORANA	ADMIN. SUPPORT AND ED. ARTIST		08/31/89	10/01/89	09/30/89	USAID MALI

129

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
* -----COUNTRY: SAHEL							
FOS	004 SAHEL	FIELD OFFICE SUPPORT		10/15/88	10/01/88	09/30/89	AFRICA REGIONAL
FOS	011 SAHEL	FIELD OFFICE SUPPORT		09/13/89	10/01/89	08/30/92	AFRICA REGIONAL
LPC	010 SAHEL	PREPARATION OF EDUC. MINI-MODULES		08/31/89	10/01/89	09/30/90	AFRICA REGIONAL
RAD	020 SAHEL	COMPARISON OF IEC STUDIES	KANE, M.	06/07/89	07/10/89	09/15/89	CENTRAL FUNDS
RAD	023 SAHEL	COMP. ANALYSIS OF HEALTH FAC. SURV.	COULIBALY, M.	08/24/89	11/01/89	12/31/89	CENTRAL FUNDS
SUP	005 SAHEL	PRITECH REPRESENTATIVES	PRYSOR-JONES, S. KONE, A.	10/15/88	10/01/88	09/30/89	AFRICA REGIONAL
SUP	068 SAHEL	REGIONAL REPS.	PRYSOR-JONES, S. KONE, A.	09/13/89	10/01/89	08/30/92	AFRICA REGIONAL
SUP	077 SAHEL	PARTICIPATE IN SAHEL CONF.	NORTHROP, R.	01/12/89	01/14/89	01/14/89	AFRICA REGIONAL
* -----COUNTRY: SENEGAL							
ICP	011 SENEGAL	KAP STUDY	KANE, M. KONE, A.	01/17/89	01/23/89	04/15/89	USAID SENEGAL
ICP	022 SENEGAL	STUDY OF NUTRITION AND ORT DATA		08/24/89	07/01/89	07/31/89	USAID SENEGAL

1090

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
ICP	033 SENEGAL	TEST COMMUNICATIONS MATERIALS	SENE, M.	09/07/89	08/28/89	09/07/89	USAID SENEGAL
SPM	004 SENEGAL	ORIENTATION DISCUSSIONS W/USAID, MOH	DAVIS, K.	12/28/88	01/18/89	01/21/89	CENTRAL FUNDS
SPM	009 SENEGAL	ROUTINE SUPERVISORY VISIT	GRANT, D. DAVIS, K.	07/24/89	08/04/89	08/10/89	CENTRAL FUNDS
STP	008 SENEGAL	MEET W/CEDPA TO DISCUSS ORT IN PRIV. HEALTH FAC.	DIENG, A.	10/13/88	10/15/88	10/15/88	CENTRAL FUNDS
* -----COUNTRY: SUDAN							
STP	011 SUDAN	PART. IN CDD PROG. EVALUATION	PRINS, A.	12/21/88	01/04/89	01/25/89	JSAID SUDAN
* -----COUNTRY: TUNISIA							
ICP	009 TUNISIA	PRODUCE POSTERS, PACKAGING RESEARCH	SHAFRITZ, L.	01/24/89	01/18/89	02/18/89	CENTRAL FUNDS
* -----COUNTRY: UGANDA							
PCP	005 UGANDA	REVIEW STATUS OF CDD PROG. ASSIST W/PLANNING	PRINS, A.	06/05/89	07/13/89	07/24/89	CENTRAL FUNDS
* -----COUNTRY: ZAIRE							
RAD	015 ZAIRE	ATTEND WHO CLINICAL MANAGEMENT WORK.	KONE, A. COULIBALY, M.	08/24/89	09/20/89	09/30/89	CENTRAL FUNDS

1/11/

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
* -----COUNTRY: ZAMBIA							
FOS	007 ZAMBIA	FIELD OFFICE SUPPORT		02/21/89	10/01/88	05/31/90	CENTRAL FUNDS
STP	013 ZAMBIA	STRATEGY ASSESSMENT	FABRICANT, S. BROWN, J. SALMONSSON, S. LEIFERT, T. SPAIN, P.	02/21/89	03/01/89	03/16/89	CENTRAL FUNDS
SUP	028 ZAMBIA	PRITECH COUNTRY REP.	FREUND, P.	02/22/89	10/01/88	05/31/90	CENTRAL FUNDS

12/1

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
** -----REGION: ASIA/NEAR EAST							
* -----COUNTRY: BANGLADESH							
PCP	002 BANGLADESH	PROMOTIONAL DISCUSSIONS W/USAID	NORTHRUP, R.	02/13/89	02/25/89	02/27/89	CENTRAL FUNDS
* -----COUNTRY: INDIA							
PCP	003 INDIA	PROMOTIONAL DISCUSSIONS W/USAID	TOMARO, J.	04/27/89	05/08/89	05/14/89	CENTRAL FUNDS
* -----COUNTRY: INDONESIA							
FOS	001 INDONESIA	FIELD OFFICE SUPPORT		09/25/88	10/01/88	09/30/89	USAID INDONESIA
LPC	002 INDONESIA	ICDDR TRAINING COURSE FOR NURSES/PHYSICIANS		11/07/88	12/01/88	12/31/88	USAID INDONESIA
LPC	005 INDONESIA	CDD TRAINING IN CAIRO		03/27/89	03/26/89	03/30/89	USAID INDONESIA
LPC	009 INDONESIA	AUSTRALIA STUDY TOUR FOR DR. SUTOTO		08/18/89	09/16/89	09/27/89	USAID INDONESIA
SPH	006 INDONESIA	ADMINISTRATIVE REVIEW	SIMPSON, R.	02/13/89	02/18/89	03/02/89	CENTRAL FUNDS
SUP	002 INDONESIA	PRITECH COUNTRY PROGRAM	EMMET, B. BATES, J.	09/27/88	10/01/88	09/30/89	USAID INDONESIA
SUP	007 INDONESIA	ASSESS MOH DRUG MANAGEMENT	FOREMAN, P.	10/31/88	11/20/88	12/23/88	USAID INDONESIA

12

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
SUP 010	INDONESIA	WORKSHOP TO ADAPT MEDED MATERIALS	NORTHROP, R.	11/15/88	11/25/88	07/07/89	USAID INDONESIA
SUP 014	INDONESIA	ORS COMMERCIALIZATION PROJECT	PATH	12/30/88	11/01/88	09/30/89	USAID INDONESIA
SUP 015	INDONESIA	NEEDS ASSESSMENT FOR ORS MIS SYSTEM	QUICK, J. FOREMAN, P. ROSS-DEGNAN, D.	12/02/88	12/15/88	01/31/89	USAID INDONESIA
SUP 018	INDONESIA	MEDED WORKSHOP	NORTHROP, R.	01/18/89	01/25/89	09/15/89	USAID INDONESIA
SUP 022	INDONESIA	YIS SUBCONTRACT: STUDY OF PHARM. PRACTICE	BIMO KURNIAWATI	02/21/89	03/01/89	04/30/89	USAID INDONESIA
SUP 031	INDONESIA	DESIGN PROGRAM FOR ORS SUPP. MANAGE.	FOREMAN, P.	03/02/89	03/16/89	04/14/89	USAID INDONESIA
SUP 034	INDONESIA	PREPARE ORS MANAGEMENT ASSESSMENT PACKAGE	P. T. FIDIARA	04/11/89	04/24/89	07/15/89	USAID INDONESIA
SUP 040	INDONESIA	DEVELOP SOFTWARE TRAIN CDD STAFF	P. T. FIDIARA	05/03/89	05/10/89	08/31/89	USAID INDONESIA
SUP 043	INDONESIA	ASSIST W/ORS MIS	FOREMAN, P.	05/12/89	07/15/89	08/15/89	USAID INDONESIA
*-----COUNTRY: JORDAN							
ACP 005	JORDAN	INTRODUCTION OF MED. ED. MATERIALS	CUTTING, W.	04/19/89	04/21/89	04/30/89	CENTRAL FUNDS

129

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
STP	009 JORDAN	STRATEGY VISIT, PROMOTE PRIVATE SECTOR INVOLVE.	SAADE, C. SPAIN, P.	11/91/88	01/08/89	01/21/89	CENTRAL FUNDS
* -----COUNTRY: MOROCCO							
PCP	004 MOROCCO	MEET W/USAID REVIEW LOCAL ORS PROC.	ROBERTS, R.	05/09/89	05/12/89	05/16/89	CENTRAL FUNDS
* -----COUNTRY: P.M.G.							
PCP	001 P.M.G.	REVIEW HEALTHCOM PROPOSAL	MITCHELL, M.	10/05/88	10/10/88	10/10/88	CENTRAL FUNDS
* -----COUNTRY: PAKISTAN							
FOS	008 PAKISTAN	FIELD OFFICE SUPPORT		02/28/89	10/01/88	01/19/89	CENTRAL FUNDS
FOS	009 PAKISTAN	FIELD OFFICE SUPPORT		02/28/89	01/19/89	09/30/89	USAID PAKISTAN
LPC	006 PAKISTAN	FIXED PRICE FEE FOR QUTABUDDIN SUBCON.		04/19/89	/ /	/ /	CENTRAL FUNDS
RAD	007 PAKISTAN	ATTEND NIH/ADR RESEARCH MTGS.	MARX, M.	03/02/89	03/18/89	03/24/89	CENTRAL FUNDS
SPM	010 PAKISTAN	DISCUSSIONS W/USAID	SIMPSON, B.	09/14/89	09/18/89	09/27/89	CENTRAL FUNDS
STP	005 PAKISTAN	CONDUCT PRIVATE SECTOR WORKSHOPS	SAADE, C.	09/22/88	10/08/88	10/27/88	CENTRAL FUNDS
SUP	020 PAKISTAN	REVIEW DTUS	NORTHROP, R.	01/18/89	02/10/89	07/15/89	USAID PAKISTAN

14

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
SUP	029 PAKISTAN	PRITECH COUNTRY REP.	FERRAZ-TABOR, L.	02/27/89	10/01/88	01/19/89	CENTRAL FUNDS
SUP	030 PAKISTAN	PRITECH COUNTRY REP.	FERRAZ-TABOR, L.	02/27/89	01/19/89	09/30/89	USAID PAKISTAN
SUP	037 PAKISTAN	DISCUSSIONS W/MOH, USAID	TOMARO, J. GRANT, D.	04/24/89	05/02/89	05/09/89	USAID PAKISTAN
SUP	041 PAKISTAN	DEVELOP CHILD SURV. COMM. STRATEGY	PARLATO, R.	05/02/89	05/08/89	05/30/89	USAID PAKISTAN
SUP	042 PAKISTAN	PRIVATE SECTOR MARKETING SPECIALIST	KHALIL, S.	06/05/89	05/01/89	07/31/89	USAID PAKISTAN
SUP	044 PAKISTAN	ASSIST W/DTU CURRICULUM, TRAINING	WELSBY, S.	05/15/89	05/22/89	09/10/89	USAID PAKISTAN
SUP	045 PAKISTAN	RADIO PRODUCTION/ AUDIENCE RESEARCH	JAMES, R.	06/05/89	06/12/89	07/31/89	USAID PAKISTAN
SUP	046 PAKISTAN	INTERIM COUNTRY REP.	WATERS, H.	05/31/89	06/08/89	07/13/89	USAID PAKISTAN
SUP	048 PAKISTAN	SET UP INFO. CENTER	AHT, B.	06/06/89	07/18/89	07/28/89	USAID PAKISTAN
SUP	049 PAKISTAN	ASSIST IN DEVELOPMENT, PRE-TEST. OF RADIO SPOTS	VIGANO, O.	06/06/89	/ /	/ /	USAID PAKISTAN
SUP	050 PAKISTAN	PREPARE AND CONDUCT HOME FLUIDS RESEARCH	GITTELSON, J. BENTLEY, P.	06/06/89	/ /	/ /	USAID PAKISTAN
UP	051 PAKISTAN	PROMOTE PRIVATE SECTOR	SAADE, C.	06/07/89	07/05/89	07/12/89	USAID PAKISTAN

1990

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
SUP	053 PAKISTAN	PARTICIPATE IN NATIONAL CDD WORKSHOP	SIMPSON, R.	07/06/89	07/07/89	07/14/89	USAID PAKISTAN
SUP	057 PAKISTAN	DEVELOP TALKING W/ MOTHERS VIDEO	AZIZ, F.	07/12/89	08/01/89	10/31/89	USAID PAKISTAN
SUP	062 PAKISTAN	PROMOTE BREASTFEEDING	JELLIFFE, D. JELLIFFE, E.	08/11/89	08/28/89	09/02/89	USAID PAKISTAN
* -----COUNTRY: PHILIPPINES							
FOS	006 PHILIPPINES	FIELD OFFICE SUPPORT		02/13/89	12/01/88	11/30/89	USAID PHIL.
STP	010 PHILIPPINES	STRATEGY IMPLEMENTATION COUNTRY REPRESENTATIVE	ALT, D.	10/26/88	09/17/88	11/10/88	CENTRAL FUNDS
SUP	003 PHILIPPINES	PRITECH COUNTRY REP.	ALT, D.	11/11/88	11/10/88	11/24/88	CENTRAL FUNDS
SUP	009 PHILIPPINES	ATTEND ORT WORKSHOP (PHIL. PED. SOC.)	PIZARRO, D.	11/02/88	11/22/88	11/30/88	CENTRAL FUNDS
SUP	021 PHILIPPINES	PRITECH COUNTRY REP.	ALT, D.	02/13/89	12/01/88	12/31/90	USAID PHIL.
SUP	026 PHILIPPINES	PRIVATE SECTOR PROMOTION	SAADE, C.	02/16/89	02/22/89	09/30/89	USAID PHIL.
SUP	036 PHILIPPINES	DESIGN INFO. CENTER TRAIN STAFF	BRACE, J. AMT, B.	04/19/89	04/24/89	08/20/89	USAID PHIL.

16

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
* -----COUNTRY: TUNISIA							
STP	007 TUNISIA	STRATEGY ASSESSMENT	PRINS, A. SAADE, C. LEBOW, R. PURVES, M.D.	10/14/88	11/03/88	11/17/88	CENTRAL FUNDS

198

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSM DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
** -----REGION: INTERREGIONAL							
* -----COUNTRY: INTERREGIONAL							
ADG	001 INTERREGIONAL	ASSIST WHO MEDED TEAM	NORTHROP, R.	09/19/88	10/16/88	09/30/89	CENTRAL FUNDS
COM	001 INTERREGIONAL	PREPARE FOR PRITECH CONFERENCE	CAI CARP, C. CURLIN, P.	01/22/88	01/01/88	01/25/88	CENTRAL FUNDS
COM	002 INTERREGIONAL	ICORT III LOGISTICS RESEARCH	CAI: DAVIS LOCKETT	03/31/88	03/20/88	03/31/88	CENTRAL FUNDS
COM	003 INTERREGIONAL	PRITECH PART. IN ICORT III: PAPERS, LUNCHEON, ETC.	HERMAN, E. HARDING, M. MARX, M. NORTHROP, R. FERAZ-TABOR, L. PRYSOR-JONES, S.	10/28/88	10/26/88	12/17/88	CENTRAL FUNDS
COM	005 INTERREGIONAL	APHA CONF.	MARX, M. CASAZZA, L. FREUND, P. FRY, S.	08/25/89	10/23/89	/ /	CENTRAL FUNDS
INF	001 INTERREGIONAL	INFORMATION CENTER	WHITE, K. BRACE, J. AMT, B. KOSTINKO, G.	04/13/89	09/01/88	09/30/90	CENTRAL FUNDS
INF	002 INTERREGIONAL	TRANSLATION OF TLU		05/31/89	05/01/89	08/31/89	CENTRAL FUNDS

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
RAD 001	INTERREGIONAL	WRITE PRITECH II CONFERENCE REPORTS	TWENTY CONSULTANTS	01/22/88	11/20/87	01/25/88	CENTRAL FUNDS
RAD 002	INTERREGIONAL	DEVELOP PAHO/HEALTHCOM VIDEO	FRY, S. BLUM, D. NORTHRUP, R.	03/01/88	12/01/87	12/31/87	CENTRAL FUNDS
RAD 003	INTERREGIONAL	PREPARE ORS PROTOCOLS	TOMARO, J. TSU, V. ELLIOT, T. FIELDS, R.	04/08/88	04/01/88	04/30/88	CENTRAL FUNDS
RAD 004	INTERREGIONAL	PRODUCE FINAL STRATEGY PAPERS	ROBERTS, R. FRY, S. HERMAN, E.	07/27/88	08/01/88	03/31/89	CENTRAL FUNDS
RAD 005	INTERREGIONAL	PREPARE PRITECH II EVAL. CRITERIA	ALDEN, J.	04/07/89	04/19/89	04/26/89	CENTRAL FUNDS
RAD 006	INTERREGIONAL	PREPARE MEDED CHRONOLOGY	FRY, S.	02/14/89	02/10/89	02/12/89	CENTRAL FUNDS
RAD 008	INTERREGIONAL	REVIEW COD DOCUMENTS	HERMAN, E.	04/14/89	04/01/89	04/30/89	CENTRAL FUNDS
RAD 009	INTERREGIONAL	ORIENTATION AT PRITECH	CASAZZA, L.	04/10/89	04/10/89	04/17/89	CENTRAL FUNDS
RAD 010	INTERREGIONAL	REVIEW SUPERVISORY MINI MODULES	FRY, S.	04/14/89	04/20/89	04/27/89	CENTRAL FUNDS
RAD 011	INTERREGIONAL	RESOURCE PERSON FOR CHILD SURV. CONF.	HUFFMAN, S.	01/23/89	08/01/88	08/04/88	CENTRAL FUNDS

1/20

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
RAD 012	INTERREGIONAL	PREPARE IEC PAPER	FRY, S.	05/01/89	05/08/89	05/15/89	CENTRAL FUNDS
RAD 013	INTERREGIONAL	REVIEW/EDIT TECH. DOCUMENTS	HERMAN, E.	05/03/89	05/08/89	06/30/89	CENTRAL FUNDS
RAD 014	INTERREGIONAL	REVIEW PPSS PROPOSALS	ROBERTS, R.	05/03/89	05/08/89	09/01/89	CENTRAL FUNDS
RAD 021	INTERREGIONAL	REVIEW INFANT MORTALITY DOCUMENT	DESMOND, K.	07/05/89	07/05/89	07/31/89	CENTRAL FUNDS
SPM 005	INTERREGIONAL	REVIEW FIELDNOTES	FABRICANT, S. LEBOW, R. ROBERTS, R. ROHDE, J. SALMONSSON, S.	03/06/89	03/01/89	12/31/89	CENTRAL FUNDS

141

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
** -----REGION: LATIN AMERICA							
* -----COUNTRY: BOLIVIA							
ICP	004 BOLIVIA	RESOURCE PERSONS FOR PVO SECRETARIAT	AGUILAR, A. MARTINEZ, S.	11/08/88	10/01/88	09/30/89	CENTRAL FUNDS
ICP	027 BOLIVIA	ATTEND PVO WORK. IN COLUMBIA		06/06/89	07/24/89	07/31/89	CENTRAL FUNDS
ICP	030 BOLIVIA	SUPERVISORY/ PLANNING VISIT	MARX, M. SPAIN, P.	09/11/89	10/08/89	10/15/89	CENTRAL FUNDS
* -----COUNTRY: COSTA RICA							
COM	006 COSTA RICA	ATTEND PED. CONF.	LEVINE, M.	08/23/89	09/16/89	09/20/89	CENTRAL FUNDS
* -----COUNTRY: GUATEMALA							
ACP	001 GUATEMALA	ASSESS INFORMATION CENTER	WHITE, K.	06/13/88	06/21/88	06/25/88	CENTRAL FUNDS
ACP	002 GUATEMALA	REVIEW DIARRHEA EPIDEMIOLOGY	KEUSCH, G.	08/11/88	08/07/88	08/11/88	CENTRAL FUNDS
ACP	003 GUATEMALA	T.A. TO INCAP EDUC/TRAIN.	BROWN, R.	06/23/88	07/11/88	08/08/88	CENTRAL FUNDS
ACP	004 GUATEMALA	DIETARY MAN. OF DIARRHEA	BROWN, K.	07/08/88	08/01/88	08/09/88	CENTRAL FUNDS
ACP	006 GUATEMALA	STUDY ON PERSISTENT DIARRHEA	BURLEIGH, E.	01/09/89	07/25/89	08/14/89	CENTRAL FUNDS

142

PRITECH II DISEASE CONTROL
ASSIGNMENT REPORT BY REGION AND COUNTRY

SEPTEMBER 30, 1989

TYPE	COUNTRY	DESCRIPTION	CONSULTANTS	TASK ASSN DATE	STARTING DATE	ENDING DATE	FUNDING SOURCE
* ----- COUNTRY: MEXICO							
CON	004 MEXICO	ATTEND PED. CONF.	SALAZAR-LINDO	08/16/89	08/21/89	08/28/89	CENTRAL FUNDS
SPM	001 MEXICO	DISCUSSIONS CON. PRITECH II FUNDING	SPAIN, P.	11/30/88	12/05/88	12/09/88	CENTRAL FUNDS
STP	014 MEXICO	DISCUSSIONS W/MCH OFFICIALS	TOMARO, J. SPAIN, P.	04/10/89	04/17/89	02/10/90	CENTRAL FUNDS
STP	015 MEXICO	IMPLEMENT PRITECH II	MONTERO, M.	04/19/89	04/01/89	12/31/89	CENTRAL FUNDS
STP	017 MEXICO	ATTEND MOH PLANNING MEETING	QUAIN, E.	06/09/89	05/31/89	06/05/89	CENTRAL FUNDS

192

PRITECH II
Level of Effort

	<u>Category</u>	<u>Person Months</u>		<u>Totals</u>
		<u>PY1</u>	<u>PY2</u>	
I.	<u>Program Development</u>			
	Promotional	.03	.90	.93
	Strategy	4.01	33.35	37.36
II.	<u>Country Programs</u>			
	Sustained	--	147.68	147.68
	Intermittent	--	68.14	68.14
	Ad Hoc	1.24	1.86	3.10
	Supervision/ Proj. Mgt	--	1.30	1.30
	Evaluation Country Program	--	--	--
III.	<u>Health Systems Support</u>	16.32	64.54	80.86
IV.	<u>Information Services</u>			
	Information Center	--	10.57	10.57
	Conferences - Sponsored	--	--	--
	Supported	--	9.99	9.99
V.	<u>Research and Development</u>	4.64	8.20	12.84
VI.	<u>Advisory Groups</u>	--	.75	.75
VII.	<u>Management</u>	40.72	98.32	139.04
	TOTAL	66.96	445.60	512.56

144

APPENDIX 2

PRITECH II

Project Expenditures

<u>Category</u>	<u>PY1</u>	<u>PY2</u>	<u>TOTALS</u>
I. <u>Program Development</u>			
Promotional	\$ 309.05	\$ 14,565.39	\$ 414,874.44
Strategy	24,230.13	313,724.01	337,954.14
II. <u>Country Programs</u>			
Sustained	20.00	1,666,214.23	1,666,234.23
Intermittent	7,092.20	314,540.79	321,632.99
Ad Hoc	14,974.17	21,883.45	36,857.62
Supervision/Proj. Mgt	-0-	29,931.40	29,931.40
Evaluation Country	-0-	-0-	-0-
Program			
III. <u>Health Systems</u>	115,353.63	730,629.55	845,983.18
<u>Support</u>			
IV. <u>Information Services</u>			
Information Center	-0-	166,796.74	166,796.74
Conferences -			
Sponsored	-0-	-0-	-0-
Supported	126,061.56	79,596.17	205,657.73
V. <u>Research and</u>	61,189.75	52,143.32	113,333.07
<u>Development</u>			
VI. <u>Advisory Groups</u>	-0-	15,446.46	15,446.46
VII. <u>Management</u>	552,074.61	1,771,636.55	2,323,711.16
TOTAL	901,305.10	5,177,108.06	6,078,413.16

DRAFT

**PRITECH II WORKPLAN
PROGRAM YEAR THREE
October 1989 - September 1990**

**By:
The PRITECH Project
Management Sciences for Health
1925 N. Lynn Street
Suite 400
Arlington, VA 22209**

**Contract No: DPE-5969-Z-00-7064-00
Project No: 936-5969**

146

**PRITECH II WORKPLAN
Program Year Three
October 1989 - September 1990**

TABLE OF CONTENTS

	<u>Page</u>
I. INTRODUCTION AND OVERVIEW	1
II. COUNTRY PROGRAMS	6
Table: PRITECH II Country Programs -- Estimated Expenditures (PY3)	11
Table: PRITECH II Workplan FY 1990/PY3 Promotional & Strategy	12
III. HEALTH SYSTEMS SUPPORT	28
IV. RESEARCH & DEVELOPMENT	33
V. MANAGEMENT	47
ANNEXES:	
Annex I PRITECH II PY3 Workplan Budget (Estimated Expenditures)	50
Annex II Principal Activities by Quarter	51
Annex III PRITECH II Workplan (FY 1990:PY3)	52
Annex IV Project Personnel (Professional)	55
Annex V Project Structure and Personnel	56
Annex VI Management Reports	59

147

ANNUAL PRITECH WORKPLAN

THIRD PROGRAM YEAR

I. INTRODUCTION AND OVERVIEW

This workplan for the third program year (PY3) is organized into five main sections: this Introduction and Overview, then Country Programs, Health Systems Support, Research and Development, and finally Management. The annexes include a summary of principal activities by quarter (Annex II). The estimate of total spending in PY3 (Annex I) is \$5.6 million; however, this estimate may be low considering that last year's program operations accelerated much more quickly than expected.

During the first two project years of the PRITECH II contract, PRITECH's program has concentrated on strengthening the Ministry of Health based CDD programs, continuing efforts that A.I.D. and PRITECH began during PRITECH I.

The 16 PRITECH I programs that have continued under PRITECH II have followed three tracks. For a few countries, PRITECH's support for Ministry of Health (MOH) based CDD activities are being assumed by technical assistance teams funded under bilateral projects. Indonesia, the Philippines, Nigeria and Pakistan are examples of countries where PRITECH's MOH based CDD activities are already or soon to be a part of a USAID bilateral program. In most countries, however, PRITECH has been requested to continue direct technical assistance usually with full mission funding or with a mix of support from the missions and S&T. The Sahel, Kenya and Cameroon are examples of programs where PRITECH has been asked to continue to provide technical assistance with either full mission funding or a mix of mission and S&T support. In a few additional countries, continued S&T support has been required because bilateral funds are not available: Mexico, Zambia and Mauritania are examples.

PRITECH continues to feel that the MOH-based CDD activities are the core of country programs. It is here that national policies and plans are made, case management standards are developed, and national training capacities are institutionalized. The leadership and continued support of Ministries of Health is crucial to establishing and sustaining country programs. PRITECH will therefore continue to concentrate the bulk of its efforts to strengthening these activities. In addition to broad case management support PRITECH plans to launch with S&T funds focused country-based activities that will break program bottlenecks and improve the overall technical quality of these country programs.

PRITECH also recognizes that no country can rely on the Ministry of Health as the exclusive resource for establishing and sustaining the national CDD program. MOH services often reach only a limited percentage of the population. With MOH budgets largely frozen, there is little prospect that public sector funding will be available to enlarge this coverage. As new national health priorities emerge, CDD will have to compete with other meritorious programs for these limited resources. National CDD programs will have to effectively engage the private sector to both achieve program coverage goals and establish the institutional base through which this national coverage will be sustained. PRITECH plans to assist national programs to engage the multiple components of the private sector, developing new programs with S&T funds.

National programs also need to exploit the constructive linkages between CDD and other primary health care preventive and curative services. These include breastfeeding and nutrition, water and sanitation, measles immunization, ARI and malaria. The program challenge is to establish linkages that enhance the quality and effectiveness of CDD without seriously diluting the capacity to deliver effective CDD services. PRITECH will continue to work with WHO and USAID Missions in identifying opportunities for establishing appropriate CDD-ARI linkages.

PRITECH's financial reporting systems to track the multiple program "buy-ins" have not been adequate. With the new reporting systems now in place PRITECH will be able to improve the quality and timeliness of these documents.

For PY3 PRITECH's program plan gives top priority to strengthening the MOH-based CDD activities; this is the starting point. Without the foundation of a comprehensive national CDD program well-supported by the MOH, PRITECH has found it is difficult to mobilize effective programs with organizations and resources outside the MOH. As the MOH programs become effective, other opportunities can be explored and pursued. The following four initiatives are based on this strategy.

A. Improvement of the Technical Quality of Country Programs.

Within the public health sector, a key responsibility of PRITECH is to assist national CDD programs in two principal areas: to assure the highest attainable quality of technical performance and to assure the greatest possible reach of services by the public sector. In every CDD program, as activities expand to national scale, the means of maintaining quality are severely challenged; problems soon appear in the clinical and home management of diarrheal disease cases. Drawing upon the lessons emerging from its country programs, PRITECH has identified ways to improve the effectiveness of CDD programs.

For example, changing diarrheal disease treatment practices among a country's physician is usually slow and arduous. PRITECH has found that gaining the commitment of a critical mass of key practicing physicians speeds the process. Giving groups of influential practicing physician/hands-on clinical training improves case management not only because of what they learn through direct experience, but because of the encouragement and support they then give to their colleagues. This critical mass approach also works when trying to change hospital breast-feeding practices. Other ways to speed changes in treatment practices include improvement in teaching of training methods. Follow-up supervision to assure use of good methods also reinforces improved case management performance of health practitioners.

Another area of weakness in many national programs is the supply of ORS. Poor management of drug supplies has been improved by a computer based program (ORSMAP) which helps a country manager determine current prescribing practices and monitor current management of ORS supplies. Information which ORSMAP provides about prescription of inappropriate, costly and often harmful, anti-diarrheal drugs can lead to work with policy makers in changing national drug policies.

PRITECH staff have identified these and other approaches which improve the effectiveness of CDD programs. The next steps are to transfer the lessons to other countries and to adapt the approach to the particular country situation. The technical unit staff in headquarters and the Senior Program Managers in the field are jointly identifying opportunities to transfer and to implement these innovative approaches.

B. Making Connections with Other Primary Health Services: Moving Beyond CDD.

Children brought to clinics with diarrhea frequently have other health problems: malnutrition, acute respiratory disease, malaria, lack of immunization. Limiting case management to only ORT can prevent death from dehydration, but the child may still die of pneumonia, or by being malnourished die of measles. The case management approach has been shown to be successful in preventing death from diarrhea in the health facility setting. PRITECH sees an opportunity to deal with other health symptoms by augmenting the practitioner's armamentarium. This would be done only where there is an established CDD case management program, and would entail adding new modules to training, particularly in refresher training. Modules have been developed by WHO for ARI, are being nutritional interventions and for malaria.

PRITECH will also explore connections with ARI programs this year, and perhaps with malaria in the future; the approach will be based upon broadening case management to concern for the sick

child presenting symptoms of dehydration, fever or cough. WHO is already making the connection operational between CDD and ARI; training materials for program managers are now ready. Joint management of the CDD and ARI programs in The Gambia will give us experience with the costs and benefits of combined programs.

C. New Initiatives in the Private Sector: Going Beyond the Ministry of Health.

In most of the countries where PRITECH is working, for example, Mali and Pakistan, government health services reach fewer than 25% of the population. In hardly any country will these services reach more than half the population. In Zambia, half the rural population may have access to health services, but most of these services come from church sponsored hospitals; the government health system is almost completely dependent on foreign physicians. Thus far, PRITECH has concentrated on national CDD programs managed by Ministries of Health. Establishing ORT in these public health systems is an essential first step: providing the policies and political support which are the bases for nationwide programs, and getting the influential public health professionals to adopt ORT practices. Even fully successful programs which mobilize all the resources of the MOH are nevertheless limited by the reach of these public systems. Most families, and perhaps those families whose remote location or low income place children at higher risk, will not be reached by these programs. PRITECH is organizing new approaches which can go beyond the reach of government services -- to increase access -- and which do not depend on government funding -- to increase sustainability.

The list of groups outside the MOH who can participate in the CDD effort is long: private physicians and their professional associations, private pharmacists and their professional associations, pharmaceutical companies and their detailmen, retail distributors and sellers who handle over-the-counter medical products, private clinical facilities often supported by religious groups or by companies, urban health services, community-based health services such as mothers clubs, traditional healers and their supporting organizations, primary schools and other educational systems. PRITECH has carried out programs which involve some of these groups, especially in the commercial private sector: physicians' professional associations in India, pharmaceutical firms in Pakistan, PVOs in Bolivia. This experience will be used in designing new activities as part of country programs. PRITECH will explore the likelihood of success of a conference of organized traditional healers. The objective would be to attempt to use organizational methods to gain acceptance of a simple technology such as ORS (ORT) into the practices of the traditionalists. A feasibility study will be conducted to determine past experiences with such a method, and to determine how to structure a conference or other appropriate

activities for the next program year. It is likewise important to increase the involvement of the private physicians in the appropriate management of diarrheal disease. The experience in India has shown that organized medicine will participate in educational efforts around ORT; the International Academy of Pediatrics has adopted a favorable position on ORT. Planning will begin for an international conference aimed at developing methods to increase the use of ORT and decrease the inappropriate use of antidiarrheals and antibiotics. Bilateral funds which require host government approval are not easily directed toward private sector programs, particularly at initial stages. Allocations of Regional Bureau and S&T/Health funds will be needed.

D. Establishing Program Activity in Eastern and Central Africa

Demographic projections make clear that the numbers of African children who fail to survive are growing rapidly each year, and begin to rival Asia's child mortality toll. A.I.D.'s African programs, with a primary focus on food production, have given lower priority to child survival programs: despite a 16% increase from FY 1987 in overall funds, the FY 1990 budget for child survival activities proposed by the Bureau is below the FY 1987 level. The Africa Bureau's requested budget for ORT programs in FY 1990 has dropped 22% below the actual budget in FY 1985. Under the contract, PRITECH's first regional priority is Africa; this priority is contradicted by the Africa Bureau's inability to devote more staff and funding to the health sector and child survival programs. For diarrheal disease, the Sahelian country programs are a notable exception. We believe that PRITECH's programs in the Sahel demonstrate that a relatively low-cost investment by the Africa Bureau can significantly improve national health programs with modest demands on Mission staff. Moreover, PRITECH's Sahel programs demonstrate how to mobilize and to make more effective the contributions of other donors. We offer the same effective program model for other African countries. We have comprehensive programs underway in Kenya and the Cameroon, mainly funded by the Missions, and in Zambia, funded by S&T/Health. We need funding and more positive support from the Africa Bureau. During the coming year, we will strengthen our efforts to present program opportunities to Missions and Bureau staff in Africa.

E. Improvement of Financial Reporting and Analysis

A.I.D. Bureaus and Missions need regular reports on the status of buy-ins. PRITECH needs current information on rates of spending for program activities and the costs of management. PRITECH financial reporting has not been able to keep up with the growing complexity of the program and the financial mechanisms

required under the contract. During the year, there will be a substantial improvement in the quality and timeliness of financial information available to project staff and A.I.D.

II. COUNTRY PROGRAMS

A. Introduction

At the end of PY2, PRITECH had 11 sustained and five intermittent country programs; the contract provides for an additional six to twelve programs. Of the 16 approved programs, twelve have all or most of the funds provided from "buy-ins", from Regional Bureaus or Missions. In fact, 80% of the funds already provided for country programs, including the African regional programs, come from "buy-ins." During PY3, PRITECH is planning 19 promotional/strategy visits; however, it will be increasingly difficult to secure buy-ins for traditional MOH based country programs. The reasons for this difficulty vary by region. In Asia, most of PRITECH's long-term technical assistance responsibilities to the public sector programs are being assumed by mission funded child survival bilaterals. In Africa, PRITECH has received more than \$5 million from the Regional Bureau and the Missions, mainly for the Sahel programs plus Kenya; PRITECH has demonstrated that effective programs can be carried out at relatively low cost to A.I.D., and with modest demands on the management capacity of Missions. Beyond the Sahel, however, most African USAID Missions are not ready to sponsor PRITECH assistance to a national CDD program; most of these Missions are cautious about taking on the challenges of the health sector. In Latin America and the Caribbean, A.I.D.'s bilateral programs for CDD have relied mainly on ad hoc assistance from PRITECH, or on Systems Support. Only Mexico, where there is no bilateral health program, has needed a planned PRITECH effort to assist the public sector CDD program.

In the future, therefore, the needs for PRITECH assistance are likely to be in the following three categories:

- national public sector CDD programs, mainly in Africa, where PRITECH can strengthen service delivery through comprehensive activities -- such as in the Sahel;
- public sector CDD programs which PRITECH can strengthen with selective, focused activities which, in the future, may lead to comprehensive national programs -- such as work on ORS supply or mobilizing traditional healers;
- private sector activities which can extend services beyond the reach of the public health system, with better prospects for being sustained. These activities would be for both commercial and non-profit organizations.

The first category is being funded mainly by existing buy-ins. The second category, primarily for central and eastern African countries, will initially depend upon S&T/Health funds, potentially leading to buy-ins. Where Missions are reluctant to become involved directly with CDD programs, UNICEF may be able to provide interim sponsorship. If the Sahel experience applies elsewhere, Missions may be better able to support specific health programs after gaining confidence from well-focused PRITECH activities financed outside the bilateral program. The third category requires innovative activities with private organizations which host governments are often reluctant to support financially, even with bilateral A.I.D. funds; Regional Bureau or S&T/Health funds will be essential to start private sector activities. PRITECH will give attention initially to private sector opportunities in the ANE and LAC Regions.

The workload involved with each of the three categories of programs is substantial. The burden of the first category falls mainly on the resident field staff. Countries in the second category -- needing organization and design of selective, focused activities -- will require intensive cooperation between the technical staff in Washington and senior managers in the field, especially for central and eastern Africa. Most of this year's 19 promotional/strategy visits will involve innovative program approaches, placing heavy demands on the creative energies of the technical staff. We will try to set up activities which can be carried out in more than one country and managed regionally -- for example, assistance to organizations of traditional healers. Private sector activities, which take PRITECH into uncharted areas, will similarly require cooperation between our innovators in Washington and the field. The management implications will be further discussed in Section V.

B. General Objectives for Country Programs

1. Improve the technical content of national CDD programs by enhancing case management of diarrhea in clinics and homes.
2. Institutionalize ORT program activities and strengthen management of CDD programs.
3. Stimulate supply of ORS and ORT services from the private sector, including both commercial and non-profit organizations.

C. Strategy for Program Year Three (FY3)

1. Strengthening PRITECH Country Program Management

The second year of PRITECH II concentrated on consolidating sustained country program activities;

this will continue in PY3 using the same country management model: a PRITECH representative resident in-country, supervised and directed by a Senior Program Manager, all supported by the technical and management staff of PRITECH/Washington. We have seen in PY2 the importance of PRITECH in-country managers who work closely with the Ministries of Health to help implement the national CDD program, in particular in those situations where manpower and financial resources are scarce. The PRITECH representative has a primarily management role assisting the MOH CDD program--a role that is growing in responsibility as more sophisticated and complex workplans and schedules for implementation are developed and followed. We are mindful of the danger of the representative being expected to play too central a role in the functioning of the CDD country program team, especially if there is no full-time operational counterpart or national CDD program manager.

The Senior Program Manager (SPM) is responsible for identifying emerging technical issues that require resolution. We are promoting more collaboration between the field staff and the technical staff in Washington; this collaboration is focused on identifying key program problems and seeking operational solutions. The SPMs will take the lead in identifying bottlenecks by urging re-examination of strategies, e.g., by supporting health facility surveys in the Sahel, the KAP studies in Cameroon, operations research studies in Zambia and Kenya, and assessment with WHO of the diarrhea training units in Pakistan. The Research and Development activities described in the next section will contribute to operational solutions.

Bearing in mind the increasing and expanding responsibilities of the PRITECH field staff, in PY3 we are planning to reinforce and supplement our staff where permitted and necessary. In Pakistan, in PY3 we will hire a Program Officer to work with our Country Representative, recognizing that the size and complexity of the program require extensive administrative and technical assistance from PRITECH. In addition, in PY3 we will recruit a Senior Program Manager to take responsibility for our programs in both Pakistan and Kenya; this person, who will be based in Washington, may have additional responsibilities for PRITECH's private sector initiatives.

2. Strengthening Case Management in Country Programs

Case management policy and practice is the foundation for country programs. Often countries lack case management experts who can improve national CDD programs' capabilities to enhance case management in both clinics and homes. PRITECH is building up its case management expertise in Washington and regionally. The two physicians resident in Washington will take responsibility for technical relevance and quality of all the country programs. Regarding the programs in Africa, however, PRITECH believes these countries also need case management experts resident in the respective regions. PRITECH has been negotiating with WHO's CDD Program for the appointment of a case management expert to be resident in the Sahel; the candidate has been working in the Sahel as a PRITECH consultant during PY2 and his permanent WHO appointment is expected in PY3. He will probably be resident in Mali and take technical responsibility for the six PRITECH interventions in the Sahel. PRITECH will pay his travel and per diem. The appointment of a technical expert for central and eastern Africa will depend on the progress of the PRITECH East Africa initiative in PY3.

3. Eastern and Central Africa

The East Africa initiative started in PY2 with approval of the PRITECH plan by A.I.D. and the appointment of the Regional Officer/Senior Program Manager and her establishment in Kenya. In PY2 the Regional Officer made exploratory visits to Malawi and Uganda at the invitation of the missions and expects to develop program plans for both countries in PY3. The Regional Officer also visited Sudan twice in PY2 and, in collaboration with the Ministry of Health, developed a plan of assistance including the appointment of a PRITECH representative. This initiative is currently on hold due to Brooke Amendment constraints and the change of government in the Sudan. The Regional Officer will visit Madagascar in PY3, following-up on the recommendations of UNICEF for possible areas for PRITECH assistance to the national program. Other promotional visits are scheduled for Rwanda, Mozambique, Ghana, and Zimbabwe. Unfortunately, we are finding that although missions in East Africa may be supportive of our plans to assist the national CDD programs, they often lack funds for health activities.

4. Private Sector

In PY3 PRITECH will give greater attention to expanding our operations beyond the purview of the Ministries of Health. Washington and field staff will collaborate in identifying opportunities in the private sector, including commercial and non-profit organizations. We hope to enlist private commercial resources in production or importation of ORS packets, and to expand ORS distribution through commercial channels. Private sector marketing capabilities increasingly can be used to generate consumer demand. For example, in PY2 PRITECH assistance in Pakistan and with the HEALTHCOM program in the Philippines included the following activities to support the ORS commercialization effort: an analysis of the commercialization issues and an assessment of the alternatives on pricing, product segmentation, brand name and distribution channels; development of an implementation plan to explore existing marketing opportunities and to develop new ones; development of specific marketing strategies and action plans involving selected companies; provision of technical support for implementing various strategies such as seminars on sales force strategy and training, advertising strategies, market research, and marketing planning. In addition, we will continue to assist non-profit organizations to integrate the ORT message and the supply of ORS packets in their health-related activities. PRITECH expertise will be used in PY3 to assist other receptive countries to develop private sector strategies.

The following sub-section, beginning with estimated costs for country programs and promotional visits, discusses country programs individually:

**PRITECH II
COUNTRY PROGRAMS--ESTIMATED EXPENDITURES**

PY3

	\$
Burkina Faso	100,000
Bolivia	70,000
Cameroon	160,000
East Africa Regional	70,000
Gambia	40,000
INCAP	20,000
Kenya	175,000
Mali	200,000
Mexico	25,000
Mauritania	40,000
Niger	130,000
ORANA	100,000
Pakistan	450,000
Philippines	200,000
Sahel Regional	225,000
Senegal	50,000
Zambia	100,000
	=====
Total	2,270,000
Sustained	1,440,000
Intermittent	400,000
Ad hoc	20,000
Regional	295,000
Promotion/Strategy	115,000

152

**PRITECH II WORKPLAN
FY 1990/PY3
PROMOTIONAL & STRATEGY VISITS**

<u>COUNTRY</u>	<u>BUDGET</u>
Second Quarter (Jan-Mar 1990)	
Madagascar	5,000
Uganda	10,000
Bangladesh	2,000
Turkey	10,000
Mexico	3,000
Third Quarter (Apr-Jun 1990)	
Ghana	7,000
Malawi	5,000
Mozambique	6,000
Rwanda	3,000
India	15,000
Philippines	7,000
Guatemala	4,000
Honduras	4,000
Fourth Quarter (Jul-Sep 1990)	
Ethiopia	6,000
WHO/AFRO & Zaire	3,000
Zimbabwe	10,000
Egypt	4,000
Indonesia	5,000
Nigeria	<u>6,000</u>
Total Budget	115,000

BOLIVIA:

A four-year PRITECH program budgeted at \$361,000 was approved in October 1988 by S&T/H. PRITECH's role in Bolivia, defined over the past year, is responsive to a set of opportunities unique to Bolivia. With the creation of the PVO Secretariat by USAID and the conclusion of the PRITECH I agreement between PRITECH and Caritas, PRITECH was able to offer the services of its Bolivian professionals to the Secretariat. These two technical people, one a pediatrician and the other a communications expert, have been available to all member PVOs, providing technical expertise that no individual PVO had on staff.

In PY3, PRITECH will be reviewing this arrangement. While the Secretariat addresses the full gamut of child-survival issues, PRITECH's abilities to contribute are greatest in the CDD portion of the PVOs' work and we want to ensure that those abilities are being called upon fully. In addition, the PRITECH pediatrician has been serving as a liaison with the government's MCH service program, acting as a technical resource and allowing the PVOs to tailor their activities to complement those of the MOH. As in most developing countries, the MOH in Bolivia is unable to provide service to the majority of the population; PVO services are essential to attaining fuller coverage. A major goal of PRITECH in the coming year is to advance the collaboration between MOH and PVOs so that adequate, up-to-date services are available as widely as possible in Bolivia.

BURKINA FASO:

Approved by S&T/Health on June 5, 1989, the program plan for Burkina Faso authorizes PRITECH to spend up to \$400,000 over four years to support a part-time resident adviser and other technical assistance. PRITECH assists the national CDD program through work in four provinces selected by the MOHSA on the basis of demonstrated interest and readiness to implement CDD activities. To date, a total of \$210,000 has been provided to PRITECH through Mission buy-ins for the implementation of activities described in the program plan. A portion of this total was channelled to the MOHSA through a one-year sub-agreement for the funding of local costs associated with training activities.

Organizing and carrying out that training for 325 periphery level health workers was the primary focus of PRITECH assistance in PY2. PRITECH also participated in a national workshop on CDD program planning; supported a study of ORS stock levels and usage in the four targeted provinces; designed, tested, and produced educational materials in three of the national languages spoken in those provinces, and purchased scales for use in 50 ORT corners for health facilities in those areas.

In PY3, PRITECH will continue to assist the national CDD program to:

- train health care providers, including village health workers;
- supervise those health care workers who have already been trained;
- establish ORT corners;
- print and distribute CDD supervisory, reporting and case management forms and educational guides;
- increase attention to nutritional status of children with diarrhea;
- present recommendations to the MOHSA on ORS policy and management.

It should be noted that the national CDD coordinator's position has been vacant for almost a year. Because the demands for contributions to the national CDD program by the PRITECH resident advisor have exceeded expectations, the status of the resident advisor will be changed from part-time to full-time. As this arrangement had not been considered at the time the original four-year budget was estimated, the budget may have to be adjusted to accommodate a full-time advisor.

CAMEROON:

PRITECH II activities in Cameroon have been funded since November 1988 with a buy-in from the Africa Bureau initially for \$250,000 but recently increased by \$47,000. These buy-ins will fund approximately two years' activities through PY3. Funding for PY4 and PY5 will be required.

Assisted by a full-time PRITECH country representative since 1987, the Cameroon CDD program has been characterized by strong multi-sectoral collaboration among the Ministry of Health, many donors, several other ministries, and both public and private sector institutions. This proactive partnership has resulted in many important accomplishments for the program over the past two years: the creation and training of a national team of CDD trainers, the creation of regional Diarrhea Training Units in all provinces, and the finalization of a comprehensive national policy and strategy document during FY1988; the completion of an extensive socio-cultural study, the training of regional

personnel in the design and implementation of CDD communications activities, and the development of a national communications strategy for CDD in FY1989. These have been the most important achievements of PY2.

To solidify and build on this progress, PRITECH will continue to work with the Ministry of Health and its many CDD partners in all the major CDD components detailed in the National Strategy. PY3 will see:

- the full-scale implementation of the communications strategy in all ten provinces;
- the training of an estimated 500 health personnel in diarrheal disease case management;
- development of a comprehensive supervision approach and training of managers to implement this;
- continued efforts to improve ORS distribution in both public and private sectors;
- increased attention to CDD information and reporting systems;
- and perhaps most important, in line with Cameroon government policy, the continued integration of CDD with primary health care, especially at the service delivery level, will continue to be a top priority.

THE GAMBIA:

The program plan for The Gambia, approved by S&T/H on sustainability February 6, 1989, authorizes PRITECH to provide a total of up to \$200,000 to support short-term technical assistance and local costs over a four-year period. Exactly half of that amount has already been provided through a Mission buy-in. During PY2, these funds were used to support the development of a national workplan, as well as PRITECH's participation in both a case management workshop for heads of MCH clinics and a training course for teachers at pre-service training schools. In addition, PRITECH assisted in the development of strategies to increase access to ORS through the private sector, helped establish a community surveillance system, supported the design and production of educational materials for distribution and use throughout the health system and in primary schools, and oversaw the integration of PRITECH CDD training modules into the nursing and medical school curricula. PRITECH also facilitated the management and supervision of national CDD program activities by providing funding for the transportation of the national CDD coordinator to various field sites.

During PY3, PRITECH will continue to provide intermittent technical support, which will focus on:

- organizing oral rehydration units;
- monitoring the utilization of CDD modules in nursing and medical school curricula;
- designing, producing, and distributing revised IEC materials which will include messages on feeding;
- studying current health worker practices with regard to use of educational materials;
- developing strategies for improving health workers' utilization of educational materials;
- furthering discussions on drug distribution practices as they affect ORS distribution, and following up on the development of strategies to increase access to ORS through the private sector.

Given the severe constraints on government funding, PRITECH is giving special attention to the sustainability of this program.

It should also be noted that The Gambia has recently been chosen by WHO and UNICEF to be one of three countries worldwide in which the integration of CDD and ARI will be tried. PRITECH will work with donors to develop strategies designed to facilitate linkages between the two programs and will assess feasibility for such linkage in other PRITECH countries.

KENYA:

The Kenya intervention will be co-funded by S&T/H (up to \$488,000, approved April 1989) and USAID/Nairobi (\$567,000, PIO/T 615-0232-3-80075). In Kenya, during PRITECH I, emphasis was on communications and operations research. Now the government has asked PRITECH II to continue its communication work, but the rest of our portfolio is much more diffuse. Operations research will still be supported, but according to guidelines that ensure its direct and immediate value to the CDD program. The PRITECH II agreement has been fashioned to have PRITECH serve as a timely provider of support to the CDD program. Support will be provided according to the MOH's definition of its technical-assistance needs in any component of the program. As PY3 begins, a key CDD activity is the changeover to half-liter packets. PRITECH has already supported consultants and a study tour by Kenyan staff to address this issue, and will be responsive to further requests by the MOH.

Other areas that may benefit from technical assistance in PY3 are financial management, health information systems, and operations research design. The Kenyan experience with food-based ORS (uji) needs assessment. ORS sales by the private sector has received little attention so far, but the private companies have agreed to confine their output to half-liter sachets, giving the government (through PRITECH) an opportunity for widespread generic promotion of the new sachets. The Kenyan CDD team is energetic, but lacks experience. PRITECH is discussing the possibility of observation tours by key CDD program staff members to other countries whose national CDD programs contain components that deserve consideration by the Kenyans. Through JHU, PRITECH will also make available case-management experts to guide the Kenyan program as needed in its technical judgments.

MALI:

On February 6, 1989, S&T/H authorized PRITECH to conduct activities described in a four-year program plan. Funding of up to \$940,000 was approved. USAID/Bamako has already obligated a total of \$800,000 through two buy-ins to PRITECH. Support has been provided for a full-time resident advisor and for short-term technical assistance to the national CDD program in a number of areas.

In PY2, PRITECH worked with the program to set up and monitor five oral rehydration units in Bamako and in three regions; developed and distributed case management strategy papers; carried out a KAP study, and participated in technical committee meetings and general supervision. A PRITECH consultant trained the national pharmacy staff to prepare for ORS production, and another consultant assisted the program with the development of ORS promotional and marketing strategies. The PRITECH resident advisor, working as a member of the national CDD team, helped the team to become more self-reliant by developing their management skills.

Many of the activities which were successfully initiated in PY2 will be continued. PRITECH will assist the national CDD program to:

- set up two more oral rehydration units in regional health facilities;
- monitor case management practices in already established oral rehydration units;
- assess production capacity in relation to projected demand and recommend ways to increase capacity, if necessary;

- design and field-test mixing and use instructions for ORS packets;
- initiate and monitor the production of ORS packets at UMPP;
- train UMPP staff in marketing, distribution, and sales techniques;
- develop marketing and distribution strategies to make ORS packets available nationwide throughout public and commercial sectors;
- develop appropriate communication material aimed at mothers, prescribers, and retailers;
- complete analysis and distribute results of the Health Facility Survey and the KAP study;
- revise program strategies as appropriate, based on results of those studies.

In addition, PRITECH will continue to provide day-to-day program assistance as part of a strategy to increase the management capability of the CDD unit.

MAURITANIA:

On February 6, 1989, S&T/H approved the Mauritania program plan authorizing PRITECH to spend up to \$100,000 for short-term technical assistance in PY2. A total of \$50,000, which was allocated to PRITECH from S&T/H, has allowed for an evaluation of the national CDD program, the implementation of a Health Facility Survey and a five-region KAP study, as well as PRITECH's participation in the first national workshop for 25 regional CDD delegates and PHC supervisors. PRITECH also monitored the integration of its training modules into the nursing school curriculum and provided input into the development of national nutrition policies and strategies.

In addition to carrying out program-related activities, PRITECH helped identify sources of funding for the national CDD program, which, like many Sahelian programs, has very limited financial resources. During PY2, continued funding from UNICEF was uncertain due to its expressed preference for support of integrated PHC programs as opposed to vertical programs. PRITECH has since gained assurance from UNICEF that its support of CDD-related activities will continue.

During PY3, PRITECH will work with the national CDD program to:

- establish oral rehydration units at national and regional hospitals in six regions;
- revise educational materials and media spots based on results of the KAP, and monitor their production, distribution, and utilization;
- continue to define and follow-up on needs for training at regional and departmental levels;
- monitor the integration of CDD training modules into the curriculum at the public health school;
- study ORS stocks and distribution channels, and devise strategies for increasing access to ORS;
- strengthen nutrition activities by developing more specific workplans;
- identify additional sources of funding.

MEXICO:

In July 1988, following concurrence by A.I.D./Mexico, S&T/H approved a proposal for up to \$500,000 over the period of PRITECH II. PRITECH has concentrated on the training of public-sector health personnel in Mexico, complementing efforts of other donors in communications and ORS distribution. With a full-time representative serving both as catalyst and trainer, PRITECH has been able to contribute to extensive training coverage in the six states with the highest infant mortality rates (IMR) due to diarrhea. PRITECH has also teamed with HEALTHCOM to fund training for teams from all 31 of the Mexican states. Many of these teams have found resources to develop state-level training for their colleagues out to the peripheral primary-care facilities. Observations in our focus states reveal that proper case management is much more common at the periphery, but that hospitals continue to use intravenous therapy far more than needed. But even where IVs persist, the in-facility use of needless drugs has dropped.

For PY3, PRITECH is seeking to put into place a new agreement with the Secretariat of Health, for training programs in an additional six states, with high IMRs due to diarrhea. In addition, the new PRITECH agreement supports on-going supervision in the six original states to consolidate those gains. To address the basic problem of doctors' non-compliance with good diarrhea case management practice, PRITECH is supporting seminars for pediatrics professors. Influencing pre-service medical training is not easy in Mexico. Not because the universities are

autonomous --government has no direct role in the curriculum. Each pediatrics professor teaches his or her own course according to a syllabus he or she has designed subject to no review. Innovation comes slowly into a system like this. The purpose of the seminars is to influence these courses and eventually to make available the MEDIAC materials when WHO makes them available in Spanish.

The Secretary of Health is restructuring the administration of the national CDD program. Selection of a representative must await decisions about the administrative structure.

NIGER:

The Niger program plan, approved February 6, 1989, by S&T/H, provides for up to \$640,000 over a four-year period to support a full-time resident advisor and short-term technical assistance as required by the national CDD program. A total of \$610,000 has already been obligated to PRITECH through two Mission-funded buy-ins.

In addition to assisting with the day-to-day management of the national CDD program through the resident advisor who works alongside the national CDD coordinator, PRITECH provided short-term technical assistance in a number of areas during PY2. A Health Facility Survey was carried out, and regional CDD coordinators and CDD committee members met to discuss the preliminary results of that survey and to receive further training in CDD. Supervision trips were carried out to at least three regions, new case management forms were introduced and tested, and the program was convinced of the importance of setting up oral rehydration units in hospitals and large health centers. Other activities included a study of ORS packet stocks, distribution and sales, the initiation of efforts to develop ORS marketing strategies, and the design and testing of television spots, ORS packet instructions, and the CDD program logo.

In PY3, PRITECH plans to work with the national CDD program to expand upon many of the activities carried out in PY2, such as:

- carrying out regional supervision;
- setting up oral rehydration units;
- training health care personnel in all regions;
- finalizing and distributing the Health Facility Survey report;
- producing, evaluating, revising, and disseminating IEC materials, including the ORS packet instructions and radio

and television spots, throughout the regions as appropriate;

- improving ORS distribution channels and developing strategies for increasing demand;
- upgrading the national pharmacy's marketing, distribution, and promotion capabilities;
- increasing the management capability of the national CDD team.

ORANA:

The program plan for ORANA, a regional nutrition research institution located in Dakar, was approved June 5, 1989 by S&T/H. PRITECH will continue its support of ORANA's CDD-related activities for four years with funding of up to \$650,000 from the Africa Regional Bureau. ORANA, which is based in Senegal, has regional responsibilities.

A major activity at ORANA supported by PRITECH in PY2 was the gathering and dissemination of CDD-related information, which incorporated diarrhea-related nutrition issues. The main products are distribution of the French version of the Technical Literature Update (TLU) approximately ten times a year to 600 decision-makers as well as the translation of Diarrhea Dialogue into French and distributor of approximately 12,000 copies, four times each year to 20 Francophone countries.

To cover steadily expanding activities, PRITECH agreed, along with UNICEF and Helen Keller International, to contribute to the funding of an assistant documentalist who will work on PRITECH-related activities at the Information Center on a half-time basis. PRITECH also funded up to 60% of the salary of Dr. Makane Kane, who is charged with the implementation of PPSS and operations research studies in the Sahel country programs. Another major undertaking carried out under ORANA during PY2 was the finalization and publication of a reference document which compiles CDD-related statistics for all the Sahel countries in which PRITECH works. Yet another document published and distributed by ORANA was a technical chart on etiologies and treatment of diarrhea in the Sahel.

During PY3, PRITECH will continue to:

- support ORANA Information Center operations and personnel;
- distribute the Sahel CDD statistics document to the approximately 600 decision-makers on ORANA's mailing list;

- fund the finalization, printing, and distribution of a fold-out poster on the physiopathology of diarrhea, to be used in training courses for health workers;
- compile, produce and distribute a list of CDD educational materials and articles on related themes.

PRITECH continues to be cautious in supporting new activities, mindful of the difficulty of sustaining activities after funding from external sources ends. Handling of Diarrhea Dialogue and related staff is the main recurrent cost likely to need continuing donor support; other activities are short-term contributions to the national programs in the Sahel which will not need continuing support. PRITECH will carry on its efforts to help mobilize donor support, for example, at the donor advisory group meetings convened by ORANA.

PAKISTAN

The PRITECH II program follows a three-year PRITECH I effort and provides a transition to the new Child Survival Project, with its five-person technical assistance team. Funding has been provided by the USAID for PRITECH's activities through November 1989; additional funding is needed to extend PRITECH, perhaps through June 1991. The centerpiece of the program is case management training for physicians, provided at a nation-wide network of Diarrhea Training Units (DTUs); new curriculum materials are being tested, staff have been hired for eight DTUs and training is well underway. PRITECH's role with the DTUs has been both administrative -- helping the GOP's National Institute of Health and USAID organize and supervise the program -- and technical -- introducing the curriculum, training trainers and working with WHO to assess the program. Other activities including development of communications materials, design of management information systems, helping plan ORS marketing, and conduct of operations research. These other activities have been useful, but have been given less attention than the rapidly expanding DTU effort.

For PY3, PRITECH will continue to support:

- establishment of DTUs, anticipating that by the end of PY3 at least eight units will be providing effective case management training and supervision, PRITECH's staff will be augmented with a resident Program Officer to help manage assistance to the DTUs.
- strengthening of NIH's capability to manage the program. A Pakistani physician is being added at NIH as a counterpart for PRITECH. PRITECH's role with the DTUs has become very prominent; during PY3, PRITECH's responsibilities will be shifted to the new Child Survival project

team. PRITECH's contribution to this transition of responsibility is an important task.

- 7 the communications area. There is a disagreement between the GOP and private agencies about the basis for payments which has stalled the program; PRITECH will push for resolution of this issue and help develop messages for broadcasting.
- operations research. PRITECH will take the lead in a study of home fluids, as a contribution to the policy discussion about the role of home fluids in preventing dehydration.
- private sector distribution of ORS. PRITECH will formulate a private sector strategy, which A.I.D. can support and the GOP can accept, to open up other routes to reaching families needing ORT.

PHILIPPINES

Beginning in from December 1988, the USAID/Manila funded the PRITECH project in the amount of \$252,000. The mission is in the process of making another buy-in of approximately \$240,000 to fund PRITECH assistance through December 1990. S&T/Health is providing \$100,000 of PRITECH technical assistance to the Philippines CDD program.

By placing a full-time resident representative in the Philippines in December 1988, PRITECH recognized that ensuring the timely provision of technical assistance to the CDD Program was essential to strengthening the capacity of the management unit and to increasing the impact of the national program. During PY2, PRITECH was called upon to provide a wide array of assistance. Funded by S&T/Health and the Mission, this included such activities as private sector commercialization of ORS, the logistics and management of ORS distribution, medical education, the establishment of a CDD/Child Survival Information Center, and continuing education for community pharmacists.

During PY3 the PRITECH representative will continue to assist the CDD program working full-time as a member of the CDD Program Management Team. He will provide overall operational/management assistance to the national program, coordinate the PRITECH short-term technical assistance, and assist in liaison with donors and NGOs. The representative will encourage interventions which can be sustained by the regions and provinces and by the NGOs, such as the Philippine Pediatric Society (PPS), the Philippine Pharmacological Association (PPhA), and the Association of Philippine Medical Colleges (APMC).

It is expected that during PY3 PRITECH will assist the Department of Health in sustaining and expanding interventions in the following areas:

- the timely procurement and distribution of ORS to all facilities within the DOH system;
- the inclusion of CDD/ORT in the PPhA program of continuing professional education for community pharmacists and in the curriculum of the sixteen colleges of pharmacy in the Philippines;
- the extension of the Association of Philippine Medical Colleges Foundation (APMCF) project to include enhanced teaching of CDD/ORT in additional medical schools;
- strengthening the function of the Child Survival Information Center;
- inter-project and inter-donor collaboration and cooperation, e.g., HEALTHCOM, WHO, and World Bank.

Additionally, PRITECH will assist the CDD Program as necessary in program problem solving studies and in the CDD Program's transition from USAID project specific funding (Primary Health Care Financing Project) to general health sector support funding (Child Survival Project) of CDD activities.

SAHEL REGIONAL OFFICE:

The continuation of Sahel Regional Office activities, which focus on the provision of technical and managerial support for the development and implementation of national CDD programs in six Sahelian countries, was authorized by S&T/H on February 6, 1989. A total of up to \$950,000 was approved to be expended over a four-year period. Most of that amount has already been obligated to PRITECH through buy-ins from the Africa Regional Bureau plus a buy-in from USAID/Bamako.

During PY2, the main functions of the Regional Office were: to monitor the Sahel country programs, to provide technical assistance from the PRITECH staff, to identify, brief and supervise short-term technical consultants, and to organize and conduct regional training activities. In addition, the Sahel Regional Office directed the development of training materials, such as the PRITECH/WHO intermediate level modules for nursing and other training schools. PRITECH consultants have assured the use of these modules in two nurse training schools in Niger, two in Burkina, three in Mali, one in Mauritania, and the midwives and regional nurse teacher schools as well as three schools for social sector staff in Senegal. Also, four schools in The Gambia have started using the English version of the modules. Other

training materials developed for national programs by the Sahel Regional office include a periphery level training curriculum for use in refresher training, and continuing education modules to be used during supervision, monthly meetings, and add-ons to other training courses. The Regional Office also directed a number of studies, such as the Health Facility Surveys conducted in Mauritania and Niger during PY2.

The Sahel Regional Office will continue to provide short-term technical assistance to the six country programs in PY3. Major activities will include:

- monitoring and evaluating the integration of PRITECH modules into training schools;
- conducting a study of the determinants of use of educational materials by health personnel in at least three of the Sahel country programs, and providing recommendations based on findings;
- finalizing the continuing education modules.

SENEGAL:

Authorization for PRITECH to provide technical assistance to the Senegal CDD Program was granted on February 6, 1989, following S&T/H's approval of a four-year program plan. Funding of up to \$820,000 for that period was approved. In PY2, the Mission provided a buy-in to PRITECH for \$231,000; however, only a very limited number of activities authorized by the MOH.

The MOH continues to be very cautious about pursuing program opportunities. Those activities which were authorized include a KAP study which was completed in July, the analysis of which has not yet been finalized, and a supervision trip to health facilities in the Fatick region, which revealed considerable confusion about case management, ORS stock-outs, and poor distribution of educational materials.

In PY3, PRITECH will continue to remain available to respond to MOH requests. Until a national coordinator is assigned, it will be difficult to mount a sustained effort to plan and ensure implementation of CDD activities. In the meantime, PRITECH will

- complete the analysis of the KAP and distribute the results;
- collaborate with the Mission to better define overall needs for communications and health information systems under its rural health project, which contains a broad PHC component.

Unexpended funds from the buy-in made in PY2 would be used to carry out mini-assessments to gather information that will be used to determine the scope of future technical assistance.

ZAMBIA:

The PRITECH II project started in Zambia in October 1988 with funding from S&T/Health up to \$400,000 over four years.

With the assistance of a full-time PRITECH Country Representative during the past three years considerable progress has been made in a wide variety of CDD activities in Zambia. PRITECH support has included a diverse array of research to answer key CDD program questions; purchase of raw materials for local ORS production; the design, production, and distribution of health education materials; use of the media (radio, popular theater); the provision of logistical, technical, and financial support for the ORT training unit at the University Teaching Hospital (UTH); technical assistance for training (an assessment of nurse training in ORT/diarrhea case management); and technical, logistic, and financial inputs for supervisory tours throughout the country.

During PY2 PRITECH has continued these activities with particular emphasis on improving case management, ensuring more effective program integration/coordination (i.e., establishment of child survival IEC committee, design of integrated growth monitoring/ child survival/ORT materials). Moreover, efforts have intensified in the areas of enhancing and improving current training of health workers at all levels, work on the health information network including ORS monthly returns has been stressed, and technical support for community-based ORT projects has been provided. In addition, PRITECH has been directly involved in program planning and evaluation.

While the CDD program has achieved a great deal over the past three years with the combined efforts of the Ministry of Health, WHO, UNICEF, and PRITECH, sustainability of these efforts will be hampered by Zambia's declining economic conditions. The most serious consequence is the rapid loss of physicians, nurses, and other trained health workers. It will be increasingly difficult to provide effective case management training, supervision, and CDD program management/coordination under these conditions. In view of this, PRITECH plans during the next phase to continue ongoing activities but to have interventions more focused on the priority issue of improvement of case management. This will involve a number of related activities such as training, supervision, operations research, and some aspects of social mobilization. In addition, PRITECH plans to work more closely with the Churches Medical Association of Zambia by appointing a physician to provide assistance and advice on case management.

In PY3 PRITECH will focus on the improvement of case management of diarrhea through both the MOH and CMAZ, emphasizing the following areas:

- Concentrate on improving case management through support of the UTH ORT training facility, through provision of training materials (e.g., Spanish language materials for the large numbers of Cuban physicians in Zambia), through encouragement for establishment of ORT corners in health centers throughout the country, through provision of a case management expert to monitor/assist with ORT case management in mission facilities, and by expanding community-based projects.
- Appoint a PRITECH-funded physician to the CMAZ who will work full-time on the case management of diarrhea in the CMAZ institutions throughout Zambia and will also assist with other CDD activities. It is hoped that the appointment of such a person would not only improve case management training but also enhance cooperation between CMAZ and the MOH.
- Develop and support a CDD supervisory network scheme to ensure better reporting and monitoring of activities including ORS distribution in each of Zambia's 57 districts.
- Achieve more effective social mobilization of ORT through use of all available media channels including involvement of political leaders and the Party organization.
- Strive for an integrated program by coordinating immunization, growth monitoring, primary health care/MCH, and CDD activities.
- Continue to support efforts to achieve CDD program sustainability through such channels as encouragement of private sector ORS marketing initiatives, alternate cost recovery/financing of ORS, training and utilization of health providers such as traditional healers, community health workers, traditional birth attendants, school teachers, community development workers to promote ORS/ORT, and coordination with NGOs/PVOs in any CDD and related child survival activities.
- Continue to carry out operations research on key program issues (i.e., feeding practices/diarrhea, case management by community health workers, and assessment of urban health care workers' case management.

III. HEALTH SYSTEMS SUPPORT

Estimated Costs
\$600,000

A. Overview

During PY2, the Health Systems Support component of the PRITECH II Project became fully operational as technical assistance formerly provided under the PRITECH I Systems Support drew to a close. During this past project year, short-term technical assistance was provided to a total of 20 countries in child survival, ORT/CDD and primary health care. Expenditures totalled \$743 thousand. The breakdown by funding source and project year is illustrated below. PRITECH II responded to requests from the USAID Missions, regional bureaus, S&T/Health, and the FVA office in the areas of project design, drug management and logistics, child survival workshops, and evaluation of PVO child survival projects. Of the 43 assignments conducted this past year, nine involved evaluations of PVO child survival projects.

Expenditures By Funding Source

	<u>Central</u>	<u>Buy-In</u>	<u>Total</u>
Project Year 1	\$ 15,938	\$ 99,415	\$115,354
Project Year 2	<u>215,141</u>	<u>528,589</u>	<u>743,731</u>
Total	\$231,080	\$628,004	\$859,085

In PY2, buy-ins continued to fund a majority of the assignments conducted under Health Systems Support. Twenty-seven of the 43 assignments, or 62% of the total, were covered by buy-ins. The remaining 16 were funded by central funds; of these 15: 6 were in Africa, 5 ANE, 3 LAC and 2 Inter-Regional. During this second year, buy-ins were received from USAID/Guatemala, Malawi, Mali and Chad. Additionally, the FVA Office, ANE Bureau, and S&T/Health provided funds for Health Systems Support technical assistance. Buy-in funding this second year totaled \$644,032. The regional breakdown of these buy-ins is as follows:

	<u>Amount</u>
Africa	\$134,514
Asia/Near East	100,000
Latin America	50,000
FVA	274,518
S&T/HEA	85,000

175

In PY2, 43 assignments were conducted in 20 countries and carried out by 102 consultants. A total of 52 person months of effort was provided. The regional and country breakdown of these assignments is as follows:

	<u>Assignments</u>	<u>Countries</u>
Africa	14	10
Africa/Near East	9	5
Latin America	12	5
Inter-Regional	<u>8</u>	<u>--</u>
Total	43	20

While in PY1 assignments were conducted exclusively in the Latin America and Inter-Regional areas, during PY2 technical assistance was provided in all regions. The largest percentage was in Africa, due in part to the three buy-ins from Mali, Chad, and Malawi. Additionally, three assignments were conducted in Africa under the FVA buy-in.

The FVA office continues to utilize Health Systems Support to support its child survival activities. During PY2, \$274,518 of buy-in funding was provided by the FVA Bureau. Assignments conducted included (1) evaluations of such PVO child survival projects as the SAWSO projects in Kenya and Haiti, Freedom from Hunger in Bolivia and Nepal, ADRA in Rwanda and Nigeria; (2) PVO child survival proposals review; and (3) child survival workshops in the U.S. and Guatemala.

Fourteen of the 43 assignments conducted this past year, or 32% of the total, were for the FVA office. Regional representation included:

Assignments for FVA Office

Africa	3
Asia/Near East	3
Latin America	4
Inter-Regional	<u>4</u>
Total	14

Over the first two years of PRITECH II, a total of 69 person months of short-term technical assistance has been provided. A balance of 181 person months remains for the life of the project, or approximately 60 person months per year.

During PY2, the tracking system for consultant reports was updated. Delinquent report lists are generated for both internal staff reviewers and A.I.D.. This management tool has been useful in monitoring the status of consultant reports.

176

The MIS system for tracking assignment costs, person months and PIO/Ts has been operational but further revisions are needed to track person months better, particularly for subcontractors, to monitor the project's program areas more accurately, and to differentiate better between buy-in and central funding. These revisions will be made in PY3.

During PY3 new staff will need to be hired. Two replacements are needed: one for the Financial Associate position and the other for the Senior Program Assistant. A third available position still needs to be defined. A job description will be developed and a decision made on the type of person to be recruited based on an assessment of project needs.

Of the 250 person months to be provided in the Health Systems Support component of the PRITECH II project, it is stipulated that the level of effort for each region be as follows:

<u>Region</u>	<u>Percentage</u>	<u>Number of Person Months</u>
Africa	25%	63
Asia/Near East	30%	75
Latin America	45%	112

Funding within each region can be from two sources: (1) central and (2) buy-ins. To monitor the Health Systems Support utilization rates, levels of use within each region need to be determined by funding source, person months, and costs. To monitor the Health Systems Support utilization rates, it is necessary to create two new categories from the "central" category, namely the FVA and S&T, to identify the technical assistance financed by these central divisions of A.I.D..

The regional funding levels by person months and the costs being projected for the final three years of the project are as follows:

<u>Region</u>	<u>BUY-INS</u>		<u>CENTRAL</u>		<u>TOTAL</u>	
	<u>Person Months</u>	<u>Costs</u>	<u>Person Months</u>	<u>Costs</u>	<u>Person Months</u>	<u>Costs</u>
Africa	30	300,000	20	200,000	50	500,000
Asia/Near East	36	360,000	24	240,000	60	600,000
Latin America	54	540,000	36	360,000	90	900,000
FVA	40	400,000	--	--	40	400,000
S&T	6	60,000	4	40,000	10	100,000
	166	1,660,000	84	840,000	250	2,500,000

177

B. Objectives

At the end of the PY3, the following will have been accomplished:

1. Health Systems Support will deliver 60 person months of short-term technical assistance.
2. PRITECH will hire and train Senior Program Assistant and Financial Associate.
3. The MIS system will be revised to fully track person months, monitor project program areas, and differentiate between buy-in and central funding.
4. Financial reports will be generated on all PIO/T expenditures and provided to Missions.
5. Regional funding levels by person months and costs will be prepared and approved for the project.
6. The tracking system for consultant reports will be implemented.
7. Maintain the consultant registry will be maintained..

C. Outputs

Planned outputs by quarter will be as follows:

First Quarter

1. Provide 15 person months of short-term Health Systems Support technical assistance.
2. Recruit and hire Senior Program Assistant.
3. Recruit and hire Financial Associate.
4. Develop job description for third available position.
5. Identify revisions needed on MIS system.
6. Implement consultant reports tracking system.
7. Maintain consultant registry.

Second Quarter

1. Provide 15 person months of short-term Health Systems Support technical assistance.

2. Train new Senior Program Assistant on management/administrative system for fielding consultants.
3. Train Financial Associate on MSH accounting system and MIS/PIO/T tracking system.
4. Recruit and hire staff for third available position.
5. Begin revisions on MIS system.
6. Update MIS with monthly financial data.
7. Generate and send financial PIO/TS expenditures reports to Missions.
8. Obtain approval for regional funding levels by person months and costs.
9. Implement the consultant reports tracking system.
10. Maintain the consultant registry.

Third Quarter

1. Provide 15 person months of short-term Health Systems Support technical assistance.
2. Test revised MIS system.
3. Update MIS with monthly financial data.
4. Implement the consultant reports tracking system.
5. Maintain consultant registry.

Fourth Quarter

1. Provide 15 person months of short-term Health Systems Support technical assistance.
2. Implement revised MIS System. Generate reports on person months utilization, program areas expenditures and funding levels for both buy-in and central funds.
3. Generate and send financial PIO/Ts expenditure reports to Missions.
4. Update MIS with monthly financial data.
5. Review and monitor regional funding levels by person months and costs.

6. Implement the consultant reports tracking system.
7. Monitor PIO/Ts.
8. Maintain consultant registry.

IV. RESEARCH & DEVELOPMENT

Estimated Costs
\$455,000

A. Overview

PRITECH is satisfied that focusing on the use of ORT for dehydration has brought about reductions in death and dehydration in numerous areas of the world. Yet, despite many successes it is clear that in many if not most of the countries where PRITECH is working, acute watery diarrhea continues to lead to dehydration and death much as it has in the past. Progress with ORT has been slower than anticipated. Many mothers and health workers now know about ORT, but in many areas of the world a significant "KAP-gap" exists. While the rhetoric of many diarrheal disease control efforts has included prevention of diarrhea, in fact most programs are not dealing effectively with preventive activities. In countries that have more successfully introduced ORT, problems of persistent diarrhea, dysentery and malnutrition are becoming more and more evident. At the same time Ministries of Health in many of the countries where PRITECH is actively involved are facing problems of addressing other priority health issues in the face of severe economic constraints.

Given these realities, PRITECH in this mid-Project year is re-assessing its approaches to strengthening country CDD programs. The Technical Unit's proposal for this year's workplan thus continues activities which PRITECH believes to be furthering this objective, but also includes a new approach for addressing some of these more complex issues. These are outlined briefly under the Technical Unit objectives. Some of these new activities will require a project amendment which will be delivered to A.I.D. under separate cover. The estimated costs given for each objective described below are levels of effort; specific budgets will accompany each activity when presented for approval.

B. Objectives

In the area of Research and Development, PRITECH hopes to achieve the following objectives by the end of the third project year:

1. The completion of products outlined for year three in last year's workplan; these are products (documents, papers) in support of PRITECH country programs and other CDD efforts;
2. The provision of effective technical support to sustained country programs;
3. The provision of technical support, liaison, and coordination to S&T/Health and other CDD related organizations, projects, and meetings;
4. The development and implementation of focused activities and interventions to achieve specific program impact in sustained and intermittent country programs;
5. The provision of selected information services to the CDD community (this will be covered in a separate section).

OBJECTIVE 1: THE COMPLETION OF PRODUCTS IN SUPPORT OF PRITECH COUNTRY PROGRAMS AND OTHER CDD EFFORTS

Estimated Cost: \$ 5,000

In PRITECH's year two workplan PRITECH proposed completion of several documents during the third project year. These included:

- a field guide for conducting studies of the accuracy of mixing/administration of Sugar Salt Solution (SSS);
- "ORT Is Best"
- field implementation aids on: persistent diarrhea, monitoring and evaluation, and participation of the non-governmental sector in CDD efforts.

Last year, PRITECH completed "ORT Is Best" and the field implementation aid on participation of the non-governmental sector in CDD efforts. Likewise, "A Field Guide for Conducting Studies of the Accuracy of Mixing/administration of Sugar Salt Solution (SSS)" was completed but not reviewed. The tasks for year three then are:

- review and final editing of the "Field Guide" on SSS
- completion of field implementation aids on persistent diarrhea and on monitoring and evaluation

121

OBJECTIVE 2: THE PROVISION OF EFFECTIVE TECHNICAL SUPPORT TO COUNTRY PROGRAMS

Estimated Cost: \$ 125,000

During the second project year PRITECH improved the effectiveness of its technical support of country programs. PRITECH has had positive feedback from field staff about this support and plans to continue last year's activities, as well as to focus on several new activities. In order to provide technical support to PRITECH country programs PRITECH will:

- provide regular technical input into PRITECH country programs
- support program problem solving studies (PPSS) in PRITECH country programs.
- update field staff skills.

A. Provision of Regular Technical Input into PRITECH Country Programs

During year two the technical and operations units established mechanisms for regular review and comment on field notes as well as review and comment on documents sent to Washington by field staff. Feedback from the field was positive. At the same time, PRITECH staff have recognized that the field notes alone do not provide a complete picture of the status of country programs. Therefore, in this year's workplan, PRITECH plans to continue the systematic review process, but it plans to also reassess and possibly change the reporting and review process to improve its effectiveness. The specific activities the Technical Unit proposes for this year under this component include:

- continued systematic review and response to monthly field notes
- continued review and comment on documents sent by field staff to PRITECH/Washington
- continued review and comment on PPSS protocols and draft reports sent to PRITECH/Washington
- assessment of PRITECH's existing field reporting and review approach for sustained country programs; instituting the changes necessary to improve the effectiveness of the review process
- technical assistance visits to the field by Technical Unit staff paid for out of ST/H funds when funds are not available through country programs.

B. Support of Program Problem Solving Studies (PPSS)

PRITECH will continue the support it has provided to PPSS studies in sustained country programs. PPSS funds will supplement country program resources to finance those studies which cannot be fully funded locally. PRITECH will continue to provide technical review of proposals for studies or other related PPSS documents even when the study itself is not funded by central funds if field staff so request. Finally, PRITECH will finance entire studies requested by sustained country programs when they meet the criteria established for PPSS and when approved by the CTO. In order to further the intent of PPSS or the resolution of implementation problems, PRITECH also proposes to finance two "non-study" activities when requested by the field and as appropriate:

- workshops or other mechanisms to disseminate findings of studies and to plan interventions arising from a study, and
- small test or pilot interventions of strategies developed as a result of a specific PPSS.

PRITECH will continue to gather reports and results from the many program problem related studies being conducted by each country, even when not supported financially by central S&T/H funds. It will also continue to share results, reports, protocols, etc. of PPSS from a given country with field staff from other countries.

C. Updating of Technical Field Staff Skills

PRITECH field staff are the key to the success of PRITECH interventions in CDD programs. PRITECH staff consist of expatriate staff, national staff and "major" consultants or consultants who spend a substantial amount of time in PRITECH country programs. They include physicians, health educators, and sociologists among others. Field staff along with counterpart staff are the ones who most directly confront and try to address difficult implementation problems. Participation in workshops, in observing successful experiences of others, in WHO training sessions, etc. can give PRITECH staff new ideas and a fresh vision of how to address the difficulties they may be confronting in their own program. PRITECH thus believes it is very important to support this type of activity to enhance the effectiveness of country interventions. This type of activity makes a permanent contribution to CDD which will remain in these countries long after expatriate technical assistance has terminated. PRITECH therefore proposes to continue support of this type of experience for its field-based technical staff members. The type of support proposed includes:

- participation in WHO program managers courses
- participation in WHO clinical courses
- observation/learning visits to the DTU effort in Pakistan or to other efforts in other countries
- participation in field staff workshops and meetings
- travel to Washington to work with technical staff on specific products (PPSS) or issues, etc.

OBJECTIVE 3: PROVISION OF TECHNICAL SUPPORT, LIAISON, AND UPDATE

Estimated Cost: \$ 125,000

A continuing important function of PRITECH's Technical Unit is the provision of technical support services to the S&T/Health Office in diarrheal disease control related areas. Likewise, PRITECH's communication and coordination activities with WHO, UNICEF, and other projects and organizations involved in CDD efforts are extremely important to make PRITECH CDD programs more efficient and effective. PRITECH will undertake the following activities in this regard:

- drafting and review of technical documents as requested by A.I.D. or by other relevant organizations
- participation in workshops, meetings, seminars as requested by A.I.D. and as deemed important to CDD
- participation in annual meetings with WHO and UNICEF, and in other meetings as relevant with CCCD, ADDR, WASH, HEALTHCOM, JHU, WELLSTART
- preparation, delivery, and possibly publication of papers concerning important CDD related topics at relevant national and international meetings; organizing field staff input into relevant meetings
- preparation of the Technical Literature Update
- preparation of other documents deemed to be of priority to CDD or to PRITECH efforts
- translation/production of selected documents of importance to CDD
- execution of up to three Task Force Meetings, restructured as described below.

- implementation of a contract-required study of sustainability
- organization and implementation of one or two contract-required selective evaluations.

In Project Year 3 there will be fundamental change in utilization of the Task Force. To date it has met on an annual basis and has dealt with a broad agenda of technical issues. As the PRITECH project has become more mature, a different type of advice is needed from the Task Force. Furthermore, a large annual meeting tends to cover similar items that the WHO TAG covers. We think that smaller and more frequent meetings would keep the scientific community better involved in PRITECH's priorities.

During the coming year there will be up to three meetings of experts who will review and advise PRITECH on specific single issues. Examples of issues to be considered would be how to test the appropriate messages for improving nutritional management of diarrheal diseases, protocols for improving nutritional management of diarrheal diseases, protocols for improving local knowledge of persistent diarrhea, problem solving approaches to integration of primary health services. The composition of each meeting group would include a representative from JHU and AED and three or four other participants to be mutually selected.

OBJECTIVE 4: DEVELOPMENT/IMPLEMENTATION OF FOCUSED NEW APPROACHES TO ACHIEVE MAXIMUM IMPACT

Estimated Cost: \$ 400,000

The future of CDD programs holds a number of exciting challenges that are relevant not only to the control of diarrhea but to all disease control endeavors. Many country CDD programs are now maturing into "middle age". They have been fairly successful at doing the "easy", i.e., in creating awareness of ORT, in developing training materials, in conducting training sessions for health staff and developing communications activities for mothers. Now it is time to focus on the more difficult aspects of achieving sustained behavior change in health workers and mothers. Some of the more difficult challenges and tasks ahead include:

- changing mothers' practices to effective use of ORT
- extending the reach of services beyond the public sector and improving the reach within the public sector
- changing health worker practices to effective case management; this involves not only using ORT effectively

181

but not using antidiarrheals and antibiotics inappropriately

- addressing complex issues of incorporating breast-feeding, nutrition, and other preventive actions into CDD efforts and of addressing to persistent diarrhea and dysentery more effectively.

The answers to these concerns are not immediately obvious. They are difficult issues to confront. Some countries are trying approaches which are more successfully addressing some of these issues. Others address less well. Yet it is PRITECH's assessment that if permanent changes are to be made in diarrheal morbidity and mortality, ways of addressing these issues must be found.

To deal with some of these more difficult implementation issues it is helpful to look retrospectively at the more successful experiences and identify the elements which might be the keys to achieving that success. Many of these may seem obvious. Yet, all too often programs do not strategically outline how they will address those elements which are key to achieving real change in their programs. Some of the lessons learned appear to be:

- The environment must be ready for real change to take place - in agricultural terms, the ground must have sufficient nutrients, moisture, light etc. for a seed to be able to grow and produce. Or, in other words, if the conditions are not appropriate, despite the greatest of efforts, these efforts will not bear fruit.
- A "critical mass" is often necessary for real change to occur. One or two lone individuals fighting the system or trying to change it will not have as great an impact as a larger group. Selection of the relevant members of this critical mass is also vital.
- The "critical" persons, key players or decision makers who influence whether certain actions can take place need to be convinced in order for system-wide behavioral change to occur; without enlisting them, change is likely to be minimal. Specific strategies are necessary for getting these key players on board -- this key activity is sometimes forgotten.
- "Choose your theme". Once the groundwork has been laid and the easier activities in CDD have been completed, focusing on selected areas where there is need and opportunity is more likely to achieve noticeable and lasting change; there is clearly a tension between an in-depth approach versus a broad spectrum approach. Focusing on strategic issues, however, brings with a

danger of abandoning other key activities necessary in CDD programs. Nevertheless, special focused efforts make it more likely reproduce results and more effectively use resources.

- To be successful, interventions need to be "actionable". One of the reasons programs may not yet be successful with nutrition and feeding interventions is because most programs do not yet have "actionable" interventions.
- "Hands on" training - no matter what the theme (case management, ORS distribution mechanisms, incorporating breast-feeding actions into programs) - appears to be critical for real behavioral change to occur; yet, this type of training is difficult to implement, lacks people who know how to do it.
- Individuals appear to learn much from careful observation or participation in similar experiences outside of their own environment; one can see more objectively when taken out of one's own environment; seeing other similar situations and solutions is a way of cross fertilizing and instilling new ideas to be used "at home". This type of exchange also has benefits for those being "observed" in that it is a source of positive feedback and of pride to "show off" your successes.
- Understanding mothers and health providers pre-existing attitudes and knowledge before designing training and communications interventions is essential for increasing the effectiveness of those interventions and the likelihood of behavioral change.
- CDD efforts are more effective when the CDD strategy involves public health sector all more providers of care.

PRITECH country programs are applying many of these principles in their country interventions. The PRITECH contract also contains a specific mechanism for approaching implementation concerns such as these - the use of program problem solving studies (PPSS). PRITECH believes that PPSS are indeed a valuable tool for country programs and CDD efforts. However, it believes that programs need to go beyond studying problems to exploring new ways of tackling them. Likewise, PRITECH country programs do not always have the flexibility to re-look at their country situations and to try out some new ideas or apply some of the principles noted above.

Therefore, PRITECH proposes in this year's workplan that A.I.D. support this special impetus to addressing some of the more difficult implementation issues. Support would involve the identification, development and testing of focused interventions

to deal with these critical issues in selected country programs when this support is not locally available.

The strategy the Technical Unit proposes for this activity involves:

- mini assessments of country programs to identify the presence of critical/difficult implementation issues, the potential for impact and the proposed approach for addressing the specific issue
- development and implementation of the specific approach.

A. Mini-assessments of Sustained Country Programs

Each sustained country program will be reviewed to identify the most pressing implementation issues or needs. Each of the issues will then be evaluated for the potential to do something about it and to identify the most relevant approach which might be taken to address it. This review process will include visits to countries only as needed. The result of this exercise will be to identify three to four country programs this year (or more if resources allow) where PRITECH will support these special focused efforts.

B. Development and Implementation of the Selected Approach

PRITECH field and Washington staff have identified a number of mechanisms based on the "lessons learned" above which they feel have strong potential for real impact on specific issues. There may also be other approaches staff have not yet identified. Some approaches may work for specific issues and not for others. Some may be appropriate in one country's context but not another. And, at this point they are ideas, not fully developed approaches specific for a given country and a given topic. These potential improvements need to be tried out in the field.

A list of possible approaches includes:

FOCUS ON CRITICAL MASS: PRITECH proposes that a large enough number persons from a given country would be involved in order to try to create a sufficient core of persons to implement the "desired" actions upon return to their jobs. Emphasis would be given to "hands on" training and actionable interventions. The issues which might be appropriate for this type of approach include clinical or program management, training of providers, incorporating breast-feeding actions, focusing on persistent diarrhea/dysentery, prescribing behaviors, or other issues. The type of approaches which might work for a "critical mass" include:

- 1) Clinical training through the WHO clinical course negotiated with WHO to focus on training many

practitioners from one country and to be supported by PRITECH if necessary

- 2) Observation/training workshops in the DTU approach in Pakistan for clinicians from other countries
- 3) Participation in the WELLSTART workshop in order to change hospital practices which negatively affect breast-feeding
- 4) Participation in the MSH essential drugs or ORSMAP workshops
- 5) Developing and implementing national or regional workshops on specific topics of concern such as "how to develop a communications strategy" or "how to market ORS". PRITECH would be responsible for supporting the organization, coordination, speakers, participants and follow-up of these workshops.

SUPPORTING NEW TRAINING APPROACHES: Most countries are struggling with ways to increase "hands on" training, to make training more participatory and to assure that training goes beyond rehydration to communicating with mothers, addressing nutrition, etc. Most do not have the flexibility to work on, develop and try new approaches. PRITECH proposes support of development and implementation of new approaches where relevant. Examples include:

- 1) Support of the development of DTUs where there is potential to change a fledgling DTU to one which could be a "star", particularly where that DTU might serve as another training resource for other countries; an example might be one of the DTUs in Cameroon
- 2) Support of the development of a more outpatient based DTU as in the Sahelian countries
- 3) Focus on the training of trainers issue in a new and innovative way. Focus would be on seeking new ways to address issues such as: how do you teach content and at the same time teach training methods? will the people who are supposed to be trainers always be the trainers? Etc.
- 4) Development of other training approaches such as the one being implemented by the Indian Pediatric Association, the development of videos, or implementation and evaluation of pilot training approaches

CROSS FERTILIZATION/INSTILLING NEW IDEAS: As noted above, many countries have successful experiences in some of the CDD program areas. Examples abound: drug distribution in Indonesia, changing the medical curricula in the Philippines, the DTU approach in Pakistan, the ORS producer marketing of ORS in Pakistan, banning anti-diarrheals in Tunisia, coordination of donors and others in Cameroon, the approach to the development of a communication strategy in Cameroon etc. Where other CDD programs are beginning to deal with similar issues, or there is the groundwork laid, visits to other countries for observation, learning, workshops, etc. can provide the stimulus for actions in their own situations. PRITECH proposes supporting where relevant:

- 1) observation visits
- 2) exchange visits
- 3) "apprentice" visits -- where an individual participates in a supervisory visit or task in another country but not as a consultant; an example is for the CDD program manager from Niger to go to Mauritania with the PRITECH SPM to conduct a field supervisory visit.
- 4) conferences to share experiences on selected issues

PRO-ACTIVE PPSS: There are a few issues which appear to be common to most CDD programs which are affecting the impact of program efforts -- examples include the difficulty in changing mothers' practices and the difficulty in changing physicians' prescribing patterns. PRITECH believes that only by understanding mothers and health providers' beliefs, attitudes, and practices regarding diarrhea and its treatment will improve the effectiveness of our interventions. Therefore PRITECH proposes to support qualitative studies on:

- 1) mothers' concepts of diarrhea and how they treat diarrhea focusing especially on concepts of volume; the question of the fathers role could also be addressed
- 2) mothers' use of home available fluids and feeding practices during diarrhea
- 3) physicians' prescribing behaviors.

PRITECH would also support test interventions after analyzing the results of these studies.

DEVELOPING PILOT OR TEST INTERVENTIONS: For many of the implementation difficulties countries face we do not have good answers or solutions. We do not have concrete actions to

propose. Examples include the areas of persistent diarrhea and dysentery, incorporating preventive activities into CDD, especially nutrition and breast-feeding. Yet dealing with these issues is critical to reaching our ultimate objectives. PRITECH would support the development and testing of small-scale interventions to try to address concerns such as these.

PRITECH proposes to support the development and implementation of the approaches selected on the basis of the assessments noted above.

OBJECTIVE 5: INFORMATION SUPPORT COMPONENT

Estimated Cost: \$200,000

In the last six years of the PRITECH Project, the Information Center's collection of technical documents pertaining to the control of diarrheal diseases and related health issues has grown to 2,800. The Information Center has now produced three annotated bibliographies of its holdings and thirty-four issues of the Technical Literature Update. During the past year, the Center began distributing French and Spanish translations of the TLU, provided technical assistance to two new child survival information centers in developing countries, increased acquisitions, and expanded dissemination activities.

As a result of an outside evaluation conducted in PY2, the Center assumed several new responsibilities: establishing central files for the project; writing the weekly activity reports to A.I.D.; and arranging for the translation, production, and distribution of key PRITECH reports. The Center will continue to respond to ad hoc information requests from A.I.D. and others. The major activity of the Information Center during the third project year will include:

- increasing the number and scope of acquisitions
- improving the effectiveness of dissemination
- expanding distribution of the Technical Literature Update
- supporting other information needs of the project

**A. Increase the Number and Scope of Acquisitions
(Estimated Costs: \$42,000)**

During PY3, the Information Center will improve acquisitions procedures, improve the quality of exchange relationships with information centers both here and overseas, and increase computer efficiency. The Information Center will continue to acquire at least 50 new documents a month, focusing particularly on CDD program implementation, social marketing, health education, role of the private sector in ORS production, behavioral science, and materials produced in the field, as well as technical articles on ORT. The Center will obtain these documents through the ISI data

base, POPLINE, PRITECH consultants and field representatives, and its own searches on MEDLINE. In addition, the Center will capitalize on contacts made with INCAP and ORANA earlier in the project to obtain Spanish- and French-language materials. The Center will also use its information exchange agreements with overseas and domestic information centers and PVOs to obtain CDD documents.

In order to retrieve technical articles from developing country medical journals, the Center will continue to conduct the searches on MEDLINE which it began in 1989. In addition, a staff member will take a training course in order to begin searching the wide range of data bases available through DIALOG.

Since SCIMATE, the Center's bibliographic software package is no longer being sold, the Information Center staff will assess the feasibility of converting its database to PROCITE, another software package. If judged feasible, this step will make PRITECH's system fully compatible with those in Pakistan and the Philippines.

B. Improve the Effectiveness of Dissemination
(Estimated Costs: \$98,000)

This year, the Information Center plans to improve dissemination by continuing to respond in a timely fashion to information requests; disseminating the third annotated bibliography; exhibiting at conferences; and arranging for the translation, production, and dissemination of key PRITECH reports.

The Information Center will continue to respond to approximately 50 requests a month from researchers, physicians, project implementors and others from developed and developing countries. In addition, the Center will handle document requests for approximately 200 documents a month from the recipients of the Monthly Acquisitions List. Recipients of the list include A.I.D. HPN officers, PVOs, A.I.D./Washington, PRITECH field staff, and child survival information centers. The Center will continue to send out mass mailings to country representatives and HPN officers and to send PRITECH consultant reports to outside data bases and organizations. In collaboration with the Senior Program Assistant, the Center will improve the internal tracking system of consultant reports.

In order to make its collection more accessible to those in the field, the Information Center will print and disseminate its third annotated bibliography of holdings, consisting of those documents acquired between January 1988 and May 1989. An additional addendum will be developed during the year and

finishes during the summer of 1990. The bibliography will be sent to PRITECH country representatives and others working in developing countries.

The Information Center will continue to maintain the computerized information request log established in late FY89. The log will enable the Center to produce statistics on the number of requests handled monthly, subjects and documents of most interest to users, addresses of users, and the turnaround time in response to requests. These statistics will appear in the PRITECH Annual Report each year.

As a new responsibility, the Center will arrange for the translation, production, and distribution of key PRITECH reports. This new activity will enable CDD field staff in French- and Spanish-speaking countries to make full use of PRITECH's technical reports for the first time.

Finally, the Information Center will provide background information for PRITECH conferences and will manage PRITECH exhibits at international health conferences.

C. Expand Distribution of the Three Language Editions of the Technical Literature Update
(Estimated Costs: \$46,000)

During PY2, distribution of the three versions of the TLU reached 6,000, including those sent out by ORANA. Distribution will continue to grow at a fast rate during PY3, partly because of the new Spanish and French editions. The Center will continue to arrange for translation of the TLU into French and Spanish and will continue to distribute the Spanish edition, while ORANA will distribute the French edition. During PY3, the new language editions will be advertised in Avances en Supervivencia Infantil and the French and Spanish editions of Dialogue on Diarrhea.

D. Support the Information Needs of the Project
(Estimated Costs: \$14,000)

During PY3, the Information Center will become much more integrated into the activities of the project as a whole. First, the Center will establish and maintain central files for the project, which will include country program documents, outgoing correspondence, project documents such as annual reports, and information on other child survival organizations. For the first time, the project's files will be arranged systematically in a single location, facilitating searches for documents on a particular country. Establishment of the files will particularly benefit new staff members and outside evaluation teams.

Second, the Center will produce the weekly activity reports to A.I.D., which highlight PRITECH's achievements both in Washington and in the field. Third, the Center will provide the documentation for the project's Technical Advisory Group meeting, tentatively scheduled for February 1990, as well as PRITECH's Task Force meeting. Fourth, the staff will better serve PRITECH field representatives by including news of their activities in the Monthly News Bulletin and by sending them selected documents with memos summarizing the contribution made to CDD.

The Information Center will continue to respond to information requests from field representatives and PRITECH/Washington staff.

V. MANAGEMENT

Estimated Costs
\$1,845,000

A. Project Organization and Leadership

1. Management Team

Management of the project is the responsibility of a team consisting of the Project Director, the Technical Director, the Deputy Director, the Chief of the Technical Unit, the Chief of Operations and the Chief of Finance and Administration. Official communication with A.I.D., including the Office of Health and the C.T.O., will occur through the Project Director on all matters. Similarly, the Project Director will handle official communications with MSH and the sub-contractors. Management of country programs is assigned to Senior Program Managers who are supervised day-to-day by the Deputy Director and Chief of Operations; however, SPMs and Country Representatives send their reports directly to the Project Director.

Until the Director and Technical Director positions are filled, management responsibility remains with the rest of the Management Team with Bob Simpson designated as Acting Director. MSH has agreed to provide Dr. David Sencer as the interim Technical Director; although Dr. Sencer will continue to reside officially in Boston, he is working virtually full time at PRITECH/Washington. John Alden, the former Director, is devoting about 40% time to assisting the Management Team.

2. Organization of the Washington Office

The Technical Director position is being redefined, following Dr. Robert Northrup's resignation at the end of PY2. The position is being shifted from the Technical Unit to work

with the Project Director in providing leadership for the entire project. The Technical Director will have broader responsibility for the technical quality of all project activities, with line authority on technical matters. Responsibility for managing the Technical Unit has been assigned to Dr. Martita Marx, as Chief of the unit. The Deputy Director will supervise the Operations Unit and the field staff with the Chief of Operations. In the absence of the Director, the Deputy Director will be in charge of administering the project. The Finance and Administration Unit functions as before, supervised by the Program Officer. A current organization chart and statement of functions for the Washington units is appended.

B. Program Management Workload

A top priority for the management team is a realistic analysis of the financial status of the project. With the help of John Alden and diligent effort by the financial staff, the financial picture is emerging. Looking ahead, the responsibility for public sector programs in Asia is being picked up by new teams funded by bilateral child survival projects, allowing PRITECH to shift its attention to the opportunities in the private sector. New program opportunities in eastern and central Africa and in Latin America require programs designed to respond to needs in each of these geographic regions.

A strategy which defines new approaches is outlined above. The task of translating the strategy into operational activities is difficult, especially with only half the project period remaining. The responsibility for designing new program activities is mainly on PRITECH's senior managers in Washington and the field, with substantial help from a few consultants who already know PRITECH well. Funding decisions, of course, will be made by A.I.D. The management team will carefully choose program activities for development, taking into account the management burdens of design and implementation. Implementation of programs will have to depend heavily on outside groups which have administrative capability in addition to technical expertise, especially because the time remaining in the contract to get programs underway is getting short.

C. Financial Reporting System

The PRITECH II contract imposed more financial reporting requirements than did PRITECH I, with detailed accounting based on PIO/Ts and contract amendment budgets. The entire financial reporting system for the project is being redesigned. More timely overall financial status reports are needed by PRITECH managers. Quarterly reports of spending against buy-in budgets have been promised to USAIDs and A.I.D. office. Reports for these purposes are expected early in PY3, with regular reports to follow. There is considerable lag time inherent in MSH

accounting reports to A.I.D., which have high standards of accuracy for payment purposes. For financial management purposes, we believe figures with 95% accuracy would be adequate and could be produced with less delay; however, additional effort will be required from the financial staff at PRITECH.

D. Technical Advisory Group Meeting

The contract calls for an annual meeting of the Technical Advisory Group (TAG), the body composed of experts in ORT/CDD and officials of A.I.D. This meeting is scheduled to take place in Washington during February 1990.

E. Mid-project Evaluation

As stipulated in the contract, A.I.D. will carry out a mid-project assessment of PRITECH II in PY3. To facilitate the implementation of the evaluation(s), which may take place in the third quarter of PY3, project staff will need to bring together and make available a range of documentation. Staff will also need to take some time from their normal routines to interact with members of the evaluation team.

F. Collaboration/Coordination with other projects

PRITECH will continue to seek opportunities to join with other A.I.D. contracts in activities of mutual interest, for example, working with Healthcom in the Philippines, with WASH in Uganda, with Nutricom in the Sahel, and with ISTI on child survival data analysis PRITECH will share reports and information, through the Information Center. PRITECH will participate in coordination meetings.

G. Contract Clarifications

A review of activities carried out during the first two years of the project suggests that certain areas of the contract need to be clarified to reflect operational realities. PRITECH will submit a request for clarifications. This management reports required by A.I.D. will be redefined according to current needs.

PRITECH II PY3 WORKPLAN BUDGET
Estimated Expenditures

I. Country Programs	<u>2,270,000</u>
Sustained	1,440,000
Intermittent	400,000
Ad-hoc	20,000
Regional	295,000
Promotion/Strategies	115,000
II. Health Systems Support:	<u>625,000</u>
A. Technical Assistance	600,000
B. Conferences - Supported	25,000
III. Research and Development Program	<u>355,000</u>
A. Research and Development Program	655,000
1. R&D Activities	(455,000)
2. Conferences - Sponsored	(200,000)
B. Information Center	200,000
IV. Management	<u>1,845,000</u>
 TOTAL:	 <u>5,595,000</u>

Principal Activities by Quarter

<u>Activity</u>	<u>Quarter</u>
1. Technical Advisory Group Meeting	
Organize	1
Convene (February 16, 1990)	2
2. Mid-project evaluation	
Define Terms of Reference	2
Document preparation	2-3
Team briefing/implementation	3-4
3. Recruit Technical Director	
Prepare job description	1
Identify likely candidates	2-3
Recruit and hire	3-4
4. Expand and Consolidate Eastern/Central Africa Operations	
Determine likely countries/define interventions	2-3
Establish Regional Office (Nairobi)	2
Secure Regional Bureau and Mission Support	2-4
5. Presentations to USAID	
S&T/H and Regional Bureaus	1, 2, 3, 4
6. Contract Modifications	
Prepare and submit draft	1
Discuss with S&T/H	1
Submit final version	
7. Financial Management System	
Revise existing system	1
Prepare and submit quarterly reports	2, 3, 4
8. Project Reports - Management	(See Annex 6)
9. Subcontractor Performance	
Monitor quarterly	1, 2, 3, 4

PRITECH II WORKPLAN
FY 1990:PY3

COUNTRY	APPROVAL STATUS *	PROGRAM PERIOD	PROGRAM BUDGET (BUY-IN)	PROGRAM BUDGET (S&T/H)	CATEGORY	A.I.D. CHILD SURVIVAL
REGION: AFRICA						
Sahel:						
BURKINA FASO	(A)	06/05/89	10/88 - 8/92	\$400,000	Sustained	
CHAD	(A)	07/05/89	7/89 - 6/90	\$100,000	Ad hoc	
GAMBIA	(A)	02/06/89	10/88 - 8/92	\$200,000	Intermit.	
MALI	(A)	02/06/89	10/88 - 8/92	\$1,200,000	Sustained	X
MAURITANIA	(1) (A)	02/06/89	10/88 - 9/89		Intermit.	
	(2) (A)	01/03/90	10/89 - 8/92		\$100,000	
NIGER	(A)	02/06/89	10/88 - 8/92	\$639,500	\$150,000	Sustained
SENEGAL	(A)	02/06/89	10/88 - 8/92	\$820,000	Intermit.	X
ORANA	(A)	06/05/89	10/88 - 8/92	\$650,000	Intermit.	X
Regional:	(A)	02/06/89	10/88 - 8/92	\$950,000		
Central & Western:						
CAMEROON	(P)	01/05/90	11/88 - 8/92	\$1,147,000	Sustained	
GHANA					Int. Cand.	
GUINEA					Int. Cand.	
NIGERIA					Ad hoc	
RWANDA					Int. Cand.	
Eastern:						
ETHIOPIA					Int. Cand.	
KENYA	(A)	07/11/89	7/89 - 8/92	\$571,000	\$344,000	Sustained
MADAGASCAR						Int. Cand.
SUDAN	(A)	06/03/88	10/88 - 9/90**	\$175,000		Sustained
UGANDA						Sus. Cand.
Southern:						
MALAWI					Int. Cand.	
MOZAMBIQUE					Int. Cand.	X
ZAMBIA	(A)	01/04/90	10/88 - 8/92		\$883,482	Sustained
ZIMBABWE						Int. Cand.

* (A) = Approved; date of approval
(P) = Plan submitted; date submitted

**Program interrupted by Brooke Amendment

PRITECH II WORKPLAN
FY 1990:PY3

COUNTRY	APPROVAL STATUS	PROGRAM PERIOD	PROGRAM BUDGET (BUY-IN)	PROGRAM BUDGET (S&T/H)	CATEGORY	A. I. D. CHILD SURVIVAL
REGION: ASIA/NEAR EAST						
Southeast:						
INDONESIA	(A)	04/20/88	10/88 - 9/89	\$667,000	\$100,000	Sustained X
PAPUA N.G.						Ad hoc
PHILIPPINES	(A)	11/09/89	10/88 - 12/90	\$491,206	\$100,000	Sustained
South:						
BANGLADESH						Int. Cand. X
INDIA						Int. Cand. X
NEPAL						Ad hoc X
PAKISTAN	(A)	01/19/89	01/89 - 12/90	\$1,061,953		Sustained X
West:						
JORDAN						Ad hoc
TURKEY						Int. Cand.
N. Africa:						
EGYPT						Int. Cand. X
MOROCCO						Ad hoc X
TUNISIA						Ad hoc

53

100

PRITECH II WORKPLAN
FY 1990:PY3

COUNTRY	APPROVAL STATUS	PROGRAM PERIOD	PROGRAM BUDGET (BUY-IN)	PROGRAM BUDGET (S&T/H)	CATEGORY	A.I.D. CHILD SURVIVAL
REGION: LATIN AMERICA/CARIBBEAN						
South America:						
BOLIVIA	(A)	10/19/88	10/88 - 8/92	\$360,676	Intermit.	X
BRAZIL					Ad hoc	
ECUADOR					Ad hoc	X
PERU					Int. Cand.	X
Central America:						
GUATEMALA				\$500,000	Int. Cand.	X
HONDURAS					Int. Cand.	X
MEXICO	(A)	11/10/88	10/88 - 8/92		Sustained	
INCAP	(A)	08/10/88	10/88 - 8/92		\$100,000	Ad hoc

TOTAL PROGRAMS:

SUSTAINED:

Approved: 11
Candidate: 1

INTERMITTENT:

Approved: 5
Candidate: 15

AD HOC:

10

54

101

Project Personnel
(Professional)

<u>Name</u>	<u>Position Title</u> <u>(contract)</u>	<u>Position Title</u> <u>(current)</u>
Vacant	Project Director	Project Director
David J. Sencer	Technical Director	Technical Director (interim)
Robert C. Simpson	Deputy Director	Deputy Director/ Director for Country Programs
Jane Brown	Prog. Specialist	Chief Operations Officer
Peter Spain	Prog. Specialist	Operations Officer
Karen Davis	Prog. Specialist	Operations Officer
Camille Saade	Technical Specialist	Social Marketing Specialist
Danielle Grant	Management Systems Specialist	Chief Financial and Administrative Officer
Martita M. Marx	Prog. Specialist	Chief Technical Officer
Lawrence Casazza	Technical Specialist	Technical Officer
Elizabeth Herman	Technical Specialist	Technical Officer
Karen White	Information Manager/Editor	Information Manager

202

Project Structure and Personnel

The current project organizational structure has been in effect during the first two years of project operations; no major structural changes are anticipated during PY3. Currently, the project is managed in Washington by a team composed of the Project Director, the Technical Director, the Deputy Director and the heads of the Operations, Technical, and Financial and Administration units. Management in the field is provided mainly by the Senior Program Managers. The field staff reports through the Operations Unit.

The Technical Unit (TU) is managed by Dr. Martita Marx and comprises the staff to routinely monitor, analyze and provide technical input on the country program interventions designed to control diarrheal disease. TU staff are responsible for ensuring the consistency and quality of the technical components of the project. The TU has the following primary responsibilities in the PRITECH Project:

To serve as the main repository of ORT/CDD technical information for A.I.D.'s Missions and Bureaus.

To provide technical support in the design, implementation, and evaluation of the clinical, social science, etc. aspects of the PRITECH interventions in ORT/CDD.

To manage the PPSS and other innovative activities to solve local problems which may have broader application for other countries.

To assess routinely and ensure the quality of PRITECH's activities, and, through contacts with WHO/CDD, UNICEF, and other A.I.D.-supported activities in Child Survival, keep the project abreast of the latest developments in ORT/CDD.

To collect, analyze, and disseminate technical information on ORT/CDD and to publish the Technical Literature Update (TLU) on Diarrhea through the Information Center.

To support the activities and serve as the secretariat of the PRITECH Task Force, the project's expert panel on ORT/CDD.

The Operations Unit (OU) is managed by Jane Brown and is staffed with professionals experienced in the management of development assistance programs. The OU has the following primary responsibilities in the PRITECH Project:

203

To manage the development and implementation of the PRITECH ORT/CDD components of country programs (sustained, intermittent and ad hoc)

To supervise and support the field staff charged with ensuring that PRITECH assistance is provided as defined in a timely manner.

The Financial and Administration Unit (FAU) is managed by Danielle Grant. Staff are charged with the implementation of the Health Systems Support component of the project, the preparation of financial reports, and the execution of general administrative functions. The FAU has the following primary responsibilities:

To implement the Health Systems Support component of the PRITECH Project.

To provide administrative support to PRITECH field and Washington-based staff.

To monitor the activities of the subcontractor responsible for organizing and implementing the conferences called for in the contract.

To prepare and forward routine financial reports and to facilitate the preparation and submission of the program reports called for in the contract.

To develop and maintain a roster of consultants in ORT/CDD.

The titles of the current core staff do not always correspond with those stipulated in the contract. As indicated in Annex 3, there are currently four (4) Technical Specialists and three (3) Program Specialists. While the Technical Specialists continue to provide the expertise called for in the contract, their job descriptions have been expanded to incorporate the responsibility to provide assistance in the case management and other program aspects of diarrheal diseases to PRITECH country programs. It should be emphasized, however, that in spite of the position modifications, the responsibilities defined in the contract are being discharged as proposed.

During the first two years of the project, it became apparent that there was a need to augment the technical aspects of the country programs, complementing the existing operational support being given. Two physicians were hired to fill this need. Their major responsibilities are to provide rapid and more continuous technical advice to the country programs and to monitor program quality. Also, in recognition of the need for greater involvement of the private sector, a specialist with

expertise in the marketing of basic health products, principally oral rehydration salts (ORS), was recruited as proposed in the contract.

225

Management Reports

<u>Report (contract)</u>	<u>Report (current)</u>	<u>Frequency</u>
Annual Implementation Plan	Annual Workplan	Annually
Annual Project Report	Annual Report	Annually
Monthly Summary Reports	Quarterly Highlights	Quarterly
Biweekly Country Activity Reports	(deleted)	(deleted)
Monthly Financial Reports	Quarterly Financial Reports	Quarterly to Missions and Monthly to
S&T/H		
Field Reports		Monthly or as stipulated

